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'On the path, off the trail':

The relational work of nurses in outreach health

A thesis presented in partial fulfilment of the degree of
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Abstract

This research study draws on the practice reflections of nurses working with people who are homeless and experiencing mental health problems to explore engagement as a core nursing practice in this setting. Therapeutic relationships and engagement are at the heart of nursing practice, and this is especially so in mental health nursing. Homeless and hard-to-reach clients are an underserved population for mental health services. This research seeks to 'make visible' the ways in which mental health nurses uniquely and successfully engage with people experiencing homelessness and marginalisation, which in turn contributes to improved health and social outcomes for those people.

Eight New Zealand registered nurses were interviewed and critical thematic analysis used to interpret the resulting data. The research findings were that nurses practicing in this specific homeless health context value relationships as a core nursing intervention. The work of engagement was described as uncertain. The research participants echoed the nursing theory and literature that argues nurses' relational work is often unseen and undervalued within health systems. Relational work is described as a defining concept for mental health nursing yet the lack of visibility of this skilled work adds to nurses' experience of uncertainty. The recommendations suggest ways to render visible and hold central the nursing work of engagement.

“The relentless complexity of the world is off to the side of the trail.”

Gary Snyder (1990, p. 145)

from the essay *On the Path, Off the Trail*.

“You do not know what wars are going on down there / where the spirit meets the bone.”

Miller Williams (1997, p. 55)

from the poem *Compassion*.

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*She stares
over my left shoulder
into blank corners
and seems to watch
who knows what
bright travellers.*

Fiona Benson (2014)

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Chapter 1

Introduction

I recall visiting the downtown city mission to meet a so-called hard-to-reach client. I was told that he had gone round to the beach. 'Which beach?', I asked a little despondently, assuming I would need to return another day. But no, he was not at the beach. He was at 'the beach', the sheltered sunny side of the mission building that ran alongside the length of car park. I was led around to the beach and introduced, then spent a pleasant while sat alongside this 'hard-to-reach' man, our backs against the warm brick, eyes lidded against the afternoon sun. Later, when writing my nursing notes back at the office, I documented my outreach contact and a summary mental state assessment. I did not mention the beach or the sun warmed bricks, and my nursing plan was simply to continue engagement. The opacity of such nursing interventions – the day-to-day relational work of community mental health services – is an ongoing curiosity for me.

- *Reflective practice journal (16/04/13)*

The human experience of health and illness is shaped, in part, by the caring actions of others. For nurses, this care happens within therapeutic relationships, which have been described as central to nursing practice. This research looks at the relational work of nursing within a particular health service context, that of providing mental healthcare to people experiencing homelessness. This research interest arises from the researchers own reflective practice as a mental health nurse working within an engagement-focused service model. Therapeutic relationships are intrinsic to nursing practice and my own experience has underscored the importance of engagement as a nursing approach. People experiencing homelessness are considered to be a population that is underserved by health and social services. This research explores the use of engagement as a nursing skill and practice for this hard-to-reach population. A brief overview of this practice context will be presented before reviewing current literature on therapeutic relationships, nursing engagement and homelessness.

Reflective practice is considered to be an important part of nursing. Fyers and Greenwood (2016, p. 29) offer a framework to guide nursing reflective practice asking: "What? So what? Now what?" For this research, the *what* is that marginalised and socially excluded people can experience difficult engagement with mainstream health services (Wright, Callaghan & Bartlett, 2011), and people experiencing homelessness are known to disproportionately experience mental health problems and coexisting substance use problems (Smith, 2007). *So what?* It is therefore useful to consider how mental health

nurses successfully engage with people experiencing homelessness in order that they provide quality nursing care to this marginalised group. Investigating this relational work will shed light on its importance to effective nursing practice within this specific clinical setting, with the intention of informing nursing practice for other vulnerable or hard-to-reach populations. DeFrino (2009), Hartrick (1997) and others argue that interpersonal practices have been submerged or devalued as a central component of nursing practice. This research seeks to 'make visible' the ways in which mental health nurses uniquely and successfully engage with people experiencing homelessness and marginalisation, with the assumption that this may contribute to improved health and social outcomes for those people.

The researcher's interest in the research topic

I am a New Zealand (NZ) Registered Nurse (RN) working in community mental health and homeless health services for the past decade. Since becoming an RN, I have developed an interest in nursing history and professional identity, including the central role of therapeutic relationships. The NZ nursing scholarship of O'Brien (2001; 2000; 1999), and Barker and Buchanan-Barker's (2005) Tidal Model both whet my appetite for further exploration of the relational work of nurses, especially working as I do in an explicitly engagement-focused model of community mental health. In my practice experience, therapeutic relationships and engagement are important nursing skills but perhaps receive insufficient clinical reflection in this NZ practice setting. My perception is that this valuable nursing work is somewhat taken for granted and yet, as O'Brien (2001, p. 135) asserts: "The therapeutic relationship may be the core concept by which nurses define their contribution to care".

Interpersonal relationships between nurse and patient or service user have been asserted as central to nursing practice since Peplau's (1952/1988) seminal text was published in 1952. This has become a question of professional identity, especially for mental health nurses. O'Brien (2001, p. 135) suggests: "Perhaps more than any other discipline in mental health, nurses are being challenged to articulate their distinctive contribution to mental health care". Raingruber (2003) argues strongly for mental health nursing as a profession to identify with relationship as a core intervention, rather than pursue a biomedical focus that is the work of psychiatry. This research study will draw on the practice reflections of nurses to explore engagement as a core nursing practice.

The significance of the study

This research inquiry echoes Barker and Buchanan-Barker's (2005) fundamental question – what do people need nurses for? People experiencing both homelessness and mental health problems may face compounded trauma and victimisation, cultural and social exclusion, uncertainty and vulnerability. Access to health care and standard nursing interventions is complicated by itinerancy and insecure housing. This combination of factors constructs a *hard-to-reach* population (McMahon, 2009) who can remain disengaged from health services despite assertive attempts by the 'helping professions' (Burns, Robins, Hodge & Holmes, 2009; Smelson et al., 2013). Furthermore, people experiencing homelessness may not receive the full range of therapies available to domiciled citizens and expected of a contemporary mental health service. For example, when the London homeless service St Mungo's sought service user feedback from those seeking support with their mental health, they found that 42% were offered medications, 22% were offered psychological/talking therapies, and only 17% felt they experienced empathetic listening and understanding (Bilton, 2009, p. 22). A reflection on the therapeutic approaches to mental health nursing for homeless clients and the place of engagement with this population is a motivation of this research inquiry.

There has been considerable research on the health and social needs of people experiencing homelessness (Gillig & McQuisition, 2006; Nikora, Hodgetts, Groot, Stolte & Chamberlain, 2012; Scanlen, 2009), where integrated, collaborative and trauma-informed services are considered best practice (Guarino et al., 2009; National Health Care for the Homeless Council, 2013). In the past decade there has also been significant study of homelessness as social phenomenon in New Zealand, including pathways into homelessness and as a lived experience (Bukowski, 2009; Groot et al., 2008; Hodgetts, Radley, Chamberlain, & Hodgetts, 2007; Hodgetts, Stolte, Nikora & Groot, 2012; Leggat-Cook, 2007). However, specific evidence-based practice models for mental health care are less well described and *nursing* practice for this marginalised and vulnerable population is largely absent from local social science literature. Nurses are providing health care at the street level of homeless outreach and health service provision in New Zealand, and yet this nursing work appears not well understood or represented within the homeless sector. This research project will explore this specific nursing work, drawing on the described practice experiences of New Zealand Registered Nurses working in this setting.

The research questions and aims of this study

This research aims to understand more about the nursing care provided to homeless mental health service users. The research is undertaken as partial fulfilment of requirements for a Masters (MPhil) program at Massey University School of Nursing. The researcher is a Registered Nurse who has worked in the Community Mental Health and Homeless sectors for many years and currently Clinical Team Leader of an intensive community mental health outreach service.

This research study is motivated by the perceived knowledge gap regarding the nurse experience of engagement and therapeutic relationships with homeless service recipients. Mental health is strongly correlated with homelessness – as both determinant and consequence – yet there are no specific guidelines for mental health nursing best practice within the New Zealand homeless sector. This research focuses on nursing care for people experiencing both homelessness and mental health problems, as described and reflected upon by nurses working in this field, in order to give voice and visibility to this nursing work. It is hoped that this research will also provide useful reflections for nursing practice for hard-to-reach populations more generally. The lived experience of homelessness and the social politics of housing and exclusion are beyond the scope of this project, as is an in-depth examination of health inequalities in New Zealand. There is substantial existing research on homelessness as social phenomenon and as a determinant of poor health outcomes (see for example Hodgetts, Radley, Chamberlain & Hodgetts, 2007). Therefore, rather than conduct further research *on* homeless people as subjects, I am interested in the unique aspects of the practice of nursing care *for* this population.

The research questions:

- What is the nursing experience of engagement with people who are both homeless and experiencing mental health problems?
- What are the challenges and specific nursing practice issues when providing mental health care to this population group?

The research aims are to describe and reflect upon nursing engagement with homeless clients as a health intervention, to improve the visibility and understanding of engagement

as a nursing intervention, and to inform nursing practice and contribute to the literature on mental health nursing and homelessness.

The Structure of the Thesis:

Chapter one introduces the research topic, as well as the research questions and aims.

Chapter two presents a background to the practice context, which is nursing outreach for people experiencing both homelessness and mental health problems.

Chapter three presents a review of nursing literature on engagement, therapeutic relationships and the relational work of nurses.

Chapter four describes the research method and design of this study using critical thematic analysis.

Chapter five presents the findings from analysis, which fall into two major themes: *Valuing Relationships* and *Working with Uncertainty*.

Chapter six presents a discussion of the findings, with reference to the practice context, theoretical influences and nursing literature. Recommendations arising from this research, as well as acknowledged limitations with this study, are also presented in this chapter.

Chapter seven provides conclusions to this research.

This Introduction chapter has introduced this research study, which investigates the experience of engagement as a core nursing practice. This research focus is informed by the researcher's own experience of community mental health nursing, and by the perception of homeless service users as being hard-to-reach (McMahon, 2009) and often poorly engaged with services (Ross & Reicher Gholston, 2006). The following chapter provides background on the nursing practice context of mental health and homelessness.

Chapter 2

Background: Homelessness and mental health

This research examines the experience of engagement for nurses working with people who are both homeless and experiencing mental health problems. This research is therefore situated within a particular practice setting, and this chapter will provide a background for nursing in this context. This nursing setting has its own unique characteristics and challenges and this background is provided in order to contextualise the practice experiences described by the participants in the Findings chapter.

The term 'homeless' refers to a range of un-housed or poorly housed living conditions, from primary homelessness as 'rough sleeping' or 'rooflessness'; secondary homelessness as the use of night shelters or emergency accommodation; and tertiary homelessness as insecure tenancies and 'sub-standard' accommodation such as some in hostels or boarding houses (Leggat-Cook, 2007; Richards, 2009). A lack of specific data regarding the homeless population has created difficulties for social and health services meeting this need, including the sector-wide argument for adequate funding (Leggat-Cook, 2007; Richards, 2009; Statistics New Zealand, 2009). Statistics New Zealand (2009), in consultation with the homeless sector, developed a new four-tier definition of homelessness which may assist with national census data:

1. Without shelter (e.g. rough sleeping)
2. Temporary accommodation (e.g. night shelters)
3. Sharing accommodation (e.g. couch surfing)
4. Living in uninhabitable housing.

Quantitative data on rough sleepers – those people sleeping outdoors, such as in city parks or on the street – has been collected annually in Auckland through a 'street count' or rough sleeper census. The results from the winter 2016 census found 177 people sleeping rough in the central city, which is more than double the figure found three years ago. It is important to note that this figure is likely an under-estimate and does not include people living in boarding houses which are also classed as secondary homelessness (Statistics New Zealand, 2009). 53 per cent of those counted identified as Māori, 33 per cent as Pākehā/NZ European, and nine per cent were of Pacific Island ethnicity (New Zealand Herald, 2016),

which reflects the established correlation between social and material deprivation, ethnicity, and poor health outcomes in New Zealand (Durie, 1998; Waldegrave, 2008). The street count found twenty five per cent of rough sleepers in Auckland central were female, which mirrors data from the United Kingdom (Veitch & Wigmore, 2003) where a majority of homeless rough sleepers are males aged between 25 and 50 years old. There is however a recognised 'hidden homeless' population of women (Bukowski, 2009).

Nikora et al. (2012) and Scanlen (2009) explore the provision of 'homeless healthcare' in NZ. These social science/social psychology researchers provide insight into the healthcare needs for the homeless population in NZ, both with a focus on the primary care clinic at the Auckland City Mission. Nikora et al. (2012, p. 9) look at Māori homelessness and appropriate healthcare responses, suggesting that it's important for "health professionals to have knowledge of the challenges that face Māori homeless people...". Scanlen (2009) interviewed both service users (patients) and primary care clinicians. Scanlen concludes that NGO¹ clinics (i.e. within the non-profit/charity sector) are an effective model for providing accessible healthcare to people experiencing homelessness. Although both studies consider clinical practice, the therapeutic input of nurses for treating mental health problems is not significantly addressed. However, for both Scanlen and Nikora et al. the development of relationships is seen as important to this healthcare provision, and the NGO is viewed as a potentially relationship-fostering space. Scanlen notes that homeless healthcare can be viewed as a relational process, and references international literature around the importance of relationships for this client group: "The focus is not just simply on providing health care to homeless people, but developing relationships with them to ensure that utilisation of healthcare continues" (Scanlen, 2009, p. 30). Scanlen also suggests: "It is evident that creating a 'space of care' (or an environment where homeless people feel comfortable, welcome, and open to developing relationships with staff and health professionals) is imperative to ensure regular use of services" (p. 33). However, nursing literature suggests that therapeutic relationships are helpful in and of themselves, in fact being a central component of nursing contribution (Raingruber, 2003).

The length of time a person has been living without secure shelter is an important consideration, with entrenched homelessness presenting an increase in all of the symptoms of social and mental health problems cited across the literature (Burns, Robins,

¹ Non-Governmental Organisation

Hodge & Holmes, 2009; Richards, 2009). Lack of personal infrastructure is cited by Veitch and Wigmore (2003) as an impediment to meeting physical and social health needs. Outreach and mobile health services have emerged as a key model for service provision, with collaborations between social and health services, and from primary care to mental health and addictions services (Kraybill, 2002; National Health Care for the Homeless Council, 2013). Much of the engagement nursing described in this research occurs at the 'street level' of outreach, as was referenced in the extract from the reflective practice journal in the introductory chapter.

Comorbid medical conditions, and a lack of access to secure or affordable primary health care, is another factor closely associated with homelessness across much of the relevant literature (Al-Nasrallah et al., 2005; Burns et al., 2009; Forchuk, Brown, Scholfield & Jensen, 2008; Leggat-Cook, 2007; Richards, 2009; Smith, 2007; Wilson, 2007). Robinson's (2003, p. 4) study of iterative homelessness in Australia found this population to be: "deeply traumatised and grief-stricken and struggl[ing] with desperation in a context of self-loathing, shame and fear". Similarly, Groot et al.'s (2008, p. 70) research in Auckland found that "homeless people are not only burdened with issues of daily survival, violence and social ostracism" but also "loneliness, depression and fear". Health care services therefore need to understand that this population experiences a lack of personal infrastructure *and* material infrastructure, a lack of secure housing tenure *and* community tenure.

The link between homelessness and mental health is well established. Smith (2007, p. 28) cites Australian research that involved a random sample of people experiencing homelessness, for whom a worrying level of complex mental health need was identified:

The study found the lifetime prevalence of psychosis was 23% for men and 46% for women, compared to 1% in the broader community ... [and] 71% of men and 83% of women met the criteria for at least one disorder in the last 12 months. This is four times higher than the broader community ... The most common mental illness for men was substance abuse disorders, primarily alcohol disorders, found in 49% of men surveyed.

New Zealand research by Leggat-Cook (2007, p. 56) cites a range of statistics suggesting 40–50% of homeless people experience mental health problems, although it is unclear how much of this would be defined as 'significant' mental illness by secondary and tertiary mental health services. For comparison, the national mental health survey, Te Rau

Hinengaro (Oakley Browne, Wells & Scott, 2006) found that 46.6% of people in New Zealand will experience some sort of 'mental disorder' in their lifetime. The US National Coalition for the Homeless (NCH, 2008, p. 1) state more specifically that "[a]n average of 16% of the single adult homeless population suffers from some form of severe and persistent mental illness". Burns, et al (2009, p. 126) claim that in Western urban settings, "approximately one-third of people who are homeless have a psychosis", where homeless men with psychosis experience greater prevalence of positive symptoms, concurrent alcohol and drug use, antisocial personality disorder, and a history of childhood abuse.

The literature notes the negative effect of stress and trauma experienced by many homeless people as contributing to mental illness (Leggat-Cook, 2007; Smith, 2007; Veitch & Wigmore, 2003), as well as the negative impact of co-existing alcohol and drug disorders within homeless populations (Al-Nasrallah et al., 2005; Smith, 2007). Mental health and substance misuse problems are more likely to be co-existing for this population (Daiki, 2007).

The lived experience of homelessness also impacts upon the general health of this population (Atkinson, 2000; Hodgetts, Radley, Chamberlain & Hodgetts, 2007). "When compared with domiciled citizens, homeless people are more likely to experience a raft of physical and mental health issues and unmet health needs, physical or sexual violence, a sense of insecurity and fear, and reduced social integration" (Hodgetts, Stolte & Groot, 2014, p. 156). Stigma and a lack of social supports "can erode the relational, physical and emotional aspects of their health" (Hodgetts, Stolte & Groot, 2014, p. 157). Integration of social and health services is considered 'best practice' within international literature (National Health Care for the Homeless Council, 2013; Gillig & McQuisition, 2006). Commonly cited medical conditions associated with homelessness include diabetes, seizure disorders, chronic respiratory disease and breathing problems, hepatitis, arthritis and musculoskeletal problems, cardiovascular disease, skin conditions, malnutrition, and poor dental care (Daiki, 2007; Nikora et al., 2012).

A note on terminology: the term 'client' will be used to describe health service recipients throughout this presentation of research. Service user, consumer, client, patient or tangata whai i te ora are all terms used by clinicians in community mental health services in New Zealand. However, with a hard-to-reach population that does not always seek out health

services (for a multitude of reasons) it seems disingenuous to use the terms *service user* or *consumer*. Barker and Buchanan-Barker (2005), as champions of recovery-focused mental health services, encourage the use of *person* rather than any other label. However, using *person* may become confusing in the write-up of this research. Therefore, the term *client* has been used, inferring as it does a relationship of service-to or support-for, which seems affirmative.

This Background chapter has described the particular practice setting within which the research participants work and which informs their reflections. As demonstrated, this practice setting has its own unique characteristics and challenges and this background is provided in order to set the scene.

Chapter 3

Literature review: Nursing engagement for a hard-to-reach population

The aim of this research study is to explore nursing care for people who are both homeless and experiencing mental health problems. The purpose of the literature review is to locate this research topic within current knowledge and to summarise the topic, and in so doing to also highlight the importance of undertaking this research (Creswell, 2014). This review of nursing and social science literature focuses on the topic of engagement and nursing, presenting an overview of existing research and what is currently considered best practice. This will map out the landscape to be explored further in this research study, and suggest any knowledge ‘gaps’ that will inform the data analysis.

The CINAHL² Complete database was used, via the EBSCOHost Platform. The key words used for searches were:

“engagement” + “homeless” + “nurs”

“therapeutic relationship” + “nurs” + “homeless”

“homeless” + “mental health” + “nurs”

The terms “homeless” + “engagement” were also searched, especially to augment the Background chapter. Grey literature was also accessed, including that already utilised by the researcher in their existing nursing practice context and involvement with specific homeless health initiatives.

This review of literature provided a broad perspective of contemporary nursing practice, as well as reflection of the health care needs specific to homeless service users. For example, there was a common theme across literature on mental health and homelessness of the advantage of integrated and mobile services (National Health Care for the Homeless Council, 2013). Likewise, there is considerable nursing literature and theory regarding therapeutic relationships, although little within the context of homelessness. As such,

² Cumulative Index to Nursing and Allied Health Literature

there is a relative research gap for nursing engagement in homeless settings, and negligible literature on this topic from New Zealand specifically. This review of literature is positioned by the researcher's own experience that therapeutic relationships and engagement are core nursing interventions for people experiencing homelessness, but also by the perception that the concept of engagement is not always well articulated in clinical settings.

Using the key words of 'engagement' and 'nursing', literature related to the mental health service model of assertive outreach was found, including specific literature on the nurse's experience of engagement within that model (Addis & Gamble, 2004). The key words of 'therapeutic relationships' and 'nursing' located literature asserting the significance of therapeutic relationships to nursing (Hartrick, 1997; O'Brien, 2001, 1999; Peplau, 1988/1952), as well as technical considerations of this interpersonal work (Coatsworth-Puspoky, Forchuk & Ward-Griffin, 2006; Kirsh & Tate, 2006). An interesting and influential theme found across the literature was of nurse's relational work being invisibilised or submerged, where tasks or measureable interventions were privileged over relational work (DeFrino, 2009; Drury & Munro, 2008).

DeFrino's (2009) theory of the relational work of nurses proved to be a significant and influential find in the literature. DeFrino reviewed literature for theoretical perspectives on nurses' relational work and, on finding a theory gap, proposed a nursing framework. DeFrino is motivated by what they describe as the disappearing or devaluing of nursing's relational work. They position this lack of value as gendered, in relation to being an historically female profession. DeFrino's theoretical framework therefore draws on gender to understand this relational work, in a similar way to the positioning of Care Ethics within feminist scholarship (Tronto, 2013). In both theories, the relational work of care is perceived to be submerged by other dominant discourses, such as biomedicine. DeFrino's nursing theory locates relational work as a skill rather than an attribute, and their investigation of relational work as a skilled task bears much relevance to this research focus on nursing engagement.

DeFrino's proposed theoretical framework is centred upon the following theoretical statements, quoted in full (DeFrino, 2009, p. 301):

1. A significant amount of nurse's knowledge of the patient comes from relational work with the patient.

2. Relational work creates positive professional rewards for the nurses.
3. Relational work is invisible knowledge work.
4. Relational work is devalued and disappeared in a biomedical model.
5. A disempowered nurse focuses more on tasks, experiences moral distress, and burns out.

DeFrino's framework locates therapeutic relationships as a fundamental nursing task, not simply a social relationship that allows nursing tasks to be performed. In other words, this relational work is considered to be a nursing intervention in itself. This consolidates the importance of therapeutic relationships described earlier (O'Brien, 2001; Peplau, 1988/1952) and the centrality of engagement in successful health outreach³ (National Health Care for the Homeless Council, 2013). Interestingly, DeFrino argues that this relational work is a source of positive reward or enjoyment for nurses. However, DeFrino (2009, p. 297) also argues that nursing relational work is "disappeared" and devalued in health service settings, which in turn disempowers and fatigues or "burns out" nurses. DeFrino's assertion is that the relational practices of nurses are "systematically ignored" (2009, p. 301), in favour of tasks and medically technical work: "The relational work exists but is, as a general rule, taken for granted as "nice" and not valued as the skilful and effective process that it is" (DeFrino, 2009, p. 294).

This view resonated with other literature located in this review, such as Hartrick's (1997) paper on relational capacity which also identifies that interpersonal relationships have been submerged as a central component within nursing practice. White and Tronto (2004), writing on the politics of care, similarly problematise this work as largely invisible, and Drury and Munro (2008, p. 318) describe the importance of relational work as a "blind spot" for mental health services. Hartrick's work asserts the importance of articulating relationships as a core nursing value in the face of what she describes as mechanistic communication approaches. Hartrick (1997, p. 526) describes five relational capacities for nurses, including showing initiative and being responsive, having mutual goals, and honouring complexity and uncertainty. Hartrick also places value on the nurse's intention within relationship and the importance of collaborating with the client to re-imagine the future, which Hartrick terms "living the question" (p. 526).

³ Outreach is the process of community rather than clinic-based contact, commonly used within the local and international homeless sector (Kraybill, 2002).

Hartrick (1997) locates these relational capacities at the centre of nursing relational work, emphasising this framework as a counterpoint to behaviourist or cognitive-focused approaches, which Hartrick considers narrowly mechanistic. As with DeFrino's (2009) theoretical framework, these capacities also resonate with other interpersonal models or approaches, such as the focus on responsiveness of Care Ethics and the techniques of re-authoring of Narrative Therapy (Tronto, 2013; White, 1995). These other models or approaches fall outside the scope of this literature review, although as 'grey literature' they are known and influential to the researcher. The nursing frameworks of DeFrino and Hartrick, however, are taken as signposts for the subsequent data analysis and interpretation.

There are also parallels between Hartrick's (1997) "relational capacities" and the guiding principles of the Tidal Model (Barker & Buchanan-Barker, 2005). Tidal is a mental health service model developed in Scotland (UK) in which clients are viewed as the experts in their own lives. The guiding principles described by Barker and Buchanan-Barker (2005, p. 39) include developing "genuine curiosity" and "becoming the apprentice", which echoes Hartrick's (1997) proposition to live the question. Similarly, the Tidal Model emphasises that "chaotic change" is the nature of mental health care (Barker & Buchanan-Barker, 2005, p. 10), whilst Hartrick argues that ambiguity and complexity are inherent to the interpersonal work of nursing. Barker & Buchanan-Barker (2005, p. 10) write: "The fluid and ever-changing nature of human experience provides the basis for the core metaphor of the Tidal Model – *water*". A study of one NZ implementation of the Tidal Model found that relationships and collaboration were amongst the positive reflections of the service users interviewed (Barker & Buchanan-Barker, 2005).

Therapeutic relationships were deemed central to mental health care across a wide array of the literature reviewed (Barker & Buchanan-Barker, 2005; Coatsworth-Puspoky, Forchuk & Ward-Griffin, 2006; DeFrino, 2009; Kirsh & Tate, 2006; Hartrick, 1997; Shattell, Starr & Thomas, 2007; Watson, 2010; Watson, 2002). The enthusiasm of Rayner's (2005, p. 485) assertion is not uncommon: "In mental health therapeutic relationships are a central feature, essential and of crucial importance within the provision of effective services". O'Brien (2000; 1999) provides a seminal New Zealand resource on the subject of therapeutic relationships, having explored the history and nursing perceptions of this basic nursing skill. O'Brien (2000; 1999) found that psychiatric and mental health nurses often

described therapeutic relationships as central to their practice but could not readily describe exactly how they were therapeutic. It is possible this abstraction relates to the submerged nature of this aspect of mental health nurse identity.

One useful definition of engagement in mental health services was provided by George, Manuel, Gandy-Guendes, McGray and Negatu (2015, p. 888), where engagement is comprised of “*providing practical assistance and developing a therapeutic relationship*”. Sitzman (2002) defines nursing practice as a combination of tasks, interpersonal relationships, and self-reflection. It is interesting to consider these definitions against DeFrino’s assertion that relational work is a skilled nursing task, and moreover a task which may be de-prioritised or disappeared in favour of more medicalised tasks.

Interpersonal relationships were championed as core nursing practice by the pioneering psychiatric nurse Hildegard Peplau and influenced in subsequent decades by the work of psychologist Carl Rogers, nursing scholar Jean Watson (Watson, 2008a) and others (Barker & Buchanan-Barker, 2005; Hewitt & Coffrey, 2005; Silverstein, 2006;). Although Peplau’s (1988/1952) framework for psychodynamic nursing is not in focus in this research it is a philosophical assumption of the researcher that nursing care is intertwined with relationship. The rise of Relationship Based Care (RBC) as a health care model in the USA in recent years (Koloroutis, 2012) was also noted in the ‘grey literature’, especially in relation to general medical practice, but there was little specific literature relating RBC to this nursing research question. Similarly, nursing theorist Jean Watson (2008a) has written extensively about their model for transpersonal human caring, a key part of which is interpersonally focused, and it is unsurprising that her body of work resonates in the review of literature for this research. For example, Sitzman’s (2002) reflection on Watson’s nursing theory of human caring surfaced in the literature review. Since Peplau’s (1988) influential work on interpersonal relationships, first published in 1952, it could be argued that Watson carried the baton for nursing emphasis on caring relationships. Watson links her theory of transpersonal nursing back to Nightingale (Watson, 2010), where nursing is not about performing medical tasks as much as it is about caring relationships. However, Watson’s framework for human caring and its associated literature was not found to be specifically linked to engagement and has not been applied as a critical lens for this research.

Barker and Buchanan-Barker (2005), authors of the influential Tidal Model for mental health workers, assert that relationship *is* therapy. Duncan, Miller and Sparks (2004) make a similar assertion, where they emphasise the importance of the relationship over any particular technique or therapeutic approach. Duncan et al.'s (2004) review of psychotherapy outcomes research found that 30% of change for the client is due to the therapeutic relationship, 40% is due to the clients' own efforts external to therapy, and 15% is due to a specific therapy technique. Te Pou o te Whakaaro Nui's (2016, p. 4) guide to developing talking therapies in New Zealand suggests a gradient from simple or brief therapeutic interventions to those requiring considerable expertise in evidence-based psychological approaches. However, if Duncan et al.'s (2004) research on outcomes from therapy interventions is accepted, then Te Pou's (2016) 'stepped care' approach to mental health treatments does not appear to fully acknowledge the importance of relational work in helping hard-to-reach populations, and nurses' role and skills in this work are arguably undervalued. As Duncan et al. (2004, p. 37) assert:

We must set aside the intellectual appeal of theoretical models, the promises of flashy techniques, the charisma of masters, and the marketing acumen of snake oil peddlers. The research indicates that therapy works if clients experience the relationship positively and are active participants.

An aim of this study is to improve the visibility and understanding of engagement as a nursing intervention by describing and reflecting upon the experience of engagement as nursing work. Several nursing scholars highlight therapeutic relationships and engagement as central to nursing professional identity. "Our core identity is relational and rooted in the interpersonal paradigm" (Raingruber, 2003, p. 108).

Drury and Munro (2008, p. 318) critique the mental health service focus on specific talking therapy techniques, where the relational focus has been marginalised by models that are more "manualised" and medically standardised. "Despite this consistent finding that the therapeutic alliance is the primary key to success in mental health, it has too frequently been relegated to a secondary role or ignored in research and policies regarding practice" (Drury & Munro, 2008, p. 318). This echoes Hartrick's (1997) argument against overly mechanistic communication techniques. Drury and Munro (2008), writing from a New Zealand perspective, further assert that treatment techniques are emphasised over who or how the treatment is provided. They argue that this devalues the relationality of a Māori

worldview, and again echo DeFrino's (2009) argument that the relational work of nursing is often invisibilised.

One key piece of literature that speaks to this service tension between measurable technique and a relational approach is Addis and Gamble's (2004) study of nurses' experience of engagement within the Assertive Outreach model. Assertive Outreach (AO) or Assertive Community Treatment (ACT) is a mental health service model with resonance to health outreach teams that are common within the homeless health sector (National Health Care for the Homeless Council, 2013). Assertive Outreach as a model has been relatively well researched and evidence-based, and it is in literature on this approach that engagement is discussed as both intervention and possible outcome measure. The literature on the AO approach asserts a primary focus is on therapeutic relationships:

Nursing philosophy and practice can be seen at the heart of this approach, where attention is paid to people rather than their pathology; where relationships are the key to success, and where the focus is achieving personally meaningful change for those individuals. (Smith & Morris, 2003, p. 373)

Assertive Outreach (AO) is defined as the provision of intensive community resources for people who are poorly engaged with mental health services and as a result may experience greater episodes of distress, more frequent hospitalisation and more identified risk to self or the community (Burns et al, 2009; Ford & King, 2005; Kent & Burns, 2005). Non-engagement with mental health services is a key referral criteria to AO services (Toynbee & Allen, 2009), and the AO model emphasises a team response with more time for intensive, needs-based community contact (Ford & King, 2005; Wigmore & Veitch, 2003) with service goals of "...reduced symptom severity, increased community tenure and improved social functioning" (Kent & Burns, 2005, p. 389). Lloyd & Bassett (2010, p. 379) suggest that a focus on engagement reflects the interest of the mental health nursing practice on service user experience – "not only diagnosis and treatment". Addis and Gamble's (2004, p. 456) research found that nurses' described their outreach engagement as "the human professional confluence", which echoes O'Brien's (1999, p. 158) finding that mental health nurses valued "[t]he minimising of the professional in favour of a personal approach ...". Both authors found that nurse-client rapport was not aided by an "overtly professional" manner (O'Brien, 1999, p. 159).

Addis and Gamble's (2004) research is one of few found in the literature search that enquired of nurses' experience of their relational work. Addis and Gamble's (2004, p. 456) findings were that nurses valued "having time" to connect and work at the clients preferred pace. In their work, they felt anxiety and fear, pressure and relief, satisfaction and dejection (Addis and Gambles, 2004, p. 456). Their research participants also emphasised time as an important part of nursing engagement work, and this reflection of needing to go slowly is echoed across the literature. For example, Gillig and McQuisition (2006, p. 10) suggest that "in some cases, it may be years before a therapeutic alliance is established". Gamble & Brennan (2006) emphasises short, frequent contact as enhancing engagement, and Ireland (2006) emphasises slow engagement. Wigmore and Veitch (2003) find that low demand engagement may continue for many years before significant health benefits are apparent, especially where there are co-existing mental health problems and substance dependency.

Wigmore and Veitch (2003, p. 394) also identify both *therapeutic* and *systemic* functions of engagement with homeless clients, where systemic functions include: "intervening with organisations or larger systems of care in order to promote more effective, equitable, and accountable services to a target client group". Short-term benefits of good engagement were identified around crisis resolution and support, where long-term benefits include rehabilitative functions, planning, symptom management and community tenure (Wigmore & Veitch, 2003). Hewitt and Coffey (2005, p. 566) argue that: "Compliance with medication, reduction in global psychopathology and better social functioning, have been positively linked with the development of a therapeutic relationship in people with schizophrenia". Williams, Labonte and O'Brien (2003) also discuss the empowering and "healing" potential of having your story listened to.

Yamashita, Forchuk and Mound's (2005, p. 68) study of nursing case management reaffirmed the importance of the nurse-client relationship, where nursing care is negotiated through clear communication and collaboration. This negotiation of care was asserted by Yamashita et al. (2005) as the basic building block of a trusting therapeutic relationship. This is a simple but important point with regard to homeless outreach nursing, where nurses should not approach people experiencing homelessness as subjects

requiring intervention, but rather as people with agency and lived experience who might collaborate with the nurse on a care plan.

Graham, Denoual and Cairn's (2005) survey of service user satisfaction in an Assertive Outreach service found that clients rated interpersonal aspects of their care relatively highly, which echoes the findings of the REACT study (Killapsy et al., 2006). Evaluation of interventions is a key part of the nursing process (Craven & Hirnle, 2003) and, as such, outcome and process measures for therapeutic engagement could be further considered. Whelton, Paulson and Marusiak (2007) and Welch's (2005) work suggests that a greater emphasis on nursing reflection and monitoring of therapeutic engagements is needed, and Killapsy et al. (2006) cite an adapted Homeless Engagement Acceptance Scale where service user engagement may be subjectively measured and considered longitudinally. Meaden, Nithsdale, Rose, Smith and Jones (2004), Paget, Meaden and Amphlett (2009), and Park, Tyrer, Elsworth, Fox, Ukoumunne and MacDonald (2002) present research on observer ratings of client engagement as possible outcomes indicators. Hall, Meaden, Smith & Jones (2001) similarly argue a psychometric measure of engagement for use within mental health services, and Meaden, Nithsdale, Rose, Smith and Jones (2004) contend that engagement can be used as an outcome indicator for Assertive Outreach services and an indicator of future psychiatric hospital admissions.

Rayner (2005) relates language and therapeutic relationships to the effective use of care pathways, identifying this as a way for nurses to consider a person's mental health without relying on the language of medicine. Rayner (2005, p. 485) argues for the use of an "engagement/relationship building reflection tool" as part of the development of such care pathways. This reflection tool will not be discussed at length here but can be seen as another attempt to formalise the concept of engagement as central to nursing practice. Although DeFrino (2009), Barker and Buchanan-Barker (2005), and Watson (2002) all emphasise the relational core of nursing practice, much of the literature on therapeutic relationships and nursing looks at the technical processes or steps of interpersonal work. For example, Kirsh & Tate (2006) discuss engagement as the foundation of the working alliance, where "being on my side", being a useful advocate and resource person, and offering real choices were identified as important to mental health service users. This echoes Gerard Egan's influential "skilled helper" model (McCrae, 2014, p. 30), although Wright et al. (2011) link the transformative power of engagement to health workers being

supporters or allies not simply problem solvers. Shattel, Starr and Thomas (2007) identified service user appreciation of attentive listening, warmth, and responsiveness. Self-awareness, sensitivity, empathy, and Rogerian concepts such as unconditional positive regard and a non-judgemental approach were also valued (Hewitt & Coffey, 2005; Nikora et al., 2012; Wright et al, 2011). Shattell et al. (2007) likewise found that availability, consistency and trust were rated as important, and clients wanted to feel they were moving toward a 'solution' and able to get help or advocacy with social needs. Cutcliffe and Koehn (2007) found that hope is strongly linked to nurse–client relationship, and as Watson (2007) writes, it is genuine engagement over time that develops trust.

Engagement is often the foundation of other treatments, which depend upon the specific needs of the person being seen. For example, Oudens and McQuisition's (2006, p. 24), in their article on the care of mentally unwell people experiencing homelessness, argue for a process of "rehabilitation" that begins with engagement before moving on to intensive provision of treatment. The Intensive Care phase includes such interventions as health assessment and diagnosis, commencing treatment – which could include hospitalisation and alcohol or other drug treatment, addressing legal issues, housing and vocational issues, and building social connections (Oudens & McQuisition, 2006). Similarly, Lee et al. (2010) describe a model of care that begins with engagement, followed by comprehensive assessment and the development of care plans in partnership with the service user, and sustained by ongoing outreach engagement to prevent relapse or crisis. Wright et al. (2011) found that engagement between AO mental health practitioners and service users could be characterised as a process of contact, dialogue, transformation, and shared understanding, where contact alone does not constitute engagement.

Howgego, Yellowlees, Owen, Meldrum and Dark (2003) found that the potential of the working alliance was indicative of health outcomes. Howgego et al. (2003) go on to suggest that strategies for therapeutic relationships should be better understood and evaluated as clinical tools. Some of the abundant literature explored the processes of building therapeutic relationships in more detail, and these are noteworthy because of their relevance to outreach nursing – for example, Coatsworth-Puspoky et al.'s (2006) discussion of the 'initial phase', which can engender hope or lead to withdrawal depending on personal rapport. Wright et al.'s (2011, p. 830) study of health workers' and service users' experience of engagement suggest that it is a process rather than a specific act, involving

“a careful balancing act between having contact with someone and not being intrusive”. Shattell, Starr and Thomas (2007) likewise discuss the process of engagement, identifying that an ‘orientation phase’ is required before a ‘working phase’ can commence.

Padgett, Henwood, Abrams and Davis’s (2008) qualitative research in New York, USA, developed a grounded theory model for engagement of homeless people needing support for mental and substance use disorders. Their research argues for a need to always listen to clients, seeking their insights for structuring services to them, which is similar to the client-centred spirit of New Zealand’s Blueprint II for Mental Health Services (Mental Health Commission, 2012). Padgett et al. (2008) note that engagement and retention of clients in mental health and addictions services improves when housing provision is combined with sensitive support from staff. However, their research focuses on client narratives of engagement, rather than the relational work of nurses (or other clinicians), and the authors rely on humanistic traits such as warmth and kindness to describe the types of positive engagement staff may cultivate. Although this echoes the fundamentals of therapeutic relationships, ‘being nice’ is not a clinical model per se.

The literature on therapeutic relationships overlaps, in tone or focus at least, with some of the literature on homelessness and health. For example, Nikora et al.’s (2012) study of a primary care clinic within a homeless social service highlighted the importance of respectful, caring, empathetic engagement with service users for good health outcomes. “Health professionals who are experienced in treating homeless clients make the importance of relationships overt, where trust and cooperation can be fostered by staff taking time to build rapport through client-centeredness” (Nikora et al., 2012, p. 9). Their research observed the central role of the primary care clinic nurse in providing a warm, non-judgmental, welcoming space for homeless patients, creating a service “where a sense of safety, trust, acceptance and connection is fostered” (Nikora et al. 2012, p. 9). The authors cite the benefits of an integrated health and social service orientated toward relationships of care, although a therapeutic context outside of the clinic is not discussed.

Ross and Reicher Gholston (2006) write of mental health outreach work in New York, where therapy happens on park benches and often without recourse to medications or reliable schedules. In such homeless health work the therapeutic relationship is vital. Engagement is perceived to build trust and knowledge between clinician and client, where:

“the eventual success or outcome for clients is dependent on their relational capacity to be cared for and to in turn... take care of themselves” (Ross & Reicher Gholston, 2006, p. 202).

There is a significant body of research in New Zealand on homelessness as social phenomena and lived experience, such as Hodgetts, Stolte, Radley, Leggat-Cook, Groot and Chamberlain (2011), but negligible literature on local nursing practice. This review of literature on nursing engagement unfortunately seems to emphasise the invisibility of nursing work in the local homeless sector. The limited New Zealand literature on homeless health appears to have a medical focus toward health care for people experiencing homelessness. For example, Scanlen (2009) highlights the importance of relationship in this practice setting but mostly addresses the GP⁴-patient relationship. Few examples across the New Zealand homeless and health literature were found to discuss the work of nurses. Bukowski (2009) researched the lives and health needs of women experiencing homelessness in Auckland, NZ, including reviewing contemporary treatment models. Bukowski (2009, p. 84–85) notes the use of various case management models – Assertive Community Treatment, Housing First, and Critical Time Interventions, but neither nursing nor engagement practices are discussed in detail.

There are a number of resonances for nursing practice across the health literature encountered in this review. These echo the concepts of engagement and therapeutic relationships, such as the key tenets of Barker and Buchanan-Barker’s Tidal Model (2005). The principles of the Tidal Model include the development of curiosity, the giving of time, valuing the person’s voice, and respecting the language of their story. Similarly, Barnes (2006) links an Ethic of Care to the qualities of attentiveness and responsiveness, echoing both the literature on therapeutic relationships and client perspectives (Shattell et al., 2007). Barnes (2006) also discusses the use of narrative as a means to surface hidden marginality and give voice to the client’s own story. As Brannelly, Boulton and te Hiini (2013, p. 5) suggest, “[c]are ethics can challenge the dominance of neoliberalism, and the individualism and self-responsibilisation that is unhelpful in understanding the experiences of many who use mental health services”. Brannelly et al. (2013) also emphasise the pivotal role of relational work within a Māori worldview of health, as do Drury and Munro (2008). Similarly, Nikora et al. (2012, p. 7) emphasise the centrality of relationships in Te Ao Māori, urging health workers to look “beyond the treatment of individuals with disease and to

⁴ General Practitioners (medical doctors).

take a more relational perspective in terms of the place of Māori in contemporary society and the dynamics of Māori engagements with health care”. Therapeutic engagement as a culturally bound process is also articulated in New Zealand by Pacific Island cultures, for example the Samoan concept of Va referenced in the New Zealand Mental Health resource *Le Va: Pasifika within Te Pou* (Faleafa, 2008). Va is described in this document, as articulated by writer Albert Wendt, as “...the space between, the between-ness, not empty space, not space that separates but space that relates, that holds separate entities and things together in the unity-in-all, the space that is context, giving meaning to things” (p. 2). These different cultural perspectives of relationality are all the more relevant to homeless healthcare given the prevalence of Māori and Pacific island populations who are experiencing homelessness (New Zealand Herald, 2016). However, as a Pākehā/European New Zealander with a commitment to culturally safe nursing practice (Wepa, 2015), and acknowledging Smith’s (1999) argument that indigenous methodologies are required for Māori-specific research, I will not be exploring indigenous concepts or asking specific questions of Māori nurses or kaupapa Māori service providers in this research.

Conclusion

The purpose of this literature review chapter was to locate this research topic within current knowledge and to summarise the topic. Contemporary nursing literature provided several academic papers of note, including DeFrino’s (2009) theoretical framework for the relational work of nursing, as well as Hartrick’s (1997) framework of relational capacity. Addis and Gamble’s (2004) research on the nursing experience of engagement within Assertive Outreach health services was another influential text. A background knowledge of therapeutic relationships and engagement as concepts in nursing practice has been established, but the gap in local knowledge of nursing was noted, especially regarding homeless health. The literature review also revealed a concern for the disappearance or invisibilisation of nursing relational work, including engagement as a core nursing skill. This review of literature will inform the following chapters of this research thesis, including the thematic analysis and interpretation of the interview data.

Chapter 4

Research design and method

This chapter describes the research design and methods used for this qualitative study. The processes for participant recruitment, data collection and analysis are presented, along with the ethical considerations for this research.

The previous chapter presented a review of selected literature regarding nursing care for people experiencing both homelessness and mental health problems. A better understanding of engagement as a nursing intervention was established to be a knowledge gap or research need. The literature review showed that engagement is important for the provision of homeless healthcare, yet several authors argued that the relational work of nursing has been disappeared or invisibilised as a health intervention. The literature review provides a context for exploring the nursing experience of health care provision for a 'hard-to-reach' population, asking how nurses' reflections and insights might inform nursing knowledge and practice in this clinical setting.

The specific research questions are:

- What is the nursing experience of engagement with people who are both homeless and experiencing mental health problems?
- And what mental health nursing practice issues are specific to care provided to this population?

The research objectives are:

- To explore the nursing experience of engagement with this population.
- To describe and reflect upon nursing engagement with homeless clients as a health intervention.
- To inform nursing practice and contribute to the literature on mental health nursing and homelessness.

Methodology

A qualitative approach

The following section presents an overview of the philosophical assumptions and theoretical concepts employed in this study, including the methods chosen for data collection and analysis. This research utilises an interpretive design to consider the experience of nursing in a particular context, with the aim of informing that nursing practice. The data was collected using semi-structured interviews and analysed using 'critical thematic analysis'.

Research methods are designed within a theory of knowledge - an epistemology - and its related philosophical assumptions (Creswell, 2009). Critical thematic analysis considers the interpretation of human experience as subjective, where knowledge is situated within a context and set of power relations (Braun & Clarke, 2013). The researcher is conscious of social context and multiple possible meanings, and the research participants are considered to have agency within the research process and not simply as subjects to be studied (Weaver & Olsen, 2006; Crotty, 1998).

Critical thematic analysis is also based on the philosophical assumption that neither quantitative nor qualitative research is value free or neutral, and that the researcher's world view determines which knowledge is privileged and which research questions are asked (Creswell, 2009). This acknowledgement of subjectivity is considered to add rigour to a qualitative research design, not detract from it, and this epistemological view then informs the method used for data collection and analysis (Carter & Little, 2007). As Braun & Clarke (2013, p. 6) summarise:

"Researchers bring their subjectivity (their views, perspectives, frameworks for making sense of the world; their politics, their passions) into the research process – this is seen as a strength rather than a weakness".

In the research presented here the research questions are informed by the researchers own experience of nursing within New Zealand's homeless and mental health sectors. The research is likewise influenced by the researcher's affinity for relational-based approaches, such as narrative therapies (White, 1995), the Tidal Model (Barker & Buchanan-Barker, 2005), and trauma informed practice (Arthur et al, 2013). The literature review chapter also introduced Hartrick's (1997) framework for relational capacity in nursing, and DeFrino's (2009) theory of the relational work of nurses. Both are applied as critical lenses in the

thematic analysis. I also draw on the concept of practice based evidence (Leeman & Sandelowski, 2012; Fox, 2003), utilising the critical reflections by nurses as research participants and existing nursing theory to contribute to nursing knowledge relevant to a particular clinical setting.

The research is also located purposely within mental health nursing as a clinical profession, where cultural safety and care ethics are influential (although neither of these are applied directly as an analytical lens). As a Pākehā/European New Zealander with a commitment to cultural safety as central to nursing practice (Wepa, 2015), and acknowledging Smith's (1999) argument that indigenous methodologies are required for Māori-specific research, I will not be exploring indigenous concepts or asking specific questions of Māori nurses or kaupapa Māori service providers in this research. I likewise cannot draw specific conclusions about Māori nursing practice. I see the resonance of care ethics and indigenous understanding of relationships - as Brannelly, Boulton and Te Hiini (2013) have highlighted - as fruitful ground for future homeless health service development in New Zealand.

Nursing knowledge is predominantly grounded in clinical practice or the social context of practice (Duffy, 2012), and nursing research data may often be analysed, and the relevant practice informed, in response to specific clinical issues. As a social science practice with specific goals, nursing research inherently holds philosophical assumptions and these have evolved as the profession has developed. Weaver & Olsen state (2006, p. 461), "Since the time of Nightingale, nursing has been concerned with acquiring theoretical knowledge for application to practice", and nursing research has often aimed towards credibility for nursing as a profession within the medical, positivist paradigms where 'hard facts' are privileged. However, it could also be argued that the concept of care, central to nursing since "the time of Nightingale", carries philosophical assumptions about social mandates, subjectivity and relationships that may have never fitted neatly into medical paradigms (Rodgers, 2005).

Nurses have long been interested in different ways of knowing, perhaps in part because science does not provide a particularly good account of what nurses do, and can only partially inform what one might recognise as good nursing (Lakeman, 2014, p. 385).

This qualitative research approach assumes a socio-political and relational context for both homelessness and mental (ill) health; a critical lens is therefore used to reflect upon and explore the experience of nursing practice within the sociocultural context and structural conditions that enable nurses' individual accounts of their nursing practice to be produced (Braun & Clarke, 2006). This research explores nursing practice to provide healthcare to a socially deprived population, drawing on the described experiences of this practice. The experience of homelessness and mental distress is not the focus of this research, however a critical lens will contextualise nursing practice within the health and social inequalities which directly influence how, where and for whom nurses provide care (Mosqueda-Diaz, et al, 2014).

Method: Identifying themes

This research utilises critical thematic analysis, which is a widely used qualitative method for identifying, analysing and reporting themes within research data (Guest, MacQueen & Namey, 2012). Vaismoradi, Jones, Turunen, and Snelgrove (2016, p. 100) describe thematic analysis as a qualitative research method that aims to provide “socio-contextual and detailed description and interpretation of the research topic”. Critical thematic analysis describes patterns within qualitative data and then considers these patterns within a theoretical framework that guides interpretation and discussion. It is a process of trying to understand something by considering the voiced experience of it (Vaismoradi, Turunen & Bondas, 2013), in this case, engagement as fundamental relational work of nurses.

Braun and Clarke (2006, p.10) describe a theme as a description that “captures something important about the data in relation to the research question”. Themes are prominent patterns or recurring ideas which purport to tell us something significant about the research topic. Coding, as the first stage of theme development, involves immersion in the data and accentuating what Vaismoradi et al. (2016, p.103) refer to as “meaning units”. As Vaismoradi et al. (2016, p. 102) explain:

“A category is an idea that is directly expressed in the text, but a theme is more than a category. The former is more general and abstract and has intellectual and affective content depending on the interpretation of the researcher. It is through the development of theme that category is given depth of meaning...”

Braun & Clarke's (2006, p. 60-69) framework for critical thematic analysis, as a method of processing and interpreting data, was applied following these steps:

1. Transcription of the interview recordings, the text of which becomes the data for analysis.
2. Reading and re-reading of the data.
3. Identifying initial patterns and linkages - termed codes.
4. The codes are compared and refined into initial themes.
5. The themes are refined and named.
6. Final analysis of the themes is reported.

This research places value on the described relational experience of nurses providing care for a population that is marginalised and hard-to-reach, but considers this experience as subjective and situated (Letherby, Scott & Williams, 2013). The theoretical framework for considering these experiences is therefore contextual, being neither essentialist nor purely constructionist (Braun & Clark, 2006), where meaning is in relation to context and culture (Reynolds, 2010). This descriptive research aims to gain perspective on nursing practice within both their social and subjective context (Rodgers, 2005).

Reality is about the meaning that people create in the course of their social interactions; the world is not about facts but about the meaning attached to facts, and people negotiate and create meaning (Strega, 2005, p. 206).

The subjective knowledge of research participants is central to this perspective, which embraces the situated individual accounts and relates these to formal theories of nursing knowledge. Nursing care can be theorised as an intersubjective relationship (Bishop & Ford-Bruins, 2003), although this research does not have the scope to consider the experience of both nurse *and* service user or patient. A comparative or dialectical study of nurse-service user engagement would be a different study altogether, whereas this critical nursing research seeks to draw practice based evidence from nursing practice.

Research rigour

Qualitative research is considered an appropriate methodology for contemplating the meanings that people draw from their experiences, and so is descriptive and specific to social and cultural contexts (Creswell, 2009). Interpretative research is subjective and therefore cannot rely on reproducibility as a bench mark of reliability in the same way as quantitative research (Braun & Clarke, 2013). However, the rigour of qualitative research

can and must still be considered, and the following section outlines key strategies for attesting to this research rigour.

Credibility

Credibility in qualitative research is comparable to internal validity in quantitative research (Liamputtong, 2009). Where a research methodology is contextual and subjective, credibility speaks to the concept of authenticity and whether the research findings can be trusted. Credibility was enhanced by giving participants back their transcripts to read and verify their interview statements, as guaranteed through the ethics approval and consent to release transcript forms supplied by the researcher to all participants. The experience and expertise of the research participants is central to the research findings, and therefore the credibility of this research is enhanced by having a sufficient number of participants (in this case eight, rather than just one or two). The congruence or clarity of themes presented in the findings also speaks to the issue of credibility.

Transferability

This qualitative nursing research seeks to be transferable or applicable to nursing practice in related contexts (Liamputtong, 2009). Having a diverse research sample is one way this research attempts to provide transferability. In this case the participants were drawn from two different cities and from both primary and secondary care settings. Transferability is also inferred by addressing the social context of homelessness to highlight aspects of health care that would apply to other hard-to-reach or vulnerable populations.

Dependability

The concept of dependability in qualitative research concerns the unambiguous links made between research data and findings. The findings must be shown to arise from the data and not based on conjecture or simply an expression of the researchers pre-existing views (Liamputtong, 2009). It should be expected that another person analysing the same interview transcripts will find similar themes, if not exactly the same. Attentive, purposeful re-reading of the interview transcripts lends dependability to this research, as does the ability to audit the process of finding themes across from the data, where research notebooks and initial coding of transcripts can be evidenced. Dependability in this research will also be shown by describing transparently the process of thematic analysis in the

method section, below, and within the findings chapter. It should be expected that another person analysing the same interview transcripts will find similar themes.

Confirmability

Similarly to the concept of research dependability, these qualitative research findings are considered confirmable if they are demonstrably derived from the data and not the researchers own opinion (Liamputtong, 2009). In other words, the researcher must show their neutrality regarding the research participants' views. With interpretative research methodologies it is important to be transparent about the researcher's approach to the topic and their related experience, as is described in the introduction.

Reflexivity

Reflexivity is considered an important component of qualitative research, adding integrity and transparency to the research process (Liamputtong, 2009). Rather than attempting to minimise the contextual influences in this research design, the context provides a basis to make meanings from the data, generating what has been referred to as practice based evidence (Leeman & Sandelowski, 2012). This nursing research is borne directly from practice-based experience and curiosity. I am a senior mental health nurse and have worked within the homeless sector for many years. As such I feel a responsibility to be 'of use' with this research, honouring the time given by the research participants and applying insights toward enhancing nursing practice for a specific population that experiences hardship. I also acknowledge that I came to this research topic with expectations and assumptions that have directed the research inquiry. The use of reflective research notes and practice supervision helped temper this subjective influence, as did the use of an interpretative method. As Vaismoradi et al. (2016, p. 108) note, thematic analysis encourages researchers "to apply creativity in the process of theme development, going through the ladder of the abstraction process step-by-step, and making a connection between developing themes and current knowledge".

Participant recruitment

Access agreements were reached with five health service providers. Advertisements were approved by the MUHEC Ethics process (Appendix B) and placed with selected health services via service managers. Those managers were asked to not request that their staff participate in this research, rather to simply alert nursing staff to the opportunity to participate in this nursing research, in order to ensure willing participation.

Participants were required to be:

1. Registered Nurses.
2. Providing mental health nursing interventions in a secondary community mental health or primary care setting.
3. Working with a service user population that experiences homelessness.

The participants

There were eight research participants recruited from Auckland and Wellington. All had more than 10 year's nursing experience and were > 35 years old. There were 3 male and 5 female participants. The data from one of the participant interviews was unfortunately shorter in length because after the first 30 minutes of interview a ukulele choir began practicing in the adjacent room, rendering the transcription of this interview difficult.

Due to the small cohort of nurses working in this clinical field the defining characteristics of the participants, such as geographic location or type of practice setting will not be disclosed, as submitted in the original MUHEC Ethics Application. Participant identity has been anonymised with the use of pseudonyms:

Dorothy, Phil, Walt, René, Hilde, Flo, Isobel, and Millie.

The gender of the participants has been obscured by being variably consistent with the gender of the pseudonyms. In other words, the gender of the pseudonyms does not consistently denote the gender of the participants.

Data collection

Semi-structured interviews were used to gather data for this study, with a list of questions and topics of enquiry that were referred to during each interview, as submitted and approved by Ethics Application (refer Appendix A). Semi-structured interviews are a common qualitative interview method, using open-ended, reflexive questions to elicit the participants' reflection on the research topic (Braun & Clarke, 2013). Structured interviews are suited to a narrower set of pre-determined questions and possible answers, whereas semi-structured interviews allow greater scope for unanticipated participant answers (ibid.). Unstructured interviews can generate a greater range of data, but this in turn can create problems for data analysis (Gibson, 1998) and are not suited to focused research questions such as this. Fetterman (2009, p. 554) asserts that semi-structured interviews are "most valuable when the field worker [researcher] comprehends the fundamentals of a

community from the ‘insiders’ perspective”. In this instance, I work within the nursing field in question and have focused qualitative research goals, therefore a semi-structured interview was appropriate. These semi-structured interviews focused on nursing interactions with people experiencing homelessness and mental health problems, with participants responding to questions about *their* experience of engagement with this client group and *their* experience and understanding of therapeutic relationships as a nursing intervention in this context.

Prior to data collection the research participants were engaged in rapport building conversations. The interview questions were not asked using the exact same language with each participant, such as with a survey questionnaire, and there was opportunity to revisit these questions for further exposition. There was also opportunity for research participants to discuss issues outside of the prepared questions, to aid the flow of interview conversation and in recognition that this specific research topic sits within a wider nursing experience (Braun & Clarke, 2013). The interviews were audio recorded and later transcribed into text for analysis. Both recordings and transcripts were securely stored, and participants were offered their transcripts for review. Three participants requested this using the MUHEC ethics approved Release of Transcript forms, and none requested any retraction of statements they had made in their interview.

Ethical considerations

Tolich and Davidson (2011, p. 150) outline five principles for research ethics:

1. Voluntary participation
2. Informed consent
3. Do no harm
4. Avoid deceit
5. Confidentiality or anonymity

These key principles were considered in the development of this research study, along with beneficence (doing good), respect for human dignity and the principle of justice, and social and cultural sensitivity. Prior to commencing this project the research proposal was reviewed and approved by the Massey University Human Ethics Committee (MUHEC): Southern A, Application 13/63 in 2013, as per the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. Ethical principles related to this research were discussed with the researcher's academic supervisor, including issues of

confidentiality and risks of harm. The research topic was also discussed with clinical and homeless sector colleagues, including consultation as described below.

To ensure voluntary participation, advertisements were placed in selected health services via managers, with the request that staff were not asked directly to participate in this research. To ensure informed consent, all research participants were sent an information sheet prior to the interview date, and all signed a consent form. Some participants took up the offer to read their transcribed interview but none sought editing or changes to the transcript. Copies of the relevant forms are in Appendices D and F.

Consultation with a homeless-sector health clinic was completed, as was consultation with a mental health service user/ consumer leader⁵, regarding, in both cases, the purpose and scope of this research. Consultation also occurred with a sector-specific advisory group, being the 'client committee' of a major homeless sector organisation in New Zealand. Note: this organisation is not the researcher's employer, and the homeless committee members are not research participants. By speaking with members of the 'client committee' as an advisory consultation, the researcher aimed to ensure the research remains ethically accountable to homeless service users. This consultation group will not know the identity of any research participant or organisation, nor see any raw data. Consultation was also carried out with two primary care providers who cater to urban homeless populations, and the Komiti Whakahaere of the New Zealand Coalition to End Homelessness. These parties all acknowledged the potential benefit of this research and supported the research proposal. This consultation process meets some of the goals of ensuring beneficence, cultural sensitivity and respect for human dignity within the purpose of this study.

The research participants were registered nurses who a) currently practice in a secondary community mental health or primary care setting, and b) who provide nursing care to people experiencing homelessness. It was considered desirable to include participants from both primary and secondary care settings in order to produce research findings with a relevance to the two practice settings where homeless people commonly receive

⁵ I consulted with Mary O'Hagan, former Mental Health Commissioner. Although not interviewing service users, I feel a responsibility to be undertaking research that is useful for mental health service users, and to found it useful and inspiring to discuss my research proposal with such wise counsel prior to data collection.

community nursing care, and confer wider transferability and applicability to other hard-to-reach-populations. Eight participants were recruited from around New Zealand using advertisements sent to clinical leaders in access-approved sites. There is no conflict of interest in regard to researcher and participants, with no research participants recruited from the researcher's own organisation/employer and no payments were made to research participants. No homeless people or health service users were research participants. The ethical considerations of doing no harm and respecting human dignity were further met through this participant recruitment process.

Confidentiality of the participants' identities were maintained in the treatment and use of the data by use of pseudonyms, anonymising any identifying characteristics such as age, gender and ethnicity, and concealment of identifying geographical information including the location of their employment. All interview data was stored on password protected on the researcher's computer, within a locked building. Consent forms were stored in a locked cabinet, separately to data and any recorded material.

Health service users were not interviewed in the course of this research, and any practice examples discussed by research participants in the course of interviewing were fully anonymised by blanking names on the transcript, using pseudonyms (if needed), and removing identifying remarks from the transcript. Ethical consideration was also given to the potential harm or discomfort that might arise should research participants disclose unprofessional practice in the course of an interview. This did not occur, but in such a case supervision would have been recommended for the participant, and the researcher would discuss the issue with their own academic supervisor.

Data analysis

Critical thematic analysis has been utilised to analyse the interview data (Braun & Clarke, 2013). This process began with note taking during the interview process, followed by reading of the interview transcripts, where familiarity with the data grew and general themes were noted. This informed the subsequent in-depth, line-by-line reading of the transcripts during which coding was noted for broad themes or categories, where "[c]odes identify and provide a label for a feature of the data that is potentially relevant to the research question" (Braun & Clarke, 2012, p61). Close reading and coding of the transcripts suggested broad identifiable themes that were then compared and contrasted to find sub-themes and patterns across all the interview transcripts.

After repeated reading and the initial coding of the data, the transcripts were printed onto coloured paper (a different colour for each participant transcript). Key text highlighted from the coding was then cut out for grouping into themes. The broad themes then 'spoke' to each other visually and across the eight transcripts. As Braun & Clarke (2012, p. 63) state, "searching for themes is an active process, meaning we generate or construct themes rather than discovering them", with each theme explored "in its own right but also in relation to the research question and in relation to the other themes". Some coding was descriptive and 'mirrors' the participants' use of language, while other codes were more interpretive based on existing theoretical perspective. Therefore, while coding and exploring potential themes the researcher's own view was being formed and interpretation of the participants' own reflections began to coalesce (Braun & Clarke, 2012).

Data interpretation is the final stage of the critical thematic analysis process, following on from coding and initial thematic analysis. Interpretation of the data involved mapping the themes and subthemes onto A3 tables, from which central and dominant themes could be visualised. This process also highlighted key interview quotations. This thematic spread was then structured and written up into the Findings chapter.

Summary

This chapter has presented the qualitative methodology utilised in this research study, justifying the research design and methods used. Participant recruitment, data collection and ethical considerations have been discussed, as well as the step-by-step process by which the data was analysed using thematic analysis methods. The philosophical assumptions and critical lens of this interpretative research study have been related to the methods used, and which carry through to the Findings and Discussion chapters that follow.

Chapter 5

Findings: Valuing relationships, working with uncertainty

The previous chapter presented the design and methodology for this qualitative study, describing the use of critical thematic analysis as a research method (Braun & Clark, 2012). The purpose of this research is to better understand and describe engagement as nursing work, especially because engagement is identified as a cornerstone of health care provision to people experiencing homelessness. Semi-structured interviews were transcribed and the data analysed using critical thematic analysis, drawing on DeFrino's (2009) theoretical framework for the relational work of nurses. The research questions and this critical interpretative lens are both influenced by the researchers' own world view and nursing experience, as discussed in the introductory and research design chapters. The research participants' words form the data that has then been analysed.

Nursing practice has been previously described as a combination of tasks, interpersonal relationships, and self-reflection (Sitzman, 2002), and the research participants described all of these elements of clinical practice. Interpretation and thematic organisation of the data is used to present the participant experience in discrete but connected stories about this nursing work. These stories will then be explored further in the Discussion chapter.

The research participants were asked to reflect on the importance of therapeutic engagement in their nursing work with people experiencing homelessness. They described the relational work involved and the interpersonal challenges they experienced. A clear theme emerged of nurses valuing the relationships at the centre of their practice, with a second major theme being the uncertainty and ambiguity experienced in this practice context. The nurses' personal experience of relationships and uncertainty became discrete subthemes – of relational and uncertain selves. Engagement as an intentional nursing practice was another subtheme that emerged, which resonates with both the research questions and DeFrino's (2009) theoretical lens. The participant descriptions of nursing documentation and clinical planning converge into another subtheme, as did the challenges and barriers experienced in doing this nursing work.

Within the theme of *Valuing Relationships* are three subthemes:

1. Relational selves: how the nurses' descriptions of their relational work highlight their personal values and attitudes, as well as their own meaning-making from it.
2. Engagement as a nursing intervention (not only as a vector for other nursing interventions).
3. Relationship difficulties: the barriers, challenges and personal distress experienced by participants in their nursing practice with a hard-to-reach client group.

Within the theme of *Working with Uncertainty* are three subthemes:

1. Ambiguous work: participant descriptions of their changeable practice experience.
2. Documenting uncertainty: how this changeable and uncertain practice is clinically documented.
3. Uncertain selves: a thematic flow-on from the *relational selves* subtheme, describing the uncertainties of clinical practice whilst putting the relationship first.

Valuing the relationship

Engagement and therapeutic relationships were described as important by all the research participants. This is unsurprising, given the centrality of therapeutic relationships to mental health nursing, as noted in the literature review chapter, and that the participants self-selected to discuss this research topic. In reply to semi-structured interview questions about their experience of engagement, the nurses gave general descriptions of connecting with clients, of relationship difficulties and of making 'real' relationships. The research participants spoke about their intention toward relationship and how this informed their day-to-day nursing practice, such as their orientation toward responsiveness and being helpful, as well as more generally their valuing of genuine relationship with clients. They also described specific rapport-building strategies they utilised, and with further reflection they described attitudes or beliefs that underpinned this practice. Relationships with colleagues and work environments also mattered highly, where health systems and collegial attitudes were described as being barriers or enhancers of engagement-centred practice. These various elements of relationship-making are grouped here as a theme termed *Valuing the Relationship*, with three subthemes of *relational selves*, *engagement as nursing intervention*, and *relationship difficulties*.

Relational selves

DeFrino's (2009) theory of the relational work of nurses highlights the therapeutic relationship as a central aspect of nursing work. The nurse's 'doing' of this relational work emerged as an important theme in the data, where in describing the experience of engagement the nurses were also noticed to be describing themselves as relational beings. The participants spoke about engagement skills – as the technical tools of this nursing work – and also the values and intentionality of this approach. They spoke about the slow building of rapport and trust, and how this connection strengthened and became a safety net in times of high need or crisis. Interpersonal relationships draw on a person's own attitudes and values - their world view - and the research participants also spoke about this aspect of their relational work. I have begun with this subtheme of *relational selves*, because the research data was rich in the personal attitudes and politics of the nurse participants, which in turn contextualises the other clinical themes that emerged.

When asked about engagement as central to their work, the participants readily described it thus:

You know, its relationship. It's that connection that you have with that individual and providing them with that care, and intervention and treatment that they, that's required (Hilde)

...I think my role in that place and their place is, is to be the rope bridge back... let's try to establish even just a thread of trust... (René)

...its like somebody who actually listened to their story and somebody who actually cares... (Dorothy)

Some of the participants described the therapeutic use of self as “a part you're playing” (Phil).

I mean you know, over the years you sort of develop a better bit of wardrobe don't you [laughs]. (Walt)

I have to change myself according to what comes through that door... (Dorothy)

Sometimes you roll your sleeves up, sometimes you pull them down (Walt)

The clients were also perceived to be playing roles or 'parts', too, within these therapeutic relationships:

You walk in and see this real staunch looking guy covered in tats, really pretty rough and really, while they're there with you they don't have to have that outer exterior in place. They can be the other person. As soon as they walk out the door they're not; they've got to go back and be that staunch person... (Millie)

The participants related their use of engagement and rapport to their own personal experiences and style. All of the participants had clinical and life experience that they described as a strength for working in this field, linked explicitly to a perceived personal ability at relating.

I've had a lot of experience as a nurse and that was really one of the big, big factors that [helped me do this work]. (Millie)

I can put myself and always have been able to... put myself at different levels of ah engagement with people; it doesn't matter how old they are, or background... you just adapt around that you know? (Phil)

I mean [pause] you just use your experience yeah and your own knowledge of how to work with different types of people in different types of situations, and with different levels of engagement with discussion and conversation and humour... (Phil)

It was expected that the participants' own life experience would influence their therapeutic use of self, and the participants' values and personality was evident in their talk. For example, Millie reflected on her career and the kind of nurse they are, including her intention and choice to work with people experiencing homelessness:

It's not training. It must be – a huge amount of it is part of who you are and I believe life experience and where you've been; I training in [a large international city], a very low socioeconomic part of [that city] and that's not where I was from... I just think I've been exposed to a whole variety of different people and I've always been open to different people. (Millie)

So, perhaps it is part of the personality of who you are and what you've dealt with before. (Millie)

When asked what was especially nursing-related about therapeutic engagement, Flo related this to interpersonal work of nurses as well as her social justice values:

The unique relationship that nurses can have with patients... the intimate relationship that nurses have with patients or clients.... And also that fact that we have and should have a public health responsibility, and looking at social determinants of health and the wider causes of health... and the greater sense of intervention around housing poverty and trauma... (Flo)

Other participants spoke about their general attraction to this marginal site of health service provision, with its relative autonomy, lack of uniforms, and socio-politics. As Walt reflected, "...this is probably always the sort of nurse I was always going to be..."

I've always wanted to be a scruffy nurse [laughing]... (Walt)

Therapeutic relationships are indicative of how much the nurse actually knows the client, and but also generate positive professional rewards for the nurse (DeFrino, 2009). As Walt stated – "It makes life richer".

It's been about six years now and I didn't think I'd find it as rewarding as I do working long term with people, through the ups and downs over the years, good and bad.... I love it. (Walt)

I think personally for me it humbles me a bit as well... I quite like it you know...in a sense of like it grounds me and I go, this is what the real world's like out there... (Phil)

I quite like being privy and having access to that sort of slightly hidden strata.. of society, if you like, all the comings and goings... It makes life richer. (Walt)

Many of the nurses spoke about working with whatever issue presented, behind the confines of their service criteria or scope. Walt spoke about a group of people experiencing homelessness who he felt were underserved. He described a potential client group who were outside the usual remit of his own health service, but who were not served by any other services. This belief, and its implicit social justice values, was apparent in much of the interview data.

Health care is a right. We have the right to have access to health care, and I genuinely believe that ... it still works out cheaper in terms of the national health budget if I spend time with somebody now and charge them nothing, and then get intervention and ... that mild to moderate [MH stuff is addressed]... it tends to cost more down the line. (René)

I think we've got a whole generation of clinicians who have grown up believing the, the neoliberal rhetoric... it's like well that's your problem... rather than you know, more thoughtful thinking of you know, the, the social, environmental determinants that get somebody to this point; what else is going on? (René)

René's reflection was that health services are too siloed, saying:

...and so the political part of my personality really sort of got drawn to the intention of the Declaration of Alma-Ata and the intention of what primary health care is not what is determined by the Primary Health Care Act, and ...for-profit GP business – primary care is something different. It's community embedded; it's accessible and affordable and ambulatory and... you are part of the community in a way that works best for the community, and you have to work really hard at that. (René)

A balance struck between boundaried professionalism, the autonomous taking of initiative, and the heart-felt rule-bending are threads apparent from the nurse's descriptions of practice with this hard-to-reach population. For René and Hilde this was a prioritisation of providing time and care, whether or not the person was registered with their service.

I will see anybody, whether they are registered [with the health service] or not. (René)

...and if they're happy to do that piece of work with me I would rather do that piece of work, rather than sort of refer them on and they fall through the cracks... (Hilde)

Similarly, Isobel described the informal referrals or expressions of concern that she received from homeless services, to which she responded with boundaried autonomy:

[Someone] would call me up and I would go down and just not tell anyone. Because I could and I was going to... [which works ok] as long as you've got a nurse that's got clear boundaries and doesn't need to be needed, because those people can really stuff it up too: "oh, I've got to rescue this person..." (Isobel)

Engagement as a nursing intervention

DeFrino (2009) identifies that the relational work of nurses is sometimes undervalued in contrast to their technical work, and George et al. (2015) give a definition of engagement as practical assistance plus therapeutic relationship. In this research context, looking at the

nursing experience of engagement, it appeared that the participants viewed their practical help and technical interventions as part of their relational nursing work.

René gave a clinical anecdote of slowly building up a working relationship with a man living in the city's green belt, which laid the ground work for trust and connection that was required during an episode of acute mental distress.

I remember, I met a guy who was sleeping in a truck in [park] and he wouldn't tell me where his truck was... he was quite delusional, sort of quite strong paranoid psychotic thoughts around posing with mercury and all sorts of stuff. And the only place I would see him was in this outreach and... it took probably a few months before you know - and it's that bridge building stuff. But you can't do anything until you've made that connection. It doesn't matter how skilled you are; you could be the best Psychiatrist, but if you actually don't have a platform to talk equitably from, you know, it doesn't matter what skill you've got. It's useless... And so, having established some connection with this bloke you know, he never told me where he slept... eventually managed to get him into the clinic. It's like say slowly, slowly, at his own pace... The only thing you can do is make connection; you can't push it, otherwise you end up pushing away...

George et al.'s (2015) description of engagement can be seen in René's anecdote, with the added important dimension of time. This is similarly described by Walt:

... if you think [about] it from a stage wise case management perspective with the first stage being engagement, a lot of our clients remain at that stage for a long, long period of time, still doing the kinds of things, the kinds of interventions in that first stage for a very long period of time, rather than progressing to more advanced treatment levels. (Walt)

René and Dorothy spoke about this process not being a one-size-fits-all, and Walt commented that relationships “forged” in argument can become strong.

...really marginalised people, I think they are truly the ones who we built up an amazingly strong relationship with. (Millie)

Several research participants identified this relational ability as a nursing skill, along with knowing the health service terrain and coordinating care, by, for example, linking between primary and secondary care.

My nursing skills come into play in the relationships that nurses are trained to build... (Isobel)

Phil wryly described his outreach nursing as “...just me talking to people on the streets...”, as well as taking therapeutic moments alongside the tasks of nursing, such as conversations had while administering an intramuscular injection.

The research participants described their engagement process, such as Walt speaking about building rapport gradually and with persistence, and René emphasising the need for nurses to try to “understand where client is coming from”.

Personally, two things of engagement are.... about flexibility and consistency, so doing what you say you’re going to do... (Walt)

Walt also spoke about flexibility and “being available”, and Hilde emphasised being “present” and “having that general chit chat”. Isobel spoke about remaining curious and the importance of “just asking” clients about themselves and their health. Dorothy suggested that telling clients your own story is important, and she valued that clients would just “drop in” to see her. These participant descriptions resonate with the principles of the Tidal Model (Barker & Buchanan-Barker, 2005), as noted in the literature review.

Dorothy voiced the importance of maintaining the connections with clients, and Hilde emphasised familiarity. Millie noted the importance of “leaving that door open” for

engagement or contact. Both Millie and Dorothy spoke about “judgement free zones” and René referred to client-owned spaces, which was identified as important from Nikora et al.’s (2012) New Zealand research. For example, Millie said she aimed to be accepted by the clients, which related to being non-judgemental and welcoming:

They’ve never been turned away because of how they look, how they smell, or in some cases how they behave. And it took a long time to build up that trust... And then the tide sort of turned a wee bit because they got to know me, and I remember one guy came in and he said... he said you’re not too bad for a Pakeha... and I thought oh wow, there we are! (Millie)

Walt described his impression that clients appreciate being ‘known’ by the nurse, and Dorothy suggested that outreach contact should be meaningful for the client and reciprocal – like an “actual relationship”. Dorothy elaborated:

I’m not stupid. I’m not going to become over-involved. I’m safe – but being human and genuine and interested in another person is actually what’s kept people connected, you know? (Dorothy)

Other nurses also emphasised the formation of ‘actual relationships’ – where a nurse’s engagement as a health intervention could result in lasting relationships:

... he still very much sees us as part of that extended family that’s still safe (Millie)

When he died after three years [of nursing contact] I said goodbye to him and... I arranged his funeral for him... (Walt)

As discussed in the literature review chapter, there is a recognised population of people experiencing homelessness and chronic psychotic disorders who struggle to meet their basic functional needs despite intensive community treatment (Burns et al., 2009). Striking a balance between assertive health interventions and not intruding on individual’s access to homeless services, such as soup kitchens, is an important consideration for the assertive

outreach model. Phil emphasised the need to not scare people off, where outreach to homeless service spaces - for example to an emergency accommodation provider – may frighten people away from accessing those important resources if that person is trying to avoid mental health services.

What we do find though is that we tend to frighten people off, because they go into places like the soup kitchen and [emergency accommodation] and really the last people they want to see is mental health services because they can be running away from them... [So] we try to do it as very low level, in the sense of that we don't want to jeopardise... previous engagement with people and make people more vulnerable... (Phil)

Hilde similarly spoke about not being intrusive but building up familiarity with rough sleepers:

I think a lot of it as well, its raising visibility isn't it? So you don't want to intrude on people and be in their face.... It's the familiarity isn't it? So, you see them a couple of times, they get used to you. You know where they're from and then it's that slow engagement and not just being in people's face... (Hilde)

An understanding of trauma informed practice was voiced by some participants, although not always using that terminology. Dorothy identified her skills in trauma-informed care as being important with this client group, where an understanding of how people respond to past trauma shapes the nursing approach. This included not expecting or asking the client to revisit their experience (Dorothy) or re-tell difficult and possibly re-traumatising stories (Walt).

I don't always dig too much because I often feel if they've got to tell that story they don't want to keep telling it (Millie)

...we try to do it as very low level, in the sense of that we don't want to jeopardise... previous engagement with people and make people more vulnerable... (Phil)

...as I've mentioned, a lot of people in the outreach there would have had experiences of mental health services, and none of them want to rehash it... none of them want to go over it... (Walt)

Flo emphasised the impact of trauma on this client group, linking this to the value of skilled nursing interventions. A trauma-informed approach influenced many of the participant's nursing practice, and was also perceived to influence the engagement ability of their clients:

Um, I find that they have real difficulties maintaining friendships, maintaining trust. They've got a lot of trust issues and there's a heck of a lot of them have got PTSD or undiagnosed PTSD and trauma induced type psychosis. (Phil)

Phil likened this more to a skilled or confident performance:

You're almost role playing all the time but it's you, you know? ...I just talk to people. That's all I do you know? It works most of the time. I can put myself and always have been able to ...at different levels of engagement with people; doesn't matter how old they are or what ethnicity they are, or background... you just adapt around that... (Phil)

...I've worked in psychotherapeutic type dynamic sort of services and that's a bit much for me – no... just let me talk to people on the street or something like that. (Phil)

Phil described outreach contacts or gradual engagement via informal 'referrals' from homeless services, for example emergency accommodation providers, where formal health service referral and initial clinical assessments are not done. Rather:

... what we have done before and which has worked quite successfully is that we'll offer them the chance to just continue some engagement with us, so every week, we'll sort of bump into and see how they go . And that has worked with that whole engagement process and people have actually – we've taken them on our team just by that slow sort of engagement, seeing them every week. (Phil)

I would see them on the street when I'm walking through town. I would – I mean it was often a great site for information or to find what's going on, or who's doing what or who's gone missing, or who can I talk to. So that, just that being a familiar conduit in the community you know. (René)

The participant descriptions also showed that the nurses were performing a consultative role, which Walt perceived as being appreciated by staff in other social or health services.

So we've got a sort of arrangement with them at the moment where they can consult us around people they've got concerns about... (Walt)

This relates to the nurse's role advocating for their clients, as well as challenging stigma and the impact of marginalisation, in order to to sustain a tenancy or get support from another agency, for example.

I'm very committed to finding out my client's needs and supporting them to get the best possible for themselves, and advocating... (Dorothy)

Flo emphasised the role of advocacy in this nursing practice, suggesting that skilled advocacy was not adversarial but based in process, which nurses bring their skilled

understanding to. As such, the relational work of nurses goes beyond the client-nurse relationship.

And that's quite a bit of work actually... talking staff through it, trying to kind of get a bit of perspective on this person and where they're coming from, really focused in on the positives about what they're doing, rather than the fact that they're singing too loudly and – or having the music up too loud, that kind of thing...

I see it in my colleagues. We can become quite fierce champions for our clients. (Walt)

Flo suggested that nursing had “lost its way” somewhat, regarding its professional role in linking relationships and advocacy. A similar social justice attitude was apparent from many participants. This also manifested in description of recovery-oriented practice, such as collaborative treatment planning and note writing. Such empowering practice is championed in mental health service models such the Tidal Model (Barker & Buchanan-Barker, 2005), but Hilde was the only participant who spoke specifically about collaborative nursing documentation and sharing what they have written with the client:

...if I've done that full comprehensive assessment and got all that information, however long it's taken. You will still have the sort of day to day documentation, but the over-all full assessment is... I'll go back to that individual, because I want to make sure I've got their story right. So I'll share my formulation [with the client]... because at the end of the day it's their story, it's not mine. (Hilde)

However, several nurses spoke about being responsive to their clients, which is a key aspect of relational capacity (Hartrick, 1997) and also of the Ethic of Care framework (Tronto, 2013). Being responsive was also reflected upon as task-oriented practice. It appeared to mean working to the limit of their RN scope, such as one nurse reflecting that attending to physical health, for example wound dressings, was outside their mental health nursing scope of practice, whereas using a sphygmomanometer to take blood pressure

measurement was within scope. This could be described as an *holistic* approach, however more than one nurse identified that a broader role would be potentially beneficial for engagement with homeless service users.

I'm a mental health nurse and I can only practice in mental health, so I have to sort of... it's a sort of limitation of my practice, which I recognise. (Walt)

Dorothy commented on the various roles and tasks of the nurse, where tasks may disrupt the engagement: "I've thought wow, I want to take your blood sugar levels – but then does that actually change our rapport? Does that actually change who you think I am?" (Dorothy)

Isobel expressed a view that, due to distinct service roles, a client's physical health needs are not always being cared for as much as mental health needs. "Sometimes their medical health, that's what I think lacks some thinking, nursing thinking..."

Personal cares are quite a biggie. I've found with a lot of mental health patients. They don't realise that their feet or something are getting into such bad state that they actually need some help with that. (Millie)

Millie also commented on the comorbid injuries seen by nurses working with people experiencing homelessness, which often involved health needs beyond the scope of mental health interventions:

They have quite serious injuries, hand injuries are the main ones, just because they get into fights... They have all of these nerves and tendons stitched back in place and they never go back, whereas the whole part of recovery is to go back and...get the physio. And they just don't do it and they end up taking off their own plasters... And you have unhealed fractures quite often... getting to appointments becomes too hard. (Millie)

The limitations of scopes for particular health *systems* was also described. Participants described their perception that service models (such as primary and secondary) can be too prohibitive or narrow to meet holistic need, such as comorbid health problems plus a need for trauma counselling plus a need for supported living environments (René).

Sometimes there were barriers there and it was difficult to get them in, and because of the type of people we're dealing with they didn't always keep their appointments or be where they were supposed to be for someone to come and see them. They were hard to find. [laughs] I mean, it wasn't always easy. I mean they aren't easy people to engage sometimes. (Millie)

But this again returns to the nursing therapeutic relationship, where the participants spoke of their persistent engagement helping to get their clients access to primary care or other services needed.

It took me four visits every day to get him there [laughing]. (Millie)

Ruling out physical or organic illness as part of basic mental health care was described as important within Dorothy's outreach contacts, as was assessing for co-existing disorders or acquired head injury. Isobel shared an anecdote referencing this same issue, and highlighting the role that relationship and nursing advocacy has for the wider health needs of clients:

I reserved a bed for him um because he was very unwell, not just with substances but he hasn't been eating, very gaunt and all that, very gaunt and um very distressed and sleep deprived – which is coming across as severe mental health. But I think if we can feed him and he gets some sleep, I think that'll settle down quite nicely thank you very much. (Isobel)

Relationship difficulties

During the initial coding of this research data a broad theme of *barriers to engagement* was apparent across the participant descriptions. Further close reading of the data, as per the process of thematic analysis (Braun & Clarke, 2012), lead to this subtheme of *relationship*

difficulties. The description of such difficulties in 'doing engagement' with a hard-to-reach client group seemed to be a more accurate reflection of the participants experiences than analysing these as *barriers* to engagement. As such, this subtheme will report the participant descriptions of the various difficulties experienced in the valued relationships of nurses, including with other clinicians and homeless social services.

As outlined in the Background Chapter, interagency networking and collaboration is relatively common in the homeless sector. Some participants spoke about expectations from social agencies in the homeless sector, where the expectations are not always in keeping with an engagement approach. There was an importance placed by several participants on collegiality and relationships across the health and homeless sectors, tempered with a feeling that social service staff did not always understand the process or role of therapeutic engagement. As Phil commented, "the NGOs would like us to do more", and sometimes "they'll wheel them [clients] in to us basically...[laughs]". Phil stressed the importance, therefore, of nurses being "...clear around what their expectations are and what we can actually bring to the table...". This seems to resonate with Hartrick's (1997) concept of relational capacity in nursing, especially the capacity to work with complexity and ambiguity.

Hilde commented that collaboration between agencies has become "the norm", at least in their local sector. Walt felt that homeless sector staff were appreciative of his consultancy role, however he also spoke about limitations with non-health services, including some Non-Government Organisation (NGO) staff "freaking out" and not being able to "tolerate" the client's behaviour. Dorothy identified a perception in the wider homeless sector that non-health service staff wanted nurses to "fix" people experiencing homelessness; this can be interpreted within general public perceptions and misconceptions of mental disorders and mental health care. Isobel also suggested that some social services had unrealistic expectations of health workers, thinking that "we'll just get them a house and then do this and then they'll be cured..." (Isobel). This is also suggestive of others placing value on nursing's practical tasks above the less visible relational work (DeFrino, 2009). Flo similarly spoke about a general lack of understanding of nurse's skill and knowledge within the NZ homeless sector, suggesting there was a "lack of understanding about competencies, about nursing, about scope..." (Flo).

Several participants commented on the wider health and social systems where “...loads of the presentations there you know, are attributable to socio-economic deprivation and stuff” (René), but there was perceived to be insufficient funding and a lack of resources (Isobel). René felt that time constraints could hinder engagement with clients, and a certain focus on health outcome measures does not translate well onto homeless health. Societal structures and public perceptions were also cited by participants as relational obstacles within health and homeless services:

*...they're [the clients] judged even before they get seen by the way they look, um and who they appear to be, without them really knowing who they are and what they've come in for.
(Millie)*

What I've notice with some people is trying to impose their own thoughts on what their life should look like. [Isobel]

Isobel felt strongly that some clinicians were unreasonable or unfair in their expectations of disorganised or transient clients: “This shit where people go oh, if they don't turn up for an appointment they're not motivated...”

René reflected on the difficulty they experienced in prioritising therapeutic engagement within a pressured work setting, comparing it to more easily quantifiable and quick medical intervention:

*Our job is to create therapy, moments of therapy and getting insulin is a therapeutic intervention. Giving somebody a cup of tea in a quiet space is a therapeutic intervention and we don't do that very well at all...
That's what I notice about health services. I have no problem making people a cup of tea. (René)*

Relationships with secondary services, especially acute services, also presented difficulties for some of the participants. This included a perspective that health services were not understanding of the needs of disorganised or chaotic clients, and that they held what

were viewed as unreasonable expectations, divorced from social context or reality. There was also the difficulty of clinical responsibility:

They'd like us to do formal assessments, yeah, but there's a bit of... there's a little bit of resistance around clinical responsibility lies. It's a battle that we have quite a lot, who's picking up the ultimate clinical responsibility. If they engage with us, well automatically they become under our service. (Phil)

Walt expressed similar reservations about clinical responsibility from outreach contacts with people experiencing homelessness:

And we just went ooh, are we just sort of sticking our heads above [laughs] you know, asking for them to get shot off, because we'll be the clinicians. (Walt)

Gate-keeping between primary and secondary care was identified by René as a barrier to engagement by mental health nurses with homeless clients. René suggested that while nurses may be may be flexible and adaptable in their own practice, the service structures are not flexible, which can limit the scope of nurse's interventions and also generate interpersonal conflict between staff. Hilde also shared the view that some health service colleagues appeared to simply lack the interpersonal skills to do the job, being poor communicators, not respectful to clients, or not good listeners.

...it all depends on the individual that you're dealing with on the phone at the end of the day sometimes... (Phil)

External relationships were still important to the nurses, with statements about the importance of networking and professional relationships to their work, such as outreach partnerships (Dorothy), joint assessments (Hilde), and support with specific clients (Phil). As Isobel put it, "...we have less resources um so we kind of have to make friends very quickly...".

Dorothy voiced a concern that secondary mental health services were generally not good at using a trauma informed approach, asserting: “They’re only interested in psychotic illnesses. They’re not interested in anything else, at any trauma, or... other kinds of distress”. Dorothy’s concern was that this created a barrier between outreach and homeless-focused services and the wider adult mental health service.

Many of these threads of perceived ‘difficulty’ in relationship resonate with DeFrino’s (2009) argument that nursing’s relational work is at times invisibilised or submerged by pragmatic, task-based nursing interventions. By inference these challenges also reinforce the core value placed on relationships by the research participants, reiterating the importance of this interpersonal work to nurses’ professional identity (Raingruber, 2003).

Working with uncertainty

The background literature reviewed on homeless health services indicated that outreach and mobile service models are an effective way to engage this hard-to-reach population. The majority of nurses participating in this research worked at least partly in an outreach capacity, with 25% working solely in clinic-based services. Outreach and mobile street-based services require additional flexibility to meet clients’ varied needs, so it was unsurprising that a major theme across the interview data relates to the challenges of nursing work in a changeable and unpredictable clinical context. Within this theme of *working with uncertainty* are three subthemes – *ambiguous work*; *documenting uncertainty*; and *uncertain selves*. This is informed by the findings of the literature review, where Hartrick’s (1997) concept of relational capacity acknowledges - even embraces - complexity and ambiguity in interpersonal nursing work, and Addis and Gamble’s (2004) research on nursing experiences of outreach engagement found that anxiety and fear were common emotions for nurses.

Ambiguous work

The participants spoke about the tension they experienced between formal nursing practice and the uncertainty of street-based engagements. Walt and Phil, in particular, gave descriptions of nursing and team processes that have adapted to this uncertainty. For example they described shared narrative accounts within their health care teams, such as multidisciplinary team discussions. Walt described “ongoing formulation... in the absence

of anything else”, and when asked further about how they recorded and shared their more formal nursing assessments, Walt reflected:

I must admit it's a little bit anecdotally. I think there's a lot of narrative rather than a full formal assessment and any kind of rating scores, scale, tool, measurement tool. It's more around anecdotal narratives week to week, telling, retelling, that kind of thing in this team.

(Walt)

...I'm not sure whether it ever becomes a you know, a comprehensive core assessment. I suspect actually it becomes more of a working rolling narrative... (Walt)

Phil described the important role that the health care team and clinical colleagues had in holding collective, working narratives about clients. These may not always be documented:

We capture [the changing work] amongst ourselves, really... And when we do our MDT every morning, you know, as a peer type support arrangement, we capture a lot of information, but we don't record that particular every interaction we have. (Phil)

The participants' descriptions of outreach nursing were congruent with that outlined in the review of literature, and outreach engagements appeared to be operationalised as a fluid team practice. For example, Walt described client engagement as involving nursing and social work colleagues, not simply a closed nurse-client interaction:

...asking your colleagues, relying on your colleagues that are out there looking for their clients to look for yours... so whole team approach, having the time to just go out and be out [doing outreach]. (Walt)

This outreach work was described as book-ended by team process and multidisciplinary reflection, which extends the rolling narrative or formulation:

And then we'll come back [to the clinical office] and we'll discuss it. And then we'll try another angle or you know... [to engage]... that hopefully will have some therapeutic value, or meaning... (Phil)

This process of outreach and gradual engagement, as described in the *valuing the relationship* theme, is suggestive of a changeable practice context for these nurses. Phil describes this as “never knowing what you’re going to get”, going on to describe how this reinforced a tendency to “stick to the basics” in his nursing practice.

It's how that person wants to engage on the day, which can ... invariably change. You never know what you're going to get on the day, you know. From one day to the other... I tend to think that we stick to the basics of it you know, mental state, how things are for them at the time, what the plan is, anything significant from the actual interaction, mood, that sort of stuff. Intoxication. (Phil)

Isobel and Millie commented on the difference between street-based engagement and clinic-based interventions, especially the factor of time for long term or chronic health problems associated with poorly engaged and homeless clients:

It's not a quick 10 minute [intervention]. (Millie)

They've taken so many years to come to that point, they can't improve in a couple of months... (Dorothy)

And, and how do you measure success? Why in health have we got this obsession that success has got to be 100% turnaround within three months? (Isobel)

Within their descriptions of ambiguity and clinical uncertainty in their nursing engagements, the participants also spoke about the impact of this on the client's wellbeing and receipt of consistent medical treatment. As Phil commented:

The majority of them probably undertreated or aren't receiving as much support with medication for both their mental and physical health. (Phil)

Documenting uncertainty

Several participants spoke about how uncertainty influenced their nursing documentation, formal assessments and plans, and the content of team hand-over meetings:

So you're dealing with the crisis that's in front of you on that day, but at the same time you're finding more stuff out and you can add to your whole picture. (Dorothy)

I mean, the way I put things in the notes is that if there's any difference between each individual engagement that I have with them... then I'd make a note of it... You know, and if I feel that the engagement and the therapeutic relationship is improving or worsening, then I'd obviously document that. I'd document that over a period of time as well, but what I don't do is go deep into that individual therapeutic intervention at the time and you know, not into massive detail [in my notes]...

[But] it'd be lovely to be able to do, you know, sit there and do narratives with people... That would be pretty good... (Phil)

Walt reflected that “the core assessment won't be updated week to week, not in any physical form, that's for sure”, and he felt that formal documents can feel like a check list rather than something substantive. But he also thought that a screening tool of some sort would be useful:

So it feels a little bit like a checklist; does the person have a partnership plan? Yes – rather than any kind of quality, any sense of quality in the document, you know. As long as it's been updated... within the last six months it's fine, but no one seems to really talk about the quality of what's in the document, the information. (Walt)

I've thought it a couple of times actually when we've been chatting to people, that it would be nice to have some sort of screening tool to hand... (Walt)

Walt went on to describe the challenge of documenting hard-to-reach engagements, where the engagement itself is the daily priority rather than completing formal documentation or clinical templates. George et al. (2015) have queried whether clients receiving practical assistance equates to actual 'engagement', but Walt's description of his engagement surely still sits within DeFrino's (2009) theory of relational work, where practical tasks, assistance provided, and therapeutic relationship together make 'engagement'. For example, Walt acknowledged that:

...without a proper comprehensive assessment, there's probably stuff you're missing. Now it's probably workable without that information... but ... I mean it's about these people who don't want to engage with us, so you never really get to sit down with them and do that bit of work.... And suddenly you've been working with them for six months maybe; that piece of work maybe hasn't been done, but you've got a workable relationship. You've engaged with them and medications working... you're doing a lot – you know? (Walt)

The dynamic issues and clinical progress described as a focus of Phil's nursing notes indicated that, in some ways, change itself became the focus of documentation.

Hilde commented that she was always interpreting as she went along, in client contacts. Several participants also alluded to not necessarily being task oriented with their written nursing plans:

What you'll see in my notes, it'll be documented in the content in the sense of I've seen today, appeared to be blah-blah-blah... it's a loose way but at least it's sort of documented in that sense... (Hilde)

I don't do specific – I mean I can ask questions, but I do it in a conversational model. (Dorothy)

*... I would suggest that our other plans are quite individual,
based on strengths and sort of hopes and dreams... (Phil)*

When reflecting on the less formally documented aspects of their nursing care, Dorothy suggested that the flexibility required in this practice context reflected different priorities:

*We have to work in a different way here ...
You just keep going and it's not quantifiable. (Dorothy)*

This lack of formality echoes Phil's comments about engagement as sometimes not feeling formally clinical, and how this can feel uncertain and anxious to the nurse:

*We are doing assessments as such but not formal assessments...
I would like it to be a bit more formalised on the assessment front, yeah...
I feel a bit like in limbo myself a lot of the time really. (Phil)*

Phil's comment echoes the cited literature on engagement, where Addis and Gamble's research found nurses experienced engagement as anxious and pressured, with feelings of both satisfaction and dejection. This is explored further in the final subtheme of *uncertain selves*.

Uncertain selves

Despite the uncertainty of this nursing context, there was a sense of enjoyment from many of the participants about the ad hoc nature of their work, with Isobel describing the necessary nursing style as "a bit creative". Dorothy reflected on the benefits of nursing autonomy that underpins this *ad hoc* practice, but also reflected that this may make their work somewhat opaque or invisible to others, including clinical managers or employers:

*There is freedom in it ... [but] how would they ever give me a
reference and say what I do? (Dorothy)*

There was a general acknowledgment that the nurses' world view and lived experience is often different to the experience of rough sleepers, especially those experiencing mental health problems, acute social stressors, or drug dependency. The clients' priorities can simply be different, the nurses felt.

We have to be realistic on how their time is spent too and it's hard to say oh they should have responsibility for their problems, but life is so chaotic and pressures so high on them that it doesn't happen. (Millie)

If someone wants to talk to you they don't want to wait two weeks for an appointment... they don't know where they're going to be. (Dorothy)

...they're so likely to disappear from care. But you know, they could be with you, coming to see you regularly for a couple of months and then gone... (Dorothy)

I just spoke to somebody a few days ago who, who had been homeless for quite some time... has managed to hold onto accommodation but is still struggling with that. He needs to bring other people in to help pay his rent, but the people he brings in are also of a similarly...chaotic disposition, so they come in, don't pay the rent, come and steal possessions...[leading to stress and tensions].... So, even though he is now stable it's... it's a tenuous stability. (René)

Walt perceived a level of base-line chaos and disorganisation which often put their client's tenancy at risk, all too frequently resulting in clients returning to rough sleeping and becoming hard to find for clinical follow-up.

...that's the reality of someone trying to meet their, their, their day to day needs um in a pretty challenging situation, with only a certain set of resources.... (Walt)

...what might seem like a risk to me is not a risk to them, you know? (Dorothy)

Um, also we'd see people who will get supported accommodation, get emergency accommodation, destroy it, be out on the street, come demanding accommodation, move in, don't pay, get kicked out. (René)

...because if your mind's not thinking straight half the time and you've got all this going on inside your head, how can you remember from day to day where you should be? (Millie)

An uncertain practice context or terrain was described across the interview data. Flo commented on issues of professional isolation and vulnerability for nurses working in the NZ homeless sector. Addis and Gamble's (2004) research on the experience of working in an Assertive Outreach model found that the acceptance of anxiety and fear was a common feeling for nurses. And DeFrino's (2009) theoretical framework links the disappearance of nurse's relational work to potential disempowerment and 'burnout'.

Some participants voiced concern about being clinically vulnerable, such as Walt's worry about seeing clients "casually in walkabout" and then being held clinically responsible, especially if an adverse incident occurred subsequent to that casual contact. René described his own emotional experience of holding hope while working with clients who are experiencing quite difficult circumstances:

It's so distressing and in terms of like therapeutic, this is a moment of therapeutic potential. We could actually do something really good here, but we could make it worse...(René)

Strong team work and collegiality was expressed by most participants as important for helping to manage worry and stress, as summed up by Phil:

We have a really good MDT, but we have a good laugh at the same time because we need to release some of the stuff that goes on... you see some things that you would never ever be able to describe to someone else you know, if they didn't think you

was having some sort of psychotic episode yourself you know?
(Phil)

Also noted by several participants was that homeless engagement and therapeutic use of self can be impactful on themselves, referencing stress, burnout and vicarious trauma. Millie spoke about there being a lack of supervision and support, and that she had experienced isolation in her role. Inter-disciplinary peer support, using breaks and going for a walk were Millie's described ways of managing stress. René suggested that this work context can be "so distressing", where being in relationship with someone in dire circumstances can be challenging to accept as a professional and as a person, giving the example of being unable to help house a rough sleeper:

Well there's nowhere to go; good luck, stay warm. (René)

This again echoes the findings of Addis and Gamble (2005), as well as Hartrick's (1997) description of relational capacity where uncertainty and ambiguity are accepted, even *expected*.

As Dorothy said, "...you as a clinician feel so helpless" but that "I work with an awareness of how I'm feeling":

...you're dealing with those emotions in yourself and I think it's really important to recognise that... (Dorothy)

However, Dorothy also mused that one personal strategy she used was to - "detach from me and deal with it later". René made a similar statement:

You don't actually think about it. That seems – that's just the process that you follow and that's what everybody else does, you know? (René)

DeFrino (2009) expresses concern that the paradox of relational work being vital but invisible could lead to nursing burnout. These later comments by the research participants do suggest a reason for concern with this uncertain nursing work. It could be that aspects

of the nurses' relational selves are a buffer for this, such as the performed role where nurses described adapting to the challenging situations and complex needs they encountered. That may be a subject worth further inquiry.

Chapter 6

Discussion

“There are some enterprises in which a careful disorderliness is the true method.”
(Melville, 1851, p. 395)

Introduction

The previous chapter presented the research findings. Two main themes and six subthemes were drawn from the participant descriptions of their nursing practice. These themes are summarised below and then discussed against nursing theory and the contemporary context outlined in the review of literature. The methodology of this study acknowledges Fox’s (2003) argument that research and theory should be linked to practice, in this case mental health nursing in a homeless outreach setting. As such, the participants' experience of engagement will form the basis for “practice-based evidence”, which Leeman and Sandelowski (2012, p. 171) define as “evidence concerning the contexts, experiences, and practices of healthcare providers working in real world practice settings”. The experience of nursing engagement with a hard-to-reach population has been identified from literature and nursing theory to be valuable relational work; this is further elaborated and explored in this chapter. The limitations of this research and recommendations for further study will also be considered.

As described in the Research Design and Method chapters, critical thematic analysis was used to identify, analyse and report themes derived from research data (Braun & Clarke, 2013). The nursing theoretical framework proposed by DeFrino (2009) guided the interpretation of interview data, as did the acknowledged place of therapeutic relationships as a central and defining aspect of nursing work, from Peplau (1988/1952) through to Barker and Buchanan-Barker (2005). Descriptions of engagement as a nursing intervention have been interpreted and presented by the researcher as a source of practice-based knowledge, meeting the research aims of increasing visibility and understanding of engagement as a nursing intervention.

The theoretical assumptions of this study include that nursing practice is informed by the nurse's own world views, which are subjective and situated (Letherby, Scott & Williams,

2013). This research inquiry is about the experience of engagement for nurses providing healthcare for a population that is marginalised and hard-to-reach, and therefore this practice experience is viewed within its context. As such, the background setting of homeless healthcare was provided and the findings likewise presented as situated knowledge. Relevant prior research was drawn on, such as Addis and Gamble's (2004) study of nursing experience of engagement in assertive outreach practice.

The research was undertaken in the spirit of reflective practice, which Fyers and Greenwood (2016) state is central to culturally safe nursing in New Zealand. Fyers and Greenwood's (2016) framework for reflective practice - *What? So What? Now what?* - was introduced as a nursing tool for generating practice questions. This research asks: what is the experience and challenges of engagement as a nursing intervention for a hard-to-reach client group? What is the importance of engagement as a nursing intervention? And how might this importance be articulated for clarifying best practice for engagement-focused nursing?

The nursing experience described was personal, with nurses valuing relationships in their work with clients and with their colleagues and teams. This experience of engagement was also described as working with uncertainty: in the clinical carrying of ambiguity and flux; in the absence of practices of documentation or measurement of engagement; and whilst fulfilling nursing roles that seem sometimes little understood by others. The larger context of relational work, as informed by the review of literature, is that it can be invisible, be disappeared or is undervalued.

Summary of Findings:

Valuing Relationships	Working with Uncertainty
Relational selves: Nurse's descriptions of their relational work highlight personal values and attitudes	Uncertain work: Nurse's descriptions of their changeable practice experience
Engagement as a skilled nursing intervention	Documenting clinical and social flux
Relationship difficulties: Barriers, challenges and personal distress experienced by nurses	Uncertain selves: Putting the relationship first despite uncertainties

The relational work of nurses

“It makes life richer”

The Findings chapter reported two major themes that emerged from the data - *Valuing Relationships* and *Working with Uncertainty*. Within the theme of Valuing Relationships were subthemes of the participants' subjective and personal experience of relationality, of their use of engagement as a nursing intervention in itself, and of the difficulties they experienced in their relational work. Within the theme of Working with Uncertainty were subthemes of participants working with ambiguity and changeable circumstances, of their nursing documentation in that uncertain context, and of returning to the participants' subjective and personal experience of uncertainty.

The literature review located engagement and therapeutic relationships as central to nursing practice in this specific context of health service provision for people experiencing homelessness. A working definition of engagement was provided by George et al. (2015, p. 888): *Engagement = providing practical assistance + a therapeutic relationship*.

Sitzman (2002), reflecting on the work of nursing theorist Jean Watson, suggests that nursing practice combines tasks, interpersonal relationships, and self-reflection. Drury and Munro (2008) and Hartrick (1997), among others, argue that the technical tasks of nursing have usurped their core relational work, yet DeFrino's (2009) theory is that therapeutic relationships are themselves the fundamental nursing task. O'Brien (2001), Duncan et al. (2004), and Barker and Buchanan-Barker (2005) assert that relationship *is* therapy. DeFrino's (2009) theory is that nurses know what they know via relationship, and while this relational work is rewarding it is also invisible, devalued and disappeared, which can lead nurses to experience "moral distress" and burnout. Linking this theory and previous nursing literature to current practice, these research findings demonstrate that engagement is not only a key nursing skill but an intervention in itself. If this work is invisibilised, as DeFrino (2009) suggests, then the importance and effectiveness of this nursing work may require efforts to increase its visibility for professional identity and to support this effective therapeutic intervention. Several of this study's participants voiced concern at their unseen and poorly understood work both within the health system and homeless NGO sector. Barriers and challenges to effective nursing interventions were described as linked to the strength of interpersonal relationships and collaborations.

The nursing experience of engagement was described as a source of enjoyment and effective therapeutic change – being ‘the rope bridge’ for someone’s recovery journey, or building genuine trust that could then be built upon in times of crisis. Engagement was also a site of uncertainty and ambiguous clinical work, with a sense of this being open-ended and intangible. DeFrino’s (2009) concern around potential burnout was echoed in some of the participants’ descriptions, although none of the participants laboured this point. The documentation of this flux was captured by healthcare teams as rolling narratives, as much as by individual nursing notes. The participants voiced a desire for better ways or means to record and measure this uncertain work.

Relational recovery

“It’s me talking to people on the streets...”

This study arose from the researcher’s own curiosity and valuing of engagement in outreach nursing in the context of homeless healthcare. The research process has highlighted nursing theories and literature that validate engagement as a key aspect of nursing practice. Raingruber (2003, p. 108) asserts that “the relational aspects of the nurse-patient relationship constitute the heart, soul and essence of our profession”, and the findings from this research suggest that the participants held a similar sense of importance for their engagement work. Engagement is identified as skilled relational work and an application of therapeutic relationship that is effective in homeless outreach healthcare. The researcher accepts the premise, validated from a review of literature, that interpersonal work is at the centre of mental health nursing practice. Previous research on homeless healthcare in New Zealand has also emphasised the importance of relationship (Nikora et al., 2012; Scanlen, 2009), and this research can contribute to this literature by highlighting the skilled role of nurses in providing healthcare to this hard-to-reach population.

Recovery is a central concept for mental health service provision, as outlined in the NZ Mental Health Commission’s (2001) *Recovery Competencies for New Zealand Mental Health Workers*, and incorporated into New Zealand’s *Blueprint II* (Mental Health Commission, 2012). The concept of recovery emphasises quality of life regardless of the experience of symptoms of mental health problems, but critics suggest this concept is too

linear and has been unhelpfully captured by governmental policy (Barker & Buchanan-Barker, 2005). From a homeless health perspective, the concept of living well regardless of symptoms seems inadequate. Recovery, for this population group, may be better viewed as a dynamic, open-ended and relational process that is always considered in a social context. In this way the relational work of nursing can be considered a recovery practice in action. This is consistent with Gergen's (2009) concept of 'relational recovery' which helpfully consolidates the mental health and interpersonal aspects of mental health nursing engagement. It resonates with the literature on nurses' relational work, such as Hartrick's (1997) suggestion that mechanistic communication approaches are over-valued, or where measurable or manualised interventions are valued over interpersonal practices (DeFrino, 2009; Drury & Munro, 2008).

In the review of literature on nursing engagement and therapeutic relationships, the Tidal Model was noted as a relational framework for mental health nursing. The Tidal Model's relevance as an interpersonal and non-medical model for mental health nursing has been reiterated by these research findings. For example, the Tidal model's emphasis on curiosity, collaboration with clients, and being non-judgemental, is directly applicable to this homeless outreach nursing context. Hartrick's (1997) framework for relational capacity was not previously known to the researcher and may also offer scope for application to practice in a NZ context (although it has not been introduced at length here).

The participants' valuing of relationship in their practice, whilst working with uncertainty, suggests that treatment, recovery and *care* happen within relationship. And this relationship happens through engagement.

The human-professional confluence

"Sometimes you roll your sleeves up, sometimes you pull them down"

Interpersonal relationships have been identified as the central component of therapeutic change (Barker & Buchana-Barker, 2005; Duncan et al., 2004), and nursing engagement can be considered a process by which this relational work is carried out (Sitzman, 2002). Engagement as a nursing practice was described by the research participants as relating to their personal values and life experience, and the uncertainty of this work likewise related to their own flexibility and anxieties. O'Brien (2001) and Raingruber (2003) highlight therapeutic relationship as central to nurses' professional identity, and it was interesting

that participants in this research described flexing their personal identity as part of this relational work. For example, participant descriptions included role playing and developing an interpersonal wardrobe. The nurse-client rapport was described as sometimes ad hoc in outreach contacts, and was balanced alongside specialist nursing work such as medication administration or mental health assessments. However, this moving between worlds was described as enjoyable, with an almost vicarious pleasure in knowing this subaltern terrain. DeFrino (2009, p. 301) describes the relational work of nurses as having “positive professional rewards”, and this seems reflected in the participants’ descriptions of flux, flexibility, and immersion in an interesting work landscape.

The human-professional confluence is a concept that Addis and Gamble (2004) interpreted from their own study of study of nursing experience of engagement. The nurses they spoke with described a desire to be relatable and ‘human’, with the stated intention of presenting a different approach to that previously experienced by service users (Addis & Gamble, 2004, p. 456). Addis and Gamble (2004, p. 456) looked specifically at the Assertive Outreach community mental health service model, where “[t]he nurses articulated their attempts to be the confluence between an ordinary caring individual and a professional...” Their UK-based research is one of few studies to look closely at the nursing practice of therapeutic engagement. Just as the confluence of two rivers is where the waters meet and flow together, the concept of a confluence of the formal and informal is a fitting description of interpersonal nursing practice.

Addis and Gamble’s (2004, p. 456) observations echo O’Brien’s (1999, p. 158) finding that mental health nurses valued “[t]he minimising of the professional in favour of a personal approach...”. Both authors found that nurse-client rapport was not aided by an “overtly professional” manner (O’Brien, 1999, p. 159). Addis and Gamble’s (2004) research is one of few found in the literature search that enquired of nurses’ experience of their relational work. Addis and Gamble’s (2004, p.456) findings were that nurses valued “having time” to connect and work at the clients preferred pace. The participants in *this* research similarly spoke about engagement as requiring time, since the difficulties encountered by clients were perceived to have been many years in the making and would likely not be solved by brief intervention.

The absent but implicit

“My nursing skills come into play in the relationships that nurses are trained to build...”

Alongside the centrality of nurses’ relational work, the suggestion that this work is less visible, is submerged or even disappeared (DeFrino, 2009), came through strongly in the review of literature on nursing engagement. The researcher's own view has been stated - that therapeutic engagement as a skilful nursing intervention is not well understood or valued in the practice context of NZ’s homeless sector - and research participants were noted to echo this concern. Lakeman (2014) describes the psychotherapeutic skills of mental health nurses as routinely undervalued in health care services, and DeFrino (2009), Hartrick (1997), Barker and Buchanan-Barker (2005), Drury and Munro (2008), Raingruber (2003) and others have been referenced in accord with this concern.

A dilemma is therefore implied, where nursing engagement is a central and effective intervention for hard-to-reach populations, and yet this work is rendered invisible by more dominant mechanistic approaches to care. Lakeman (2006, p397) describes nurses “seeking certainty in uncertainty”, especially where there is an impulse to “do something” (such as medicating or housing). The relational work of nurses, however, is more comfortable with a curious, non-judgemental approach that honours complexity and values collaboration with the client (Barker & Buchanan-Barker, 2005; Nikora et al., 2012; Rayner, 2005). Lakeman refers to an “unknowing stance” that echoes the non-expert stance of narrative therapy (White, 1991):

The nurse is socialised into maintaining a deferential relationship to medical doctors, and not making competing knowledge claims. While this subordinate position might be oppressive and belie the real balance of expertise and experience in relationships, it nevertheless equips the nurse to be able to maintain a position of unknowing⁶... to genuinely attempt to meet and know the person in the context of their life (Lakeman, 2014, p. 385).”

Franks (2004, p. 99) writes about evidence-based uncertainty in mental health nursing, reflecting on the dynamic relationship between an individual and their culture and societal structures. Having asserted that “...the feeling of uncertainty is a reality for most mental

⁶ “Unknowing, in this sense, does not mean being ignorant, unwitting, careless, or being without hope or confidence...” (Lakeman, 2014., p. 385)

health professionals”, Franks (2004, p. 99) proposes a psychodynamic framework for tolerating uncertainty. Franks (2004, p. 104) opines that people often have “... confused and contradictory relationships to themselves and others”, and therefore a nursing framework that accepts a level of uncertainty is both honest and pragmatic. No nurse participant in *this* research explicitly referenced a psychodynamic framework for their practice; however the acceptance of uncertainty has been taken as a key principle for further exploration.

As well as the uncertainty of engagement as nursing work, the disappearance or submergence of this relational work, as described by DeFrino (2009), Hartrick (1997), and Drury and Munro (2008), was also resonant in the research data. This was most apparent in descriptions of team work and their documentation of uncertainty, which participants described as anecdotal and oral, rather than written down or always formally documented. One implication of this may be to exacerbate the invisible nature of this engagement work. Some participants also indicated they felt in limbo and said they’d value having more formal processes or outcome measures. Team processes and interdisciplinary meetings were described as very important for collegial support, and also for holding client stories and developing “rolling formulations”. The informal rolling formulations shared in the team process suggest that team structure and processes are important for this uncertain and engagement-focused work.

The Assertive Outreach model is team-based, and where nurses are not working with such a team-based structure the development of peer processes could be clinically useful. NZ homeless research by Nikora et al. (2012) and Scanlen (2009) suggest that access to health care is hindered by fragmented service provision, which is an indication that integration of health and social services would also improve access and service provision. Lakeman (2014, p. 385) suggests that “health care teams ought to assume a humble position in relation to the client, and be open to discovering and formulating problems in new ways”. The described experience of the research participants, presented in the Findings chapter, appears to embody such humble and innovative team-based practice.

The concept of *absent but implicit* is drawn from narrative and family therapy (Carey, Walther & Russell, 2009, p. 320), where the distinction is made between “what is presented to us (privileged meaning) and what is 'left out' (subjugated meaning)”. The

concept seems highly applicable to engagement and relational work as a “neglected territory” of nursing practice (Carey et al., 2009, p. 319).

Rolling narratives

“You just keep going and it’s not quantifiable.”

The research participants spoke about the tension between a changeable and uncertain clinical context, often without set schedules or location. Like all clinical work, the engagement that occurs in variable settings, be it for assessment, medication administration or a brief check-in conversation, requires nursing documentation. The research participants noted that they would document changes in engagement, or draft a full client history form if transferring the client’s care to another service, but day-to-day documentation was often described as a rolling narrative, held informally and in shared team accounts. This demonstrates the importance of team structure and process, as these enable the shared narratives and collegial support that participants described as valuable. Use of nursing models or approaches that ‘capture’ shared narratives and uncertainty may help formulate collaborative plans for outreach engagement, with care plans that are pragmatic and clear but open to change.

Some participants worked within a team-based structure, such as an Assertive Outreach service, whereas other participants were more isolated and less able to rely on shared process. This has implications of engagement-focused homeless healthcare, where integrated services and multi-disciplinary teams may provide nurses with similar structures for working relationally and with uncertainty. Collaborations and integrated service structures are strongly recommended by the USA’s National Health Care for the Homeless Council (2013) for outreach and clinic-based homeless health services, and by local researchers Nikora et al. (2012) and Scanlen (2009).

The research participants echoed the nursing theory and literature review, which asserts that nurses’ relational work is often unseen and undervalued within health systems. Relational work is described as a defining concept for mental health nursing, yet the lack of visibility of this skilled work adds to nurses’ experience of uncertainty. This Discussion chapter provides a partial ‘map’ of the terrain of engagement and a validation of the relational work that defines the nursing profession, and mental health nursing in particular.

The following recommendations describe ways to develop the structure, process and evaluation of nursing engagement work.

Recommendations

1. Individual nurses and health teams working in the homeless sector would benefit from use of processes that buffer uncertainty and emphasise relationality in their clinical work. Existing models that may be applicable are the Tidal Model (Barker & Buchanan-Barker, 2005) and trauma informed approaches (Arthur et al., 2013)⁷.
2. This research affirms engagement as important relational nursing work and indicates the benefit of nursing professional development around specific relational skills. For example, exploration of the use of discursive therapeutic approaches, such as narrative therapy (White, 1991), could be readily applicable to this practice setting. Te Pou's (2016) guide to evidence-based talking therapies is oriented toward session-based psychological interventions, such as cognitive behavioural therapy, whereas outreach-oriented engagement practices may be more appropriate for hard-to-reach service users.
3. The development of integrated outreach team structures may assist nurses to practice relationally by meeting the need for working with uncertainty and rolling narratives. This is in keeping with best practice suggestions from the international literature and could be an opportunity for Primary Health Organisations and District Health Boards to meet the vision of Blueprint II (Mental Health Commission, 2012) regarding provision of holistic mental health service provision in primary care settings.
4. A valuing of relational nursing approaches presents an opportunity for services to better align with relationship-focused Māori and Pacific models of care, as indicated by Brannelly, Boulton and Te Hiini (2013), Faleafa (2008), and Groot et al. (2008).
5. Outcome and process measures for engagement should be developed and applied to clinical practice settings such the one described here. This should include better screening tools or process measures which would help with team development and evaluation of rolling formulations, as well as professional visibility. The literature review chapter presented the possibility of using engagement as an outcome measure or a reflection tool:

⁷ Trauma informed approaches are considered best practice in international homeless services (Klinic Community Health Centre, 2013).

- a) Rayner (2005, p.485) proposed an “engagement/relationship building reflection tool” as part of the development of health care pathways. Rayner argues that this may assist nurses to consider clients' mental health without reliance on medical discourses.
- b) Killapsy et al. (2006) cited an adapted Homeless Engagement Acceptance Scale
- c) Paget et al. (2009), and Park et al. (2002) present observer ratings scales of client engagement.

Limitations

There are some limitations to the research study described in this thesis. These include a relatively small cohort of participants (eight), which is related to the small number of nurses working in this specific clinical setting in New Zealand. The researcher was not able to recruit participants from their own healthcare team due to potential conflicts of interest, which further reduced the potential pool of research participants. A larger pool for potential participants from comparable clinical settings would have been available in Australia, but recruiting participants outside of New Zealand was beyond the financial and organisational scope of this research. Given that outreach nursing was a particular participant setting, the participant recruitment pool could have been extended to District Nursing and nurses working within Community Alcohol and Drug services. On the other hand, the core mental health nursing focus may have been diluted by widening the participant scope so the decision was made to restrict it to the current scope.

Chapter 7

Conclusions

“Margins are margins because that’s where discourse begins to fray, where whatever paradigm we’re in starts to lose its explanatory power and all those inconvenient exceptions begin to cause problems” (Witchins, 2004, p. 71).

The aim of this qualitative research was to understand more about the nursing care provided to people who were experiencing both mental problem problems and homelessness. Of key interest was the nurses’ experience of engagement, especially within an outreach clinical role. Eight nurses were interviewed as participants, with thematic analysis applied to the subsequent qualitative data.

The nursing experience of engagement was found to embody several contradictory themes. Engagement has been described as central to practice but invisible or ‘disappeared’; as a skilled and effective nursing intervention, but uncertain and difficult to document. Therapeutic relationships are a defining feature of nursing professional identity and yet in engagement with a marginalised client group this professional identity appears to be marginalised itself.

A major socio-political context for nursing practice in the New Zealand homelessness sector is the impact of poverty and inequality (Rashbrooke, 2013). Nurse scholars Carryer (2009) and Watson (2008b) challenge nurses to address social and health inequalities as nursing issues, and it is clear that homelessness, poverty, lack of access to resources, cultural displacement and social stigma, all significantly compound health inequalities (Hodgetts et al., 2007).

Nursing engagement is a therapeutic intervention for people experiencing homelessness, providing a form of *relational recovery*. The relational work of nursing for this hard-to-reach population is both *on the path* and *off the trail* (Snyder, 1990). Engagement is a skilled nursing practice that has been described as ‘disappeared’ work, a blind spot for mental health services. Engagement is the basic foundation of outreach nursing in

provision of homeless healthcare, but this rich and complex nursing practice occurs off to the side of the trail, largely out of view. This research has helped to map the terrain of outreach nursing in NZ and validated the relational work that defines the nursing profession, especially mental health nursing.

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Appendix A

From: Broad, Patsy [mailto:P.L.Broad@massey.ac.nz]
Sent: Thursday, 19 September 2013 12:46 p.m.
To: Garrick Martin (ADHB)
Cc: Brannelly, Petula
Subject: HEC: Southern A Application 13/63 - Application outcome

13/63 Mental health nursing and engagement: Providing care at the margins

Garrick Martin (HEC: Southern A Application 13/63)

Department: School of Nursing

Supervisor: Dr Tula Brannelly

The Massey University Human Ethics Committee: Southern A considered the above application at their meeting held on Tuesday 10 September 2013.

The application was provisionally approved, subject to the fulfilment of the conditions below to the satisfaction of Dr Brian Finch (Chair).

Please note that the Committee is always willing to enter into dialogue with applicants over the points made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

SECTION B

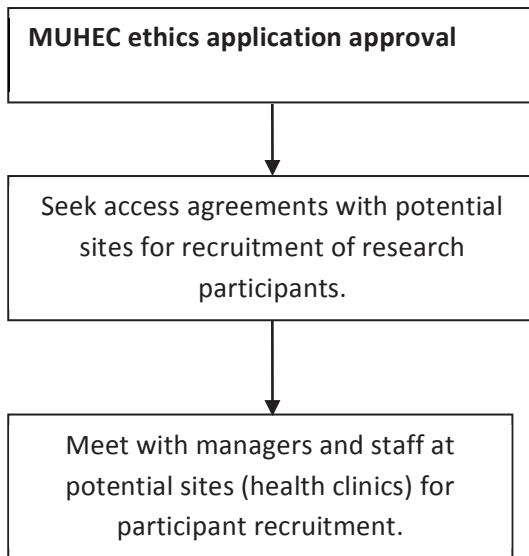
Q10

• Is the aim to “develop” nursing knowledge and practice or should the aim refer to “enhance” or “increase” nursing knowledge? Note: Develop might be seen as implying that there is no knowledge currently available in this area at all. Please comment.

This has been changed to “increase”.

Q12

• Please provide further detail in the response regarding the process to be used, specifically the approach/procedures for data collection.



The linked image cannot be displayed. The file may have been moved, renamed, or deleted. Verify that the link points to the correct file and location.

Advertise directly to staff at access-approved sites, *without direct management involvement in participant recruitment.*

Participants respond confidentially to advertisement. Suitability for research participation assessed, i.e. is the RN working in primary or secondary health setting, providing health care to the specified population (homeless and mental health needs)?

Potential participants will be supplied the MUHEC approved information and consent forms, and agreed time arranged to meet with researcher.

Q13/38/39

- If interviews are held in a private setting, e.g. home of the participant, please provide details in regard to the management of researcher safety, e.g. will the supervisor be advised of the time and place of interviews; will the researcher carry a mobile phone in case of emergency?

The interviews will be held in the participants work space or at Massey University. By “private” I was referring to quiet and confidential.

The research supervisor will be advised of the time and location of all interviews.

The researcher will carry a mobile phone in case of emergency.

Q16

- Paragraph 3 – Please provide further detail regarding “advisory consultation”, e.g. is it prior to data collection or might it be considered as a type of focus group? If it is in an advisory capacity prior to data collection, there needs to be a letter of agreement from the Chair of the “client committee”.

I presented the research proposal to the Homeless Client Committee on Monday 21st October. The information was well received by a quorum of 8 committee members, with specific request made that the researcher return later in the research process to report on findings.

This was neither a consultation nor a focus group. The purpose of this advisory meeting was to inform the Homeless Client Committee at the Auckland City Mission that this research had been proposed.

Nurses are the proposed research participants, not homeless service users. However, the proposed research will hopefully produce findings directly relevant to homeless health service delivery, and therefore the researcher wished to announce their research intentions to the Homeless Client Committee. As such it can be considered transparency to an interested third party.

Q18

- Will an even number of participants be recruited from primary and secondary care settings (4 from each)? Please provide further detail.

The research question does not seek to draw direct comparison between primary and secondary care settings, so the spread of participants need not be even. The research seeks to have sufficient participants for qualitative validity.

Q31

- Will transcripts be sent back to participants for review? Please provide detail as to how this will be managed.

The transcripts will be sent back to research participants for review.

Participants will be offered their transcripts for review and comment. The researcher will supply these by secure courier post, or by email.

Specific comments from participants will be discussed with the research supervisor, for example if participants request that sections of transcript not be included.

SECTION C

- Please provide further consideration to the questions in this section. For example, might individuals feel some discomfort if they feel their own knowledge, skills, attributes are inadequate? Might the interview highlight shortfalls in the service?

There is potential for the research participants to feel discomfort or vulnerable when reflecting on their practice. Likewise, shortfalls in service or ethical dilemmas may be disclosed during interviews. Ethical issue or practice shortfalls will be discussed by the researcher with their research supervisor.

The research purpose is not an evaluation of individual nurses practice. As such, if shortfalls or ethical issues are disclosed during interviews, the researcher will suggest that the participant speaks with their own clinical supervisor. Establishing that all participants have access to confidential supervision will be strongly recommended for participation. The information sheet has been amended to reflect this expectation.

Q39/INFORMATION SHEET

- The committee noted that it is inappropriate for the researcher to be discussing supervision with the participant's supervisor. Please reconsider how this might be managed through discussion with your academic supervisor in order to develop a strategy for such an occurrence. Include detail in the information sheet.

To clarify: The researcher would speak to the research supervisor, and the participants would speak with *their own* practice supervisor.

All research participants should have access to practice supervision.

The information sheet has been amended with this addition:

"It is suggested that research participants have access to professional supervision. This research is not an appraisal of nursing practice, and should any concerns about participants nursing practice arise in the course of research interviews, it will be suggested that participants discuss this with their supervisor."

SECTION D

Q44/INFORMATION SHEET

- Please provide further detail regarding contact with participants two weeks prior to interviews, e.g. is this part of the recruitment process, or after recruitment has taken place to set up possible interview times?

Participants will self-select from advertisement.

Participant information sheets and consent forms will then be emailed to them. Interview times will then be arranged by email and/or telephone, preferably at least 2 weeks prior to interview dates.

Refer to flow chart for Q12.

SECTION E

Q51

- How will the researcher ensure confidentiality of "client" details?

Health service users will not be interviewed in the course of this research.

Health service users that are discussed by research participants in the course of interviewing will be fully anonymised by blanking names on the transcript, using pseudonyms (if needed), and removing identifying remarks from the transcript. At the start of each interview, the researcher will state to participants: “if you would like to speak about a specific client please use a pseudonym”.

SECTION E

Q53

- Is the researcher referring to a person, work (ADHB) or Massey computer?

I was referring to my work (ADHB) computer – being the most secure.

All data will be password protected on the researcher’s secure workplace computer, located within locked offices within a locked building.

The data will also be stored on the research supervisor’s computer at Massey University, password protected within a locked office within a locked building.

SECTION I

Q61/63

- Consultation with the Komiti Whakahaere of the New Zealand Coalition to End Homelessness should have been carried out prior to the submission of the ethics application.
- Please provide further detail following consultation.

A consultation letter was supplied to the Komiti Whakahaere of the NZCEH prior to submission of MUHEC application.

A verbal response of support was received, with promise of a formal letter to follow. Email and telephone communications to the NZCEH representative over the past 3 months has been met with further verbal support for the research project, but an email or letter is still not forthcoming.

Consultation with the NZCEH was considered respectful by the researcher, due to our common social topic of homelessness. Similarly, with Māori over-represented as experiencing homelessness, the Māori caucus of the NZCEH seemed the appropriate forum to consult with. However, the NZCEH is largely focused on homeless people from a social service perspective, not from a nursing or health service perspective. Since this research does not propose to interview homeless people as participants, the lack of a written response to my consultation should present no ethical issues to the project proposal.

Please note, two other consultations prior to MUHEC application have produced written responses, as supplied.

SECTION J

- Q69 indicates that ‘there will be consultation with specific groups prior to data collection’. The committee would like to receive specific details about the consultation and evidence of it having commenced, prior to approval being given.

Consultation has been with:

1. Te Aro Health Centre (Wellington) – representative of the health setting of interest in this research. This consultation was completed prior to MUHEC application.

2. **Calder Centre (Auckland City Mission) – email response to consultation now supplied, below.**
3. **Komiti Whakahaere of the New Zealand Coalition to End Homelessness (NZCEH) – verbal support given but still awaiting consultation letter.**
4. **Homeless Client Committee at Auckland City Mission: information sharing – research proposal presented to the Client Committee in October, with commitment to present findings to the Committee later in 2014.**

PUBLIC DOCUMENTATION

- The committee noted that proof-reading of all public documentation is necessary in order to eliminate grammatical, typographical and other errors, e.g. advertisement – correct the spelling of “participants” in the titles.
- Please ensure inclusion of the following statement: “This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/63. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.”
- Provide a copy of the amended documentation.

ADVERTISEMENT

- Correct typographical errors.
- Currently very wordy. The committee suggests revising section titled “What’s the research about?”
- Provide a copy of the revised advertisement.

Public documentation has been ammended.

Please note – the address given is a work address, not a home address. This has been made clearer on the public documents.

A personal email address has been given, rather than a work email address.

The MUHEC application number 13/64 has been added to public documents.

Consent form: I have clarified the use of audio recording of interviews, and have added the statement: “Data will be used solely for this research and will not be used for other purposes or placed in official archives.”

INFORMATION SHEET

- Refer to Qs 39 and 44 above – include relevant details.
- Paragraph 1, sentence 2 – suggest rephrasing, e.g. “This research is being *carried out/conducted/undertaken* by ...”
- Include a section on potential benefits/risks of the research.
- Suggest the researcher does not include home address details in the information sheet (this may breach the privacy of the researcher); however, the final decision rests with the researcher.
- Does the researcher have a gmail or Massey email that could be included (rather than work email address)?
- Please ensure inclusion of the following statement: “*This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/63. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University*”

Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459,
email humanethicsoutha@massey.ac.nz.”

- Provide a copy of the amended information sheet.

**I have not used a home address – this is a work address: I have clarified by adding St Lukes
Community Mental Health Centre**

Changed email address to : garrick.nz@gmail.com

Amended documentation provided.

CONFIDENTIALITY AGREEMENT

- Who is this intended for?

**The confidentiality agreement was intended for participants but is now understood to not
be required, given the use of a consent form.**

CONSENT FORM

- Ensure only relevant statements are included, e.g. are interviews being image recorded? Is data to be placed in an official archive?
- Please provide a copy of the amended consent form.

Amended.

RESEARCH ACCESS LETTER

- Ensure thorough proof reading in order to correct grammatical and other errors (some correction in tenses is currently required).
- Provide a copy of the amended letter.

Amended

INTERVIEW QUESTIONS

- Q4 is repeated further down the page (Q9).
- Provide a copy of the amended questions.

Amended.

Consultation response (email):

From: Dimitri Germanov [<mailto:Dimitri.G@aucklandcitymission.org.nz>]

Sent: Monday, 14 October 2013 9:43 p.m.

To: Garrick Martin (ADHB)

Subject: RE: research consultation

Hi Garrick:

Thank you for consulting with me about your Masters research project. I am of opinion that the topic about engagement of the nurses with difficult to engage client group (homeless with mental health problems) is well chosen. It seems that your research would be a logical continuation of the research completed by Anna Scanlon from Waikato University in 2009 about the health and wellbeing of the homeless people in Auckland.

I am supportive of what you would like to accomplish in your Masters Research Project. Please let me know if our service could be of assistance.

Regards,

Dimitri Germanov | Calder Centre Team Leader

mail: PO Box 5352 | Wellesley St | Auckland 1141 | New Zealand.

street: 136-140 Hobson Street | Auckland City

m : 027 314 7043 | **ddi:** 09 303 9247 | **f:** 09 303 9305 |

www.aucklandcitymission.org.nz

From: Brannelly, Petula [mailto:P.M.Brannelly@massey.ac.nz]

Sent: Wednesday, 06 November 2013 11:07 a.m.

To: Finch, Brian; Broad, Patsy

Cc: Garrick Martin (ADHB)

Subject: FW: Massey University Human Ethics Committee: Southern A, Application 13/63

Dear Brian and Patsy,

Please see below for Garrick Martin's response.

Thanks again for the Committee's helpful recommendations and I do hope that everything has been answered satisfactorily.

Please do not hesitate to contact me should you require any further clarification on any point.

Kind regards,

Dr Tula Brannelly

Senior Lecturer

School of Nursing

College of Health

Massey University, Wellington

Email: P.M.Brannelly@massey.ac.nz

Phone: 0064 4 801 5799 Ext 62575

Staff webpage: <http://www.massey.ac.nz/massey/learning/departments/school-health-social-services/staff-listing.cfm?stref=638930>

Appendix B

Mental health nursing and engagement: providing care at the margins

RESEARCH PARTICIPANTS NEEDED

- ARE YOU A REGISTERED NURSE?
- DO YOU WORK IN COMMUNITY MENTAL HEALTH OR A PRIMARY CARE SETTING?
- DO YOU PROVIDE MENTAL HEALTH NURSING CARE TO HOMELESS PEOPLE?

What's the research about?

This research aims to understand more about the nursing care provided to people who are experiencing homelessness *and* mental health problems. It is thought that 40-50% of homeless people in New Zealand experience mental health problems. However, marginalised and socially excluded people can experience difficult engagement with mental health services. What are the challenges specific to providing mental health care to homeless people? What characterises nursing engagement with this population?

The research will be undertaken by Garrick Martin (RN), as part of a Masters program at Massey University School of Nursing. Garrick has worked in both mental health and homeless services.

What will participation involve?

Participation in this research will involve an audio recorded interview no longer than 2 hours, at a time and place convenient to you. You will be able to review the written transcript of this interview, and your participation and comments will be anonymous.

If you are interested in participating, please contact Garrick Martin:

Email: garrick.nz@gmail.com

Phone: 021 241 8301

(09) 845 0940 / 815 5660

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application [13/63](#). If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

This research will be supervised by Dr Tula Brannelly, Senior Lecturer, School of Nursing, College of Health, Massey University Wellington.

Email: P.M.Brannelly@massey.ac.nz Phone: (04) 801 5799 Ext 62575

Appendix C



MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

Mental health nursing and engagement: providing care at the margins

INFORMATION SHEET

This research aims to understand more about the nursing care provided to homeless mental health service users. The research is being undertaken by Garrick Martin (RN), as part of a Masters (MPhil) program at Massey University School of Nursing. Garrick has worked in the Community Mental Health and Homeless sectors, and is currently Clinical Coordinator of an intensive community mental health outreach service in Auckland.

Therapeutic relationships have been described as core nursing practice, especially within mental health services, yet marginalised and socially excluded people can experience difficult engagement with health services. It is thought that 40-50% of homeless people in New Zealand experience mental health problems, with a greater than average proportion experiencing significant mental ill health. If engagement with services is a key factor for positive health outcomes, then it is useful to consider how mental health nurses successfully engage with homeless people.

This research aims to develop nursing knowledge and practice regarding care for people experiencing both homelessness and mental ill health. Up to 8 nurses providing mental health care within a primary or secondary care setting will be interviewed, from Wellington and Auckland. The key research questions are - How do nurses experience their engagement with people who are both homeless and mentally unwell? What are the challenges and specific nursing practice issues when providing mental health care to this population group?

I would like to invite you to participate in this research project. This will involve meeting with me for a audio recorded discussion/interview that will take no more than 2 hours. I will travel to see you at an agreed time and place that is convenient for you. The data will be anonymised, and will be analysed for themes and key nursing practice issues. I may ask research participants to also allow me to accompany them for additional hours on a usual day of work prior to an interview, as a way to become familiar with participants' practice environment and to inform our subsequent discussion. You will be under no obligation to offer this additional time, and if you do it will not be recorded.

Audio recordings and transcripts will be stored securely at Massey University. You will be offered access to your own transcript, and this recording will not be used for any other purpose than this research project.

If you would like to participate, please contact me by email and we can arrange a convenient time.

Providing nursing care to homeless people is a specialised role that has not been extensively studied, so I hope that you will consider participating in this research project. I hope to provide useful insights into nursing practice and health care for homeless people. The data will be used to inform nursing practice, to be disseminated through journal articles and conference presentation(s).

It is suggested that research participants have access to professional supervision. This research is not an appraisal of nursing practice, and should any concerns about participants nursing practice arise in the course of research interviews, it will be suggested that participants discuss this with their supervisor.

Participant rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study (specify timeframe);*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*

Project Contacts

Researcher

Garrick Martin (RN)
615 New North Rd
Kingsland
Auckland
Email: GarrickM@adhb.govt.nz
Phone: 021 241 8301
(09) 845 0940 / 815 5660

Supervisor

Dr Tula Brannelly
Senior Lecturer
School of Nursing
College of Health
Massey University, Wellington
Email: P.M.Brannelly@massey.ac.nz
Phone: (04) 801 5799 Ext 62575

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/63. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.



Appendix D

Mental health nursing and engagement: providing care at the margins

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature:

Date:

.....

Full Name - printed

.....

This research will be supervised by Dr Tula Brannelly, Senior Lecturer, School of Nursing, College of Health, Massey University Wellington.

Email: P.M.Brannelly@massey.ac.nz Phone: (04) 801 5799 Ext 62575

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/63. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

Appendix E

Semi-structured interview questions:

I'm interested in your nursing engagement with homeless clients/patients. But firstly can you tell me about your current nursing role?

How long have you been a registered nurse? And how long working in your current role?

How many homeless people do you provide care to in your current nursing practice?

What do you notice about the kind of nursing interactions you have with homeless clients or patients?

Can you describe the nurse-patient relationships you have with homeless people?

What do you notice about the level of engagement you have with homeless patients?

How important do you think nurse-patient relationships are for the homeless clients/ patients you see?

What kind of health problems do the homeless people you see in your nursing practice present with?

It what ways, if any, is your engagement with homeless patients different to patients who are housed?

Do you think that the level of engagement you have with homeless clients/patients effect's their health outcomes?

Can you describe what you find challenging, or not, when engaging with homeless people?

What strategies do you use to maintain engagement or connection with homeless people in your practice?

In addition to these key questions, I will also use secondary probing questions such as:

Can you speak more about that?

Can you give me an example of that?

Can you elaborate?

Can you explain that in more detail?

Script for pre-interview participant briefing:

For the purpose of this research, engagement refers to the interpersonal relationships between nurse and client/patient. It is about rapport, connection, warmth, attention, focus. A person who is 'hard to engage' may seem hard to connect with and difficult to provide nursing care for. The nurse may struggle to provide a full health assessment or understand what the client/patients needs are. A poorly engaged patient may not been seen regularly, or their contact with the nurse may be challenging. Conversely, a person may present without clear health needs, perhaps seeking conversation, company, reassurance. In these various ways engagement - the strength of the therapeutic relationship - is a central part of mental health nursing care.

I am interested in the relational aspect of mental health nursing. I would like to talk to you about your experience of providing nursing care to a specific population group - homeless people - as a way to explore nursing relationships with marginalised or 'hard-to-reach' people.

This research will be supervised by Dr Tula Brannelly, Senior Lecturer, School of Nursing, College of Health, Massey University Wellington.

Email: P.M.Brannelly@massey.ac.nz Phone: (04) 801 5799 Ext 62575

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application **13/63**. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.



Appendix F

Mental health nursing and engagement: providing care at the margins

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Data will be used solely for this research and will not be used for other purposes or placed in official archives.

Signature:

Date:

Full Name - printed

This research will be supervised by Dr Tula Brannelly, Senior Lecturer, School of Nursing, College of Health, Massey University Wellington.

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/63. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.