Reckoning with Complexity: The Intersection of Homelessness and Serious Mental Illness, and its Implications for Nursing Practice

Persistently high levels of homelessness are a symptom of deeply unequal societies. The disproportionately adverse health-related outcomes observed in homeless populations in developed countries- including their high morbidity, mortality and disability rates-constitute a public health and a human rights emergency (Aldridge et al., 2018). Homelessness is often aptly conceptualised as the adverse socio-economic sequela of concomitant forms of deep social exclusion such as poverty, housing exclusion, institutionalisation, interpersonal violence, substance use and others. Homelessness and housing exclusion can be profoundly disruptive biographical experiences that emerge from intersecting axes of inequality.

The availability of housing, the welfare state provision and the capacity and accessibility of healthcare services are among the structural determinants that shape the nature, duration and severity of the homeless experience (Shinn, 2007). The intersection of inequality-generating forces contributes to the heterogeneity and persistence (or 'wickedness') of homelessness, especially in individuals with co-occurring mental health and substance use problems. Myopic, reductionist and uncoordinated approaches to service provision can no longer meet the increasingly complex and chronic needs of homeless populations. From a mental health (nursing) practitioner's perspective, understanding and ameliorating the effects of homelessness and multiple disadvantage demand both 'whole-person' *and* 'whole-system' competencies and care practices.

Beyond the loss of physical shelter and security, homelessness represents a multi-pronged assault on individuals' capabilities to initiate and sustain effective mental illness self-management, personal recovery, and engagement with formal care (Karadzhov, Yuan, & Bond, 2019). Individuals with pre-existing mental health difficulties and other disabilities are especially vulnerable to chronic, repeat and unsheltered homelessness, which, in turn, tends to perpetuate ill-health (Padgett et al., 2016). The accessible, holistic and structurally competent

support that nursing practitioners offer can, in many cases, be critical to preventing clients with complex needs from descending into a chronic pattern of homelessness and social exclusion.

In many jurisdictions, however, the structural and cultural 'chasm' between homeless clients and mental health and social care practitioners continues to widen. Persons with a history of repeat or chronic homelessness, in particular, tend to be characterised as *'entrenched', 'chaotic', 'service-resistant', 'complex', 'hard to reach'* and *'hard to help'*. The fragmented and ineffective health and social care provision for homeless clients with complex needs has contributed to unacceptably long periods of untreated (mental) health conditions, high drop-out rates and client dissatisfaction, as well as to the commonplace distrust in care providers and institutions (Farrell, 2012).

Implementing a recovery-oriented, person-centred and humanising approach to nursing care and service provision can be the antidote to the structural chaos and uncertainty that many homeless persons with complex needs endure. Embodying the recovery philosophy involves gaining a dynamic understanding of the person-in-context and using this holistic knowledge to support clients' autonomy, choice and self-determination (Conlon et al., 2015). The centrality of clients' lived experience and authentic self-directedness underpins the recovery ideal. Clients' histories of chronic housing instability, relational traumas, institutionalisation and other adverse life events can profoundly hinder their capabilities for envisioning and enacting personally defined goals, alternative selves, and ultimately, hope. It is therefore incumbent on nursing and other health professionals to provide those clients with the physical and emotional *space* necessary for clients to safely explore their past, constructively 're-story' their lives, and, ultimately, re-build their authentic, empowered selves outside of the stigmatising public discourses surrounding multiple disadvantage. Such a caring stance is likely to not only assist clients in narratively reconfiguring the adverse consequences of personal losses, social exclusion and poverty but also help create the conditions conducive to clients' personal growth, resilience and meaningful coherence in life. Paying narratively competent attention to clients' dynamic and diverse biographies is also likely to enable nurses to discern the effects of severe and multiple disadvantage on clients' well-being and self-identity. Such contextualised understanding, in turn, can inform nursing interventions aiming to

support clients in navigating socio-structural constraints in everyday life to enable better well-being and recovery.

Nursing care is a vital nexus between institutional service provision and community reintegration for clients that are in the process of reclaiming a meaningful, productive and dignified life from the trenches of homelessness and marginality. To successful fulfil this role, however, nurses should integrate their responsibility for providing individualised, person-centred care with the commitment to helping raise awareness of, and reduce, the social inequities that fundamentally undermine homeless clients' recovery, rehousing and social reintegration efforts.

Mental health nurses supporting homeless (or formerly homeless) clients with complex needs are often required to deliver daily support and formal interventions in multiple and organisationally challenging contexts including emergency accommodation (e.g. shelters, sanctuaries), healthcare institutions, transitional housing, permanent supportive housing, and other settings-including the streets. Flexibility, creativity and resilience are vital professional competencies that nurses must uphold if they are to optimally fulfil their multiple roles-namely therapeutic, mediatory and advocacy roles. Simultaneously, mental health nurses should remain reflexive about their professional positioning as part of the healthcare, welfare and housing systems that ultimately cause and perpetuate clients' homelessness and complexity of needs.

Housing First-the paradigm-shifting evidence-based solution to homelessness for individuals with complex needs-is an example of an integrated, client-centred and humanising approach to care (Padgett et al., 2016). Housing First provides a unique opportunity for mental health nurses to meaningfully engage with clients with complex needs at a crucial stage of their transitions out of homelessness and journeys into full and active citizenship. Emerging research has suggested that the physical and psychological safety and the autonomy afforded by one's own stable housing expand the opportunities for clients and professionals to collaboratively pursue a wider range of person-centred outcomes including re-engagement with social activities and exploring alternative recovery pathways (Clifasefi et al., 2016). Those possibilities

afforded by the provision of stable, permanent housing mandate the increased flexibility and creativity in nurses' ongoing support of residents' journeys. Flexibility and creativity in the orientation to practice are indeed critical for nurses' capacity to respond to the diversity in clients' recovery stages and patterns of service engagement. For instance, mental health nurses working with Housing First clients likely to need to adapt their practice to accommodate and encourage clients' decision-making power, autonomy and self-determination, including clients' decisions as to if, when and how they engage with nursing support. Those changes in the intensity and patterning of support, in addition to the complexities of multiagency working, are likely to present challenges to nurses' therapeutic and reflective practices. Nursing practitioners should therefore be continually supported in adapting both their practice *and* reflexive stance to the emerging demands of innovative service models for clients with complex needs.

Tensions can arise, however, between the focus on individualised interventions, which is oftentimes institutionally programmed, and the principles and values of the nursing profession that emphasise the role of advocacy in system transformation (Conlon et al., 2015). The provision of individualised, client-centred care is not necessarily antithetical to social justice-oriented praxis. Indeed, compassionate engagement with clients' lifeworlds can empower nurses to pursue '*informed advocacy'* (MacKinnon & Moffitt, 2014)-including safeguarding and advocating against inequities. Arguably, nurses' contextualised knowledge about their clients' concerns *and* capabilities can give impetus to initiating and taking part in critical and transformative action aimed to redressing injustices across the healthcare, housing, welfare, social work and other vital systems. Nurses are also in the unique position to influence ameliorative and transformative policy-making by sharing their practical understanding of *how* those systemic forces 'trickle down' to enable or constrain clients' capabilities for achieving stable housing, positive well-being and, ultimately, dignity and self-respect. This emancipatory sensitivity and commitment may then allow nursing practitioners to discern the seemingly 'chaotic' patterns of clients' behaviours and attitudes towards services as acts of resistance towards oppressive structural forces and self-determination (Karadzhov et al., 2019).

Furthermore and relatedly, mental health nurses working with clients who are experiencing and episode of homelessness should strive to develop *intersectionality-informed*

understanding of how clients' multiple sources of disadvantage interact and exacerbate one another to create the complex and often injurious social locations of co-occurring serious mental illness, homelessness, poverty and others. Intersectionality, for example, is likely to be a useful framework for nurses to discern how the welfare state, with its bureaucracy, conditionality and responsibilisation, may perpetuate one's experiences of mental ill-health (Conlon et al., 2015).

Nurses seeking to meet the multifaceted needs of clients who are homeless and have co-occurring mental health difficulties, including serious mental illness, should aim to deliver humanising, recovery-oriented and biographically and contextually informed care. This ethos of care should be enacted as the dual orientation towards *understanding* clients' personally defined goals and subjective experiences of health, illness and recovery, and *critiquing and challenging* clients' structural contexts that may constrain their capacities for well-being and recovery. Simultaneously, nurses should balance the focus on clients' vulnerabilities engendered by their unique intersectional locations of disadvantage with the goal of facilitating clients' intrinsic capacities for resilience, resistance and self-determination.

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