Increasing Empathy and Reducing Stigma in Healthcare for Unhoused Individuals: Utilizing A Street Medicine Approach

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Statement of the problem

Research shows people experiencing homelessness are subject to stigmatization regularly, including in healthcare settings (Canham et al., 2021; Grech & Raeburn, 2019; Rae & Rees, 2015; Wen et al., 2007). According to Canham et al. (2021), stigma is experienced on three socio-ecological levels: intrapersonal, interpersonal, and structural. The internalized stigma that stems from the messages fed by society occurs on the intrapersonal level. Internalized stigma was a theme that also emerged during stakeholder interviews. Interpersonally, stigma is projected upon people experiencing homelessness from being viewed by society as less than others, helpless, and unable to control themselves. The structural level includes criminalizing activities commonly associated with homelessness, such as creating laws that prohibit individuals from "sleeping, eating, and panhandling in public areas". People experiencing homelessness expressed feelings of disrespect and stigmatization contribute to their lack of willingness to seek care (Omerov et al., 2020; Wen et al., 2007; Rae & Rees, 2015). However, healthcare professionals who provide non-stigmatizing care to unhoused individuals have positive impacts on the health and well-being of this population of individuals and the larger community (Grech & Raeburn, 2019; Kneck et al., 2021).

There are several communities that have historically been the subjects of stigma and discrimination in various settings, including healthcare settings. There is extensive research on the experiences of stigma and discrimination experienced by Black women in healthcare settings. Black women have historically been diagnosed at later stages of cervical cancer resulting in higher rates of mortality than their white counterparts (Washington & Randall, 2022). Adebayo et al.'s (2022) study on Black women's maternal experiences in healthcare concluded that Black women are subjected to unequal care due to structural and institutionalized racism in the form of racially discriminatory practices that are considered "standard practice" (p. 1135). This level of discrimination is also experienced amongst other marginalized communities.

Individuals from the LGBTQ community are another marginalized group that is subject to stigma and discrimination in healthcare. Howard et al.'s (2019) study examines the experiences of transgender people of color (TPOC) in healthcare settings. The study concluded both race and gender identity are impacting factors that lead to intersectional effects on healthcare disparities. Skosireva et al. (2014) argued "a cumulative effect of various types of discrimination could be especially detrimental for individuals who belong to multiple stigmatizing social identities" (p. 8). Other examples of marginalized groups that experience stigma and discrimination in healthcare settings include undocumented individuals and those who are uninsured (Ferrada et al., 2016). The health disparities experienced by these marginalized groups have been well-documented and the stigma and discrimination are compounding when individuals belong to more than of these marginalized communities, including unhoused populations.

Systemic racism was identified as a systemic influence that creates, maintains, and perpetuates the stigma and discrimination that is experienced by unhoused populations in healthcare settings. Mr. Thompson[1], one of my stakeholders, stated "Unhoused individuals have the disadvantage of being a part of marginalized communities." He continued to talk about the wealth gap as another systemic influence, explaining that the wider the gap gets the more intense

1. Pseudonyms were assigned to all participants to ensure confidentiality.

the disparity gets. He stated that the wealth gap perpetuates the notion that unhoused populations are morally inferior and contributes to their inability to access basic resources. He also discussed how unhoused populations are viewed as living outside the legal structure, “they're seen as a squatter or someone who needs to be moved along.”

Healthcare systems were also identified as a systemic influence contributing to the social problem. Mrs. Jackson, another one of my stakeholders, argued “Just the system, navigating it is difficult. It’s not made for everybody.” She continued to explain that unhoused populations are seen as individuals that “don’t fit in” to the way healthcare systems are designed. They struggle to show up to appointments on time, or at all. And most healthcare systems have policies and procedures about late arrivals and no-shows. “You can’t be late to so many appointments, or you can’t miss so many appointments, or that doctor won’t see you anymore” (Jackson, personal communication).

Lastly, the criminalization of homelessness contributes to the stigma and discrimination that unhoused populations experience. Sleeping, eating, and panhandling in public are common activities that have been prohibited by law. Tacoma most recently passed Amended Second Substitute Ordinance 28831 that prohibits sleeping and storing personal belongings within a ten-block radius of temporary shelters, “and all public property within 200 feet of Tacoma’s mapped rivers, waterways, creeks, streams, and shorelines” (City of Tacoma, 2022, p.1). Individuals who violate the ordinance can face up to $250 in fines and up to 30 days in jail. Such laws contribute to the stigma and discrimination of unhoused populations by labeling them as criminals for simply trying to survive.

Target population

The project that I am proposing is intended to serve the houseless population in Thurston County, which includes individuals that are staying in emergency shelters, encampments, parks, cars, and other places not meant for habitation.

Needs Statement

Medical providers need more direct community-centered and outreach-based training/practical experiences to enhance their empathy and reduce stigma while providing care to unhoused individuals.

Theoretical Frameworks

Through a review of the literature, two theoretical frameworks emerged that help to better understand the social problem of stigma and discrimination as experienced by unhoused individuals accessing healthcare services, cultural health capital, and the health stigma and discrimination framework. Shim (2010) applied cultural capital theory to unequal treatment within healthcare, known as cultural health capital. Cultural health capital theory implies that well-educated, middle-class individuals are better at attending to preventive healthcare measures and suggests that society fits into a hierarchy based on social status. Cultural health capital applies to unhoused individuals as it helps explain the unequal treatment in healthcare based on their social status and lack of cultural health capital. The health stigma and discrimination framework is different than other health stigma frameworks in that it examines more than one

health condition at a time and the different intersections of compounding stigmas (race, gender, sexual orientation, class, etc.) (Stangl et al, 2019). The framework is explicit in how to intervene in the stigmatization process using a multi-level approach. Stangl et al. (2019) argued stigma is a well-documented barrier to health-seeking behavior.

Effective Interventions

There is a lack of research that suggests effective interventions for combating the stigma and discrimination that unhoused individuals experience in healthcare settings. However, the literature does identify the need for such interventions. Varcoe et al. (2022) argued for increased responsiveness and capacity in primary care, "including interprofessional and team-based care tailored to serving those with barriers to accessing care and those who experience stigma and intersecting forms of discrimination and, importantly, linking patients to social agencies for housing and income support" (p.111). The article continued to argue in support of "broader structural efforts" that address housing and homeless strategies to reduce the strain on emergency departments. Schreiter et al. (2021) concluded that peer support, intensive case management, and harm reduction strategies are all effective approaches for unhoused populations but again called attention to the lack of interventions that address trauma, stigma and discrimination, community integration, and mental health needs for people experiencing homelessness.

Interventions to address this social problem are needed on a multiple-level approach, from the individual level to the structural level (Nyblade et al., 2019). Despite not directly addressing the stigma and discrimination in healthcare settings, outreach programs, such as street medicine programs, be effective interventions. Street medicine programs reduce ED visits and hospitalizations by 75 and 66 percent, respectively (Lynch et al., 2022). While healthcare systems are poorly suited to address the needs of unhoused individuals, street medicine programs use a person-first approach that has proven to be successful in addressing the prioritized needs of individuals experiencing homelessness. During my stakeholder interviews with both Mr. Thompson and Mrs. Jackson, they identified how exposure and experience with working with unhoused populations in the community, in spaces where they are more comfortable, have had tremendous impacts on themselves and the residents that get that opportunity. All three of my stakeholders spoke about the importance of building connections with the individuals, meeting them where they are, in the encampments at their homes, helps build that connection and allows for the professionals to get a better idea of the impacts their living situation has on their lives and their ability to conform to healthcare standards.

Marginalized Perspectives

Unhoused individuals experience marginalization based on their lack of housing. The perspectives of unhoused individuals will be incorporated into this project using qualitative interviews at three-to-four-month intervals. The qualitative interviews will allow for rich, contextual data collection by gathering lived experiences from unhoused individuals regarding their perceived welcomeness in traditional healthcare settings. Using qualitative interviews will also help capture their experiences receiving medical care from the providers and residents that are participating in the medical outreach project. Unhoused individuals' perspectives will also be incorporated into this project through the adapted Internalized Stigma of Mental Illness (ISMI) questionnaire that will be gathered at the beginning of the project, at the six-month mark, and at the twelve-month mark.

Academic, Professional, and Personal Motivation

As an Intensive Case Manager on the Houseless Outreach Stabilization and Transition (HOST) team in Thurston and Mason counties, I was hearing from a significant number of unhoused individuals that they felt unwelcomed or mistreated while seeking healthcare. I have also witnessed firsthand how their perceived welcomeness or experiences of stigma and discrimination has impacted their willingness to seek medical attention. These accounts and experiences are what lead me to consider looking into the stigma and discrimination unhoused populations face in healthcare settings as an area of research for my project, and furthermore, was evidence of the need for an outreach-based intervention.

Description of Project

My proposed project is a community-centered, outreach-based medical outreach program that will be developed using a partnership between existing behavioral health outreach teams and medical residency programs in Thurston County. This street medicine approach will allow residents to gain practical, outreach-based experience and training while meeting unhoused populations in their communities. The medical outreach team will conduct an outreach once a week for five hours with the intention of meeting the medical needs of as many unhoused individuals as possible in that time frame. Using existing behavioral health outreach teams will be beneficial to the success of the medical outreach program because such teams have long - standing rapport within the unhoused community.

Goal Statement

Unhoused populations will receive compassionate, non-stigmatizing and non-discriminate care when receiving medical services in traditional healthcare settings.

Project Outcomes

There are two objectives for the medical outreach program, which include outcomes and indicators. Each outcome has two corresponding indicators. The first outcome will be an increase in empathetic, non-stigmatizing medical care to unhoused populations, including those with mental health and substance use disorders. The first indicator of this outcome is an increase in empathetic and non-stigmatizing care based on unhoused individuals' reports. The second indicator for this outcome is a reduction in score on the adapted Stigma Scale for medical providers.

The second outcome will be an increase in help-seeking behavior among unhoused individuals. The first indicator of this outcome is a decrease in internalized stigma score using the adapted Internalized Stigma of Mental Health (ISMI) questionnaire, resulting in an increase in help-seeking behavior among unhoused individuals. The second indicator of this outcome is an increase in perceived welcomeness in healthcare settings per participant report.

Project Timeline and Activities

The medical outreach program is proposed as a 12-month program. In addition to the weekly medical outreaches, there are other various activities associated with the medical outreach program. These activities include the program facilitator coordinating with the behavioral health

volunteers to submit appropriate referrals for individuals that participate in the medical outreach program that also indicate their desire to receive behavioral health support. The program facilitator will also coordinate with the medical providers to ensure that referrals to specialty care, when needed, are submitted to the appropriate facilities. The other activities are outlined in the Personnel section as they directly relate to the duties of the program facilitator.

Promotion of Project

The program will be promoted by the program facilitator through various avenues, including but not limited to, community partner collaborative meetings, email, and in-person program overviews for service providers that work with unhoused populations in Thurston County. A program flyer has been developed that will be distributed through both email and print to local service providers that work with unhoused individuals, including but not limited to local hospitals, behavioral health agencies, primary care clinics, emergency shelters, local law enforcement agencies, and local food banks and libraries.

Barriers to Implementation

Some of the potential barriers to implementing the medical outreach program include funding, lack of support from behavioral health agencies and medical providers, and poor relations between unhoused populations and the medical outreach team. The medical outreach program cannot operate without the funding needed as outlined in this proposal. The partnerships with behavioral health agencies and medical residency programs are also imperative components of this proposal. Lastly, building and fostering rapport among the unhoused populations are what will allow this program to be well received in the communities in which it will operate.

Political Climate Factors and Policies to Consider

Despite the continued policies that criminalize behaviors and activities related to homelessness, the current political climate reflects support for services and support for unhoused communities. For instance, the Division of Behavioral Health Resources within the Healthcare Authority has recently contracted with four Behavioral Health Agencies across five regions in Washington State to bring a new program titled Homeless Outreach Stabilization and Transition (HOST). Thurston County is one of the regions that has recently received a HOST team that provides behavioral health support for unhoused populations. The Department of Commerce in Thurston County has also been diligently working to find housing solutions for unhoused individuals that reside in what is considered right-of-way locations across Thurston County. This effort is a direct result of the Rights-of-Way Safety Initiative submitted by Governor Inslee during the 2022 Legislative Session (Washington State Department of Commerce, 2023).

Evaluation

In order to measure the success of the medical outreach program, data will be collected at various points of the program. Qualitative interviews will be conducted every 3 to 4 months to gather lived experiences from the unhoused individuals that participate in the medical outreach program. Using an adapted Stigma Scale for Unhoused Individuals Survey, a baseline score for stigma towards this population will be determined to compare the change in stigma over the course of the intervention for the medical staff providing care. Similarly, using an adapted ISMI

questionnaire, a baseline level of internalized stigma will be determined to compare the change over the course of the intervention. Surveys and questionnaires will be conducted at the beginning of the program, at the 6-month mark, and then again at the 12-month mark.

Reliability and Validity

Reliability will be measured by giving participants the same amount of time to complete the pre, mid, and post-surveys and questionnaires. Surveys and questionnaires will also be tested using focus groups to determine if the length is suitable for an outreach setting. Validity will be measured using two established measurement tools, the Stigma Scale for mental illness survey and the Internalized Stigma of Mental Illness Inventory (ISMI) questionnaire. Both tolls will be adapted to be used for unhoused populations. The adapted versions will be tested using focus groups to ensure they are measuring the intended outcomes.

Personnel, Facilities, and Equipment

To carry out this project, I've proposed to have a full-time MSW serve as the program facilitator. Their duties will include building and fostering partnerships with local behavioral health agencies and medical residency programs to recruit volunteers to participate in the weekly medical outreaches. Additional duties will include developing qualitative interview questions and adapting established tools for data collection purposes, facilitating weekly debrief sessions with those conducting outreaches, and facilitating monthly outreach planning meetings. Those recruited to volunteer will be mental health professionals, substance use disorder professionals, case managers, and peer counselors from existing behavioral health outreach teams. In addition to the behavioral health volunteers, medical staff will include Registered Nurses (RN), Nurse Practitioners (ARNP), and Medical Doctors (MD).

Facilities

The medical outreach program is intended to take place in the community, including encampments, parks, city sidewalks, etc. The program facilitator will build and foster relationships with community partners, including all local emergency shelters, and coordinate use of their spaces if an individual residing there is in need medical attention. There will be a mobile unit that will also be used to provide a sterile environment for procedures to be done in the field during outreach.

Equipment

The need for equipment to operate this program is minimal. There is, however, the need for engagement tools that can be given to unhoused individuals that are participating in the medical outreach program. Such tools will include survival gear like tents, sleeping bags, snack bags, gloves and hats, and other basic need items. Other equipment will include the medical supplies used to conduct medical attention in the community, such as wound care supplies.

Budget

The proposed budget for this project comes to a total of $244,339 and outlines the cost for a 12-month program. The projected salary and benefits for the one full-time equivalent Master of Social Work position, which will assume the role of program facilitator, account for a

majority of the budget. Another large portion of the budget is allocated for purchasing a mobile unit that will offer medical providers a sterile place to conduct procedures in the field, without the need to be in a clinic or hospital. Additional costs will be accrued for purchasing survival gear, such as tents, sleeping bags, and tarps that will be used as engagement tools that will be passed out to unhoused individuals during outreach.

To cover the cost of the program, I will be requesting $100,000 in private grants from each of the local healthcare systems, Providence Health & Services, and MultiCare Health Systems. I will also be requesting $20,000 in governmental grants from Thurston County. The remainder of the cost of the program will be covered through individual contributions, for which I will be requesting support from the local churches. Medical supplies will be donated as an in-kind contribution from various medical facilities that have a surplus. Please see Appendix A for a full breakdown of the estimated budget.

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Appendix A

Estimated Budget

Capstone Annual Budget Template							
Revenue							**Notes**
Individual Contributions					$	4,339	Contributions from local churches (St Michaels, etc).
Private Grants					$	200,000	
Grant 1				100,000			Providence Health & Services
Grant 2				100,000			MultiCare Health Systems
Government Grants					$	20,000	
Grant A				20,000			Thurston County
Grant B							
Program Fees							
In-Kind					$	20,000	Medical supplies from healthcare systems surplus
Other							
TOTAL REVENUE					**$**	**244,339**	
Personnell Expenses	**FTE**	**Hrly Wage**	**Annual Wages**	**Taxes & Benefits**	**Cost to Program**		
Position 1	1.0	$ 37.00	76,960	23,088	$	100,048	1 FTE MSW
Total Personnell Expenses					**$**	**100,048**	
Non-Personell Expenses							
Mobile Unit					$	75,000	Estimated @ $75,000 for mobile unit with capacity to do in the field procedures
Communications					$	1,920	1 cellphone @ $60/month for 12 months and 1 laptop at $1,200
Survival Gear					$	38,800	400 sleeping bag @ $25, 400 tents @ $60, 400 tarps @ $12
Travel					$	2,358	milege rate of 65.5 cents/mile @ 300 miles per month for 12 months
General Operating							
In-kind					$	-	
Other Expenses					$	4,000	Various case management expenses (IDs, perscriptions, etc).
Subttl Non-Personell Expenses					**$**	**122,078**	
Subtotal All Expenses					**$**	**222,126**	
Admin/Indirect Costs					$	22,213	10% Admin/Indirect
TOTAL EXPENSES					**$**	**244,339**	
Net Revenue (Deficit)					$	0	

Appendix B

Internalized Stigma of Mental Illness Inventory (ISMI)

We are going to use the term "mental illness" in the rest of this questionnaire, but please think of it as whatever you feel is the best term for it. For each question, please mark whether you strongly disagree (1), disagree (2), agree (3), or strongly agree (4).

	Strongly disagree	Disagree	Agree	Strongly agree
1. I feel out of place in the world because I have a mental illness.	1	2	3	4
2. Mentally ill people tend to be violent.	1	2	3	4
3. People discriminate against me because I have a mental illness.	1	2	3	4
4. I avoid getting close to people who don't have a mental illness to avoid rejection.	1	2	3	4
5. I am embarrassed or ashamed that I have a mental illness.	1	2	3	4
6. Mentally ill people shouldn't get married.	1	2	3	4
7. People with mental illness make important contributions to society.	1	2	3	4
8. I feel inferior to others who don't have a mental illness.	1	2	3	4
9. I don't socialize as much as I used to because my mental illness might make me look or behave "weird."	1	2	3	4
10. People with mental illness cannot live a good, rewarding life.	1	2	3	4
11. I don't talk about myself much because I don't want to burden others with my mental illness.	1	2	3	4
12. Negative stereotypes about mental illness keep me isolated from the "normal" world.	1	2	3	4
13. Being around people who don't have a mental illness makes me feel out of place or inadequate.	1	2	3	4
14. I feel comfortable being seen in public with an obviously mentally ill person.	1	2	3	4
15. People often patronize me, or treat me like a child, just because I have a mental illness.	1	2	3	4
16. I am disappointed in myself for having a mental illness.	1	2	3	4
17. Having a mental illness has spoiled my life.	1	2	3	4
18. People can tell that I have a mental illness by the way I look.	1	2	3	4
19. Because I have a mental illness, I need others to make most decisions for me.	1	2	3	4
20. I stay away from social situations in order to protect my family or friends from embarrassment.	1	2	3	4
21. People without mental illness could not possibly understand me.	1	2	3	4
22. People ignore me or take me less seriously just because I have a mental illness.	1	2	3	4
23. I can't contribute anything to society because I have a mental illness.	1	2	3	4
24. Living with mental illness has made me a tough survivor.	1	2	3	4
25. Nobody would be interested in getting close to me because I have a mental illness.	1	2	3	4
26. In general, I am able to live my life the way I want to.	1	2	3	4
27. I can have a good, fulfilling life, despite my mental illness.	1	2	3	4
28. Others think that I can't achieve much in life because I have a mental illness.	1	2	3	4
29. Stereotypes about the mentally ill apply to me.	1	2	3	4

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Appendix C

Stigma Scale for Mental Illness

*Respondents used the following Likert scale to respond to each question:

strongly agree, agree, neither agree nor disagree, disagree, strongly disagree.

1 The general public is understanding of people with mental health problems (D)
2 Other people have made me feel ashamed of myself because of my mental health problems (A)
3 The way people have treated me upsets me (A)
4 I have been discriminated against by housing departments/landlords because of my mental health problems (A)
5 I have been discriminated against in education because of my mental health problems (A)
6 Sometimes I feel that I am being talked down to because of my mental health problems (A)
7 Having had mental health problems has made me a more understanding person (D)
8 I am to blame for my mental health problems (A)
9 I feel ashamed of myself that I have had mental health problems (A)
10 I do not feel bad about having had mental health problems (D)
11 Other people think less of me because I have had mental health problems (A)
12 Newspapers/television take a balanced view about mental health problems (D)
13 I am open to my family about my mental health problems (D)
14 I worry about telling people I receive psychological treatment (A)
15 Some people with mental health problems are dangerous (A)
16 Other people have never made me feel embarrassed because of my mental health problems (D)
17 People have been understanding of my mental health problems (D)
18 I have been discriminated against by police because of my mental health problems (A)
19 I have been discriminated against by employers because of my mental health problems (A)
20 I have been physically threatened or attacked because of my mental health problems (A)
21 My mental health problems have made me more accepting of other people (D)
22 Very often I feel alone because of my mental health problems (A)
23 I am scared of how other people will react if they find out about my mental health problems (A)
24 I would have had better chances in life if I had not had mental health problems (A)
25 I am as good as other people, even though I have had mental health problems (D)
26 I do not mind people in my neighbourhood knowing I have had mental health problems (D)
27 I would say I have had mental health problems if I was applying for a job (D)
28 I worry about telling people that I take medicines/tablets for mental health problems (A)
29 People's reactions to my mental health problems make me keep myself to myself (A)
30 I am angry with the way people have reacted to my mental health problems (A)
31 I have not had any trouble from people because of my mental health problems (D)
32 I have been discriminated against by health professionals because of my mental health problems (A)
33 People have avoided me because of my mental health problems (A)
34 People have insulted me because of my mental health problems (A)
35 Having had mental health problems has made me a stronger person (D)
36 I do not feel embarrassed because of my mental health problems (D)
37 I avoid telling people about my mental health problems (A)
38 Having had mental health problems makes me feel that life is unfair (A)
39 When I see or read something about mental health in the papers or television, it makes me feel bad about myself (A)
40 I feel the need to hide my mental health problems from my friends (A)
41 I find it hard telling people I have mental health problems (A)
42 I do not understand the diagnosis I have been given (A)

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Appendix D

Example Questions for Qualitative Interviews

1. Did you feel like you were treated with respect and dignity while receiving treatment from the medical outreach team?

2. Did you feel like your voice was heard or your concern was taken seriously during the medical outreach?

3. Did you feel like you were treated differently based off your living situation during the medical outreach?

4. Would you feel comfortable receiving care from the medical outreach team again?

5. Would you recommend the medical outreach team to other unhoused individuals?

Appendix E


THURSTON COUNTY
Medical Outreach
FREE SERVICES FOR INDIVIDUALS EXPERIENCING HOMELESSNESS
Weekly Outreach
Medical Providers and Behavioral Health volunteers will be conducting weekly outreaches to support the medical needs of those living unsheltered in Thurston County.
Prescription Assistance
The outreach team will be able to provide various types of services, including prescription assistance, referrals to specialty care, and education.
Wound Care
The medical outreach team will have a mobile unit that will assist them with conducting in the field wound care for those in need.
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