Street outreach with no streets: In a new take on a proven program, a rural s...
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COMMUNITY

Street Outreach with No Streets

IN A NEW TAKE ON A PROVEN PROGRAM, A RURAL STREET NURSE IS TAKING AN OUTREACH PROGRAM TO THE HIGHWAYS AND BYWAYS OF THE B.C. INTERIOR, REACHING PEOPLE WHO OTHERWISE MIGHT NOT HAVE ADEQUATE ACCESS TO SERVICES.

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In 1999, Cariboo Health (now the Northern Health Authority and the Interior Health Authority), the health unit responsible for public health promotion and prevention in the interior of British Columbia, created a street nurse position in the Cariboo region to address the needs of street-involved or otherwise marginalized client populations. Offering a street outreach program in rural and northern areas raised some eyebrows. One person who heard of the program laughed and asked how a nurse does street outreach where there are no streets.

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ABSTRACT
A street nurse position in the rural and small-town interior of British Columbia has been addressing the needs of street-involved or otherwise marginalized client populations by bringing healthcare services to wherever those clients are, rather than waiting for the clients to seek care. The primary reason for a street outreach approach is that marginalized populations face a variety of barriers to accessing traditional healthcare services — barriers such as homelessness, mental health problems, criminal involvement, lack of transportation, lack of ability to pay for prescriptions, lack of specialized or knowledgeable providers and provider discrimination.

In the rural street nurse program, the target population includes the usual street nurse populations of illegal drug users and sex trade workers, which are more hidden in small communities than in larger urban centres, creating the community denial that is a barrier to healthcare access. Yet another barrier is the co-location of services common in small communities, where public health clinics might share a building with police services, making marginalized clients reluctant to attend clinics.

The rural street nurse collaborates with public health nurses and other care providers (mental health workers, social workers, etc.) to provide care, advice, and support, including receiving and facilitating referrals and working with the street nurse to address the specific needs of each client.

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many years in larger urban centres in Canada and throughout the world, the Cariboo rural street nursing program is perhaps the first to operate in a small community or rural area. The purpose is the same as that of the urban programs: to bring health care to marginalized clients wherever the clients are, rather than waiting for the clients to seek care.

The primary reason for a street outreach approach is that street-involved or marginalized populations face a variety of barriers to accessing traditional healthcare services. Some of these barriers are related to such lifestyle issues as homelessness, addictions, mental health problems, involvement in criminal activities, lack of transportation and lack of ability to pay for prescriptions (Griffiths, 2002). Other barriers relate to the provider. For example, intravenous drug users (IDUs) “are often viewed as ‘difficult to manage’ by care providers, and may have behaviours and appearances that are disturbing to others” (Millar, 1998). This provider attitude can hold true with other marginalized people as well. As a result, these people may be discriminated against in their attempts to access services (Gunn, White, & Srinivasan, 1998; Millar, 1998). Clients who have experienced such discrimination may be reluctant to request services in the future.

Additional barriers to healthcare access exist at the agency or system level. A healthcare service can be perceived of as high threshold or low threshold (Marlatt, 1996). “Threshold has to do with the extent of barriers that must be crossed in order to access a health care service. … If you have to make an appointment, sit in a waiting room, go to a lab and then find a pharmacy, that’s high threshold. It doesn’t work for a lot of people” (Griffiths, 2002). Low-threshold agencies and outreach workers seek to remove as many of these barriers as possible by providing services when and where the clients need them.

Outreach workers who aggressively seek clients rather than wait for the clients to come to them reach a higher proportion of clients at risk (Greenberg et al., 1998). Street nurses can provide preventive and other services to difficult-to-reach clients before a health issue reaches the crisis level. They are also able to link clients with additional service providers who are skilled in working with these populations and their unique health concerns (Gold, 2003).

Street nursing is based on the strategy of harm reduction (Centers for Disease Control, 1993). Although a health professional may philosophically desire to eliminate risk behaviours, the reality of street nursing is that the focus must be on providing non-judgmental support and strategies to reduce the risk of harm to both the client and the community (Marlatt, 1998). Further steps to decrease or eliminate risk behaviours happen only if a client indicates a readiness to move in that direction.

Gaining the trust of marginalized clients is an important component of street nursing. A first step is simply spending time in areas where clients are located and engaging in small talk without an obvious health-related agenda. Offering services or products (condoms, syringes, testing for sexually transmitted infections [STIs], etc.) with no strings attached is another means of trust development. Maintaining confidentiality is crucial, except when required by law to report (such as in cases of child abuse or if subpoenaed). One of the most important ways of developing trust in working with this population is demonstrating the non-judgmental acceptance of them as people. Research has shown that the most effective outreach programs gain not only the trust of clients but also an understanding of their lifestyles (Greenberg et al., 1998; Griffiths, 2002).

**THE CARIBOO RURAL STREET NURSING PROGRAM IS PERHAPS THE FIRST TO OPERATE IN A SMALL COMMUNITY OR RURAL AREA**

The Cariboo-Chilcotin region stretches from the Pacific Ocean at Bella Coola to the Cariboo Mountains in the east, comprising more than 82,000 square kilometres. The population of about 77,000 people is concentrated in the east-central third of the region in three communities and their surrounding areas: Quesnel, Williams Lake and 100 Mile House. The main economic base is resource extraction, mostly logging, sawmills and pulp mills, with some mining. There are numerous service and support businesses, as well as a significant ranching industry. Most people are Euro-Canadians, but approximately nine per cent of the population are First Nations people and almost four per cent are Indo-Canadians (B.C. Ministry of Health and Ministry Responsible for Seniors, 1993).

The rural street nurse program's target population includes the usual street nurse populations of IDUs and sex trade workers (STWs). Although many people may believe that drug use, prostitution and the related health issues are big-city problems, the reality is that small communities and regions outside metro areas also support varying degrees of these activities (B.C. Coroners Service, 2003; Millar, 1998). Small communities have fewer numbers of IDUs and STWs and they also tend not to congregate in visible locations. The invisibility contributes to a community denial of the problem, which in turn can become another barrier to healthcare access for this group.

Another barrier to healthcare access in small communities can be the co-location of services. Marginalized
people who have had negative experiences interacting with one system (such as the criminal justice system) may be reluctant to use other services located nearby. Smaller centres often have one street or even one building housing many different provincial agencies and services. In Williams Lake, for example, the provincial building is directly across the street from the RCMP detachment. The provincial building houses misdemeanor court and sheriff services on the main floor, public health nursing (including the needle exchange) on the third floor and the provincial court and judge's chambers on the fourth floor. Thus, when IDUs with a criminal record want to exchange their needles, they run the risk of bumping into the same RCMP officer or judge who charged or sentenced them. The rural street nurse can address this barrier by offering needle exchanges or other health services in discreet locations where the IDUs are more comfortable.

Another healthcare access issue in small or rural communities is the dearth of service providers specialized in working with marginalized populations. Larger urban centres may have low-threshold agencies geared to these populations (Wood, Zettel, & Stewart, 2003). Smaller communities seldom have enough clients in any one group to warrant a separate agency. When this dearth is combined with the issues of invisibility and denial that such groups exist, the result is that few, if any, professionals have a solid understanding of their needs. Even when professionals are sympathetic, they still may not have the specialized knowledge that is needed. For example, IDUs may want information on how to inject certain substances safely, but may not be able to find anyone in the community with the answers. The rural street nurse is available to share this information with clients and with other healthcare providers who want to improve their understanding of issues pertaining to IDUs, STWs, and other marginalized groups.

Barriers to healthcare access can exist, for non-street-involved clients as well. In urban centres, the large numbers of people assist in maintaining anonymity, but in small towns the old adage that everyone knows everyone else's business may be literally true. A middle-class, 15-year-old girl worried about an unwanted pregnancy and seeking a pregnancy test may be reluctant to visit a physician who knows her parents well, to purchase a kit in a pharmacy where she is known or to sit in an emergency department while a parade of neighbours and family friends walks by. The lack of anonymity in small communities means that, at times, people who are not marginalized in the traditional sense nevertheless become at risk of not getting the health care they need.

**Collaboration**

Because many rural areas in the Cariboo do not have the resources for the variety of outreach services that clients may need, the rural street nurse is sometimes the only professional involved with a client. In other areas, a variety of providers is available, including mental health workers, social workers, needle-exchange outreach workers and youth workers; however, many of them operate in offices or clinics (i.e., high threshold) or with a narrow target group, such as youth. Thus, the rural street nurse sometimes has to assume responsibilities that go beyond nursing. Given the variety of issues that marginalized people often have, the rural street nurse may have to provide support simultaneously in nutrition counselling, social work, mental health counselling and drug and alcohol intervention. Yet no one care provider can have expertise in many different areas; therefore, collaboration with other providers is essential.

The service providers with whom the rural street nurse most often interacts are public health nurses. The interactions include collegial advice and support, making and receiving referrals and generally mutually assisting each other. For example, the public health nurses once called on the rural street nurse to locate the sexual contact of a client with chlamydia. The contact had no regular home and was "sofa surfing" (staying with friends for a few days at a time), and so was difficult to track down. The street nurse was able to locate the person through connections with other marginally housed youths, whom he had met by spending time on the streets.

In some cases the rural street nurse becomes the delivery agent for another professional. For example, a healthcare provider had a client who was an alcoholic and street-involved. The client was not attending the clinic regularly for his medications, so the healthcare provider approached the street nurse for assistance. The street nurse regularly tracked down the client and brought him his medications on behalf of the physician. In other situations, clients have asked the street nurse to go with them to another service provider as their advocate.

**The Rural Street Nurse Must Be Prepared to Deliver Services Anywhere — A School, a Drop-in Centre, a Park, a Mall, a Youth Centre or Simply the Street**

The rural street nurse is often geographically remote and so must be prepared to deliver services anywhere — a school, a drop-in centre, a park, a mall, a youth centre or simply the street. Services provided include STI testing (HIV, hepatitis, syphilis and chlamydia), chlamydia treatments, pregnancy testing, emergency contraception pills and assistance with filling out forms for financial support.
Accordingly, the street nurse’s truck is equipped as a mobile treatment centre and office. A cellphone is carried for contact, referral and information gathering. The truck is stocked with testing and treatment supplies, educational pamphlets, diagnostic tools, referral information, syringes, containers for sharps, alcohol swabs, filters, bleach kits, male and female condoms and other supplies.

Condoms are distributed in the obvious places, such as secondary schools, colleges and youth centres, but also through bars, adult drop-in centres, taxi companies, beer and wine stores, pawn shops and, most recently, highway weigh-scale stops for truckers. A Vancouver street nurse who instructs at “john school” (a mandatory education program for convicted patrons of STWs to learn about the risks to themselves and to gain insight into the lifestyle from the STWs’ perspective) has found that a significant percentage of STW patrons are long-haul truck drivers (K. Wrath, RN, personal communication, June 2001). The possibility of these drivers importing STIs to rural regions is a considerable public health concern.

Several times a year, usually in the spring and fall, the rural street nurse learns of impending bush or pit parties attracting young people. If possible, the street nurse attends, distributes condoms and encourages participants to use designated drivers. Sometimes there are simultaneous parties in different communities, making it impossible for the street nurse to attend all of them. In this case, the street nurse seeds the party area with posters encouraging the young people to “Party safely,” “Know what you’re drinking” and “Get a safe ride home.” The posters, along with packages of condoms and the nurse’s business card, are stapled to trees. Another seasonal street nurse activity is delivering influenza and pneumonia immunizations in income-assistance offices and Salvation Army drop-in centres (Weatherill, Buxton, & Daly, 2004).

Having no fixed route means that the street nurse is able to respond to crises as they arise, which is an important aspect of street nursing. An example was an incident in one small Caribo community when 15 or more youths were tattooed with the same homemade needle by two young adult men.

The two adults came from a larger city and stayed in the community a short time, making friends with some of the local youths and even staying in some of their homes. The men tattooed the youths and themselves and also slept with four or five of the young teen women. Shortly after the men left town, it was learned that one of them was HIV positive. A parent called the health unit, and the street nurse worked with a public health nurse to contact, test and educate the youths on safer needle and sexual activities. The flexibility of the street nurse schedule meant that he was available to devote extra time to this situation when it was needed. It was also helpful that the street nurse had already built up a level of trust with several of these youths through his other activities.

Sometimes the interventions are quite simple. In one case, a homeless youth was content to sleep in a tent during the summer, but he had no bedding. The street nurse acquired a used sleeping bag for the boy. This kind of intervention may not be in the usual scope of nursing practice, but providing clients with what they actually need, rather than adhering tightly to a more limited definition of healthcare provision, can greatly promote health. Other street nurse activities in this context include providing transportation, helping an evicted pregnant teen move her belongings, finding shelter for an elderly, disabled schizophrenic returning to the community, referring people to legal aid, delivering food from the food bank, advocating with landlords on behalf of clients and dropping in on isolated geriatric and alcoholic clients.

The flexibility required and the lack of a regular schedule mean that the rural street nurse never knows what challenges and experiences are likely to arise on any given day. Some days the work seems routine. But the next new challenge is just around the corner, making the work of a rural street nurse both stimulating and rewarding.

REFERENCES


