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Client-Provider Relationships in a Community Health Clinic for People Experiencing Homelessness: A Critical Ethnography

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A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

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CLIENT-PROVIDER RELATIONSHIPS IN A COMMUNITY HEALTH CLINIC
FOR PEOPLE EXPERIENCING HOMELESSNESS: A CRITICAL ETHNOGRAPHY

(Spine title: Health Care Relationships With People Who Are Homeless)

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by

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Graduate Program in Nursing

A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

The School of Graduate and Postdoctoral Studies
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London, Ontario, Canada

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THE UNIVERSITY OF WESTERN ONTARIO
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**Client-Provider Relationships in a Community Health Clinic for People
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ABSTRACT

People who are experiencing homelessness have the highest rates of morbidity, and the lowest age of mortality in Canada. The importance of health care relationships in addressing the needs of people who are experiencing homelessness has been demonstrated. However, two gaps still exist in the literature. Firstly, the dialectical relationship between space/place and social relations has been neglected in the context of health care and homelessness. Secondly, there is a dearth of research on the role of formal and informal policies on the enactment of client-provider relationships in this context. Therefore, in this study three research questions are addressed: 1) How is 'place' experienced by clients and providers within a community health clinic for people who are experiencing homelessness? 2) How are client-provider relationships enacted within this contexts? 3) How do clinic-level and broader social and health policies shape relationships in this context? These questions are explored within a critical theoretical perspective, and utilizing a critical ethnographic methodology. Data were collected using multiple methods of document review, participant observation, in-depth interviews and focus groups. The participants included clients at a community health clinic, and all clinic service providers.

Findings from this study focus on the power relations between clients and providers as they negotiate formal and informal policies to meet convergent and divergent needs to promote health. Similarly, clients and providers contested the space of the clinic to form their meanings of the place. This study has implications for individual health care practices, developing health promoting places, informing local policies, and advocating for the refinement of system policies. Health care providers

must ensure that they are attuned to the structural factors that will enhance or limit their ability to practice optimally. As well, opportunities for clients to assume leadership positions need to be considered so that clinics will be responsive to client needs. In terms of system policies, health care providers need to continue to give time to political advocacy in order to refine systems to better serve clients. In conclusion, promoting health with people who are experiencing homelessness will take refinement both in personal practice and in local/systemic policies.

Keywords: Homelessness, health care, relationships, power, power relations, nursing, community nursing, place, ethnography, critical ethnography, critical theory, health promotion

CO-AUTHORSHIP

Abram Oudshoorn performed the work for this thesis under the supervision of Dr. Catherine Ward-Griffin, Dr. Helene Berman, Dr. Cheryl Forchuk, and Dr. Blake Poland who will be co-authors on the publications resulting from Chapters 4, 5, and 6 of this dissertation.

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Chapter 1 - Introduction

Homelessness in Canada, at one time considered a temporary concern that could be solved, has proven to be persistent. The complexity of personal, familial, social, and structural factors involved in homelessness has made simplistic, short-term solutions relatively ineffective. Unfortunately, it appears that most developed nations will need to consider providing services for homeless persons for many years to come. One of the services that need to be considered is health care, as myriad studies have shown that the experience of homelessness is detrimental to one's health. Homeless persons suffer significantly higher rates of morbidity and mortality than other citizens (Daiski, 2007). The specifics of these health concerns will be investigated further herein; one particular point to highlight is that negative attitudes of health and social service providers have been identified as the primary barrier to homeless persons accessing formal health care services (Ensign & Panke, 2002; Lester & Bradley, 2001). With this in mind, understanding client-provider relationships in the context of health care with homeless persons is of particular importance, as it is within these relationships that clients will encounter positive or negative attitudes.

This dissertation study will use a health clinic for homeless persons as the setting to look at two particular components of the client-provider relationship. Firstly, the concepts of space and place will be explored, as there is a dialectical relationship between social relations and place (Soja, 1989), and in particular, power, as enacted in space and place. For this study, 'space' is considered to be physical structures, whereas 'place' is defined as the meaning attributed to structures/locations (Bender, Clune & Guruge, 2007). Secondly, the interpretation and enactment of formal and informal

policies is examined, as these shape the relationships in the clinic. Ultimately, it is hoped that insights in client-provider relationships in this context will lead to both the refinement of existing services, and the creation of new services that better meet the health needs of homeless persons.

Background and Significance

Defining homelessness. Although defining the word ‘homeless’ appears at first to be a simple task, there is an underlying complexity in terms of who counts and who doesn’t. That is, being homeless simply means to be without a home, but there are many ways that this is lived out within a Canadian context. So, as both Layton (2008) and Begin and colleagues (Begin, Casavant, Miller Chenier & Dupuis, 1999) point out, how you define the phenomenon will determine the statistics that you obtain. Although there is rarely disagreement that someone sleeping in a park, under a bridge, or in an alley is homeless (sometimes referred to as absolute homelessness, or sleeping rough), the following scenarios are less clear-cut: living in a shelter for homeless persons; living in a building not considered a home, such as a shed or abandoned building; living temporarily in someone else’s abode for which one may or may not be paying a rent (sometimes referred to as couch-surfing, relative homelessness, or proto-homelessness); living in a halfway house or substance treatment centre; or living in an apartment or house that one owns or pays rent for, but does not meet the minimal codes for an inhabitable shelter. Another level of complexity is how quickly and how often these housing statuses can change over time, which is why many services also include those considered to be ‘at risk of’ homelessness’ within their scope. This status-over-time dimension is why Begin and colleagues (Begin, Casavant, Miller Chenier & Dupuis,

1999) chose three labels of ‘chronically homeless’, ‘cyclically homeless’, and ‘temporarily homeless’ to refine their definition of homelessness. However, it seems somewhat disconcerting to label a person based on their past housing history in such a way that presumes what their future will be, such as cyclically versus temporarily homeless.

Defining homelessness is a very political act, as how one defines the phenomenon will thus determine its scope (Layton, 2008). And, it is often the quantitative scope of a problem that is used as the primary indicator of whether a reaction is necessary, rather than the qualitative nature of the experience. Thus, if one wishes to make an argument for the requirement of more services, one simply uses a broader definition, and vice versa. A striking example of the power of definitions is when Statistics Canada (2001) in their Census 2001 found that at the time of the census 14,145 persons were living in shelters. However, these data were collected through a telephone survey of service providers, only cover those persons living in shelter, and only provide figures for a single moment in time. In contrast to this number, in the following year it was found that 31,985 people stayed in shelter at least once in the city of Toronto (City of Toronto, 2003). With Toronto representing 16% of the Canadian population at the time, and with only one of the living situations considered, one can begin to understand how the statistics can vary drastically both based on definition and methods of data collection.

For the purpose of this study, a definition of homelessness that includes both those who are absolutely homeless and those who are couch-surfing, in shelter, or any other situation that does not include owning or renting a place to live, is utilized. This

is not solely to be inclusive of the multiple ways that people can experience homelessness, but also because this is the same as the inclusion criteria of the clinic for homeless people that was the setting of the study.

The roots of homelessness in Canada. Rosenthal (2000) explores the simplistic perspectives in the public discourse of homeless persons as being either deserving or undeserving of aid. This is based on whether homeless persons are conceptualized as victims of their own irresponsibility, simply lacking in capacity, or victims of circumstances beyond their control. Therefore, in reflecting on the causes of homelessness, it is helpful to hold the agency/structure dialectic, as proposed by Giddens (1984), in mind. Giddens defines ‘agency’ as being able to act freely, unconstrained by external forces, and ‘structure’ as the social institutions and norms that influence human relationships. Therefore, in looking at any individual case, we need to recognize that both personal agency and social structures play a role in one’s current housing status.

Frankish (2008) breaks down the agency/structure dialectic further in looking specifically at homelessness, and proposes four sets of factors that contribute to homelessness: societal factors, organizational factors, interpersonal factors, and intrapersonal factors. Societal factors include: access to social assistance, funding for shelters and other resources, social assistance rates, availability of affordable housing, crime and drug policies, and housing policies. Organizational factors include: agency availability, resource availability, location of services, design of service provision, and availability of service providers. Interpersonal factors include: family issues, cultural issues, social network problems, and interactions with providers. Lastly, intrapersonal

factors include: biological problems, lifestyle choices, knowledge, addictions, criminal activity, and beliefs. These categories are similar to the findings of the Mayor's Homelessness Action Task Force (Golden, Currie, Greaves & Latimer, 1999) out of Toronto, Ontario. The Task Force defined the four essential causes of homelessness in Canada to be increased poverty, a lack of affordable housing, mental health care deinstitutionalization, and social factors such as violence, abuse, and social network alienation.

Of the causes identified, much of the recent focus has been on public policy in the housing realm. Various organizations have promoted educational campaigns suggesting that homelessness is a housing issue. This intuitively makes sense, as extremely comprehensive supportive, supported and subsidized housing programs would hypothetically assist all individuals regardless of their personal constellation of agency and structure challenges. It has been found that having stable housing increases the likelihood of leaving social assistance, finding employment, leads to better outcomes for children, and decreases morbidity and mortality (Ontario Municipal Social Services Association, OMSSA, 2005). And, the increase in homelessness in Canada over the last few decades has been termed by some as a 'dehousing process' (Hulchanski, 2009), suggesting that the dismantling of national and provincial affordable housing programs has caused the current crisis of homelessness. Therefore, 'housing first' models of assistance have been suggested, meaning that to assist homeless persons, we must first provide them with stable housing. However, it is important that a focus on housing does not lead to a neglect of other important social

determinants such as income, education, and support networks, all relevant issues for homelessness.

So, coming full circle, let us again consider what the root cause/s of homelessness is/are in Canada. Both inter/intrapersonal factors and public policy play a major role in causing homelessness. There is likely no single root cause, but suggest that some root causes are farther reaching and more amenable to change than others. For example, statistics from nations such as Norway (with a homelessness percentage estimated at 0.11%, Sveri, 2003) demonstrate that with strong enough public policies, almost all constellations of inter and intrapersonal factors can be accounted for, and homelessness can be averted. Therefore, I would suggest that one root determinant of homelessness in Canada that requires particular attention is problematic public policies. More comprehensive health, social and housing policies would lead to provision of adequate shelter for all Canadians, regardless of health status, employment status, or income level.

The extent of homelessness. Homelessness is a growing concern in most high-income nations around the world. In North America, both Canada and the United States (U.S.) have recognized the importance of this social dilemma (Registered Nurses' Association of Ontario, RNAO, 2004; Wright, 2000). Although compiling statistics regarding the scope of this problem has proven difficult, some work has been done in this area in North America. Wolch and Dear (1993) developed an estimate of 840,000 to 1.1 million episodes of homelessness in 1991 in the United States by compiling estimates of various governmental and non-governmental organizations. An American study (Link, et al., 1994) involved a random digit dialling of a representative sample of

households exploring the lifetime and 5-year prevalence of homelessness. In this study, the researchers found a lifetime prevalence of ‘literal homelessness’, which includes those living in shelter or on the street but not those who are ‘couch-surfing’, to be 7.4%, and a 5-year prevalence of 3.1%. This means that at a time when the U.S. population was 185 million, approximately 5.7 million people had been homeless at least once in the past five years. This number is surprisingly high, as the methodology of only accessing those individuals who had a home phone would exclude a large number of people who were currently experiencing extreme poverty and/or homelessness. Two years after the results of this study were published, the Urban Institute, a non-partisan economic and social policy research organization based in the U.S., developed estimates for the extent of homelessness in America. Their findings of 2.3 to 3.5 million homeless persons, or 0.9 to 1.3% of the population (Urban Institute, 2000) are widely quoted to this date. More recently, the National Alliance to End Homelessness and the Homelessness Research Institute (Henry & Sermons, 2010) came out with a number of 671,859. However, homeless persons had to be rostered in one of the 457 individual communities that were aggregated, creating a number of methodological limitations, and an expectedly low estimate.

Another means of determining the scope of the problem is by looking at the number of services and programs dedicated to assisting those who are experiencing homelessness. An American study in 1999 (Burt, et al., 1999) found 6,307 services with 11,983 programs serving homeless persons within a nationally representative sample of 76 census areas. Burt and colleagues obtained a truly representative sample with a variety of large urban, small urban, and rural areas selected in proportion to

national demographics. Knowing that there are 3,141 census areas in the U.S., these numbers obtained in 1999 can then be extrapolated to suggest that there were approximately 263,000 services with 496,000 programs serving homeless persons across the U.S., at a time when the U.S. population was 281 million.

Canadian statistics are harder to obtain, but present a similar picture that homelessness is a major social problem in Canada. Survey data from the late 1980s estimated that over 100,000 Canadians were homeless (McLaughlin, 1987). However, at the same time an estimate of 130,000 to 250,000 began to circulate based on a belief that such surveys underestimated the true numbers (Begin, Casavant, Miller Chenier & Dupuis, 1999). This number is likely quite inflated, as we do have regional statistics from which to extrapolate. Homelessness counts have been done in many regions, and tend to vastly underestimate true numbers, but have found 2098 homeless persons in Vancouver, British Columbia (Eberle Planning and Research, et al., 2002), 3079 homeless persons in Edmonton, Alberta (Homeward Trust Edmonton, 2008), and 5,052 homeless persons in Toronto, Ontario (FCM, 2008). These numbers coincide roughly with the Federation of Canadian Municipalities (FCM, 2008) report that found 14,190 regular shelter beds in 21 participating Canadian municipalities. Recognizing that shelter users are only one group of people who experience homelessness, estimates around 30,000-50,000 or 0.1 to 0.2% are likely most accurate. However, this number is far less than the 1.5 million Canadians who are at risk of losing housing (Laird, 2007). In recognition of the seriousness of this problem, the municipalities of Toronto, Durham Region and Ottawa (RNAO, 2004), as well as countless non-governmental organizations, have all declared homelessness in Canada a national disaster.

In terms of the community where this study was located, London, Ontario, statistics are again difficult to obtain. A study in 2003 found that shelters in London served approximately 4000 persons in a year (De Bono, 2003). These statistics point to the transitional nature of homelessness, as in a review of shelters in London in 2005, it was found that there are 641 total shelter beds (Curry, 2006), and 500 to 600 in 2008 (FCM, 2008). Therefore, each shelter bed is occupied by six to seven different individuals through the year. Again, individuals who stay in shelter only represent a portion of the homeless population, for example, often excluding those from racialized communities (Forchuk, et al., 2007). There are 18 food banks and 33 agencies that provide meals within the city (Matyas, 2009), although these service all persons living in poverty, not just homeless persons. Finally, 12% of London families are considered to be low-income (OrgCode Consulting Inc, 2010).

Although these statistics assist in helping one understand the approximate scope of homelessness, they are most likely flawed in that counting the number of homeless persons is methodologically very difficult (Wright, 2000). The main difficulty lies in defining what is meant by 'homeless', prior to attempting a census of homeless persons (Reid, Berman & Forchuk, 2005). In collecting statistics, defining homelessness prior to collecting data is the first and most important barrier, but there are also challenges in the actual data collection process (Frankish, Hwang & Quantz, 2005). In terms of counting those who are living on the streets, how are those who are doing the census to know whether a person is homeless? Is it appropriate to approach a person and ask, and how accurate is the response? Also, there is the challenge that homelessness is a transient experience, and people may find shelter in a different location each night, or

multiple locations in one night. Lastly, much of the data collection will require collaboration with community organizations, particularly shelters. For various reasons, particularly the political nature of collecting data regarding one's clientele, community organizations may be unwilling to participate. Therefore, accurately defining the scope of the problem through statistics is an ongoing challenge.

Despite these challenges, it is not necessary to have exact statistics on homelessness to know that this is a major health and social concern that needs to be addressed (Redburn & Buss, 1986). Human Resources and Social Development Canada (2007) on reviewing the available statistics on homelessness suggested that obtaining these numbers would be useful, but still recognized the importance of the problem and in 2007 granted \$269.6 million over two years to partner with community agencies to address homelessness. What is more important than the absolute numbers is that it has been found that the incidence of homelessness is increasing, and has been increasing consistently since the post-depression era (Timmer, Eitzen & Talley, 1994). This increase may be influenced by a myriad of structural factors, such as increased costs of living not being paralleled by increases in social assistance, or the loss of a national housing program in Canada. As early as 1985, researchers noted that national estimates of homelessness in the U.S. were increasing steadily, including increases in specific populations such as homeless children (Jackson & McSwane, 1992), but also in the national homeless population (Tolomiczenko & Goering, 2000). The most conclusive data to support that this is an increasing problem comes from shelter usage statistics, which have increased consistently and continuously across North America (Wright, 2000). Official statistics are important, but we also must not ignore personal

anecdotes coming from service agencies and providers highlighting the increase in homelessness. And, the problem is not only a local one, but homelessness on a global scale has been increasing (Begin, et al., 1999). The scale of homelessness is the impetus that is causing national, provincial and local governments to take action, not the absolute numbers, but the fact that this is an increasing social concern.

A final risk in attempting to tally the number of homeless persons is that by developing these statistics we are grouping together a multitude of very diverse individuals and families (Tolomiczenko & Goering, 2000). When we create a single number of the people who are homeless, there is a risk that we will see homelessness as a single problem, rather than as multiple problems that work together to create this negative experience (Wright, 2005). There is no way of describing a single archetype of a person who is experiencing homelessness. Frankish, Hwang and Quantz (2005) sought to define a few key research priorities for homelessness, but found this to be a difficult task as homelessness affects all ages, genders, races, ethnicities, beliefs and backgrounds. It is important to understand that homelessness is a heterogeneous experience, and poverty is not a homogeneous construct.

Homelessness and health. In spite of the variation in causes and experiences of homelessness, for all who experience it, homelessness is an experience that compromises one's health (Crowe & Hardill, 1993; Hatton & Fisher, 1999). And, as suggested by the Ottawa Charter (World Health Organization, 1986), the health challenges that arise during homelessness have to do with more than physical illness, and include the social determinants of health (e.g. income and social status, social support networks, education and literacy, employment/working conditions, social

environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture; Public Health Agency of Canada, PHAC, 2003). For most individuals, homelessness is a transitional state rather than a permanent situation (Buck, Rochon, Davidson & McCurdy, 2004), and during this time much can occur that exacerbates existing health concerns, or creates new ones.

Understanding the health impacts of homelessness is somewhat complicated in that many of the conditions faced (such as mental illness, substance use and chronic health conditions) can be both causes of and results of homelessness (NHCHC, 2009), but the case of negative health impacts of homelessness is well established (Daiski, 2007). One study of homeless women found that 35% had been hospitalized in the past year, five times the rate of the national average (Lim, et al., 2002). Most striking in terms of the negative health effects of homelessness is the high mortality rates of homeless persons (Frankish, Hwang & Quantz, 2005; Levy & O'Connell, 2004), including youth (Klein, et al., 2000), with the life expectancy of homeless persons averaging 35-47 years (Podymow, Turnbull & Coyle, 2006). This coincides with findings from Denmark of age and sex standardised mortality ratios for homeless persons of 2.8 for men and 5.6 for women (Nordentoft & Wandall-Holm, 2003), and an average age of death for homeless persons in Germany of 44.5 years (Ishorst-Witte, Heinemann & Puschel, 2001).

Statistics on acute and chronic conditions and homeless persons are striking. Street Health in Toronto, Canada found that 55% of homeless persons have a serious physical health condition, and 63% of these have more than one (Street Health, 2005).

Kinzel, Flagg and Vredevoe (1991), in an ethnography of self-perceived health amongst homeless persons, found that 25% were currently experiencing hypertension. Burt and colleagues (1999), in a survey of homeless persons in 76 U.S. census areas found that 46% had chronic conditions and 26% had acute infectious conditions. These chronic conditions often occur very prematurely amongst homeless persons in comparison to housed persons (Daiski, 2007). Additionally, in Paris, France, Kovess and Mangin Lazarus (1999) found a lifetime incidence of 58% for psychiatric conditions and 34% for substance abuse amongst homeless persons. In Western nations, psychiatric conditions such as psychosis, major depression, personality disorders and addictions are higher amongst homeless persons than the general public (Fazel, Khosla, Doll & Geddes, 2008). These conditions can, in part, be caused by and exacerbated by the challenges that homeless persons face: taking medications as prescribed (Burt, et al., 1999), risk of injury (Ensign & Gittelsohn, 1998), lack of access to good hygiene (Gerberich, 2000), poor nutrition and exposure to the elements (Jackson & McSwane, 1992), social isolation (Kinzel, Flagg & Vredevoe, 1991), and exposure to physical and sexual violence (Levy & O'Connell, 2004). When asked about their health concerns, homeless men focused on broader health and safety needs and acute conditions, rather than chronic illnesses (Lafuente, 2003), an important consideration for the structuring of health care services for homeless persons. And, in the face of these myriad difficulties, studies have found that homeless persons still actively work to promote their health, but often in what would be considered unconventional ways (McCormack & MacIntosh, 2001; Rew, 2003). For example, Rew (2003) demonstrates how homeless youth may carry weapons as a means of self-preservation, or use dangerous means of

transportation such as riding on the backs of buses in order to access free meals or shelters before they are closed.

All of these health concerns are aggravated, or possibly caused, by the fact that homeless persons encounter barriers to accessing formalized health care services beyond emergency rooms. Statistics demonstrate the lack of formalized care that homeless persons receive. A study in Germany found that 90% of homeless people are “urgently in need of medical treatment” (Trabert, 1997, p. 378). In a large American study (Burt, et al., 1999), it was found that of the sample of homeless persons involved, 24% required treatment from a physician but were unable to obtain this treatment. Similarly, in a French survey of 838 homeless persons (Kovess & Mangin Lazarus, 1999), only 53% of those who were experiencing an active psychiatric condition were accessing formal care. A recent Canadian study found somewhat lower numbers of 17% of homeless persons reporting unmet needs for health care (Hwang, 2010).

The barriers to care are many, and vary with the local context, but generally include social isolation. Social isolation is both a causal factor and an outcome of experiencing homelessness. In a phenomenological study of the experiences of homeless men, Lafuente (2003) found that homeless men are socially isolated in that they experience rejection both from within (i.e. rejection of one’s self) and from others. This social isolation from others, and the degree to which it occurs, is predictive of not receiving regular formalized health care (Gallagher, Andersen, Koegel & Gelberg, 1997). The mechanisms that link social isolation to a lack of accessing regular care have been studied, and include the development of a mistrust of health professionals (Levy & O’Connell, 2004) and an unwillingness to disclose personal information

(Hatton & Fisher, 1999). Additionally, by being isolated from society, people who are experiencing homelessness may have a decreased knowledge of the available services and the means of accessing these services. These barriers to care are even more problematic amongst older homeless adults who require access to a greater number of specialized services (Watson, George & Walker, 2008).

Competing demands or priorities, also referred to in psychology as the hierarchy of needs (Maslow, 1943), may prevent homeless persons from taking the time to access formalized health care services (Berne, Dato, Mason & Rafferty, 1990; Frankish, Hwang & Quantz, 2005). Kushel, Gupta, Gee and Haas (2006) found that housing instability, taken as a proxy for competing demands, was associated with having no usual source of formalized health care. This finding is identical to previous work that measured ‘competing demands’ directly as an independent variable (Gallagher, Andersen, Koegel & Gelberg, 1997). Homelessness is a chaotic experience in which individuals struggle to meet their basic needs. Homeless persons need to simultaneously find food, shelter, and clothing, attend appointments, obtain transportation, obtain or maintain an income, and attend to their acute health care needs. If one’s time is consumed simply trying to survive, dealing with health concerns may be seen as a luxury and therefore may not be attended to until they become completely unmanageable and threaten this ability to survive. Additionally, the length of time required to receive health care services compounds the issue of competing demands, and links directly to the third issue of prohibitive bureaucratic structures.

Within the American context, the main bureaucratic barrier to health care for homeless persons has for many years been a lack of Medicaid (McKinney, 1978). With

a public health care system, Canadians do not face this barrier, but many bureaucratic barriers still exist. For homeless Canadians, a major barrier is the lack of personal identification, including the lack of a health card (Ensign & Panke, 2002; Frankish, Hwang & Quantz, 2005). Within the turbulent existence of a homeless person, identification is frequently lost or stolen, and is difficult to replace due to complicated procedures, the requirement of having other identification to replace missing identification, and fees charged for replacement. Another barrier is the accessibility of health centres that specifically serve homeless persons, such as community health centres (CHCs) or shelter-based health centres, as they are often only open during business hours (Ensign & Panke, 2002). Additionally, these centres often have complicated intake procedures to ensure that people are not receiving care from more than one physician. These intake procedures may be too complicated or too prohibitive for people who are living a chaotic life, dealing with mental illness, or dealing with addictions. For example, these intake processes may involve multiple scheduled visits, with a population for whom keeping scheduled appointments may be difficult. Lastly, there is often a cost involved in transferring health records from previous sources of care to the current physician, a process that is often a mandatory step before care is available.

In addition to the barriers of social isolation, competing demands and bureaucratic structures, homeless persons frequently experience negative attitudes from health care providers (Nickasch, 2009). These negative attitudes have been identified as the primary barrier that homeless persons face in obtaining health care services (Ensign & Panke, 2002). Negative attitudes do not go unnoticed, with one Canadian study

showing that 40% of homeless persons felt they had received less-than-ideal care, and one third had been treated rudely when using emergency rooms (Crowe & Hardill, 1993). Young-Mason (1999) presents a striking case study of a homeless person identified as 'Henry' and the mistreatment he receives in an acute care setting, being treated like a child and being feared. Studies have shown time and again that homeless persons face disrespect (Ensign & Panke, 2002), stigma (Boyce, 2001; Hatton, Kleffel, Bennett & Gaffrey, 2001), discrimination (Baumann, 1993), prejudice (Bhui, Shanahan & Harding, 2006), dehumanization (Buck, Rochon, Davidson & McCurdy, 2004; Lafuente, 2003), judgmentalism (Ensign & Gittelsohn, 1998), being ignored (Mykhalovskiy & Farrell, 2005), and insensitivity (Gerberich, 2000) from health care professionals; this includes those professionals who practice in centres specifically created for homeless persons, where optimal care would be anticipated. However, although much work has been done on health care relationships, there is a dearth of work in the area of health and homelessness that both takes account of the power within client-provider relationships, and addresses policy factors at both the organizational and systemic levels that affect these relationships.

Caring for/with people who are experiencing homelessness. Concerns of increasing homelessness, problematic public policies, and the health impacts of homelessness mean that more work needs to be done on homelessness and health care. The primary goal would be to eliminate homelessness, although that is beyond the scope of this study. That being said, there are some excellent suggestions currently available on models for comprehensive social housing (Shinn, 2009) and healthier public policies (Layton, 2008). In the meantime, health care services for homeless

persons, and the individuals who work for them, need to evolve to better meet the needs of homeless persons.

Various suggestions have been put forward in working to eliminate barriers to care faced by homeless persons. From a public health perspective, suggestions have been made to both increase the reach of public health services to include those who are least likely to seek care, and to create specialized services for homeless persons (Wright & Tompkins, 2006). The focus of the increase in public health services is on enhancing harm reduction services to enhance primary prevention. Building on this, Power and colleagues (1999) suggest that promoting the health of homeless persons needs to go beyond disease prevention and include system navigation, meaning the steering of people towards appropriate resources. They also suggest attention to the social determinants of health, including such things as clean and protective clothing. In their “Healing Hands” newsletter, the National Health Care for the Homeless Council Clinicians’ Network (NHCHC, 2010) provides practical suggestions and resources to providers for working around barriers of the lack of identification, and the lack of health benefits. In this way, people who are experiencing homelessness may tap into existing services from which they would normally be barred. However, when existing services are not sufficient, programs need to be created to bring health care to homeless people on the streets. Programs and models exist to help health providers create these street-level, outreach-based services (Howe, Buck & Withers, 2009; Ollari, 2008).

Study Purpose

In spite of the preceding resources, the problem that remains is still that which has been identified as the primary barriers to health services for homeless people, how

negative attitudes of health care providers towards people experiencing homelessness impact health care relationships (Ensign & Panke, 2002). Although some work has been done in this area, as is presented in the review of the literature, there are still two primary gaps in the knowledge base. Firstly, the dialectical relationship between space/place and social relations has largely been neglected in studies on client-provider relationships in health care services with homeless persons. Of particular interest is the concept of power in places, as clients are engaged in care within place-mediated power relations. Secondly, there is a dearth of research on the role of both formal and informal policies on the enactment of client-provider relationships in this context. The role of policies needs to be studied with an eye to the culture in which health care is provided, as the policies that govern relational practices in health care are culturally created, enacted and resisted. Therefore, this study is two-fold. In the first section, I will address the question: How is 'place' experienced by clients and providers within a community health clinic for people who are experiencing homelessness? In the second, I will answer the questions: How are client-provider relationships enacted within the culture of community care with people who are experiencing homelessness? and, How do clinic-level and broader social and health policies shape relationships in this context?

Study Significance

With the ultimate goal of providing more adequate health care to people who are experiencing homelessness, my goal is to add to the literature that provides guidance to health professionals on how to create more health promoting places for care, and how to create and enact more health promoting policies. On shedding light on the power within spaces and places, and on the role that power plays in policy creation, enactment

and resistance, it is my hope to facilitate critical consciousness-raising, both for individuals who are experiencing homelessness and accessing health care, and for the providers who work with them. Ultimately, it is my desire to create a space in which homeless persons can empower themselves to meet their health needs, across the social determinants of health.

Overview of Chapters

This thesis follows the integrated-article format as accepted by Graduate Studies at The University of Western Ontario. Chapters 4, 5, and 6 are considered stand-alone chapters to be submitted for publication, hence some repetition within these chapters particularly around the background, literature review and methodology components. Chapter 2 consists of a review of the literature looking particularly at studies on health care relationships, power within health care relationships, and client-provider relationships in the context of health care with people who are homeless. Chapter 3 provides an in-depth look at the methodology of critical ethnography, and particularly the challenges of engaging in critical ethnography in one's workplace setting. Chapters 4 and 5 present the study findings of the above-mentioned research questions, with Chapter 4 covering power and space/place, and Chapter 5 covering client-provider relationships and policies. Chapter 6 presents the contributions of this thesis in terms of research, education and practice for health care with people who are experiencing homelessness.

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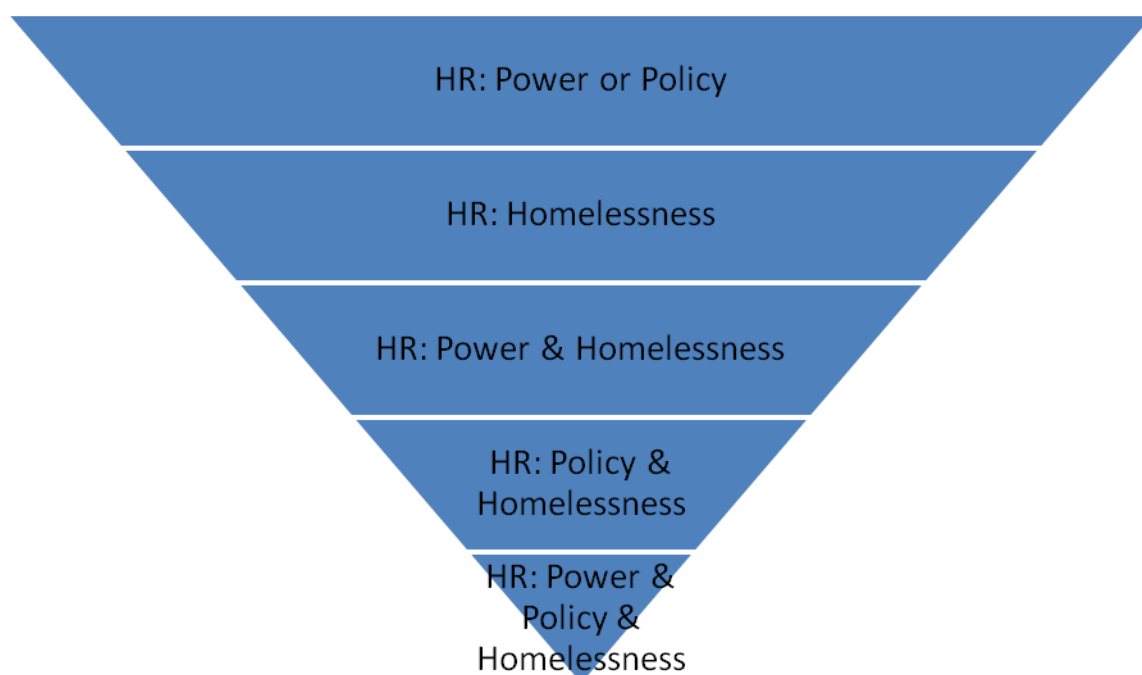
Chapter 2 – Literature Review

In this chapter I present a critical review of the state of the literature on health care relationships, particularly focusing on power and policy, and health care relationships in the context of care with people who are experiencing homelessness. I start with more general work, and move towards studies most similar to this dissertation, meaning those that look at client-provider relationships with people experiencing homelessness, taking into account both the power within the relationship, and how policies frame these power relations. The ultimate goal of this chapter is to identify gaps that exist in helping health care providers engage meaningfully with people who are experiencing homelessness, and explore the broader policy context that frames their work. In all, 47 theoretical and empirical articles were found that spoke explicitly to health care relationships and homelessness.

The literature review began with a primary search using SCOPUS, CINAHL, and MEDLINE. General search terms were used initially, such as “therapeutic relationships”, “caregiving relationships”, “health care relationships”, “health promoting relationships”, “nurse-patient/patient-nurse relationships”, “nurse-client/client-nurse relationships”, “physician-patient/patient-physician relationships”, and so-on through the health disciplines. These results were then combined with searches on “power”, “power relations”, “relational power”, “control”, and “empowerment”, and searches on “policy”, “contextual factors”, “policy context”, and “governance”. The same process was then repeated with the terms “homeless” and “homelessness” added. A secondary search process was then conducted, with a review of references from found articles serving to find older articles, and with the use of

Google Scholar's 'cited by' function serving to find newer articles. Articles were screened out that were very specific and demographically different from my own work, such as 'homeless women of colour with children in rural France', or that spoke to relationships that were significantly different than health care relationships, such as 'relationships with formerly incarcerated food bank volunteers'. As relational power is the primary focus in this study, these types of relationships represented a different power dynamic. However, as will be evident in the review, articles were maintained even if there were significant philosophical or methodological differences with my own work.

The review is presented from broad to specific as follows: health care relationships (HR), looking at power or policy, health care relationships and homelessness, power in health care relationships and homelessness, policy and health care relationships and homelessness.



Many of the articles retrieved focus on nursing research and understanding therapeutic relationships as conceptualized by nurses, but all health and social care disciplines were included. I conclude with identifying ways that the research can be moved forward to fill existing gaps.

Health Care Relationships

There is much that has been written on health care relationships in the context of health care. In a review of the literature, O'Brien (2001) found that health care relationships were addressed as early as the beginning of the 19th century. These relationships occurred and were fostered within a context of asylum care being delivered by attendants. A relational focus continued to be valued within the mental health care system into the 1900s (Russell, 1988), particularly as mental health care practice became increasingly professionalized and nurses replaced less educated attendants. Significant progress in conceptualizing health care relationships occurred in the 1950s across disciplines. In nursing, Peplau (1952) led the way with the publication of "Interpersonal Relations in Nursing", in which she incorporated therapeutic relationships as a key component of the definition of nursing, laying out a preliminary theory for the development process of a therapeutic nurse-client relationship. At almost the same time, social scientist Talcott Parsons and psychiatrist Harry Stack Sullivan were each developing theory around the doctor-patient relationship (Parsons, 1951; Sullivan, 1953). This was followed closely by the work of Szasz and Hollender (1956) who developed a typology of doctor-patient relationships, and the work of Balint (1957) who used concepts of psychotherapy to lay the groundwork for patient-centredness in

medicine. In social work, “The Casework Relationship” by Biestek (1957) defined social work practice with a focus on therapeutic client-provider relationships.

More recently, within each health discipline there are texts written on health care relationships, such as nursing (Stevenson, Grieves, & Stein-Parbury, 2004), medicine (Owens, 1999), dentistry (Welie, 2000), social work (Robb, Barrett, Komaromy, & Rogers, 2004), complementary health care (Mitchell, & Cormack, 1998), and others. Research has been conducted on teaching relational care practices (Chant, Jenkinson, Randle, & Russell, 2002; McKlindon, & Schlucter, 2004; Novack, Epstein, & Paulsen, 1999), how to conduct research on health care relationships (Forchuk, 1994; Hojat, et al., 2002; Horvath, & Greenberg, 1989), and how to engage in health care relationships (Li, 2004; Nolan, et al., 2004). In terms of engaging in health care relationships, research has been conducted on health care relationships in the context of nearly every population and medical condition, such as in palliative care (Li), clinical psychology (Horvath, 2000), pediatric psychotherapy (Shirk, & Saiz, 1992), intensive care (Dyson, 1999), primary care (Wissow, Brown, & Krupnick, 2010), cancer care (Kruijver, Kerkstra, Bensing, & van de Wiel, 2000), and geriatrics (Nolan, et al.). For nursing, a key document in the last few years has been the Registered Nurses’ Association of Ontario’s “Establishing Therapeutic Relationships” best practice guideline (RNAO, 2002; RNAO, 2006). This guideline has been tested as a whole (Edwards, Peterson, & Davies, 2006), as well as each component of the therapeutic relationship being researched, such as communication (Fleischer, et al., 2009), active listening (Richter, Parkes, & Chaw-Kant, 2007), empathy (Brunero, Lamont, & Coates, 2010), trust (Goldberg, 2008), and respect (Hughes, Davies, & Gudmundsdottir, 2008).

Overall, research has demonstrated that positive relationships in health care equate to better health outcomes, and that guidelines such as those developed by RNAO are effective in improving the chances that relationships will indeed be positive (Edwards, Peterson, & Davies, 2006).

Power in health care relationships. Although health care relationships are well researched, one piece that is constantly overlooked in this work is the presence of power. Leaders in health research have identified that if we want to achieve a social mandate of confronting injustice, we must be attuned to power structures and power relations (Kagan & Chinn, 2010). In this way, much of the work that seeks to guide health professionals in navigating health care relationships, presents that relationship as completely benign. For example, Shattell, Starr and Thomas (2007) conducted a phenomenological study seeking to refine our understanding of the therapeutic relationship by focusing on the client's perspective. This research identifies ways that nurses can improve communication and create a more genuine connection, but could be enhanced by also speaking to the vast power differential experienced between a person living with a mental illness and a nurse. According to Giddens (1973), power exists in all social relations and arises from differences in social location such as race, class, gender, age, and ethnicity. Health professionals have worked to evolve a meaningful understanding of power, starting at the basics of recognizing that there is 'power to' rather than just 'power over' (Hokanson Hawks, 1991). The idea of 'power to' recognizes that we all have access to power, and power is not necessarily just used abusively against others, but can be a positive resource for change. This is useful, as studies, such as Hewison's (1995), that only see power as a negative concept come up

with unsophisticated conclusions that power is a barrier to relationships that can somehow be eliminated. However, it may be time to move beyond the process of understanding and defining power as more recent studies continue to reach the same conclusions of power being more than just a negative concept (cf. Polifroni, 2010). In fact, these theories of power being available to all might actually be disempowering if they are used to conclude that clients must all take power in their lives, without also addressing broader structural power relations (cf. Barrett, 2010). That is, there is a risk that marginalized groups will be set-up for failure if the conclusions of power-focused research are simply that individuals must take more power and there is no broader structural change.

Although some of the theorizing on power and health care has been for the purpose of empowering health professionals themselves (Bogue, Joseph, & Sieloff, 2009; Bradbury-Jones, Sambrook, & Irvine, 2008), or addressing power differentials between professions (Porter, 1993), exploring power has been an important part of the move towards client-centredness. There is a growing recognition that health care is inherently based in relations of control (Cutcliffe & Happell, 2009), and that enhancing, or co-opting, client participation in their care is one means to breaking down this power differential (Felton & Stickley, 2004; McCann, Baird, Clark, & Lu, 2008). Marnocha (2009) states, “Change in patient behavior is not ‘orchestrated’, but rather discerned through close listening” (p. 196). This quote demonstrates a move away from ordering and enforcing health behaviour changes, to working relationally with clients to meet their needs together. However, on the other hand, there is still an undertone here of tokenism, that the health care professional is the expert who must benevolently grant

their expertise upon clients in order to coerce them into making changes that the professional knows are best. This same pejorative attitude (Manias & Street, 2001) lives on in empowerment-based literature where it is presumed that ‘we’ empower ‘them’ (Laschinger, Gilbert, Smith, & Leslie, 2010), that is, professionals break down the power differential by sharing some of their power with clients (Christensen & Hewitt-Taylor, 2007; Welch, 2005). Secondly, client participation in care might simply mean colluding in the very structures of power that limit control in their own lives. Instead, perhaps a truly empowering view of empowerment might be that health providers can work to help create spaces where clients can empower themselves (Holmes, Perron, & Savoie, 2006).

This last point brings me to three articles that highlight the issue of power in the provider-client relationship, and led the researchers to confront it in a manner that is neither tokenistic nor disempowering. Confronting power differentials is important, because even when power is well conceptualized, it doesn’t necessarily mean that health care providers are willing to confront power differentials (Henderson, 2003). In a critical ethnographic study of an acute care psychiatric ward, Cleary (2003) recognized the power inherent in all social relations, and explored how nurses, driven by the desire to be more client-centred, actively worked with clients to lessen the power differential. This involved being proactive in demonstrating respect, being proactive in making information available to clients, and getting to know the person as an individual apart from their illness so that interactions could be better contextualized. Lastly, Cleary suggests that we need to be honest as practitioners when we think about client-centredness in terms of whether and where we are truly seeking consensus, and

particularly in the case of acute care psychiatry, when we will be forcing compliance upon individuals. Proactively demonstrating respect, providing information, and relating on a personal level is different from the usual discussion of fostering therapeutic relationships because it does not take for granted that clients will respect providers; it makes no requirement of clients to have to identify their informational needs and seek support, and assessing clients takes back-seat to 'being with' clients. However, it should be noted that these techniques can be used as easily for 'power over' and securing compliance, as for creating spaces with clients where they can empower themselves.

Johansson, Skarsater, and Danielson (2006) using an ethnographic approach, examined an acute care psychiatry locked ward. Johansson and colleagues looked at how the power of both the health professional and the client is used in navigating relationships. Using 'control' as the central motif, Johansson and colleagues framed client 'outbursts' in a positive manner, as the natural human reaction to excessive control. Noting that excessive control can be counter-productive, they made reference to the fact that altering organizational and mental health care policies might be beneficial. Holmes, Perron, and Savoie (2006) offered a more nuanced exploration of power in client-provider relationships, looking at how nurses influence decision-making around dialysis in end-stage renal disease. Holmes and colleagues speak to the Foucaultian concept of pastoral power, or how nurses guide client self-regulation by formulating the desires of the client who then sees them as their own. In this way client autonomy becomes almost tokenistic, as their subjectivity has been formed by the nurse in how information is presented and explored. Like Johansson and colleagues, the

analysis of the power in this interaction would be enhanced by further exploring the policy context in which these relationships are being enacted.

Policy and health care relationships. Both workplace and broader health and public policies have been subjects of health research. However, at times the focus on how policies impact such areas as nursing work neglects to focus on health care as a relational process (Laschinger, Gilbert, Smith, & Leslie, 2010; Norrish & Rundall, 2001). Alternatively, the relational component is minimized, seen as one component of health care practice (Ritter-Teitel, 2002), or one variable within the concept of ‘processes of care’ (Sidani, Doran, & Mitchell, 2004). Others, however, have developed frameworks for health care that account for both the inherently relational nature of practice, and the influence of policy components on this practice (McCormack & McCance, 2006). Explorations of the impact of policy on health care relationships have at times focused on how policies can be supportive of relationships, such as the current policy shift to supporting client-centred care (Bury, 2004), but have more often demonstrated how policies can be barriers to the health care relationship. For example, the client-provider relationship can be hindered by policies that download care to families (Ward-Griffin, & Marshall, 2003), policies that uncritically look to confront risk behaviours (O’Byrne & Holmes, 2007), policies of cutting costs around staffing levels (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007), and policies that push the public health system towards competitive-bidding under the auspices of cost-containment (Antrobus, 1997). That said, Hewison (1999) takes a more positive approach to these challenges, suggesting that policy change is always a conversation,

and health professionals can have a voice in that conversation to move policies in a more supportive direction.

Two articles were found that explore in detail both policy and power in the context of health care relationships. Perron, Fluet, and Holmes (2005) provide a conceptual analysis of bio-power in nursing, meaning the organization by the state of power over life, the individual body and the population. Perron and colleagues note that much of nursing is focused on the control or training of bodily activities, termed as health promotion, for the good of the individual but also of the state. Structures are built around nursing that both legitimize and enhance the 'efficacy' of this control. Nurses are tasked with surveillance in order to find and intervene with non-normalized behaviours. In public health, the connectedness of managing both individuals and populations is most evident. These relational practices of power are greatly influenced by the policy context, with policies often serving to legitimize the 'power over' component of bio-power. Christensen and Hewitt-Taylor (2006) explore the same issues, although they use somewhat different language. Looking at the shift to client-centred care, they critically question how much clients can truly be empowered without completely altering the policy and political context in which we currently deliver health care services. Both Perron and colleagues, and Christensen and Hewitt-Taylor point out that attempts to shift the power structures within individual client-provider relationships are often tokenistic, and possibly doomed to failure unless the broader ways in which health care is conceptualized and enacted are simultaneously re-considered.

Health Care Relationships and Homelessness

The preceding articles looked at relationships, power, and policies, but outside of the area of health care with people who are experiencing homelessness. Unfortunately, the relational nature of health care practice with people who are experiencing homelessness has largely been neglected in the research, with comprehensive reviews of how to improve medical services for people experiencing homelessness often focusing on the pragmatics of care and not the relationship (Howe, Buck, & Withers, 2009). That said, a limited number of researchers have been exploring health care relationships in this context for decades, with ideas around the negative attitudes of health professionals being a barrier to care going back to Pittman (1974). Indeed, these negative attitudes have been a primary focus of the research on health care and homelessness when relationships are taken into account. Grounded theory studies (Nickasch, & Marnocha, 2009), phenomenological studies (Wen, Hudak, & Hwang, 2007), and qualitative descriptive studies (Lester & Bradley, 2001; Sachs-Ericsson, Wise, Debrody, & Bradley Paniucki, 1999) speak to the commonality of experiencing negative relationships, and that this experience is often the primary deterrent to accessing formal health care services.

Kryda and Compton (2009) interviewed chronically homeless adults in New York City, particularly focusing on why certain individuals made limited or no use of formal services. Participants spoke to experiences of mistrust, stereotyping, limited choices, and having a general sense that workers were focused on getting paid rather than truly helping, based on repeated experiences of unfulfilled promises from providers. Chinman, Rosenheck, and Lam (1999) unpacked this further and looked at

contributing factors to negative attitudes, identifying that having spent less time homeless and having more education were predictive of a better therapeutic alliance. This finding speaks to social distance, as mental health case managers were able to more easily relate to those who were less marginalized.

Recognizing the powerful influence of these negative attitudes, much research has looked at how to improve relationships with people who are experiencing homelessness. This includes the basics of therapeutic relationships, such as being sensitive listeners (Hatton & Fisher, 1999), establishing trust and being non-judgmental (Hudson, Nyamathi, & Sweat, 2008; Walsh, Rutherford, Sarafincian, Sellmer, 2010), establishing autonomy and being flexible (Morse, et al., 1996), and demonstrating a commitment to care (McCabe, MacNee, & Anderson, 2001). The importance of providing basic necessities as a first step has also been highlighted, including both in outreach psychiatry (Christensen, 2009), and in social work practice (Cohen, 1989). Negative attitudes have also been addressed at an educational level, based mostly on the contact hypothesis that stigma towards homeless people can be decreased through increased contact (Aberson & McVean, 2008; Lee, Farrell, & Link, 2004; Ugarriza & Fallon, 1994). The Attitudes Toward Homeless Inventory (ATHI) and the Public Attitudes Toward Homeless (PATH) scales have been used in pre-post intervention studies to explore the impact of clinical placements for health provider students and general undergraduates on attitudes. This clinical exposure has been found to have a positive effect on attitudes towards people who are experiencing homelessness for medical students (Buchanan, Rohr, Kehoe, & Jain, 2004; Buchanan, Rohr, Stevak, & Sai, 2007), nurse practitioner students (de la Cruz, Brehm, & Harris, 2004) nursing

students (Minick, Kee, Borkat, Cain, & Oparah-Iwobi, 1998; Zrinyi & Balogh, 2004), communications students (Hocking & Lawrence, 2000), interprofessional health care students (Rose, Lyons, Swenson Miller, & Cornman-Levy, 2003), and paramedical students (Zrinyi & Balogh).

Unfortunately, similar to the literature reviewed in the previous section, much of the work on relationships in homelessness and health has neglected to include the presence of power within these relationships. This omission can lead to recommendations that are of limited value, such as simply recommending that ‘caring professionals’ are needed to work with people who are experiencing homelessness (Carter, Green, Green, & Dufour, 1994), or making note that homeless youth who seek mental health care have limited control in their personal lives without similarly reflecting on the limited control they have of health care services (Darbyshire, et al., 2006). Worse yet, work that does not recognize power in the health care relationship might actually add to the disempowerment of people who are experiencing homelessness. By way of example, Gerberich (2000) describes a clinic for homeless men in a shelter, and suggests that the nurse must create a caring connection in order to influence men to make healthy lifestyle decisions. This puts the formation of the relationship solely in the hands of the nurse, and for the purpose of altering behaviours rather than working with people, and assumes that “unhealthy” lifestyle decisions are the cause of homelessness. Similarly, Moneyham and Connor (1995) conducted a phenomenological study of homeless men who were in treatment for substance use issues, in order to look at roads into and out of homelessness. Having identified the road into homelessness as having to do mostly with personal agency, health care

relationships were seen as a curative tool for personal recovery. The authors go so far as to suggest that there needs to be a greater focus on personal components of recovery from homelessness, rather than policy. Lastly, Lafuente and Lane (1995) looked at social disaffiliation with homeless men, but used a conceptualization of drug addiction as voluntary withdrawal from society. In this conceptualization there was no room for considering structures of power, or even that some homeless men might not identify as socially disaffiliated. With no recognition of interpersonal or political power structures, Lafuente and Lane's suggestions for health professionals focused on helping homeless men formally 'buddy' with each other offer little promise for long-term change.

Power in health care relationships and homelessness. While some researchers have made small steps towards recognizing power, such as working with strengths rather than thinking of helping victims (Martins, 2008), or paying attention to power relations (Ensign & Panke, 2002), others have confronted the issue of power in health care relationships and homelessness directly. Some of this has simply involved looking at the concepts of client-centredness or partnership, and exploring how these have promise for confronting power relations in health care with people who are experiencing homelessness (Cohen, 1989). In a deeper analysis of client-centredness, Wilson and Neville (2008) presented their perspectives of having worked at a nurse-managed clinic for homeless people, and addressed the issue that providers can become "hardened" if they have unmet expectations of clients. Reflecting on the danger of pushing our agenda against that of the client, Wilson and Neville offer valuable advice for making relationships more equitable, such as re-thinking conversations with clients as being opportunities for developing mutual understanding versus being assessment

and subsequently illness focused, and also taking the concept of ‘non-compliance’ completely out of the professional vernacular. In an ethnographic study of a day centre for people experiencing homelessness in the UK, Shoemaker (2010) provides similar advice in questioning how we engage with personal agency of clients in the light of interpersonal and structural power imbalances. Shoemaker suggests, “[client] responsibility grows organically from respect and reciprocity rather than through the imposition of a conformist moral discourse of self-responsibility’ (p. 286). This statement reflects that health providers do want to see their clients living healthier lives, but questions a lifestyles-based conceptualization of promoting health.

Three other articles were identified that address power at the personal, interpersonal, and social levels in health care relationships and homelessness. At the personal level, Gill (2000) reflects on the process she engaged in to set up a nursing outreach program at a local shelter. She took the time to consider her various social locations, and how clients might perceive her. She went so far as to consider how she would dress when working, seeking to find a balance between not being crass and flaunting her wealth by over-dressing, but also not suggesting that she was in the same situation as her clients. At the interpersonal level, Myhrvold and Ma (2006) looked at the idea of providing care across difference, recognizing that difference is important to humanity, but that too great a social distance can become a barrier to empathy. They speak of positionality and the need to understand how we are both equal to and different than the clients we serve. They also balance the imperative to confront power imbalances with a warning to avoid disempowering clients by feeling that the entire relationship rests on the health care provider. At the social level, Rowe and colleagues

(2001) bring a critical lens to assertive mental health outreach for people who are experiencing homelessness, noting that for most, a move off the street is simply a move to second-class citizenship. They question whether our programs as they currently exist will ever truly break down social exclusion. Rowe and colleagues present a program that moved recovery out of organizations and into the broader community, creating a space for active citizenship. This creation of participatory spaces is a key piece in confronting power relations, recognizing that simply doing things how we currently do them, but a little bit better, might not be enough. This recognition of doing things differently leads into an examination of the impact of policy on health care relationships and homelessness.

Policy and health care relationships, and homelessness. Policy can impact health care relationships between care providers and people experiencing homelessness at a number of levels. This includes policy structures that prejudice people towards social services, broader systemic policy structures, policies local to the organization, or policies that frame social assistance that clients will encounter after having spent time in the organization. Before a person who is experiencing homelessness encounters a specific supportive service, such as a health care clinic, they are likely to have engaged with social services of some kind. Hatton and colleagues (2001) conducted focus groups with staff and managers from shelters serving homeless women and children in the U.S., and found that women were coming to their services already having a negative opinion of social services. This negativity was due to the ‘zero tolerance team’ established in the social assistance department, which was often the first contact women had with the system. This team was tasked to ensure that there was zero fraud in the

social assistance programs, but how this is enacted was very confrontational and invasive conversations at times when the women were most vulnerable. In particular, one of the study participants referred to it as an “interrogation model”. Clients carried these negative feelings into relationships with shelter staff, seeing a discrepancy between social assistance services that were designed both to assist them, and to keep them out if possible. The authors suggested that because of the impact that policies can have on the health care relationship, care providers need to be involved in political advocacy as well as personal advocacy.

Systemic policies that guide the design of social supports can also negatively impact on health care relationships. Buckingham (2009) provides a critique of the shift in the United Kingdom towards competitive-bidding models for social services. Under the rhetoric of creating more efficient services, in 2002 the social service system was revised and regionalized, measurement standards were introduced, and contracts were set to limited terms. This very concept is based on the idea that there is waste within social services, and that increased competition will decrease waste. However, this philosophy does not meet with the reality of social services that are already making do with extremely limited funds, and utilizing volunteer labour and private donations to subsidize government funding. Buckingham, as well as Ilcan and Basok (2004), notes that this competitive model has created incentives for services to both limit their work to that which is most measureable, and limit services to those clients who are most likely to have positive outcomes. In terms of direct impacts on relationships, staff find that they spend significantly more time on paperwork to meet measurement requirements, and there are increased overhead costs. Most crucially, if services are

out-bid and lose government contracts, there can be major relational discontinuity when services are shifted from one organization to another. Le Dantec and Edwards (2008) looked at the same phenomenon, focusing on the adoption of state-mandated data management systems. They found that the data management systems were impairing communication with clients and from staff-to-staff. They also noted that in terms of interagency communication, the data were mostly used punitively to determine who might be accessing an inappropriate quantity of services.

Not directly related to formal health care, but very much part of the social determinants of health perspective, Flint (2009) studied the governance of housing for people who are experiencing homelessness, and had already had one eviction from social housing. Within the UK context, these individuals are offered a second chance at social housing, with the threat that after a second eviction there will be no further assistance. Flint questions some of the rationale of using the same ‘carrot and stick’ that has already failed the individual previously, but comes to the conclusion that it is personal agency that needs to be reformed, and this threat will help do so. I find this analysis somewhat limited in that the power within the relationship component is neglected, in terms of asking the questions of who is doing the evicting, who is doing the supporting, and are there any data that this works? Building on the previous articles that demonstrate the importance of therapeutic relationships in meeting the needs of people experiencing homelessness, it can be concluded that having the social assistance worker threatening to remove an individual from social housing is going to increase the power differential.

This concern of policies that use punishment in order to reform personal agency is explored in Kidd and colleagues' (2007) narrative study with youth outreach workers mostly in Toronto. The authors focus on the importance of flexibility in policies so that there can be individual responses to individuals' situations. They speak to low-barrier services for homeless youth, in particular eliminating 'zero-tolerance' policies that break down relationships, and instead having policies such as short-term bans that don't restrict people from accessing the services they need to meet the basic necessities of life. Similar to Marnocha (2009), Kidd states, "Limit setting evolves primarily from relationship rather than agency policy" (p. 23). Kidd and colleagues focused on the importance of broader social policies, noting that it is harder to work with youth and maintain a positive relationship if the 'door' into homelessness is much broader than the 'door' out. That is, policies can create skeptics out of service recipients if the promise of assistance is not met with a real change in one's life situation. This is echoed by Ng and McQuiston (2004) who note that with limited social assistance rates and the lack of social housing, relationships between providers and people who are experiencing homelessness become strained when offers of assistance begin to look less genuine over time. If affordable, supportive, and supported housing were readily available, providers would have genuine solutions with which they could connect clients.

There is a dearth of research detailing exactly how health care providers can become engaged in confronting policies that impede health care relationships with people who are experiencing homelessness. Many articles give basic suggestions that providers need to be engaged in addressing policies that are barriers to services for people who are experiencing homelessness (Jezewski, 1995), or give detailed guidance

around policy engagement, but not around homelessness and health (Spenceley, Reutter, & Allen, 2006). That said, O'Sullivan and Luysne-Duscher (2006) explore policies and youth homelessness, unpacking specific policies such as mandatory reporting to parents, and giving specific guidance around engaging the public to build political will. What is particularly limited is work that both takes account of the power within client-provider relationships in homelessness and health, and addresses policy factors at both the organizational and systemic levels.

Addressing both power and policy, Hoffman and Coffey (2008) accessed a database of 515 interviews with clients of a cafe run by the Catholic sisters that provided food for people who are experiencing homelessness. What they found was that clients are often objectified and infantilized in accessing social and health services, with participants frequently being treated as just a number or not given the respect and choice due to an adult. Such participants might subsequently choose to opt-out of formal care in order to maintain their self-worth. Framing the negative attitudes of providers in the context of a system with limited funds that force providers to protect budgets, the authors do not question the good motives of providers, but rather look to the policy context. The system is also built around the idea of moving clients through the system, meaning getting them from homeless, to housed, to meeting their health needs, and finding employment. However, Hoffman and Coffey found that the biggest barrier to movement through the system identified by participants was experiences of negative attitudes of health professionals, with power being used mostly to control, followed by an implicit or explicit demand for clients to express 'appropriate' thanks for what they do receive. The authors concluded that providers can make changes in the

system by both relating in a way that creates space for people to empower themselves, and by engaging in social and political action to create change at the structural level. Unfortunately, as a secondary analysis of qualitative client data, this study did not get at the actual interactions between providers and clients, and how both this therapeutic way of being is enacted, and how the social and political action that was suggested could be enacted.

Summary and Gaps

In summary, much research has been conducted on therapeutic client-provider relationships. This work has outlined skills that health and social care providers can refine in order to improve their relationships with clients. However, this work has at times been uncritical, neglecting to acknowledge the existence of power within all social relations. As well, as predicted by Cooke (1993), the work has often lacked adequate reflection on the policy contexts that frame these relationships.

The critique of a lack of focus on power in relationships can be made around work on therapeutic relationships in the context of care with people who are experiencing homelessness. It has been well demonstrated that negative attitudes of providers are the primary barrier to accessing formalized services, and so much has been done on how to influence these negative attitudes. However, less work has looked at confronting the power within the relationship, and finding ways that providers can help to create spaces where clients can empower themselves. The policy context is particularly pertinent when looking at homelessness, as most people who are experiencing homelessness are engaged in multiple components of the social support system. In this way, both organizational and broader system policies will impact upon

client-provider relationships. Although some work has been done on addressing some of these policies, this work fails to simultaneously recognize that addressing the policies must be done within the context of an inequitable client-provider relationship. In all, only one study was located that covered both these aspects (Hoffman & Coffey, 2008), and it focused on clients of a soup kitchen, not a health care agency. As well, the study did not look at the interactions of clients and providers, but rather was a secondary analysis of client-only data.

Making meaningful progress in addressing the health needs of people who are experiencing homelessness will require action on the personal, public, and political levels. That is, providers will need to: address the power in therapeutic relationships with clients, confront public perceptions of homelessness and find ways to foster citizenship of people who are experiencing homelessness, and engage in refining health and social policies. To do this effectively requires an understanding of how health promoting client-provider relationships are enacted, with particular attention on power in the relationship, and the policy context that influences their enactment.

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Chapter 3 - Methodology

The overall aim of this study was to create knowledge for action regarding caregiving relationships in community-based health care with people who are experiencing homelessness. The selection of a critical perspective coupled with evidence that negative attitudes of health care providers are barriers to accessing formal care led to the examination of power and policy, two relevant components of client-provider relationships. The preliminary research questions were: How are client-provider relationships enacted within the culture of community care with people who are experiencing homelessness; and, How do clinic-level and broader social and health policies shape relationships in this context? However, in the process of conducting the study, two other concepts were identified that would help enhance the understanding of what was being observed, these being space and place. It became evident over time that power relations are space-mediated, and that there is power in how place is conceived and contested. Therefore, I iteratively formulated a third research question, which is explored in my first findings chapter: How is 'place' experienced by clients and providers within a community health clinic for people who are experiencing homelessness? A community health clinic for people who are experiencing homelessness was selected as the setting of the study. Seeing the clinic as a culture enacted, and focusing on power in relationships, place and policy, critical ethnography was the chosen methodology. In the following sections I will outline critical ethnography, explore positionality and the insider/outsider dynamic, consider how I located myself within the study, and present detailed explanations of the methods used.

Critical Ethnography

Like all methodologies, critical ethnography lives in the space between philosophy and method. It serves as a guide to help users situate themselves ontologically and epistemologically. That said, critical ethnography carries a specific philosophical history, and lends itself particularly well to certain methods. In this section I will bridge the conceptual and the pragmatic by both exploring how critical ethnography has been described, and how it has been enacted. It is important to note that there is no single critical ethnography, but it is rather a concept that continues to evolve and be defined and re-defined by each theoretical reflection and empirical application. As ethnography is concerned with culture, the definition of culture by Poland, Lehoux, Holmes and Andrews (2005, p. 172) is used for this study: “cultures involve common/shared beliefs or values at a variety of scales; cultures give meaning to ways of life and act as a lens through which we look at the world that both affects and represents our behavior; and cultures produce (and are reproduced through) material and symbolic forms”.

Critical ethnography traces its roots to ethnography, which is a methodology rooted in the field of anthropology (Foley, 2002; Hammersley & Atkinson, 2007) and was first advanced in Nursing by Leininger (1985). Historically, ethnography is a methodology by which one better understands culture or cultures as they are experienced in the daily lives of the people who “live them out” (Crang & Cook, 2007, p. 1). This methodology most often was enacted as a single ethnographer going to a distant land to spend significant time ‘in the field’, in everyday settings rather than labs (Savage, 2000), with a group or groups of people considered in some way to be exotic,

or ‘other’. The time engaged in this fieldwork was considered ethnography (Hammersley & Atkinson, 2007). Research was considered ideal if the researcher thoroughly removed themselves from the data, eliminating any bias and simply recording what was observed. Therefore, though often engaging, intriguing, or even titillating, ethnographies have traditionally been largely descriptive, providing stories and observations that illustrate what is shared, what is enacted, and what is reproduced. A shift to a more ‘critical’ ethnography grew out of the feminism and anti-racism movements of the 1970s (Carroll, 2004), as well as out of new cultural studies in the 1960s (Hammersley & Atkinson, 2007). Critical ethnography grew from a frustration with essentializing cultures, and suggestions that culture is actually a struggle of resisting shared meanings (Tompkins, 1995). Although at times relegated to political science rather than sociology or anthropology (Foley, 2002), critical ethnography was a move forward from conventional ethnography, which was seen as insufficient to shed light on issues of power and oppression (Holmes & Marcus, 2005). More recently, within health care, focused ethnography has evolved, requiring less time in the field and focused on a particular issue or research question (Muecke, 1994).

Foley (2002) captures well the task of the ethnographer:

“All cultural groups produce an intersubjective reality which is both ‘inherited’ and continually constructed and reconstructed and is lived or practiced....a well-trained, reflexive investigator can know that historical, socially constructed reality in a partial, provisional sense through an intensive, experiential encounter with people who live by these cultural constructions of reality; and [an ethnographer]...can portray this cultural space and its people in a provisionally

accurate manner” (p. 472-73).

In this manner, the researcher attempts to provide rich descriptions that capture social interactions (Edmunds, 2007). Muecke (1994) goes beyond referring to ethnographies as ‘provisionally accurate’, and suggests that they are fictions, co-authored by the engagement of researchers and participants. This is reflective of an ontological stance that sees reality as socially and historically created and re-created. It is important to note from this that within critical ethnography it has been suggested that there is no single ‘true’ representation of a given culture, but rather multiple, valid perspectives (Angrosino, 2005), inviting the researcher to “move beyond assimilated experience” (Kincheloe & McLaren, 2000, p. 279). Moving ethnography to critical ethnography, Save (2000) suggests that culture, rather than what is shared, is a dynamic and constant struggle for meaning-making, which inherently includes social power. Rooted in critical social traditions, it has been suggested that the focus is to uncover what is taken-for-granted, including oppression (Roberts 1994), exploitation (Kincheloe & McLaren, 2000), exclusion (Averill, 2006), and marginalization (Browne, 2005). With an explicit anti-oppression stance, critical ethnographers tend to be open to and accepting of being ‘spoiled’ by ideology (Kincheloe & McLaren, 2000), meaning that confronting oppression takes precedent over objectivity.

An understanding of power and oppression is sought through active engagement within the everyday lives of participants (Roberts, 1994). As opposed to an ethnographic description of the ‘other’, critical ethnography represents a relationship in a culture that becomes both other and self (Baumbusch, personal communication), meaning that the researcher is both an insider and an outsider, as I will explore further

in the section on positionality. Critical ethnography has been conceptualized as a collaborative process of meaning-making between the researcher and participants (Manias & Street, 2001a), finding ways to address the challenge that the researcher can only be expert in their own experience and interpretation of meaning (Savage, 2000). This is similar in many ways to participatory action research (PAR), although not all PAR is critical ethnography, and not all critical ethnography is PAR (Cook, 2005). It is important to note that the research process itself is a complexity of power relations (Manias & Street, 2001b), so the collaborative process between researcher and participants is never an equal one as has been falsely suggested by Boonyasopun (2000). To avoid themselves being a tool of disempowerment, critical ethnographers can think of their role not as to empower participants, but to help create a space where participants can empower themselves (Manias & Street, 2001b). Unfortunately, some research done under the auspices of critical ethnography is indistinguishable from the very issues which critical ethnography was created to address (Bland, 2007), the extracting of cultural truth from others for the purpose of enlightening the research community. As Hammersley (1992) warns, uncritical ethnography can actually perpetuate oppression by accepting and normalizing oppression. A final piece to consider in thinking about engagement in the field is disengagement from the field. Rehner Iversen (2009) warns that the deep engagement that makes critical ethnography meaningful also means that disengaging from researcher-participant relationships can have a negative impact upon participants.

Engagement in the field, and engagement in the enactment of power relations is important for understanding these relationships, but another hallmark of critical

ethnography is couching these relationships within broader structural relations of power (Roberts, 1994). That is, it has been suggested that quality critical ethnography sheds light on how external forces of power impact on everyday interactions (Carroll, 2004). Critical ethnography includes participating in narratives of everyday life, but these should be situated within a broader social context of social narratives (Myers & Young, 1997; Smith, 2005). As Mykhalovskiy and Farrell (2005) term it, ethnography “explores the social determinants of everyday experience” (p. 164), or similarly captures the “macro-social structural determinants of people’s behaviour” (Hammersley, 1992, p. 99). Cook (2005) suggests that including the socio-political context can only enrich the understanding of the power relations being observed and discussed, and Muecke (1994) suggests that this level of analysis helps to make the behaviours of participants make sense to the reader. This balance of addressing both the power relations and the broader power structures has been termed linking the agency/structure divide (Porter & Ryan, 1996), or bridging the macro and the micro (Tompkins, 1995). An excellent example of this is Tim Diamond’s (1986) institutional ethnography of long term care where he examined power in interactions such as within language, but also demonstrated how broader policy issues serve to create oppressive contexts.

Building on the action orientation of critical research (Tompkins, 1995), one potential outcome of critical ethnographic research is to gain a knowledge of power relations so that they can be confronted (Carroll, 2004). Building also on the focus within the critical paradigm of making spaces for positive change, the critical ethnographer is often not content with developing a cultural critique, but engages with

the culture of study to be a catalyst of change (Cook, 2005). Recognizing that the meaning attributed to the research texts, be they field notes, documents, or interview transcripts, is a reflection of the lens of the researcher (Gardezi, et al., 2009), the researcher is responsible to ensure that the conclusions reached are based in a constructed reality that fits with participants (Averill, 2006). In this manner, gauging the quality of critical ethnography has much to do with catalytic validity (Hammersley, 1992; Lather, 2007), demonstrating relevance rather than generalizability (Bungay, 2008). Balancing the multiple realities of research participants, and being reflexive of one's own lens, the critical ethnographer can work collaboratively with participants to balance their expertise with resources to which the researcher may have privileged access. Ultimately, the project has a social justice outcome, leaving the culture of study more equitable than at the outset of the project.

Positionality

Having touched on it in brief, in this section I will explore further the issues of positionality, and my own location skirting the boundaries described by Roper and Shapira (2000) of being both an insider and an outsider. I was an insider in that I had intimate knowledge of the clinic, the providers, and many of the clients, and had been a part of the culture as an employee for approximately five years. I was an outsider in that at the time of the study I terminated my staff position and was only present at the clinic for data collection. I was also an outsider in terms of the clients, in that I have never experienced homelessness, and was recognized as an educated, paid provider. However, it is important to note that this conceptualization of being either insider or outsider is flawed in the exclusivity these terms suggest (Labaree, 2002). Relative

position can differ depending on the relationship from one provider to the next or one client to the next (Cartwright & Limandri, 1997). It can also shift over time or from one interview to the next (Chavez, 2008), with Cartwright and Limandri (1997) outlining how relationships between the researcher and participants in their study fluctuated from stranger-stranger, to researcher-participant, to friend-friend, to nurse-client, to guest-host. With that said, the decision was made to conduct this study in my former place of employment due to a general sense that the benefits out-weighed the challenges, based on the idea that I was more of an insider in this context than I would be in another health clinic.

What one perceives as the challenges and benefits of insider research depends on the lens which one brings to this project. So, although the lack of objectivity has often been cited as a problem (Hewitt-Taylor, 2002), this concern is not relevant to a critical ethnographic study. However, role confusion is a relevant issue (Cartwright & Limandri, 1997), as I was recognized as both a staff member and yet was working as a researcher. This can, and likely did, manifest in interviews when participants are skeptical about confidentiality and limit the breadth of the discussion (Brannick & Coghlan, 2007). Additionally, if participants manifest strong grief reactions during the study, there is more ambiguity around the appropriate reaction as nurse researchers are professionally trained to respond to such instances, but ethics bodies usually request referral to a third party (McConnell-Henry, James, Chapman, & Francis, 2009). I was aware that clients were actively choosing what to disclose or not to disclose during interviews due to seeing me as a provider. The preconceptions that an insider brings can also risk limiting the breadth and depth of the ethnography if the researcher misses

the importance of mundane, every-day-life of the culture, rushes the analysis to focus on personally prioritized issues (Brannick & Coghlan, 2007; Labaree, 2002), privileges their meaning-making over that of participants (Kanuha, 2000), takes for granted meaning and misses the critical ethnographic imperative to dig deeper (Labaree, 2002), or misses the multiplicity of discourses (Van Heugten, 2004). Lastly, an insider may be implicitly or explicitly requested by participants to take sides on an issue (Chavez, 2008), which has implications around both confidentiality and peer relationships with other providers.

These challenges are balanced by the benefits of having some degree of insider status, the primary in this case being the building of rapport, which is generally considered to be valuable in ethnographic research (Borbasi, Jackson, & Wilkes, 2005). Coming to a study already possessing a degree of insider knowledge and status can be an advantage in terms of the time required to develop rapport (Asselin, 2003). In this case it was particularly important as one of the data collection methods was participant observation, and a stranger in the clinic might have been disturbing to clients as s/he could be misconstrued to be an undercover police officer or other security official. Kauffman (1994) advocates developing rapport by following the customs of clients and learning the language. This was something that I was already used to doing based on my years of working in the clinic, in particular mimicking the language and even inflection of clients. As a close friend once noted, “You speak differently around homeless people.” Similarly, having previous knowledge of the setting offered very practical benefits in terms of establishing rapport quickly and accelerating the data collection process. This was a key factor in the selection of the setting, and featured

heavily in discussions with the Research Ethics Board (REB) overseeing the study as they had initially identified role confusion as a concern. In regards to my insider status and working with providers, understanding the context assisted in picking up on nuances in both actions and discussions of providers.

To address the possibility for role confusion, reflexivity (Van Heugten, 2004) and role clarity (Groenkjaer, 2002) have been suggested. I attempted to address role confusion by terminating my role as a nurse in the clinic and taking on a role solely as a volunteer working the waiting room of the clinic. Both the change in roles and the fact that I was present in the clinic for the sole purpose of conducting a research study was shared with clients verbally, through hand-outs, and with posters on the wall as suggested by the REB. However, in spite of these precautions, changing roles did prove to be uncomfortable for myself at times. For example, it was difficult when clients asked for nursing assistance and were told they had to wait for the staff nurse, while I sat in the waiting room apparently unoccupied, but was actually engaged in observation. Knowing I was a nurse, clients often verbally or non-verbally expressed frustration that they had to wait for the other nurse rather than seeing me immediately. I did participate as a 'volunteer' in responding to requests for socks, food, access to the bathroom, and other such needs, but did not meet with individual patients for nursing care. However, being recognized as a staff member in the setting naturally impacted my observations, as interactions within the waiting area can be presumed to be different when a staff member is present or not. Overall, some researchers have concluded that we need to be less concerned about insider or outsider status, as the quality of this style of research has more to do with how the individual researcher negotiates power relations (Labaree,

2002), and how reflexive they are (Chavez, 2008). As Corbin Dwyer and Buckle (2009) suggest, insider status doesn't necessarily make a researcher better, it just makes them different. In my case, I felt that the significant time invested in studying role confusion and insider/outsider status prior to conducting the study greatly enhanced my ability to be reflexive.

Reflexivity: A Personal Narrative

Reflexivity is a self-reflective activity that involves researchers locating themselves in the socio-historical contexts that they study (Tsekeris, 2010). This builds on the recognition that research knowledge has an inherently subjective component, and that the researcher alters any context in which they enter, simply by being present (Tsekeris). As Bourdieu (2003) suggests, reflexivity is not simply about laying out one's preconceptions, but considering one's social locations and how these shape the preconceptions. To enhance the discussion of positionality, in this section I will reflect more on the historical basis and personal perspectives that I bring to this project. This research project, although guided by a Dissertation Committee, is inherently mine. Therefore, it is important to understand what I bring to this study as the author and lead investigator. This should provide context not to judge reliability and validity, vestiges of scientific positivism, but to enhance critical engagement with this text and all its parts.

I come to research on homelessness not through the benign selection of an area of interest, but due to strong personal feelings, built out of family experience. As suggested by Bungay (2008), this critical ethnography is driven by personal compassion. When I was fourteen years old, and my older brother sixteen, he was

expelled from the family home at the height of a conflict with my father. We grew up white, conservative, and middle-class, in the suburbs of a medium-sized Canadian city, and had little experience with issues of poverty and homelessness. For the next two years, my brother found himself absolutely, relatively, and nearly homeless. He drifted from sleeping rough, to couch surfing, to paying board in friends' basements, and back-and-forth along this continuum, until eventually becoming 'housed' in a college residence. Growing up sheltered from issues of poverty, he also had no idea of services that might have been available to him as a homeless youth. My brother and I were, and are, very close, having shared a room together from my birth until his expulsion from the home. During his experience of homelessness he served as a mentor to me on the things he was learning, opening my eyes to the varied experiences that serve as pathways to homelessness. He left me with one comment, which forever changed my life, which was to work with people who are experiencing homelessness if I ever had the chance.

Nursing school provided the chance that I needed. Throughout my undergraduate studies, I felt drawn towards community and mental health, and through the mentorship of Dr. Catherine Ward-Griffin have always looked to the social determinants of health to understand the experiences of my patients/clients. In the final term of the final year of our studies, we were asked to complete a full-time practicum, and had the opportunity to seek out where to do this. I had heard of a clinic in town that served people experiencing homelessness, and following on the advice of my brother, chose this for my practicum. It has been suggested that personal narratives are most effective in changing the way individuals regard homelessness. The clinic offered me

the opportunity to hear dozens of personal narratives each day, and these did indeed greatly enhance my understanding of many social and health issues. To this day, I use some of these stories as an educator, hoping to enhance the perspectives of nursing students. Following the completion of my studies, I was hired at the community health centre in which the clinic for people experiencing homelessness is located. I worked in a variety of contract, casual, and part-time roles, in the homeless clinic but also in the family health clinic between May 2004 and July 2009. As a faculty member, I continue to be engaged with the population with which I worked.

My experiences in the clinic served a major role in the topic selection and research questions of this study. From what I observed, there was variety within client-provider relationships in the clinic. I observed relationships that were far from the therapeutic ideal outlined within the health professions, but also observed (and participated in) relationships that were mutually life-altering for clients and providers. I saw providers stretching the professional boundaries in relating with clients, being simultaneously chastised by management and encouraged by clients. I saw clients once, and never saw them again, because of the enforcement of rules that they experienced. This provided the background to my initial somewhat simplistic stance in starting this study, that some providers related well with clients, and others not so well, and that perhaps a research project could help them all relate well with clients. This conceptualization was enhanced by my experiences of weekly team planning meetings. These meetings were held to help the team navigate challenges, and often involved heated and philosophical questions around the best way to deal with two key issues: limited resources, and client behaviours deemed 'inappropriate'. Over time, providers

tended to divide themselves down the same lines, one group arguing for more clear and consistent policies, the other for fewer restrictions on client behaviours and more individualized responses. I spoke of this divide as the behaviourists versus the humanists, those who focused on behavioural control and modification against those who focused on respectful relationships and meeting the needs of those in crisis.

These ideas were admittedly simplistic, and each staff meeting disproved my conceptualization as the perspectives of providers were much more complex than a simple dichotomy. However, what was important was that I sensed certain interactions that bothered me. These included, but were not limited to:

1. Observing fellow providers refuse to give a resource, such as food, socks or bus tickets, to a client whom I had previously deemed eligible.
2. Hearing complaints from clients that other providers kept them waiting to engage in personal activities on the computer or the phone.
3. Having to tell a client that they have to wait until we receive their medical records before they can have a first appointment with the physician.
4. Keeping a bathroom locked when there is a long line-up for the sole reason of being able to better monitor bathroom use.
5. Having to deny client requests for food because the food cupboard was empty and it wasn't the start of the month yet, when more food is purchased.
6. Having other providers insinuate that I was naïve or being taken advantage of for taking certain client requests at face value.

What I believe I was sensing here, was the importance of power relations, how these are mediated by space and place, and how these are contextualized by policy. It was in

doing the study that I was able to see past seeing individual providers, and believing them to be better or worse at what they did, and understanding that focusing on personal agency without recognizing structure in the lives of providers is as fraught with problems as focusing on personal agency as the cause of homelessness for clients.

This history and these perspectives that I brought to the study obviously impacted upon how it was conducted, and how results were interpreted. Having engaged in staff discussions around many philosophical and pragmatic issues, I came with having taken a previous stance on many of these issues, and risked valuing more those providers who corroborated my own feelings and observations. I also came to the study with long-standing relationships with many of the clients. Some I had known and worked with for over five years, and had intimate details on their life histories and personal lives. As I purposefully selected some clients to recruit for interviews, there was again a risk of focusing on those who I had agreed with in the past. That said, this was balanced by open recruiting and taking suggestions from all providers regarding clients who they felt should be recruited. As can be noted from the examples of things that frustrated me, preexisting relationships with clients also helped formulate the project as a whole. It was concerns of clients that I heard while working as a nurse that combined with my personal concerns that guided the focus of the project. As well, while formulating the results, I often wondered, 'How will the clients or providers see this,' or even reflected on how individual clients or providers might react to certain conceptualizations.

Theoretical Perspective

These experiences and perspectives reflect the theoretical lens of critical social theory (Campbell & Bunting, 1991) that I bring to this study. This lens is intimately integrated with components of critical ethnography. My understanding of the way the world works has been influenced particularly by the writings of sociologist Anthony Giddens on power and the agency/structure dialectic (Giddens, 1984). According to Giddens (1984), agency is the ability of individuals to act freely, a hypothetical state of unconstrained action that does not exist in reality, whereas structure refers to the social institutions and norms that in reality influence and constrain or enable human behavior and relationships. These social structures are inseparable from agency, as they are created and re-created by human action (Giddens). An awareness of this agency/structure dialectic assists the researcher in framing the behaviours of individuals within their social, political, and environmental contexts. Within a critical theoretical perspective both epistemological relativism and absolutism are rejected and a moral stance is taken regarding inequity, meaning that the elimination of inequity is seen as inherently valuable. Likewise, it is understood that reality is socially and historically constructed through various social and political structures, and is constantly changing (Watzlawick, 1984). Therefore, to increase awareness, both individual experiences and social contexts are explored in order to understand both subjective experiences, and how these are shaped by structures of power. Not only is the subjective experience of research participants valued, but the researcher does not see her/his 'self' as objectively external to the social world being studied, but rather, as linked with research participants (Eakin, et al., 1996). Findings are intersubjective, rather than purely

subjective or objective. Multiple bases of inequality are recognized, based on varying social locations such as class, age, gender, ethnicity and race (McMullin, 2010).

Subsequently, in seeking to uncover power in this study, Giddens' (1973) pluralist and Foucauldian conceptualization of power, namely that power arises from multiple social inequalities, was used. Rather than essentialising individuals on these bases of social inequality, it is understood that within group variances are often greater than between group variances (Duffy, 2001).

The goal of critical research is to help create empowering spaces where people can empower themselves. This process includes encouraging researchers and participants to question dominant ideologies and taken-for-granted assumptions in order to make space for alternative voices to be heard (Eakin, et al., 1996). Although critical researchers are not the only researchers who seek to create positive social change, within the critical paradigm solely generating research knowledge is insufficient; there must be a facilitation of change that seeks the elimination of oppression, defined by Giddens (1991) as “differential power, applied by one group to limit the life chances of another” (p. 212). According to Habermas (2001), this change may be achieved through the raising of awareness of false-consciousnesses, meaning the way in which power relations are hidden in society, and subsequently the uncovering of oppressive structures. Ultimately, the aim of critical research is social transformation through critical consciousness-raising, which helps make explicit and addresses power imbalances (Ford-Gilboe, Campbell & Berman, 1995).

Ethics

Ethics approval for the study was obtained from the REB at the university with which I am affiliated (Appendix A), and informal approval was granted by the clinic in which participants were recruited. Approval from the REB proved to be a lengthy process, as there were concerns around conducting participant observation within a health care setting being counter to existing privacy legislation.

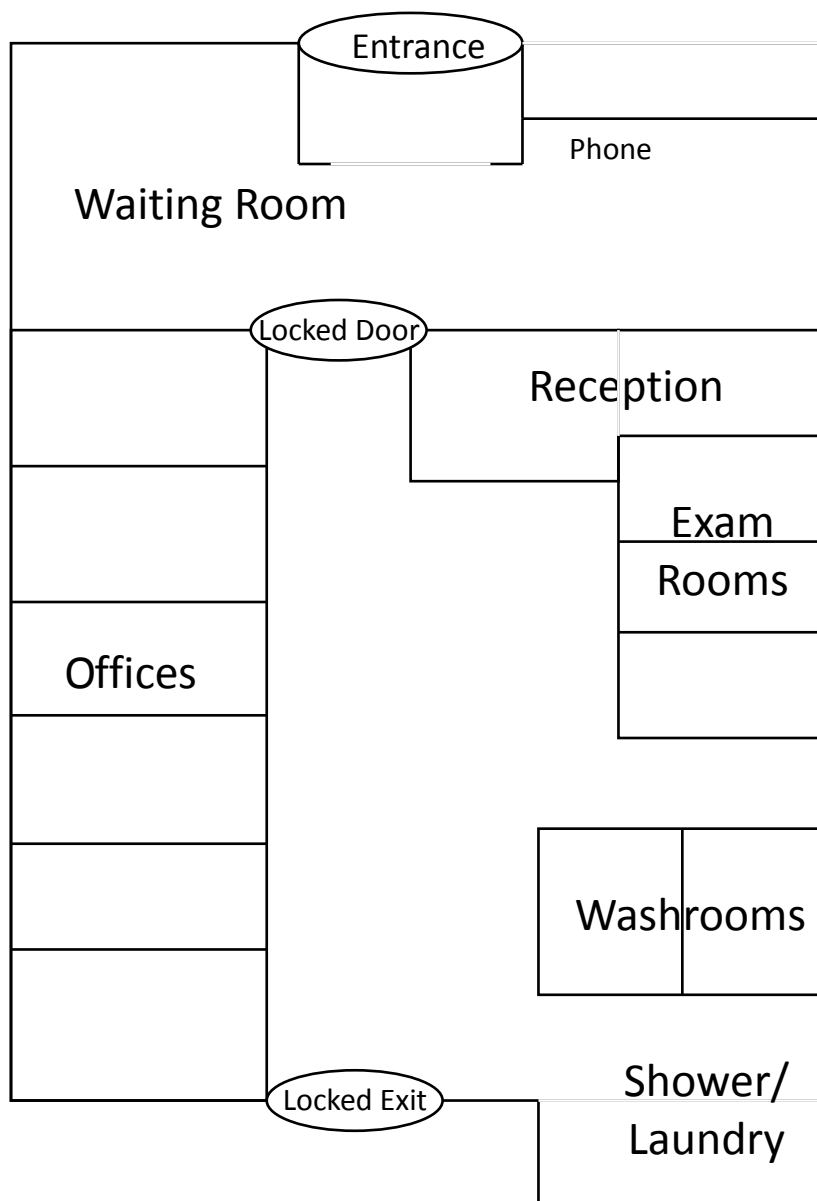


Figure 1: Health Clinic Configuration

These concerns were eventually alleviated by providing a diagram of the clinic to the REB (Figure 1), and suggesting that the waiting area in which observation would occur was actually a public rather than a private space. That said, it is important to note that similarly to Oeye, Bjelland, & Skorpen (2007), this is not an acceptance that participant observation should not be conducted in private, clinical settings. Rather, we accepted the suggestion not to do observation in 'health care spaces' as a pragmatic concession in order to make this study happen. As well as ethics approval, a letter of information was provided (Appendix B) to participants, informed consent was obtained from participants prior to data collection (Appendix C), and notices were posted (Appendix D) and information cards handed out at reception to all clinic clients (Appendix E).

Conducting research with people who are experiencing homelessness presents some ethical concerns. These concerns include the giving of incentives, the vulnerability of participants, obtaining informed consent, maintaining confidentiality, and the risk for sensationalism (Ensign, 2003). In terms of giving incentives, client participants were offered a stipend of \$5 for their time if they agreed to an approximately one hour interview. When considering reimbursement, Ensign (2003) recommends approaching the community for their input; in this case, previous studies in the community have set a precedent of paying for qualitative interviews. More importantly, consistent with what has been termed a wage-payment model (Dickert & Grady, 1999), it is my belief that time is valuable for all people, and clients giving of their time to this study must be recognized. And, as suggested by Schonfeld and colleagues (2003), payment-in-kind is not an appropriate substitution for cash, as it inherently decreases the autonomy of participants. It was my intention that the amount

of \$5 would strike the balance between recognizing participation while not providing a value so high that a person living in absolute poverty would be coerced into participating. However, as the life situation of each individual is different, this balance is never perfectly achievable (Paradis, 2000). In retrospect, a higher wage could have been provided more in-line with working wages and incentives paid to others for research studies. It would become a part of process ethics to consider whether clients were feeling coerced to participate. In this study, there was one client interview where it was clear to me that the client was not interested in engaging with questions, but rather preferred to answer them as quickly as possible. It was my feeling that the client was simply participating for the incentive, and I ended the interview quickly and did not transcribe it or add it to the data set. Other than that example, I believe a balance in the size of the incentive was achieved in that there was not an endless stream of potential participants, but rather open recruitment spanned a number of days.

In terms of participant vulnerability, participants who are experiencing homelessness have been considered a vulnerable population, and researchers must recognize the power imbalance that will be present (Ensign, 2003). That said, Grady (2009) warns that vulnerable persons must be included in research, as excluding certain voices carries as much of an ethical concern as exploitation of vulnerable persons in research. It was decided early on that the project would not be identified as participatory action research as there was no overall participant control of the project, which was considered problematic for a dissertation project, and I wanted to avoid the tokenism of suggesting control over irrelevant decisions (Cowden & Singh, 2007). However, I did want to address the vulnerability of participants by finding ways to

make the researcher-participant relationship more equitable (Karnieli-Miller, Strier, & Pessach, 2009). To address this potential imbalance, participants were given the opportunity of group interviews, addressing any discomfort they might have with talking with me (Salmon, 2007), and two clients took me up on this offer. Like Gill (2000), I continually reflected on the image I projected, which included in addition to monitoring the language I used, dressing in a manner that was not too fancy, but also not falsely impoverished. However, this was done with the recognition that I cannot hide the fact that I am a healthy, wealthy, highly educated, white male nurse. I was also honest with clients who asked about the purpose of my doing research, and my future in the clinic. This was difficult at times, because it is generally frowned upon for providers to move out of the direct service area of homelessness, seen as an abandonment or a form of pretension. Regardless, I was honest in saying that I was seeking a PhD and moving on to employment in a university, while also continuing my involvement with the clients in other ways.

Informed consent was a concern in this study as the data collection and knowledge translation processes occurred over a two year period of time, and multiple clients moved in and out of the clinic with differing levels of engagement. Additionally, questions about whether people truly understand to what they are consenting arise in research around homelessness as many people who experience homelessness face literacy challenges or have no context in which to understand the concept of research in general (Runnels, Hay, Sevigny, & O'Hara, 2009; Smith, 2008). I approached these challenges by understanding consent not as a one-time event, but as process consent, an ongoing dialogue between myself and the participants (Usher &

Arthur, 1998). For example, information cards (Appendix E) were continuously handed out to people at reception, to continually remind them of my current role within the clinic. Invitations to participate in interviews or focus groups were accompanied by a full description of the study, to not take for granted that clients recalled what I was currently doing, even if they had previously been informed of the study. To address potential literacy issues, I verbally explained the study and obtained consent, in addition to providing the letter of information and obtaining written consent.

Confidentiality is always a concern when reporting detailed qualitative findings (Goodwin, Pope, Mort, & Smith, 2003; Richards & Schwartz, 2002), and particularly in this small clinic. Maintaining client confidentiality was not very difficult while I was actively recruiting and during open recruitment, as I was able to unobtrusively bring clients to another area in the clinic for interviews, however this was more difficult when providers identified a client and recruited on my behalf. Because of this, in presenting the data it was possible that some providers would know some of the client participants. Fortunately, as per Kaiser (2009), all participants were informed up-front that participant focus groups would be a part of the process, and it was clear that participants were self-screening for confidentiality, making anonymous many of the stories they shared with me. For providers, presenting the data was even more challenging than clients as for most roles there was only one provider, ie. one physician, one manager, one community worker. Therefore, I had to mask the role of the provider where it was otherwise relevant in presenting quotes, to protect confidentiality. This did not mean that I was unable to openly critique the way certain roles were enacted, but I was committed to maintaining the confidentiality of what was shared in research interviews.

The same challenges presented for observation, and some depth of analysis is lost, for example, in describing client-provider conflict when the provider role is removed and the situation is made anonymous, but the ethics took precedent. However, with that said, complete confidentiality was impossible when we moved to focus groups and openly discussed the data and the findings, as clients and providers shared personal anecdotes, or in one case, a provider identified herself in data that I had made anonymous. Focus group members were requested to not share discussions outside of the group, and to be respectful of each other during the discussion.

The last potential ethical concern, and that which has received the least attention in the literature, is the possibility of sensationalizing the findings. Whenever researchers present the experiences of a population that is unfamiliar to the mainstream, there is a risk that their experiences may be sensationalized and further marginalization may occur (Said, 1978). The focus groups served an important role in addressing this, as the participants were presented with findings (Tolomiczenko & Goering, 2000) and had the opportunity to respond to them, leading to significant revisions. Using a critical ethnographic lens was also beneficial, as it allowed me to contextualize the actions and interactions of clients and providers within broader social structures, thereby allowing the reader to make more sense of what might be unfamiliar (Muecke, 1994). In knowledge translation strategies, I explicitly attempted to address misunderstandings and prejudicial attitudes, such as in a presentation I made to the general public on three misconceptions of homelessness in my municipality (Oudshoorn, 2010). Using non-traditional dissemination strategies such as this enhanced the value of the study, but also enhanced the ethics by responding to the ethical imperative to benefit the participants.

It was my feeling that research articles alone would not suffice to influence the kind of change that participants were seeking.

Setting and Sampling

The study was conducted in a community health centre (CHC) in a moderate-sized urban area in Southwestern Ontario. CHCs are unique cultural contexts as compared to more traditional in-patient settings or family medical clinics. Four components of CHCs make them unique: clients may access services on an as-needed basis; CHCs may also function as drop-in centers; clients may request basic necessities; and there is a culture of people who have or are experiencing homelessness. Unlike other settings, clients do not need a referral to access services at CHCs and they do not need to schedule an appointment to receive health care. Therefore, unlike more traditional health care settings, when individuals require care they simply come to the centre and request to access a service. As well, they may use the centers when they have no specific health needs, simply on a drop-in basis. This creates a unique setting where clients may come to know providers and other clients on a social level, rather than only seeing providers when they have an identified health need. In addition to accessing what would be seen as traditional health care services, clients can also obtain basic necessities from the centers. Depending on the centre, this may include emergency food, showers, laundry facilities, clothing and bus tickets. Providing other services related to the determinants of health that are not available in most family medical clinics leads to the co-creation of very different values, behaviours and beliefs, making the culture of community care unique. Lastly, many clients who access the centers are already part of a particular culture of those who are experiencing

homelessness, and are often familiar with each other through the use of other services or through social acquaintances. Therefore, the culture of CHCs in this context is one component of a larger culture of people who are experiencing homelessness. The setting has a bearing on the nature and delivery of care, including the development of relationships between and among peers and providers.

The particular CHC in this study included a health clinic for people experiencing homelessness, which was the focus of the study. This clinic provides both health and social services, with providers consisting of one physician, three nurses, one nurse practitioner, two social workers, one community worker, and two administrative staff. Services include medical appointments, urgent medical care, social work appointments, washroom and laundry facilities, emergency food and clothing, a telephone, and various need-specific clinics and groups. Clients were those individuals who qualified as being homeless, which ran the gamut from being absolutely homeless and living on the streets, to being in shelter or temporary housing, to being formerly homeless at admission to the clinic but currently being housed, albeit precariously for most.

The clinic is well known in the struggling neighbourhood in which it is situated due to the large number of impoverished individuals who mingle in front during hours of operation (Monday to Friday, 9am to 3:30pm). Entering through the double-doors brings one into a waiting and reception area (see Figure 1) that is often quite full and quite active, and that carries the smells of abject poverty, such as body odours, mouthwash, and excrement. It is into this waiting area that I inserted myself for the three months of intensive data collection. The reception area is staffed by two receptionists, who although unanimously identified by clients in interviews as being

friendly, are also the front-line of rule enforcement, so frequent altercations can be heard at their window. If granted permission, passing through the locked door beside reception leads one to the back area, surrounded by offices and examination rooms, where people can be found waiting for the washroom, doing laundry, obtaining personal supplies, or resting in a recliner.

In sampling, all providers were included, and clients were recruited throughout engagement in the field based on their potential for enriching the findings of the study, as determined by myself and other research participants. This included my own assessments during participant observation as I saw interactions regarding which I wanted more information, such as conflict, non-verbal behaviour, or relationships that appeared very mutual. Recruitment was also assisted by clinic providers and clients as they identified individuals who were key members of the culture of the clinic. The sample size was flexible, but the goal was that it be broad enough to elicit a variety of experiences that shed light on the culture of the clinic, without producing an unmanageable amount of qualitative data (Sandelowski, 1995). Inclusion criteria for clients were: 1) being over the age of 24; 2) self-identifying as being homeless (defined as absolute homelessness or at risk of homelessness); 3) speaking and understanding English; 4) being a current client at this CHC; and 5) willing to participate. Only adult clients were selected, as the experiences of homeless youth tend to be quite different from homeless adults, and homeless youth self-identify as a unique culture (Rew, 2008). Twenty-five was used as the minimum age as services for homeless youth in the area, including drop-in and shelter services, are available until one turns twenty-five. As all clients were encountered in a community health centre for homeless persons that

utilizes an intake process to determine current housing status, clients were assumed to have self-identified as being homeless. Inclusion criteria for providers were: 1) being currently employed in the Health Outreach Project for Homeless Persons at this CHC; 2) having personal contact with people who are homeless; and 3) willing to participate.

Due to the small number of providers employed at the centre, all providers were invited to participate in order to obtain an adequate and appropriate provider sample. Recruiting a total sample of providers was insured by having the clinic staff involved throughout the development of the research proposal (Anderson & Hatton, 2000). Providers were not reimbursed as the data collection occurred during paid time, with the permission of the clinic manager. In light of the previously mentioned concerns on positionality, I took an intentionally inquisitive stance with providers where I frequently asked for further elaboration and explanation.

For clients, sampling was purposeful (Morse, 2008) in that a variety of experiences were sought, and individuals who were expected to enrich the study were approached, as described above. This included varying sampling based on social location, such as age, gender, sexual preference, race, ethnicity, and health status. The sample size was flexible, but was broad enough to elicit a variety of experiences that shed light on the culture of the clinic, without producing an unnecessary and unmanageable amount of qualitative data (Sandelowski, 1995). Interviews were completed when no further participants self-identified, and when the researcher collecting data felt that the nuances of relationships in this cultural context had been well observed. . As Charmaz (2006) phrases it, “categories are ‘saturated’ when gathering fresh data no longer sparks new theoretical insights” (p. 113). Recognizing

that not all people were likely willing to participate based on my own multiple social locations, whether it be my race, age, gender, or professional status, the recruitment strategies yielded a diverse sample of clients, including some who were most vocal within the community, and others whom I had not previously met.

In all, 22 interviews were conducted, with the total clinic sample of 10 providers being interviewed a total of 12 times (2 providers were approached for second interviews as they expressed that they had more to contribute) and 11 clients being interviewed in 10 interviews (2 chose to be interviewed together). The sample size was flexible, but was broad enough to elicit a variety of experiences that shed light on the culture of the clinic, without producing an unnecessary and unmanageable amount of qualitative data (Sandelowski, 1995). Demographic information was gathered dialogically within the interviews to avoid collecting unnecessary data (Morse, 2008). Clients represented the spectrum of individuals seen within the clinic, ranging from being free of addictions to having both drug and alcohol addictions, having been born locally to having migrated across the country, from young to old, and both male and female. Although a representative sample was not necessary for this study, what was sought and achieved was variety across a number of social locations, such as age, gender, familiarity with the local community, and a substance dependence or not. As a group, participants did tend to be those who were more chronically homeless than would be representative of the clinic (mean years homeless = 7.9), which was likely an artifact of sampling for clients who would have the most to say about relationships with providers, which in most cases were those who had been attending the clinic for an extended period of time. There were also no clients in the group interviewed who

would be considered as non-Caucasian. Although the clients at the clinic are mostly Caucasian, there is a significant portion of First Nations clients at the clinic who are not represented in the interview data, possibly because of the social distance between Caucasian researchers and homeless First Nations clients, and the history of exploitation of First Nations groups in research. Two First Nations persons were approached for an interview, but both politely declined.

Methods

In keeping with the critical ethnographic methodology, data collection methods were used that were thought most appropriate to grasp a broad understanding of the health clinic, the individuals who relate within this clinic, the nature of relationships, and the role of power within these relationships. This involved multiple qualitative data collection methods in order to develop a deep engagement with, and understanding of, the culture of the clinic. Data collection methods ran consecutively for the most part, with some overlap, and included document review, participant observation, in-depth interviews, and focus groups. As the topic of focus within the culture was identified at the outset (power within the client-provider relationship) and the unit of analysis was a small health clinic, the methods were reflective of a focused ethnography (Muecke, 1994) rather than a full ethnography.

Document analysis. Document analysis occurred within the first week in the field, which in this case meant I was no longer employed as a nurse in the clinic, but rather occupied the waiting area doing participant observation and serving in a volunteer role. The intention of document review was to analyze the full clinic policy manual in terms of how the policies framed client-provider relationships in the setting.

However, the insight gleaned from this review was the lack of formalized policies that addressed these relationships. The only relevant statements were found within the clinic 'Values' statement and the 'Client Rights and Responsibilities' statement. The 'Values' statement included inclusivity, which speaks to participation in the clinic, and professionalism, which relates to treating clients with respect and dignity. The 'Client Rights and Responsibilities' statement included a promise to treat clients with respect, to give them time to talk, and to listen to their concerns. These are all common values for health care settings, but they provide little to guide the providers in everyday practice.

Participant observation. Participant observation of care provided and the enactment of policies at the clinic was conducted for 103 hours, spanning three months (October-December, 2008). This timeframe corresponded with the study design of a focused ethnography (Knoblauch, 2005; Muecke, 1994), and allowed opportunities to both observe and participate in interactions at different times of the month. This is important as both the purchase of clinic resources and the provision of social assistance income occur on a monthly basis, leading to an alteration of the clinic environment through the month. The purpose of this participant observation was to observe and actively participate with clients and providers, with a particular focus on relationships in this culture, for the purpose of collecting observational data. Though the focus of this study is client-provider relationships, peer relationships amongst clients and peer relationships amongst providers were also observed and documented as a component of the culture of the clinic. Observation was a key component of data collection as semi-structured interviews afforded only a limited understanding of relationships and the

culture within which they occur; observation provided an opportunity to tap-into what was being left unsaid.

During participant observation I served as an active member researcher in the clinic (Adler & Adler, 1987). The physical set-up of the clinic includes a waiting area (see Figure 1) that simultaneously functions as a drop-in clinic. The health providers at the clinic take turns staffing this area, providing clients with essential needs such as toiletries and referrals to other services, but not seeing clients for individual appointments. I worked in this area of the clinic, helping to differentiate my role from that of being ‘the nurse on duty’ (the nurse who sees patients individually in the examination rooms), but still being involved in the services of the clinic. As I was already a known individual in the clinic as a staff member, to take a non-participatory role would have been dishonest and confusing. As Johnson, Avenarius, and Weatherford (2006) note, there are many instances when participation is ideal in the setting, including when it makes one’s role more ‘normal’ within the setting. Active strategies, such as posting notices around the health clinic and handing out small information cards about the study, were used in order to maximize client awareness of my dual roles of researcher and waiting room volunteer member, and to inform people that I was conducting participant observation. Observational notes were recorded intermittently throughout the day in a private office reserved for the task. The volunteer role allowed for flexibility in leaving the clinic floor to complete these notes while the experiences were fresh.

Participant observation was also conducted in examination rooms or offices where providers met with clients, while they were meeting with clients. In all, seven

client-provider dyads were observed in this manner, with three providers being unavailable due to holidays and one being away on long-term disability at the time of the study. These observational experiences allowed me to see more private interactions than were observable in the context of the waiting room area. As suggested by Bonner and Tolhurst (2002), my partial insider status made this experience more comfortable for all parties, as most of the clients whom I observed were used to talking with me within the examination rooms and offices. Fieldnotes were recorded intermittently throughout the day in a private office ensuring that my observations were immediate but were recorded in an unobtrusive manner (Groenkjaer, 2002), and followed a fieldnote guide (Appendix F). Disengagement from observation was both pragmatically easy and emotionally difficult. As I had already terminated my employment at the clinic, the end of observation indicated the end of my regular presence there, which coincided well personally with increased employment duties as a new faculty member elsewhere. However, Snow (1980) warns that disengagement can be difficult when strong interpersonal relationships have formed with participants. In my case, not only was it the relationships that has grown over the three months of observation, but it was also the five years I had been employed at the clinic. Because of this, the termination of observation always felt personally to be a certain amount of abandonment, which had an influence on the selection of knowledge translation strategies. These included a continued engagement in the community through the development of an action network, significantly defraying these feelings.

Interviews. While conducting participant observation I made personal invitations for interviews based on observations and discussions that I felt required

greater understanding. Additionally, I advertised for any individuals who were interested in participating. Both clients and providers had the opportunity to participate in these formal, solicited interviews (Hammersley & Atkinson, 1995). A semi-structured guide was used for the interviews (Appendix G) to ensure that all research questions were covered sufficiently; however, this was balanced by a dialogical interview technique (McLeod, 1999). This involved a balance of both leading the interview through asking open-ended questions, and following the lead of participants by following up on issues of concern (Manderson, Bennett, & Andajani-Sutjahjo, 2006). Client participants were offered the option of group rather than individual interviews (McLafferty, 2004) to enhance comfort if necessary. Lastly, demographic information was collected dialogically within the interview rather than through the use of a questionnaire so that I could iteratively determine what was meaningful to know and avoid collecting unnecessary data (Morse, 2008). Interviews were completed when no further participants self-identified, and when the researcher collecting data felt that the nuances of relationships in this cultural context had been well observed. Regular meetings during data collection between myself and my doctoral supervisor, Dr. Ward-Griffin, provided a form of debriefing as recommended by Wray, Markovic, and Manderson (2007).

Focus Groups. Following the preliminary analysis of observation and interview data, focus groups were held separately with providers and clients. These focus groups were used for multiple purposes, including the collection of further data, but more importantly not to enhance trustworthiness as has been suggested by some interpretive and critical researchers (Lambert & Loisel, 2008), but to add depth to the

analysis of the data. As will be elaborated further in the section on knowledge translation, they also served to stimulate participants to critically reflect on the findings and collaboratively identify creative means of moving forward. Focus group templates were created based on preliminary analysis rather than at the outset of the study. Although anonymity was impossible around the focus group tables, confidentiality was addressed as the sources of information presented from the participant observation and in-depth interviews were kept confidential through removing names and removing identifying data such as provider role. Two focus groups were held with providers to present the data as it was being formulated into two different chapters, one on power relations and policy, and one on space and place. All providers who were present on the two days of these focus groups participated. The professional hierarchies suggested by Clavering and McLaughlin (2007) in focus groups did indeed present themselves. In particular, the manager led and directed much of the discussion, often reflecting on issues that were frequently discussed in staff meetings. I did my best to negotiate this dynamic, and re-direct the conversation when I felt it was not particularly relevant to the study findings. Interestingly, most likely because of this dynamic, two providers asked to talk with me privately after the focus group to share their feedback. I did so, but did not record these as formal interviews, as the conversations were informal and considered confidential.

For clients, a single focus group was held with six participants reflecting a size recommended by Morgan (1997) of 6 to 10. The size of the focus group was kept relatively small as the purpose of the study and this phase of the data collection was to stimulate critical reflection and dialogue (Tang & Davis, 1995). The complete study

findings were presented to clients, including revisions that had been made based on feedback from the provider focus groups. Recognizing the suggestion of Lehoux, Poland and Daudelin (2006) that the co-creation of knowledge in a focus group is related to the relational position of participants with each other and the moderator, and that the experiences of becoming or being homeless were often intensely personal, I used the extent that participants personalized their reflections as opposed to making vague statements as a way to gauge the depth of the group. In this case, the participants, some of whom did not know the others in the room, shared deeply personal stories of addictions, abuse, conflict with staff, and what they expressed as personal failures.

It was my original intention that all participants would be invited to a final focus group that bridged both clients and providers, in the form of facilitated dialogue. This process would challenge the power differential that exists between credentialed professionals and lay-people (Giddens, 1973) by having the clients equitably involved as co-educators with providers. In putting this together, I recognized that this experience of bringing together clients and providers must take into account the inherent dangers of dialoguing across difference, particularly those faced by individuals located further from the dominant center (Ellsworth, 1989). Therefore, I laid out the following principles from Garrison and Kimball (1993): 1) The focus group would only occur if there was expressed interest by clients and providers; 2) the participants would not have to agree on the content of the focus group, only on the goal of seeking understanding; 3) that it would be impossible to fully empathize with the situation of another, only sympathize; 4) that the risks in dialoguing with each other would be made

explicit. At the client focus group I asked if anyone would be interested in being involved in this final group, and none expressed interest. I then went to some individuals who had been involved in interviews, but none were interested. Lastly, I tried open recruiting, but again, although some interest was expressed, no clients committed to participating. Therefore, based on the first point, I decided to cancel this step in the process to respond to clients, not wanting to force something that was not in their interests. This experience was a fascinating piece that could be explored further in future studies, as there was no difficulty in recruiting client participants for a client-only focus group, but no clients would sign up for a client and provider focus group. It might be possible that clients were still conceptualizing the focus groups as an opportunity to air grievances, rather than co-construct solutions.

Analysis. In analyzing the observational, interview, and focus group data, Lather's (2007) work on understanding validity post-structuralism was used to enhance quality. Recognizing that our findings represented a constructed rather than a found world, it was deemed useful to follow Lather's conceptualization of 'achieving' validity as struggling with the various problematics of epistemology rather than a set endpoint. Consistent with a critical perspective, Lather's first framing is validity as simulacra, or the recognition that in re-presenting data we are not describing an objective reality. That is, the findings are not a description of something that truly exists, but one representation of multiple realities. Interviewing both clients and providers and intentionally dialoguing with those who held diverse opinions on how care should be enacted in the clinic served as a reminder throughout the study that there was no one correct understanding of the relationships being studied. Lather's second

framing of validity is paralogy, which represents a rejection of the need to reach consensus and an acceptance of contradiction. In the findings, contradictions have been allowed to remain and meaning is sought in divergent perspectives rather than in bringing these perspectives together. Her third framing of validity is rhizomatic validity, or understanding that in creating constructs to understand findings we must be attuned to the intersectionality of these constructs. Thus, in the findings the agency-structure dialectic, or the balance between one's personal power to act and the systems that constrain or enable action, is explored. Lastly, Lather speaks to voluptuous validity, or the importance of pushing beyond rigid boundaries and in a way tempting the reader to react to study findings. This served as an impetus to engage the difficult issues of power and disempowerment, and to struggle with the potentially uncomfortable engagement of clients and providers labeling each other as 'bad' or 'good'. Attention to Lather's conceptualization is integrated through the study and is evident in the tentative nature of the re-presentation, in the appreciation of contradictory perspectives, and in the challenge to health providers to move beyond what is taken-for-granted in "health clinics" and advocate for spaces where people can empower themselves.

Data analysis occurred as an ongoing process during participant observation as fieldnotes evolved from simple transcription of what was observed, to reflections on themes, inconsistencies, tensions, and concerns. These preliminary thoughts then informed and refined the in-depth interview guide. Interview findings were then the basis for creating the focus groups, the results of which were used to refine the ongoing analysis. With the permission of participants, all individual and group interviews were

audio-taped. These audio-taped data were transcribed verbatim by a transcriptionist, although attention was paid to the fact that this was her first transcription experience. Therefore, recognizing the transcriptionist's level of experience, and that the idea of 'verbatim' is prone to much interpretation (Poland, 1995), the transcripts were read and edited by myself while simultaneously listening to the interviews in order to try to capture the nuances of language in a manner most meaningful to the analysis. The fieldnotes and transcripts were then entered into NVIVO, a computer program used to organize qualitative data. The documents were again re-read while I memoed initial thoughts and highlighted key passages. Consistent with rhizomatic validity (Lather, 2007), the next step in the analysis was to construct multiple typologies of the clients and providers in an attempt to explore the diversity of relationships and perspectives. These initial discourses represented the extreme ends of what I came to recognize as continua of the ways that clients and providers perceive each other, and were heavily reflective of my own social locations, and my own membership within the clinic.

I next re-read the transcripts, making note of text that unsettled me and that challenged norms and authority, (Berger, 1995) and created a preliminary coding scheme, building off my initial memos. The transcripts were then coded electronically in NVIVO. Subsequently, consistent with neo-pragmatic or paralogical validity (Lather, 2007), I did a final reading of the transcripts and fieldnotes, making note of paradoxes, complexities, limitations of language, hegemony, and counter-hegemonic practices. Throughout, I attempted to be reflexive of where explicit tentativeness was needed in order not to essentialize experiences, and conversely, where I needed to be more deliberately excessive, as per voluptuous validity (Lather, 2007), in order to

capture the power of human experiences. The notes from these stages of analysis were compiled to identify themes, both hidden and explicit. This personal analysis was what was brought back to the client and provider participants in the focus groups. Through this process I was able to observe convergences and divergences between my own reflections of importance and my own analysis with that of the participants. In particular, at the first focus group with providers, there was a strong reaction against my initial characterization that was interpreted as saying that some providers didn't understand homelessness. Our combined critical reflections and dialogue constitute the findings of the study.

Knowledge Translation

Knowledge translation with this study started with the focus groups, which served purposes of data collection, data analysis, and knowledge translation. Study participants were considered to be those who had the most vested interests in the findings, and so were made privy to the findings first. The focus groups were considered an opportunity for all present to learn from each other, including participants engaging with preliminary study findings as presented. It was noted that provider focus groups stimulated much discussion both within the group, but also afterwards. Participants approached me to discuss the findings further, and also noted at subsequent meetings that the findings were still stimulating thinking, and were being discussed formally and informally within the group. It is unknown whether the same level of engagement with the findings occurred with clients, which might have been followed-up by questioning providers whether clients approached them around the issues central to this study. This stimulation of reflection and impact it might have on perspectives

and actions is an important component of knowledge translation, particularly within the critical paradigm where the ultimate outcome is action to create positive change. That said, it is too soon to assess long-term alterations that might be precipitated within the clinic from this project.

At the completion of the study, knowledge translation activities have followed both traditional and non-traditional routes. In terms of traditional routes, study findings were shared at research conferences on community health nursing, poverty, homelessness, and the social determinants of health. The findings and conclusion chapters will be submitted to scholarly journals. In terms of non-traditional routes, I have leveraged municipal and social media connections to disseminate findings. I keep a blog at <http://www.abeoudshoorn.com/blog> that covers issues in health and homelessness. This has been a platform for disseminating my findings, and reflecting on how they connect with other research. To date, the blog has had over 2500 ‘hits’, or visits. I also utilize a twitter account (@abeoudshoorn) that has to date over 330 followers, and use this to disseminate study findings and connect followers with other information on homelessness. Using this social media resource has connected me with researchers in the U.S., the U.K. and Australia. Additionally, I presented a talk from my findings on homelessness in London at a public forum called “Ignite London” that brought together speakers on a variety of topics, and was attended by over 200 delegates. The video from this presentation has been posted on YouTube, and has had over 430 views to date. I have also written guest blogs related to my research for the National Alliance to End Homelessness, the London Community Foundation, the Homelessness Hub, and a local blog called Inventing a Planet. This social media

presence has led to my participation in documentaries for university and high school media students, as well as a social justice and peace student, and a video for It Gets Better, London. All of these formats have led to the dissemination of my findings to other academics, but also to the broader public in London and worldwide.

The most important component of knowledge translation that has grown out of this project is the founding of the London Homelessness Outreach Network (LHON, <http://www.londonhon.ca>). In disseminating my findings, I found myself constantly approached by people who were interested in finding a way to respond practically to the issues around health and homelessness in London. By engaging with interested charitable and funding organizations, as well as direct service providers, this group grew to over 50 members. In November of 2010 we formalized our existence, creating the LHON. This group consists of academics, service providers, and concerned citizens, and we are currently working on adding policy makers and persons with lived experiences of homelessness. The goal of the network is to develop practical ways to confront the challenges faced by people experiencing homelessness in London. The network is being conceptualized as a community of practice, meaning that we are a diverse group of individuals gathered around a single topic, and the group is free to develop its own directions over time. Our first three projects are: 1) creating a network of health professionals to provide voluntary street-level care; 2) developing innovative arts projects that engage public perceptions of homelessness, and 3) finding ways to connect citizens in social relationships with people who are experiencing homelessness, such as having our members attend a drop-in for homeless persons. Working on three levels of political action, public perceptions, and personal engagement, this network

will be a means to both translate knowledge from this study, and to create new knowledge and action.

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Chapter 4: Creating a Health Promoting Place With People who are Experiencing Homelessness

Homelessness is an experience of being dis-placed, being removed from one's place. Therefore, those who offer services to people who are experiencing homelessness need to be attuned to the nature of the place in which these services are delivered. In this chapter the results of a critical ethnographic study of a health clinic for people who are experiencing homelessness are presented, with a focus on creating health promoting places.

Background

People who are experiencing homelessness are barred access to health promoting places in which to 'be'. Ultimately, by definition, people who are experiencing homelessness lack the primary private place that is taken-for-granted in high-income countries. The loss of home is not a benign experience, but a traumatic one, encompassing such experiences as evictions (legal and relational), convictions, and hospitalizations (Morrell-Bellai, Goering & Boydell, 2000). Once finding oneself homeless, a person then faces being removed or barred from public spaces. As such, society seems more interested in removing people who are experiencing homelessness from sight than in helping them acquire housing (Kawash, 1998). Where private security guards or other authority figures are unable to move those considered 'undesireables' out of the public eye, laws dating back to 1349 in Britain (Harman, 1989) are implemented to make use of police force to clear persons from private and public places. In being removed or 'moved along' in public spaces, it becomes clear that there is a legitimate and illegitimate public (Kawash), meaning those who are or are

not challenged for being present in public spaces. The difficulty for many people who are experiencing homelessness is that they often lack a private alternative and only exist in public spaces. Being constantly uprooted, the homeless individual is constantly forced to reinvent their sense of place (Vandemark, 2007), which individuals have been found to internalize as a feeling of non-existence (Kawash).

Multiple definitions exist for the term 'place', and different conceptualizations exist within health and human geography. However, in this paper, 'place' is considered to be a location that has meanings (Bender, Clune & Guruge, 2007), or "culture manifest" (Poland, Lehoux, Holmes & Andrews, 2005, p.172). In contrast, 'space' is considered as a physical structure. In this way, place goes beyond space to encompass the social, psychological meanings ascribed to, and cultural enactment of, the location. A simply geographical understanding of spaces hides the power relations that give them their social meanings (Soja, 1989). As such, there is a dialectical relationship between social relations and place (Soja); relations give meanings to place, and places shape the enactment of social relations (Bender, Clune & Guruge; Cresswell, 1999, Sack, 1993). Thus, Anthony Giddens' work on the agency-structure dialectic (Giddens, 1984) can be expanded to understand that structure is not just about the socio-political context in which we function, but also includes actual spatial structuring (Soja). The physical design of the spaces in which we function can impose limitations on our personal and social functioning within that space. Thinking particularly then of health promotion, if health is promoted in the context of a relationship, and relationships are mediated by place (Malpas, 2002), then we must be attuned to the places in which health is promoted (Andrews, 2002).

Of particular interest in this study is the power within place and how homeless clients are observed and regulated in place-mediated power relations with health care providers. Foucault's (1977) description of the elimination of private spaces for criminals in order to enhance observation and regulation rings true in this context as well. One of the roles of health care providers is to 'assess' their clients in order to form a judgment regarding their fit with societal norms (Bradbury-Jones, Sambrook & Irvine, 2008). Those who do not fit the norm must then be disciplined to conform (St-Pierre & Holmes, 2008). This idea of health care providers as involved in social control may be difficult for providers to accept in a time when concepts of empowerment, client-centred care and partnerships for health are taking precedence within health care research and practice. Within a lifestyle perspective of health promotion is the idea of assisting others to change in order to improve (Eakin, Robertson, Poland, Coburn and Edwards, 1996), and within lifestyle-focused understandings of health, this relates directly to enforcing behavioural change (Cloke, Johnsen & May, 2005). The way in which health promotion is most commonly conceptualized and enacted as enhancing personal skills is a good example of the role that health providers take in social control through disciplinary processes (Perron, Fluet & Holmes, 2005). Harmful health behaviours are identified, healthy norms are idealized, individual actions are governed, and under the guise of 'caring', the population is controlled (Holmes & Gastaldo, 2002). However, more recent perspectives of health promotion, consistent with a critical theoretical perspective, encompass ideas of power within social structures and social relations (Eakin, Robertson, Poland, Coburn, & Edwards). Use of these perspectives is informative in terms of configuring health promoting places.

In summary, there exists the possibility that the spaces which seek to meet the health needs of people who are experiencing homelessness instead become part of a disempowering system of control. Keeping in mind the importance of what have been termed the broader determinants of health, or social determinants of health (Raphael, 2008), if health care providers are to promote health, they need to think of health promoting places (Carolan, Andrews & Hodnett, 2006), and there is a particularly urgent need for health promoting places for people who are experiencing homelessness (Conradson, 2003).

Review of the Literature

In considering place and homelessness, the aforementioned social question of where people who are experiencing homelessness should be located both at day and at night has received much attention. It is important to note that in addressing this issue, the underlying assumption is often that in considering the placement of people who are experiencing homelessness, to witness poverty is an affront to decent society. Recognizing the pressures in high-income societies to remove people who are experiencing homelessness from visible public spaces, some research has been done on how individuals respond to these pressures. In particular, researchers who respect the personal power of homeless individuals in spite of structures of domination have looked at the occupation of visible public spaces as a form of resistance (Casey, Goudie & Reeve, 2008; DeVerteuil, Marr & Snow, 2009). By refusing to be removed or by b(e)aring their poverty blatantly and visibly, people who are experiencing homelessness work to assert themselves as legitimate public. However, other social locations such as gender come to bear on this as well. In particular, May, Cloke and Johnsen (2007)

explored how homeless women hold a more marginalized position of navigating public spaces in the context of risk for physical and sexual violence. Therefore, inserting oneself into public spaces is recognized as inherently dangerous, and May and colleagues share stories of homeless women being driven out of the public eye by experiences of violence.

Confronted by danger and exposure in public spaces, people who are experiencing homelessness often turn to service agencies not only to meet their health and material needs, but also to find some form of privacy and safety. Evans (2010) explored both the positive and negative aspects in creating spaces for people who are experiencing homelessness to receive services, concluding that these spaces serve to politically affirm that people who are experiencing homelessness matter in society, while also functioning to contain a population deemed by many to be dangerous and undesirable. To this could be added that it serves to contain them largely outside of the view of the general public. Harman (1989) addresses this 'catch-22' that services within the volunteer sector created out of compassion to meet the immediate needs of people who are experiencing homelessness also serve to mask homelessness, making the need for such services less obvious to the public.

These explanations of homelessness and place help frame any ethnographic exploration of a service for people who are experiencing homelessness. However, as this study was conducted as a dissertation in the discipline of Nursing, there is also a focus on the links between place and health, recognizing that settings have a strong influence on how health promotion is enacted and experienced (Poland, Krupa, McCall, 2009). This is not to medicalize homelessness, making it a diagnosis that simply

requires a treatment, a risk to which it has been pointed out that many researchers have already succumbed (Lyon-Callo, 2004), but to recognize that people who are experiencing homelessness face some of the highest rates of morbidity within high-income nations (Daiski, 2007). Therefore, this review of the literature concludes by exploring three studies deemed most pertinent to the topic at hand.

Johnsen, Cloke and May (2005) explored the development and inner workings of day centres for people who are experiencing homelessness in England. Concerned with the continuous push of people who are experiencing homelessness out of public spaces, they explored whether day centres are truly offering spaces of care as alternatives. Through observations and interviews, the authors found that day centres served service-users as a means both of accessing material resources, and of finding refuge, respite, and even empowerment. Day centres provided a space where certain behaviours were more tolerated than in other agencies, although this was balanced by a degree of policing and control, as one manager described, “It’s a fine line between sort of creating a prison-like environment to actually making it a comfortable, warm, welcoming environment, but also safe” (Johnsen, Cloke & May, p. 21). Service providers were not the only ones who controlled behaviours, as service-users policed each other and ‘self-policed’. Consistent with St-Pierre and Holmes (2008), the authors highlighted how the day centres served as a form of containment for ‘undesirable’ individuals. To build on the work of Johnsen, Cloke and May, how clients experience the balance between freedom and discipline in the context of health care delivery needs to be further explored.

Hodgetts, Radley and Hodgetts (2007) used photo-elicitation interviews with people who are experiencing homelessness in the United Kingdom to explore how social deprivation is literally embodied by individuals and evidenced in health disparities. Similar to Johnsen and colleagues (2005), the authors speak of accessing 'spaces of care' to meet both social and physical needs. These spaces only partially mitigated the feelings expressed by participants having little choice day-to-day of spending time in spaces other than those which they deemed to be unhealthy. Kawash's (1998) description of an illegitimate versus a legitimate public is evident in the findings as Hodgetts, Radley and Hodgetts describe fear demonstrated in the actions of housed persons towards people who are experiencing homelessness. Building on Sibley's (1995) "Geographies of Exclusion", the authors suggest that being feared is used at times as a source of empowerment as dis-placed persons turn the tables and create spaces where the 'legitimate' public feel uncomfortable and unwelcomed. In negotiating public spaces, people who are experiencing homelessness at times find ways to resist being conceptualized as being unwelcomed.

Parr (2000) conducted an ethnographic study of a drop-in centre in Nottingham, UK in order to explore the social geographies of persons with mental illness in the community. Similar to the preceding researchers, Parr questioned the lack of spaces where homeless people can genuinely 'be'. Even though the drop-in centre was a more accepting place, with wider social boundaries, the clients of the centre were forced to live out their private identities within a public space. Like Johnsen and colleagues (2005), Parr speaks to a Foucauldian disciplining of behaviours as there were still limits and norms in the centre, and both staff and fellow clients worked actively to enforce

these, “The other members of the drop-in reinforced the isolation of [a particular member] as *too* transgressive, *too* ‘ill’ even for [the centre]” (Parr, p. 234). Parr highlights that ‘othering’ and social distancing exist as pressures within ‘othered’ groups, as well as external to them.

To further explore the balance between freedom and discipline, and to shed light on how norms are enforced within health care with people who are experiencing homelessness, this paper will address the question of: How is ‘place’ experienced by clients and providers within a community health clinic for people who are experiencing homelessness?

Theoretical Perspective

This study falls within what has been referred to as a critical theoretical perspective (Campbell & Bunting, 1991), channeling the passions and perspectives of critical social theorists. Alignment with this perspective or paradigm grows from my clinical experiences and graduate studies. Having worked clinically as a nurse within the community clinic for homeless people, I have observed and even been a participant in the oppression and marginalization experienced by many within our society. This has led to a passion for seeking social justice for those who are not afforded the basic human right of having a place to call home. This clinical experience has been supplemented by academic exposure to the works of Michel Foucault (in particular “Discipline and Punish”, Foucault, 1977), Paulo Freire (in particular “Pedagogy of the Oppressed”, Freire, 2002), Jurgen Habermas (in particular “The Theory of Communicative Action”, Habermas, 1984) and the Critical Social Science in Health Group (in particular Eakin, Robertson, Poland, Coburn and Edwards, 1996), as well as

multiple theoretical and empirical works within this paradigm. Subsequently, the focus on oppression and seeking to make spaces for positive change to occur in this study fits well with a critical perspective. The reader should also find the tone of the paper consistent with the epistemology of critical science as I seek to engage the reader in my own subjective reflections in the hope that my words can serve as a catalyst for creative growth, rather than an attempt to train others in objective truths.

Methodology

This study was conducted using a critical ethnographic methodology.

Ethnography is a methodology by which one better understands culture or cultures as they are experienced in the daily lives of the people who “live them out” (Crang & Cook, 2007, p. 1). Countless definitions of ‘culture’ exist. Drawing on the work of Poland, Lehoux, Holmes and Andrews (2005, p. 172), this study defines cultures as: “common/shared beliefs or values at a variety of scales; cultures give meaning to ways of life and act as a lens through which we look at the world that both affects and represents our behavior; and cultures produce (and are reproduced through) material and symbolic forms”. Therefore, though often engaging, intriguing, or even titillating, ethnographies have traditionally been largely descriptive, providing stories and observations that illustrate what is shared, what is enacted, and what is reproduced. The addition of ‘critical’ to ‘ethnography’ then represents both a shift in focus and a shift in how one engages in ethnographies. In terms of focus, within critical ethnography it is taken-for-granted that one of the things produced and reproduced in all cultures is oppression (Browne, 2005). Therefore, there is an explicit focus on power relations and marginalization within critical ethnography. Building also on the focus within the

critical paradigm of making spaces for positive change, the critical ethnographer is not to be content with developing a cultural critique, but must engage with the culture of study to be a catalyst of change (Cook, 2005).

Roper and Shapira (2000) discuss extensively positionality and the nurse researcher who is engaging in ethnographic study. In particular, they describe how researchers find themselves to be both ‘insiders’ and ‘outsiders’ in the culture of study by being physically present over a period of time. This idea of the researcher as insider/outsider is particularly relevant to this study as I had been employed as a nurse within the health clinic for 4.5 years prior to conducting the study, either full-time, part-time, or within other programs attached to the clinic. Coming to a study already possessing insider knowledge and status can be an advantage in terms of the time required to develop rapport (Asselin, 2003). In this case, advantages included knowing what possible questions to ask, being able to navigate the setting, and having a better sense of when not to take provider or client testimony at face-value. Conversely, being known in the clinic can lead to role confusion (Cartwright & Limandri, 1997), which I attempted to defray by terminating my role as a nurse in the clinic. However, changing roles proved to be uncomfortable for me at times as, in reality, roles cannot be ‘turned on’ or ‘turned off’. An example of the discomfort was when clients of the clinic asked at reception for nursing assistance, and were told they had to wait for the staff nurse while I sat in the waiting room apparently unoccupied but actually conducting observation. I did participate as a staff member in responding to requests for socks, food, access to the bathroom, and other such physical needs, but did not meet with individual patients for nursing care.

Being recognized as a staff member in the setting naturally impacted my observations, as interactions within the waiting area can be presumed to be different when a staff member is present or not. As well, what clients and providers chose to disclose or not disclose during in-depth interviews was invariably impacted by my being recognized as a provider. In particular, I was known in the clinic to be a strong client advocate, and leaning towards bending clinic policies to meet immediate client needs. This had put me at odds with some providers in previous staff meetings, and likely impacted on our interview dialogue. The other risk was that I, being already steeped in the issues of the clinic, found myself wanting to move quickly to collecting data on these issues, and missing the importance of the mundane, every-day-life of the clinic, a risk identified by Labaree (2002). In the end it was determined that the benefits of being an 'insider' outweighed the risks, and the research team and focus groups served as a means to enhance the construction of the findings.

Methods

The study was conducted in a community health centre in a moderate-sized urban area in Southwestern Ontario. This centre included a health clinic for people experiencing homelessness, which was the focus of our study. This clinic provides both health and social services, with providers consisting of one physician, three nurses, one nurse practitioner, two social workers, one community worker, and two administrative staff. Services include medical appointments, urgent medical care, social work appointments, washroom and laundry facilities, emergency food and clothing, a telephone, and various need-specific clinics and groups. Clients were those individuals who qualified as being homeless, which ran the gamut from being absolutely homeless

and living on the streets, to being in shelter or temporary housing, to being formerly homeless at admission to the clinic but currently being housed, albeit precariously for most.

The clinic (Figure 1) is well known in the struggling neighbourhood in which it is situated due to the large number of impoverished individuals who mingle in front during open hours (Monday to Friday, 9am to 3:30pm). Entering through the double-doors brings one into a waiting and reception area that is often quite full and quite active, and that carries the smells of abject poverty, such as body odours, mouthwash, and excrement. It is into this waiting area that I (AO) inserted himself for the three months of intensive data collection. The reception area is staffed by two receptionists, who although unanimously identified by clients in interviews as being friendly, are also the front-line of rule enforcement, so frequent altercations can be heard at their window. If granted permission, passing through the locked door beside reception leads one to the back area, surrounded by offices and examination rooms, where people can be found waiting for the washroom, doing laundry, obtaining personal supplies, or finding rest in a recliner.

Multiple qualitative data collection methods were used in order to develop a deep engagement with, and understanding of, the culture of the clinic. Data collection methods ran consecutively for the most part, with some overlap, and included participant observation, in-depth interviews, and focus groups. Participant observation involved 103 hours over the course of three months in the clinic waiting room and observations of seven client-provider dyads within examination rooms or offices.

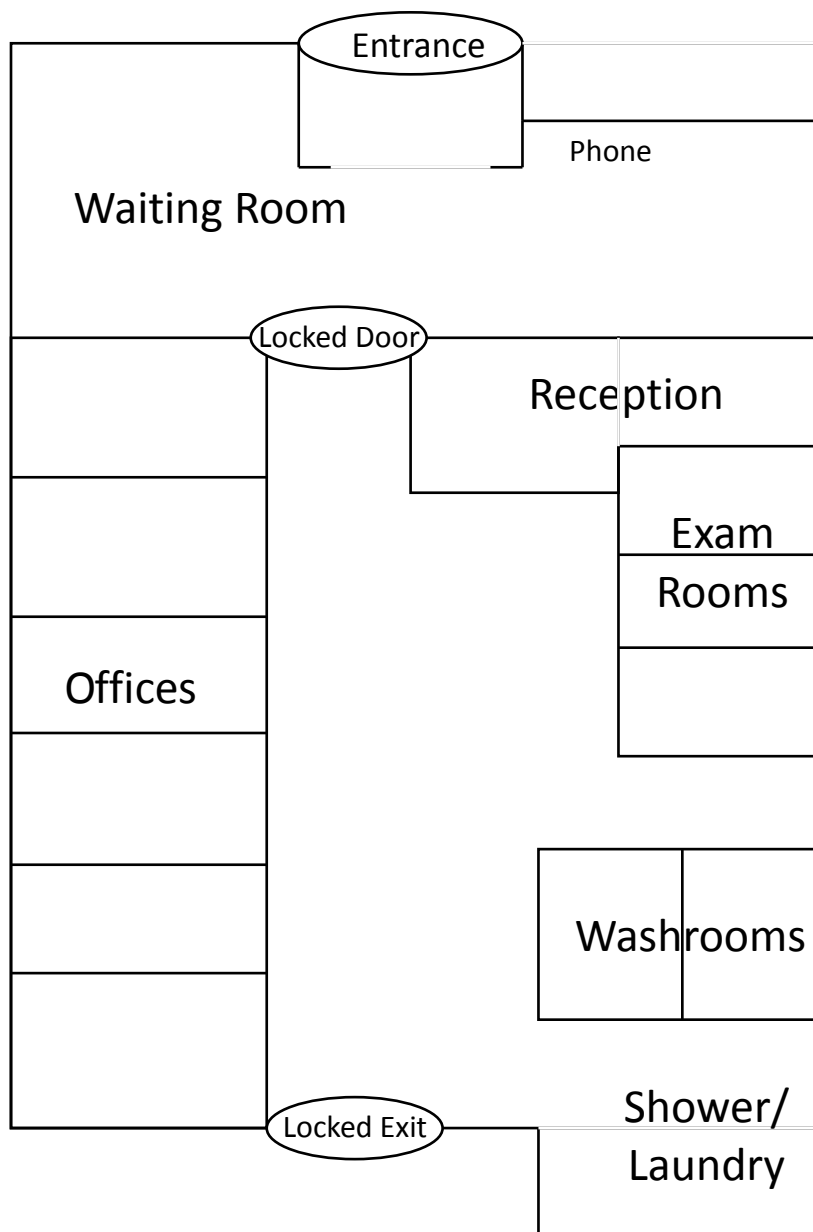


Figure 1: Health Clinic Configuration

These dyads were selected when the clinic was client and observations were limited by asking permission of the providers to observe their next interaction. There was a risk that providers would self-screen for clients with whom they related well, but not providers refused requests. Clients who were next for an appointment were also asked permission, and both the provider and the client signed consent (Appendix C). As the

focus of the ethnography was pre-determined and the setting was relatively small, guidelines of what has been termed a ‘focused ethnography’ (Muecke, 1994) were utilized for the length of time in the field (Knoblauch, 2005). Participant observation played an important role in facilitating focused observations of a clinical area that was already familiar. It allowed for much more time spent in the waiting room than a provider would typically experience. As cultural values and practices are enacted and re-enacted, observations afforded an exposure to the culture of the clinic that would have been missed by only conducting in-depth interviews. Conducting observations in exam rooms and offices as well as the waiting room helped expose more private interactions between clients and providers. Fieldnotes were recorded intermittently throughout the day in a private office so that they were recorded immediately and also unobtrusively (Groenkjaer, 2002). Fieldnotes started as simple description of observations, but evolved over time into insights and analysis as certain patterns were observed and particular themes were determined to be pertinent.

During participant observation, preliminary themes were developed that were built into the interview guide for in-depth interviews. Observation also provided an opportunity to identify key individuals for in-depth interviews. In particular, there were times when a client-provider interaction was observed, after which I requested an interview with the client for further discussion on the interaction. Participants for interviews were also obtained through open recruitment, as a balance was sought between targeting key informants who were recognized long-standing members of the community, and others who were interested in participating in the study.

Although a semi-structured interview guide was utilized initially, as themes started to develop, these became the guiding points for discussion. In all, 22 interviews were conducted, with the total clinic sample of 10 providers being interviewed a total of 12 times (2 providers were approached for second interviews to focus specifically on emerging themes) and 11 clients being interviewed in 10 interviews (2 chose to be interviewed together). Demographic information was gathered dialogically within the interviews to avoid collecting unnecessary data (Morse, 2008). Clients represented the spectrum of individuals seen within the clinic, ranging from being free of addictions to having both drug and alcohol addictions, having been born locally to having migrated across the country, from young to old, and both male and female. Although a representative sample was not necessary for our study, what was sought and achieved was variety across a number of social locations, such as age (ranging from mid-20s to mid-60s), sex, familiarity with the local community, and having a substance dependence or not. As a group, participants did tend to be those who were more chronically homeless than would be representative of the clinic (mean years homeless = 7.9), which was likely an artifact of sampling for clients who would have the most to say about relationships with providers, which in most cases were those who had been attending the clinic for an extended period of time. There were also no clients in the group interviewed who would be considered as non-Caucasian. Although the clients at the clinic are mostly Caucasian, there was a significant portion of First Nations clients at the clinic who were not represented in the interview data, possibly because of the social distance between Caucasian researchers and homeless First Nations clients.

In analyzing the data, Lather's (2007) work on understanding validity post-
poststructuralism was used to enhance quality. Recognizing that our findings represent
a constructed rather than a found world, it was deemed useful to follow Lather's
conceptualization of 'achieving' validity as struggling with the various problematics of
epistemology rather than a set endpoint. Lather (2007) provides four reminders to
researchers: acknowledge that the text is a representation of that which does not truly
exist; avoid seeking consensus and allow contradictions to remain; resist the urge to
simplify and add arbitrary structure; and recognize the partiality of all viewpoints, being
engaged and self-reflexive, and pushing beyond the boundaries. Attention to Lather's
conceptualization is integrated through the manuscript and is evident in the tentative
nature of the re-presentation, in the appreciation of contradictory perspectives, and in
the challenge to health providers to move beyond what is taken-for-granted in "health
clinics" and advocate for places of health promotion.

Data analysis occurred as an ongoing process during participant observation as
fieldnotes evolved from simple transcription of what was observed, to reflections on
themes, inconsistencies, tensions, and concerns. These preliminary thoughts then
informed the in-depth interviews, which were audio recorded and transcribed by a
transcriptionist. The transcripts were read and edited while simultaneously listening to
the interviews in order to try to capture the nuances of language in a manner most
meaningful to those doing the analysis. A loose coding structure was created in order to
identify the passages most pertinent to our research questions, which was then used to
pull out a series of quotes. This served as a way to make the 22 transcripts and 35 pages
of fieldnotes manageable, but also represents 'our' choices regarding what was

important about ‘their’ words. Although various social locations such as race, class, gender, sexual preference, and others had an impact on the interactions within the clinic, for the sake of coherence and length the primary focus of this paper is the difference in status as a client or a provider at the clinic. Data analysis was enhanced by three focus groups, two with providers and one with clients, in which preliminary findings were brought back to original participants or other clients and providers to solicit their feedback. This feedback was not primarily for the purpose of collecting new data, but was to help refine the organization, interpretation and presentation of findings to be more meaningful to those most invested in the findings.

Findings

The findings section will focus on contesting space, looking at what is contested, and making place, looking at how clients and providers exert power to make place. On the surface, the clinic functions well to meet the health needs of the homeless clients, and to provide a space for them to be during the day. Clients speak well of the clinic, comparing it favourably against other agencies that are more rule-intensive. In particular, clients highlight the positive relationships they have with providers:

It’s a good place to come. I always feel safe here and there’s always, you know, help from people here if I need any assistance in any way. There’s some great people here.

In general, the providers are seen as ‘getting it’, which means understanding the plight of homelessness, and being knowledgeable about their jobs. Similarly, providers speak well of the clients, highlighting the positive relationships they have with many clients, and the level of personal meaning that they achieve from the job. However, there is an

inherent structural tension to the clinic where multiple and often divergent accountabilities towards funders, the surrounding community, and clients must be balanced. Certain clients will present with certain needs that do not fit the mandates of the clinic, making conflict inevitable. Interestingly, in navigating this conflict, clients and providers often drew upon the same narratives of safety and consistency. The positive veneers of 'getting along' in some ways mask the contested nature of the physical space in the clinic, and the ways in which clients and providers assert themselves to create the meanings of place.

Contesting Space. The clinic can be seen as a contested space, with client and providers asserting themselves to create and re-create a physical space that best suits their sometimes mutual and sometimes competing needs. Although in observations this contested space evidenced itself as personal struggles between clients and providers, it speaks more to structural considerations and the set-up of a clinic in which power struggles are inevitable. This will be demonstrated by exploring four areas around which clients and providers assert formal and informal power: the clinic atmosphere; what is deemed appropriate use of the clinic; safety; and private spaces.

Both clients and providers spoke to the atmosphere of the clinic, which seems to centre on the concept of 'chaos'. Providers accepted that some level of chaos/confusion/distraction can be anticipated when working with large numbers of individuals experiencing such challenges as addictions and mental illness. However, many providers conceptualized the purpose of the clinic space as delivering medical services, and therefore the level of chaos often experienced within the space is seen as detrimental. For example, the physician described trying to work with clients in the

exam room while there were “bodies bouncing off my door”. Of note is that much of the chaos has to do with the flow of clients through the clinic, and is therefore inextricably connected with physical space. At the time of collecting data for this study, clients had free access to all providers and to all facilities in the space of the clinic (see Figure 2).



Figure 2: Health clinic prior to construction of “The Wall”

This free movement provided more of a sense of ownership among clients regarding the space, but proved challenging for some providers, particularly for the physician.

Clients would use the open access to the physician to talk to him when he moved between his office and the exam rooms, or waited for him to open the exam room door.

Some providers saw this level of freedom as detrimental to the quality of care,

I mean, we try to build barriers in the system I guess, on appropriate access.

Because of the excessive need for clients, whether they, whether it be emotional neediness or drug-seeking or whatever.

The movement of clients in the space was therefore seen by some providers as something that needed to be controlled.

It is inevitable that space will be contested when there is a discrepancy between the goals of an agency and the needs of its clientele, in this case the discrepancy between the clinic focus on meeting medical needs versus the need of people who are experiencing homelessness to have a somewhat private space in which to 'be'. This is evident in the discourse around the appropriate use of clinic space. The previous configuration of the clinic as a more open space also led to what some providers and clients considered a misuse of the space, particularly using the bathrooms to consume alcohol or use illegal drugs, and dealing drugs in obscured corners. This is a contentious issue in the clinic, as some see increasing barriers to drug and alcohol use as increasing harm by pushing people to use in unsafe places and unsafe ways, where others see facilitating drug and alcohol use as both harmful and as putting the clinic at risk of losing funding if found to be condoning illegal activities. Interestingly, neither

of these positions was supported by evidence, as, for example, there was no way of knowing how funders, in this case the Local Health Integration Network, would react to drug use in a public washroom. One provider captured the issue well,

The bathrooms were such a problem because people were using [drugs] in there so we cut it down to one. So it got to, it was at one point I thought we were going to have a flashing light in there or something, that it was going to be so controlled. And that kind of stuff drives me crazy, there's fine lines sometimes between power tripping and using your authority.

What the provider is referring to is one of the proposed solutions that was implemented by management, eliminating one washroom and increasing the monitoring of washroom use. This process evolved while this study was being conducted. Another potential solution was implemented approximately three years prior to this study, which was to reconfigure the space so that most of the clinic was behind a locked, glass door controlled by reception (see Figure 1). This locked door is collectively referred to as “The Wall”, and featured prominently in in-depth interviews as a contested reconfiguration of the space.

In contesting space, the concept of ‘safety’ was used almost as a form of currency, with any conceptualized improvement in safety trumping other client and provider needs. When working with individuals who experience the desperate needs of absolute poverty, and who are often also dealing with addictions, mental illnesses, or both, people are bound to assert themselves physically. The clinic has been host to numerous altercations, ranging from more benign verbal altercations, to assaults with weapons. Although most violent altercations occur between clients, there has been the

intermittent incident of a provider being assaulted. However, what is important to note is that safety is connected to the physical design of space, but it is also connected to the quality of relationships between clients and providers. Therefore, the manager spoke to promoting safety by creating a wall with a locked door access. Conversely, clients spoke of the safety afforded to providers by working in a clinic in which clients felt respected and treated well. Clients spoke of another facility that had much higher levels of security and surveillance, but in which staff were still assaulted much more frequently as clients felt like they were in jail rather than treated respectfully there. Therefore, it is contested whether more control necessarily equates to more safety, and whose safety is given priority.

The fourth issue around which clients and providers asserted themselves was that of private space. People who are experiencing homelessness are displaced from their private spaces, and forced to live entirely within public space. This, for example, means being without a private space in which to make phone calls, sleep, use the toilet, be intimate with a loved one, or consume alcohol and drugs. All of these activities, and others, instead were observed to occur within the clinic. On one occasion, a health provider chastised a client for ‘popping’ another client’s pimples in the waiting room. Clients were also observed discreetly consuming alcohol and drugs, or would be banned from the clinic for the day when caught drinking in the shower. Those who had been outside all night, or those who were very intoxicated, would often try to rest in reclining chairs,

We’re walking around these people sleeping. I don’t know why they’re sleeping, I don’t care. I just know they’re not getting the proper care that I

would give them as a human being, to make them sit up in a chair to sleep. Let them lay down. Okay, you don't have to staff it per-se but just a cot would do. That's all they want, they don't want a bed with covers and pillows and drapes on the windows.

This issue of privacy is inherently tied to dignity, particularly as it relates to the use of washrooms. Clients consistently expressed concern with being timed in the bathroom and how this made them feel as if they were being treated like a child or a prisoner. Thus behaviours that are considered appropriate for a private space are deemed as inappropriate or a misuse of clinic space.

Making Place. Place, or the meanings attributed to the physical space, is inextricably linked to this physical space. There have been explicit and deliberate efforts by providers and management to create a place that is optimized for the delivery of health care services. However, the institutional logic of managing the movement of people and creating an environment that facilitates task-completion collides with the logic of everyday life of the homeless clients and the meanings they ascribe to the clinic. The 'Wall' is the most obvious of these, and still represents much tension within the clinic:

There continues to be a lot of resistance to the structure. Physical structure and scheduling structure enhances the work. There are other members of the, of the care team here that would say exactly the opposite but I think it's certainly, for the type of work I do, I have to do it in a thoroughly structured way or otherwise I'm not serving my clients very well.

This provider went on to state how strong the feelings are around the Wall,

It's like the storming of the Bastille...there are people on staff here that would tear that wall down in a moment if they could.

Both providers and clients try to negate the existence of and reconceptualize the meanings of the Wall by holding the door open for others rather than making them go through reception. With the washrooms on the other side of the locked door, there is a constant enough flow that this occurs frequently, leaving the receptionists with the difficult decision of whether or not to address those who go through without permission. In this way, it is re-asserted that the clinic is the clients' place, and they should not therefore require permission to move throughout it. Providers also resist the restructuring of the space by maintaining flexible schedules and accommodating clients who 'drop-in' at their office door rather than scheduling through reception. However, this is less manageable for some providers, such as the nurses, who have to carefully manage a constant flow of individuals attempting to get access to the physician to receive prescriptions. What was apparent in comments from providers is that not all providers have benefited from the building of The Wall.

So, the clinic is changing, as clients and providers attempt to create and re-create a place that best meets both their mutual and competing needs. However, there is a general sense among clients that the change is not driven by their needs, and a sense among providers that the change is not driven by provider consensus. Participants spoke to four concerns that still exist: barriers to accessing providers, an institutional aura, access to bathrooms, and the lack of privacy. Recalling that it is the people that have the greatest influence on the meanings of a place, there is grave concern amongst clients that they were now separated from providers.

You put [Provider 1], [Provider 2], people like this in bubbles, they're unapproachable. These are the people that can help the most, and yet they're the most unattainable. Why?

I found it different when they did put that wall up. It cuts you off from the staff and other things like that.

Working with a very heterogeneous population of clients, the Wall was never going to be a popular change for all clients. However, after approximately three years of being present, the majority of clients do not see The Wall serving the purpose that was suggested when it was built,

Nobody knew what was going on, nobody understood why. My impression was, put the people in the bubble so that they can do their jobs better. Have they done their jobs better? I don't think so.

Here the client has a particular idea of the role of a provider, and The Wall is an obstruction. One client suggested a possible solution that doesn't involve removing the wall completely,

I'd really like to see somebody out in the [waiting room]. I'd like to see an outreach worker [in the waiting room] that was available for those, you know, 'I need to get to court', 'I need to get Ontario Works', 'I need, I can't read the paper work', 'I can't do this', 'I need this housing assistance', and a lot of these things.... You know, an advocate there, right there, that's what I'd like to see.

The Wall changed the very meanings and feel of the space, decreasing the size of the area in which people are free to circulate in the clinic. One client saw a need for

more control, but expressed how this same control conceptually equates for a lot of clients with their experiences of prisons,

You know, I'm still against that front wall thing. I used to like the open concept, but I realized as this place grew, popularity wise, and how many people you're dealing with now, you had to have some sort of block structure.... It was a little rough, it felt like we were walking into a probation office or an institution that was, you know. Remember, you're dealing with a lot of street people here and a lot of those people have been involved with that kind of surrounding so it's not comfortable, not comfortable at all.

Many clients did express how things are better in terms of the chaos and some even discussed how they personally feel much safer since The Wall was built. They recognize that the doctor could see more people more efficiently this way, and that equates to less time that they have to wait for an appointment, which they tentatively appreciated,

I can see how they needed [The Wall]. I didn't need it but they needed to do it.

They needed control and it certainly worked.

...maybe it helps the doctor and the nurses out.

This next quote illustrates the tension, as some desire to regain the flexibility of movement, while at the same time agreeing that providers should be able to work uninterrupted,

You need to open up the offices again. You need to cut down the wall so people can mingle through. If you want [Provider 1] and [Provider 2] and [Provider 3] and the doctor to be in a separate room sort of thing, put them in another room

somewhere, but give the people here more room here to mingle. This is too tight at the front.

The same concern was demonstrated around what it means to have to ask permission to get to the washroom, and the closing of one of the washrooms,

And the loss of one bathroom, I don't know, might not be the best thing cause you have to wait in line so much, cause people go in there and stay in there for a long time. Maybe having a specific clean room for those that aren't just using the washroom.

This comment reflects a shared opinion between clients and providers that clients need a safe place to use drugs, recognizing that the washroom is not the ideal place to do so.

The wall did improve one component of a feeling of privacy in that by decreasing the number of people in the open area behind the wall, those who were there sleeping in chairs had more privacy. However, it also aggravated the congestion in the waiting area. And, by moving the phone from a corner by the bathrooms to the front area, people's phone calls are no longer private. One of the things that is appreciated about the clinic is that clients understand it is a place where they can vent some of the frustrations in their day-to-day lives. Because rules about behavior are not as strict as other agencies, clients come in and often talk loudly and swear about something that is bothering them. They usually receive support from their peers through agreement with their concern.

That's where you get people flipping out and having some episodes out there and it's a place for people to do that. Take that as a good thing. Here's a place where people can vent and not get arrested for it.

Decreasing the space for people to circulate freely has a negative impact on the sense of the place, as one client stated,

I get upset out there in that front hallway, now in a smaller enclosed area that we're all bunched into. You guys should...give these people more room so that when they go off, there's a place that they can go. There's no place to hide in that small room up front.

Discussion

Clients in this study compared the clinic to other agencies they frequented, and found it to be generally more comfortable than those that placed a greater focus on behavioural control. However, clients and providers contested the space, exerting themselves to meet both mutual and conflicting needs. Participants spoke to the strategies that have been implemented over time, but highlighted the lack of consensus amongst both clients and providers around these solutions. Lastly, they identified that many challenges still exist, or that the solutions have simply led to new challenges. In particular they highlighted barriers to accessing providers, the change in the feel of the clinic to being more institutional, the lack of access to bathroom facilities, and that there are still no private spaces for clients to utilize. Although some clients spoke highly about the clinic, other clients and providers were concerned regarding a perceived direction of the clinic to being a less health promoting place, as being more rigid and regulated. The discussion will be framed around three questions, which are important to many fields that seek to create spaces that are health promoting. Recognizing the gaps in the literature around exploring space and place in the context of health care with people experiencing homelessness, these questions both start to fill the gaps as well as

provide direction for future research. I provide some of my own reflections here, but note that these questions do not invite simplistic answers, and will hopefully be helpful for others in creating optimal services. The questions are: 1) Whose space is it? 2) What constitutes a health promoting place? 3) Is safer always healthier?

Whose Space is it? Fisk, Rakfeldt, Heffernan and Rowe (1999) conducted a study of an outreach project for persons experiencing a mental illness and homelessness. They found that the location of care influenced the ability of workers to set boundaries. In particular, when outreach workers went outside the outreach project facility to visit individuals who were sleeping on the streets, they found it difficult to set boundaries around intrusive sexual comments. This demonstrates the importance that meaning of space has in health promoting interactions, leading to questions in this study of who ‘owns’ the clinic space, whose space is it, and who makes the rules in the space? In this study we observe the implications of policy-setting being done by providers in order to address challenges of space, but often having negative implications on the meanings of place. The same questions around ownership of space can be asked of the health clinic, and are pertinent reflections in the context of the above findings that speak to providers as gatekeepers, permitting or denying access to some or all of the clinic space.

All health and social systems contain an element of social control, order, and compliance. However, in the context of homelessness, and having no space of one’s own, the sense of being policed is felt more acutely. This invites reflection on how service providers and service users might work together in a more mutual manner, sharing ownership for the management and function of the space. This is supported by

a reflection that as a publicly funded health service, the clinic is owned by the public and the providers are paid from the public-purse. Therefore, providers are being paid by the public to provide a service to a portion of the public, the homeless clients, hence the terminology of 'client' rather than 'patient'. Unfortunately, at times it felt that this terminology was simply tokenism (Boyce, 2001), as control over official decisions on how to both arrange and manage the space rested almost solely with providers.

Decisions around care delivery must not only reflect accountability towards funders and the surrounding community, but more importantly reflect the needs and desires of the clients. However, this is not a simple solution due to the heterogeneity of the clients that makes consensus an impossibility. Therefore, questions must be asked regarding how clients are to participate in, and, based on the concepts of capacity building and empowerment (Holmes, Perron, & Savoie, 2006), ideally lead decision-making processes, and how decisions will be made in light of diverse opinions. Clients made it clear that the clinic is their space in how they shared the control of space with providers. Although only providers had formal power to ban clients from the space, clients also enforced norms by verbally berating those who went beyond what was considered reasonable behavior, and resisted undesired policy or structural changes by subverting the rules.

What Constitutes a Health Promoting Place? Health is more than the absence of disease, it is a resource for everyday living (WHO, 1986). Promoting health must take into account the determinants of health, such as income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills,

healthy child development, biology and genetic endowment, health services, gender, and culture (Raphael, 2008). As such, the food, clothing, washrooms, phone and bus tickets provided in the health clinic are as much a part of promoting health as the prescriptions, stitches and annual health examinations. This is well understood in the clinic, but what I would add to this conceptualization is that the 'place', the meanings attributed to the 'space', of the clinic is also an essential part of what makes it health promoting. Taking the World Health Organization (WHO) definition of health promotion being to have increased control over ones health and the social determinants of health (WHO, 2005), a health promoting place involves self determination in care. If clients feel uncomfortable, infantilized, and unheard, then although a visit to the clinic may yield the client a pair of socks, they may be left feeling less healthy based on the experience of the space. An important point to highlight here is the need for privacy and the need for spaces in which clients feel free to act naturally without unwanted limitations on their behaviours (Kawash, 1998). Perhaps the clinic is not the appropriate space for this, but many clients identified the lack of these features as limitations of the clinic. There exists a need for clinic staff to continue to define its purpose, to determine how they will choose to be health promoting, and how they will make clear their purpose to clients and other agencies. Clients and providers need to mutually consider how clients will be involved in all of these choices. This has implications for local, clinic-level policies that set the context of whether decision-making will be a mutual process or be 'top-down'.

Is Safer Always Healthier? What is considered safe and how is safety assured? Poland, Lehoux, Holmes and Andrews (2005) capture well the tension

between care and safety, “Often, therapeutic demands (care) and security imperatives collide” (p. 174). Many of the policy and physical changes that clients and providers were reacting to negatively were made under the auspices of enhancing safety. Where providers operate within the rhetoric of safety, clients seek more essentially to find a place where they can simply ‘be’. As highlighted in the findings, there were some very real issues of concern with both clients and providers having been physically assaulted in the past. The question is, to what extent do we enforce behavioural control before we create an unhealthy place?

Behavioural control is inseparable from a secondary question of safety, and whether safety is solely the mandate of providers, or if clients have a role in this, and what that role might be? In fact, clients worked hard to discipline the behaviours of other clients for fear that further freedoms would be lost in the clinic if things were considered to be too unruly. Again, there is no easy answer to these questions as the heterogeneity of clients and providers means that each will define safety and a health promoting place differently. Karabanow and Rains (1997) highlight well how the enforcement of structure upon a youth shelter in order to enhance safety and personal development was interpreted by the youth as uncaring, and the worst thing about the shelter. If health promotion is about increasing control over one’s health, then spaces that limit control create challenges for those seeking to enact health promotion. In the current study, a provider suggested that differences between clients and providers in conceptualizing safety may be because many clients have a higher tolerance for risk based on the other contexts in which they live. Critical reflection is required to explore what level of risk is deemed appropriate in order to facilitate a health promoting place.

Conclusion

To conclude, recommendations are offered relevant both to this particular clinic, and to other health care facilities that provide services to persons who are homeless, and highlight areas for future research.

People who are experiencing homelessness are in urgent need of health promoting places (Vandemark, 2007). Driven from public spaces to spaces in agencies that provide little privacy and strictly regulate behaviours, homeless persons experience acutely social control. Agencies that serve people who are experiencing homelessness must reflect on their location within the lives of their clients: what meanings do clients and providers attribute to their space, and how do they fit within the broader spectrum of client services? For example, do clients have other spaces that they can go to in order to meet private needs such as drug use or intimate relations? In addressing the health needs of clients, on what components of health should health providers focus? How will services for people who are experiencing homelessness delivered under the auspices of 'health care' be configured in order to respond to the broader/social determinants of health? What role will clients play in the development and management of their services? This last question requires deep reflection as client involvement in managing services can be done well, but it can also be tokenistic or poorly adopted (Boyce, 2001). In fact, one could go further to suggest that in answer to the first discussion question of 'whose space is it', one finds some help in answering the other questions of 'what constitutes a health promoting space' and 'is safer always healthier'. By building client ownership and control into the processes and policies of the clinic, we move closer to both a health promoting and a safer space. It is telling,

and unfortunate, that although client involvement in services is discussed at the clinic where this study was conducted, it has not been embraced to date beyond feedback forms and annual questionnaires.

Enhancing spaces to be health promoting must also be done within the context of the broader health care system. Within the Canadian context of this study, health care agencies are facing increasing pressures to demonstrate quantifiable outcomes in order to support requests for funding. These outcomes are most often individual medical indicators rather than nuanced changes at the population level in such areas as a sense of place, or involvement in one's own health care. These system pressures can make such processes as building client ownership and control less attractive if they increase the complexity of decision-making and include risk of clients making decisions that don't align with the directions of funding bodies. A shift to thinking of health promoting places must be supported at a system level if it is to be attractive to individual agencies.

This study was limited in that it was a cross-sectional picture of one clinic at one point in time. Further research needs to be conducted to explore novel ways of providing health promoting places for people who are experiencing homelessness. In the context of this study, clients were able to identify agencies that were doing more or less to meet their needs, and understanding these differences in quality would be beneficial. Client ratings of the quality of services from different agencies would not be collected with the intent to conform all agencies to one type of practice, but to assist each one individually to provide the best possible care. In this light, individual municipalities or neighbourhoods would benefit from utilizing a lens of space and place

for identifying possible gaps or limitations in existing services. Lastly, much of the analysis in this study has focused on the clinic as a whole, but many opportunities exist to explore how individual providers and clients work to create spaces of empowerment, although this is only possible if we are aware of and address both the opportunities and constraints of social control.

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Chapter 5 – Client-Provider Relationships in a Community Health Clinic for People who are Experiencing Homelessness

The experience of homelessness is one of compromised health. Health promoting relationships have been proposed as one key component of improving health care services for persons experiencing homelessness. Therefore, the purpose of this focused ethnography is to critically examine client-provider relationships within the culture of community health care for people who are experiencing homelessness.

Background

Statistics on homelessness are both controversial (Layton, 2008) and difficult to obtain, but those that exist demonstrate that homelessness is a major health and social problem in Canada. Survey data from the late 1980s estimated that over 100,000 Canadians were homeless (McLaughlin, 1987). As of 2007, estimates of homelessness in Canada have grown to 200,000 to 300,000 persons (Laird, 2007). In the same year, Miloon Kothari, the United Nations Special Rapporteur on the Right to Adequate Housing reprimanded federal and provincial governments in Canada for failing to adequately address homelessness in Canada (Johal, 2007). In recognition of the seriousness of this problem, the municipalities of Toronto, Durham Region and Ottawa, as well as non-governmental organizations, have declared homelessness in Canada a national disaster (Ottawa Regional Council, 1998; RNAO, 2004).

Rooted in powerlessness (Wallerstein, 1992), homelessness is an experience that compromises one's health (Crowe & Hardill, 1993; Hatton & Fisher, 1999). For most individuals, homelessness is a transitional state rather than a permanent situation (Buck, Rochon, Davidson & McCurdy, 2004), and during this time much can occur that

exacerbates existing health concerns, or creates new ones. Understanding the health impacts of homelessness is somewhat complicated in that many of the conditions faced (such as mental illness, substance abuse and chronic health conditions) can be both causes of and results of homelessness, but the negative health impacts of homelessness are well established (Daiski, 2007). Most striking in terms of the negative health impacts of homelessness is the high mortality rates among people who are experiencing homelessness (Frankish, Hwang & Quantz, 2005; Levy & O'Connell, 2004), with the mean age at death of people who are experiencing homelessness in Toronto, Canada being 46 years (Hwang, 2000).

All of these health concerns are aggravated, or possibly caused, by the fact that people who are experiencing homelessness encounter barriers to accessing formalized health care services beyond emergency rooms (Burt, et al., 1999). In addition to the barriers of social isolation, competing demands and bureaucratic structures, people who are experiencing homelessness frequently experience negative attitudes from health care providers (Nickasch, 2009). These negative attitudes have been identified as the primary barrier that people who are experiencing homelessness face in obtaining health care services (Ensign & Panke, 2002; Lester & Bradley, 2001). It has also been found that positive attitudes towards persons experiencing homelessness, meaning respect and a sense of enjoying working with this population, are statistically significantly related to the likelihood of the provision of quality care (Zrinyi & Balogh, 2004). In light of these barriers to accessing formalized health care services, studies have shown that many people seek these services as a last resort (Kushel, Gupta, Gee & Haas, 2006; Martins, 2008). Therefore, more research is required that explores the relationships between

clients who are experiencing homelessness and health care providers within the various contexts that care is provided.

In exploring health promoting relationships, it is important to first situate ourselves contextually in terms of health promotion theory. Like any core disciplinary concept, 'health promotion' has evolved and been conceptualized in many different ways. In this study a perspective of relational health promotion with a critical social leaning is utilized. Within a relational perspective, the researcher focuses on the importance of relationship in all things, meaning that the act of health promotion involves being in relation with others (Hartrick Doane & Varcoe, 2005). This understanding of interrelatedness goes beyond how one practices health promotion, and includes an understanding of all determinants of health as interrelated (Hartrick, 2002). Within a critical social perspective, "health is seen as embedded in social relations of power and historically inscribed contexts" (Labonte, 2005, p.1). As opposed to the dominant ideology of our capitalist society, critical health promotion researchers promote economic equity and redistribution, rather than absolute wealth generation (Poland, Coburn, Robertson, Eakin, et al., 1998). Critical health promotion engages with the importance of the social determinants of health, conceptualized as: aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security (Raphael, 2004).

Review of the Literature

Although little research has focused exclusively on the client-provider relationship in health care with people who are homeless, many of these published

studies do touch upon relationships within the discussion. Where relationships are mentioned, the research is unanimous in supporting that health promoting client-provider relationships are essential in providing quality health care services for people who are experiencing homelessness (Chinman, Rosenheck & Lam, 1999; Christensen, 2009; Hatton, Kleffel, Bennett & Nancy Gaffrey, 2001; Minick, et al., 1998). However, this work has at times been individualistic, focusing on personal agency without acknowledging the impact of broader socio-political structures on the formation and enactment of client-provider relationships. In this light, what is particularly lacking in the empirical literature is how both formal and informal policies, meaning courses of action or procedures, shape the enactment of health promoting relationships between homeless clients and healthcare providers.

Cohen (1989), writing to a social work audience, explored how best to engage with homeless clients experiencing mental illness, in community-based care. She suggests that in light of the past negative experiences that these individuals may have had with health and social care providers, we must seek to maximize their control in client-provider interactions. Additionally, Cohen explores the importance of meeting basic personal needs prior to addressing other physical and mental health issues. The importance of meeting basic needs is two-fold: it provides means to initiate relationships with clients by which the provider can show that they care for the comfort of the client, and by meeting the most pertinent needs of the client, it allows them a space to then consider other needs such as healthcare.

Martino Maze (2005) conducted a literature review of nurses' responsibilities to care for disenfranchised persons, recognizing that personal attitudes may be a barrier to

engaging potential clients in formal care. Noting that discriminatory attitudes have been identified repeatedly in other studies, Martino Maze suggests the importance of reflexivity, exploring one's values, attitudes, and beliefs, a common strategy for addressing potential discrimination. In a similar literature review of the concept of 'caring' across broad social distances, Myhrvold (2006) suggests that the burden of responsibility for developing a relationship lies with the provider, rather than with the client, due to power asymmetries. Although the consideration of power asymmetries is important in this context, putting the full onus of relationship-building on the nurse is problematic. This nurse-centric view risks both not recognizing the power that clients have in the relationship and its enactment, and obscuring the constraints that policies can have on nursing practice (RNAO, 2006).

Other work that demonstrates the importance of client-provider relationships with people who are experiencing homelessness has been developed based on the lived experiences of delivering care to people who are experiencing homelessness in community based health clinics. Gill (2000) was involved in developing and coordinating a health clinic for people experiencing homelessness that was staffed by nursing students. Similar to the conclusions of Martino Maze (2005), she found that reflexivity is crucial in developing relationships with persons experiencing homelessness, and incorporated this into the students' clinical experiences. Lafuente and Lane (1995) found that when clinic personnel had positive attitudes towards clients they were able to assist these individuals in meeting their psychosocial needs. Carter, Green, Green and Dufour (1994) describe a clinic for people experiencing homelessness in which the focus is on fostering accessibility through non-judgmental attitudes of

staff. To promote these positive attitudes the clinic administration developed and fostered an environment that encouraged casual conversation between clients and staff, which served a dual purpose of building relationships.

In a study outlining a nurse-managed clinic for homeless men, Gerberich (2000) suggested that to make the clinic health promoting, nurses must establish and maintain interpersonal connections with clients. Moneyham and Connor (1995) conducted a phenomenological study of pathways into and out of homelessness involving eight adult males who used substances. One of three components of the road out of homelessness was having caring relationships, which included relationships with care providers in their substance treatment programs. However, although highlighting the value of caregiving relationships is important, this finding is limited if the structural and policy context do not support these relationships. Even more striking is the work of McCabe, Macnee and Anderson (2001) that developed a tool of satisfaction with care for people who are experiencing homelessness. The five themes measured by the tool all address the issues of relationships and power: commitment, respect, trust, freedom from assumptions, and control. The results of these studies suggest that health promoting client-provider relationships are essential in engaging people experiencing homelessness in formal health care services. However, what continues to be missing is that although these relationships are purported to be health promoting, the formal and informal policy context in which they are enacted is rarely addressed.

In conclusion, homelessness is an experience that compromises one's health; there are barriers to people who are experiencing homelessness accessing formalized health care services, and one of these barriers may be the negative attitudes of health

care providers. Therefore, it can be argued from the existing literature that health promoting client-provider relationships are central to providing health care services to people experiencing homelessness. However, the majority of research in this area has been conducted focusing on enacting relationships without understanding the policy context in which the relationships occur. Policies can have an important impact in terms of framing the relationship, defining resource availability, organizing space, and creating a power base. Suggestions for providers to create a welcoming environment for people who are experiencing homelessness (Wen, Hudak & Hwang, 2007) that are not accompanied by a critical analysis of the policy context may in fact be setting up providers and clients for failure.

Therefore, in this study of relationships between people who are homeless and health providers, I explore: 1) How are client-provider relationships enacted within the culture of community care with people who are experiencing homelessness? and, 2) How do clinic-level and broader social and health policies shape relationships in this context?

Theoretical Perspective

This research study was undertaken from a critical theoretical perspective, influenced particularly by the writings of sociologist Anthony Giddens on power and the agency/structure dialectic (Giddens, 1984). According to Giddens, agency is the ability of individuals to act freely, unconstrained by external forces, whereas structure refers to the social institutions and norms that influence human relationships. An awareness of this dialectic assists the researcher in framing the behaviours of individuals within their social, political, and environmental contexts. Within a critical

theoretical perspective both epistemological relativism and absolutism are rejected and a moral stance is taken regarding inequality, meaning that the elimination of inequality is seen as inherently valuable. Likewise, it is understood that reality is socially and historically constructed through various social and political structures, and is constantly changing (Watzlawick, 1984). Therefore, to increase awareness, both individual experiences and social contexts are explored in order to understand both subjective experiences, and how these are shaped by structures of power. Not only is the subjective experience of research participants valued, but the researcher does not see her/his 'self' as objectively external to the social world being studied, but rather, as linked with research participants (Eakin, et al., 1996). Findings are intersubjective, rather than purely subjective or objective. Multiple bases of inequality are recognized, based on varying social locations such as class, age, gender, ethnicity and race (McMullin, 2010). Subsequently, in seeking to uncover power in this study, Giddens' (1973) pluralist conceptualization of power, namely that power arises from multiple social inequalities, was used. Rather than essentialising individuals on these bases of social inequality, it is understood that within group variances are often greater than between group variances (Duffy, 2001).

The goal of critical research is to create empowering spaces where people can empower themselves and be socialized to empowerment. This process includes encouraging researchers and participants to question dominant ideologies and taken-for-granted assumptions in order to make space for alternative voices to be heard (Eakin, et al., 1996). Although critical researchers are not the only researchers who seek to create positive social change, within the critical paradigm solely generating research

knowledge is insufficient; there must be a facilitation of change that seeks the elimination of oppression, defined by Giddens (1991) as “differential power, applied by one group to limit the life chances of another” (p. 212). According to Habermas (2001), this change may be achieved through the raising of awareness of false-consciousnesses and the uncovering of oppressive structures. Ultimately, the aim of critical research is social transformation through critical consciousness-raising, which helps make explicit and addresses power imbalances (Davidson, et al., 2006; Ford-Gilboe, Campbell & Berman, 1995).

Methodology

A critical ethnographic approach, as explicated by Thomas (1993; personal communication), was used for this investigation. Critical ethnography has its roots in conventional ethnography, learning from people in order to understand their culture (Roper & Shapira, 2000). However conventional ethnography is insufficient to shed light on issues of power and oppression (Holmes & Marcus, 2005). Critical ethnography takes the conventional methodology of ethnography and incorporates components of critical theory or critical social theory in order to critique culture (Thomas, 1993; Thomas, personal communication), and goes beyond local experience to situate participants in broader social narratives (Smith, 2005). Additionally, the historically static definition of culture is reworked to be “understood as a shifting, changing, relational process that is lived within and among groups and people, and therefore as deeply enmeshed in power relations and in economic, political and historical contexts” (Browne, 2005, pg. 63). It is assumed that culture can produce a false consciousness in which power and oppression become taken-for-granted

'realities'. In this way, critical ethnography goes beyond a description of the culture to action for change, by challenging the false consciousness and ideologies exposed through the research (Cook, 2005). Additionally, within critical ethnography it is understood that there is no single 'true' representation of a given culture, but rather multiple, valid perspectives (Angrosino, 2005). The ontological scope of critical ethnography is broader than that of conventional ethnography, which is limited to the location of study. Using critical ethnography as a methodology for this study was appropriate in that it focused on moving beyond a description of the culture to a critique of the agency/structure dialectic as represented in the formation and enactment of policy.

Methods

The study was conducted within a community health clinic for people experiencing homelessness. In keeping with the critical ethnographic methodology, diverse data collection methods were used in order to grasp a broad understanding of the culture of the clinic. Data collection involved multiple, concurrent and consecutive methods. As the focus on client-provider relationships within the culture was already identified and the unit of analysis was a small health clinic, the methods were reflective of a focused ethnography (Muecke, 1994).

The first of three methods was participant observation of care provided and the enactment of policies at the clinic. This observation was conducted for 103 hours, spanning three months (October-December, 2008). This timeframe corresponded with the study design of a focused ethnography (Knoblauch, 2005), and allowed opportunities to observe interactions at different times of the month. This is important

as both the purchase of clinic resources and the provision of social assistance income occur on a monthly basis, leading to an alteration of the clinic environment through the month. The purpose of this participant observation was to personally engage with the clients and providers, with a particular focus on relationships in this culture, for the purpose of collecting observation data. Though the focus of this study is client-provider relationships, peer relationships amongst clients and peer relationships amongst providers were also observed and documented in a private office as a component of the culture of the clinic. Observation was a key component of data collection as semi-structured interviews afforded only a limited understanding of relationships and the culture within which they occur; observation provided an opportunity to tap-into what is being left unsaid.

During participant observation I served as an active member researcher in the clinic (Adler & Adler, 1987). The physical set-up of the clinic includes a waiting area (see Figure 1) that simultaneously functions as a drop-in clinic. The health providers at the clinic take turns staffing this area, providing clients with essential needs such as toiletries and referrals to other services, but not seeing clients for individual appointments. I worked in this area of the clinic, helping to differentiate my role from that of being ‘the nurse on duty’ (the nurse who sees patients individually in the examination rooms), but still being involved in the services of the clinic. As I am already a known individual in the clinic as a staff member, to take a non-participatory role would have been dishonest and confusing. Active strategies, such as posting notices around the health clinic and handing out small information cards about the study, were used in order to maximize client awareness of my dual roles of researcher

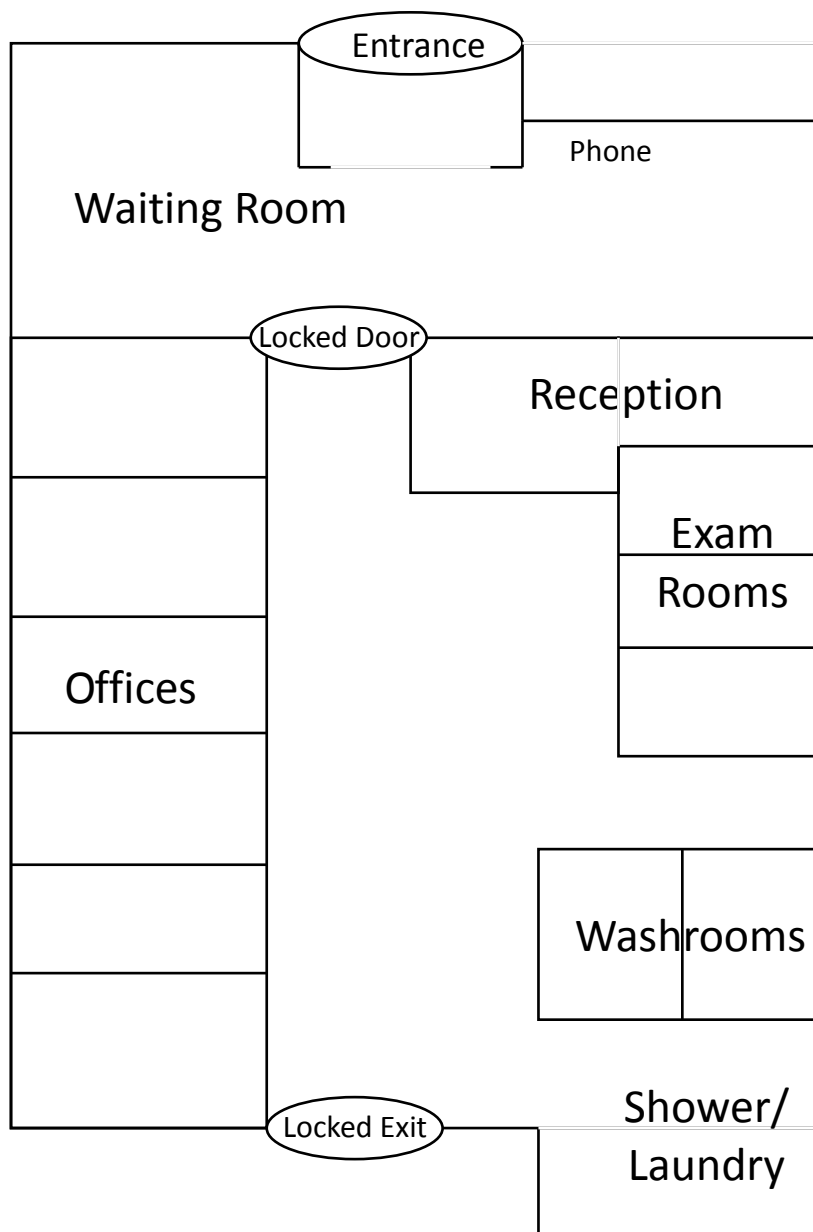


Figure 1: Health Clinic Configuration

and waiting room staff member, and to inform people that I was conducting participant observation.

Participant observation was also conducted in examination rooms or offices where providers met with clients, while they were meeting with clients. In all, seven

client-provider dyads were observed in this manner, with three providers being unavailable due to holidays and one being away on long-term disability at this point. Dyads were randomly selected by requesting of providers to observe their next interaction at times when the clinic was quiet and other observations were limited. No providers refused the request, and consent was obtained from both the client and provider. These observational experiences allowed me to see more private interactions than were observable in the context of the waiting room area. Fieldnotes were recorded intermittently throughout the day in a private office ensuring that my observations were immediate but were recorded in an unobtrusive manner (Groenkjaer, 2002).

While conducting participant observation I made personal invitations for interviews based on observations and discussions that I felt required greater understanding. Additionally, I advertised for any individuals who were interested in participating. Both clients and providers had the opportunity to participate in these formal, solicited interviews (Hammersley & Atkinson, 1995). A semi-structured guide was used for the interviews to ensure that all research questions were covered sufficiently; however, this was balanced by a dialogical interview technique (McLeod, 1999). This involved a balance of both leading the interview through asking open-ended questions, and following the lead of participants by following up on issues of concern. Client participants were offered the option of group rather than individual interviews (McLafferty, 2004) to enhance comfort if necessary. Lastly, demographic information was collected dialogically within the interview rather than through the use of a questionnaire so that I could iteratively determine what was meaningful to know and avoid collecting unnecessary data (Morse, 2008).

In all, 11 clients were interviewed within 10 interviews (2 chose to be co-interviewed), and 10 providers were interviewed within 12 interviews (2 providers were involved in second interviews to develop further knowledge). The 10 providers represented a total population sample of the providers who worked in the clinic at that time: one physician, three nurses, one nurse practitioner, two social workers, one community worker, and two administrative staff. The sample size was flexible, but was broad enough to elicit a variety of experiences that shed light on the culture of the clinic, without producing an unnecessary and unmanageable amount of qualitative data (Sandelowski, 1995). Interviews were completed when no further participants self-identified, and when the researcher collecting data felt that the nuances of relationships in this cultural context had been well observed. Inclusion criteria for interviews for clients were: 1) being over the age of 24 years, which is the criteria used to define 'youth' at other agencies in the community; 2) self-identifying as being homeless (defined as absolute homelessness or at risk of homelessness; 3) speaking and understanding English; 4) being a current client at the clinic, and 5) willing to participate. Only adult clients were selected, as the experiences of homeless youth tend to be quite different from homeless adults, and homeless youth self-identify as a unique culture (Rew, 2008). Inclusion criteria for interviews for providers were: 1) being currently employed in the Health Outreach Project for Homeless Persons at the CHC in question, 2) having personal contact with people who are homeless, and 3) being willing to participate. Client participants were provided with a \$5 cash gift as a small token of appreciation for their time.

Ethics approval for the study was obtained from the university with which I was affiliated, and informal approval was granted by the clinic in which participants were recruited. As well, a letter of information was provided and informed consent was obtained from participants prior to in-depth interviews and exam room participant observations.

Data analysis of clinic policies, fieldnotes from the two methods of participant observation, and transcripts from interviews were reflective of Lather's (2007) criteria for rigour in poststructural research. With the permission of participants, all individual and group interviews were audio-taped. These audio-taped data were transcribed verbatim by a research assistant, and the transcripts were read while simultaneously listening to the interview to ensure that the subtle nuances of language were appropriately captured. These documents were then re-read while memos were recorded to capture initial thoughts and highlighted key passages. I next constructed multiple typologies of the clients and providers in an attempt to explore the diversity of relationships and perspectives. These initial discourses represented the extreme ends of what came to be conceptualized as continuums of the ways that clients and providers characterize each other. I next re-read the transcripts, making note of text that unsettled me and that challenged norms and authority, (Berger, 1995) and created a preliminary coding scheme. The coded transcripts were then entered into NVIVO and coded electronically.

Throughout data collection and analysis, Lather's (2007) four framings of validity were used to enhance the quality of the study. Consistent with a critical perspective, the first framing is validity as simulacra, or the recognition that in re-

presenting data we are not describing an objective reality. That is, the findings are not a description of something that truly exist, but one representation of multiple realities. Interviewing both clients and providers and intentionally dialoguing with those who held diverse opinions on how care should be enacted in the clinic served as a reminder throughout the study that there was no one correct understanding of the relationships being studied. Lather's second framing of validity is paralogy, which represents a rejection of the need to reach consensus and an acceptance of contradiction. In the findings, contradictions have been allowed to remain and meaning is sought in divergent perspectives rather than in bringing these perspectives together. Her third framing of validity is rhizomatic validity, or understanding the in creating constructs to understand findings we must be attuned to the intersectionality of these constructs. Thus, in the findings the agency-structure dialectic, or the balance between one's personal power to act and the systems that constrain or enable action, is explored. Lastly, Lather speaks to voluptuous validity, or the importance of pushing beyond rigid boundaries and in a way tempting the reader to react to your findings. This served as an impetus to engage the difficult issues of power and disempowerment, and to struggle with the potentially uncomfortable engagement of clients and providers labeling each other as 'bad' or 'good'.

Findings

The research methods afforded a unique opportunity to hear how clients speak to other clients regarding their relationships with providers, and how providers speak to each other about relationships with clients. Within the clinic, relationships vary as much as the personalities of clients and providers. Not only do relationships vary from

client to client and provider to provider, but they vary from day to day and circumstance to circumstance. In speaking of each other, both clients and providers tend to dichotomize and essentialize, characterizing each other as either 'good' or 'bad'. If pressed, clients or providers would reject these simplistic essentializations, however, this is the exact terminology most frequently used. These characterizations take somewhat different forms and serve different purposes for clients than for providers, and reflect differing social locations of clients and providers. Clients tend to characterize providers based on how caring the provider is perceived to be; these judgments tend to be more fluid from day to day, and there is frequent disagreement amongst clients over what constitutes caring. Providers tend to characterize clients based on how they conform with expected behavioural norms; these judgments tend not to be amenable to change, and conversations between providers serve to promote agreement amongst providers over which clients are 'good' and which are 'bad'. How clients and providers characterize each other, the agency-structure dialectic, the importance of basic necessities, and role of system level policies will be explored in-depth.

How clients characterize providers. It must be emphasized that no provider, or client, is truly 'good' or truly 'bad', but simply that in discussing their relationships with providers, clients tend to characterize providers as such in various terms. As well, there is no agreement amongst clients regarding their characterizations of providers, and changing circumstances can quickly change impressions. Overall, providers are characterized as 'good' if they are perceived as truly caring for the client, being respectful, and actively seeking ways to lessen the power differential between

themselves and clients. In this way, clients tend to conceptualize provider practice as a matter of personal agency, and little is said about the impact of structures on provider practice. Many clients are estranged from their families, and providers at times are viewed as ‘surrogate’ family. One client said:

Because I felt like nobody cared but then I come to [this city], and I hit this place and I felt like you guys all cared about me. And I felt like we were family. Yah. Yah it did, it felt like a family.

Providers are seen as ‘good’ when they make decisions collaboratively with clients rather than forcing their own ‘professional’ opinion. Clients see respect demonstrated when providers are flexible with clinic policies, at times breaking rules in order to meet immediate needs. One client reflected:

Remember the methadone thing, oh that fucked me right up...like I can tell you stories about the staff here that I’m not supposed to tell, you know. How [name removed] helped me out when I was hooked on morphine. Man, those were the things.... That’s really stretching it...taking me out to lunch and stuff like that.... You don’t find that in a lot of places, you know. She saved my life, my soul sometimes.

Providers are seen as ‘good’ when they actively seek to lessen power differentials between themselves and clients by doing such things as being actively involved in the local community, being observed outside of the workplace as a neighbour. This involves focusing more on solidarity with clients versus being the professional expert, while also not pretending that clients and providers are friends on an equal social level. Clients tend to dichotomize between providers that ‘get it’ or

don't 'get it', referring to an understanding of the experience of homelessness, so providers are 'good' when they are perceived as focusing on systemic inequalities versus individual behaviours. The provider who clients say "gets it" provides relational care while understanding that homelessness is grounded in system inequalities rather than individual weaknesses. During the study, providers demonstrated their care for clients by holding clients in high regard:

The people that I serve are remarkable individuals. They blow me away everyday in terms of their will to have hope for themselves...they're yearning for dignity and yearning for change in spite of tremendous obstacles.

Interestingly, the same characteristics that were identified in providers being perceived as 'good' by clients, become sources of contention amongst providers. For example, providers' beliefs on managing limited resources in the context of great need come into conflict. Breaking the rules to meet the immediate needs of a client is perceived by some providers as being a victim of client manipulation. Bending or breaking rules becomes a major point of contention in the power struggle between some staff and management. The manager stated:

[Providers] go to any lengths to [help people], and that's including breaking policy and because it's always the thought of, oh just this one time you know. And the problem is there are grey areas you know, there just are, especially with the population that we deal with, there is no black and white. So it's very difficult to create a policy that fits every single [client]. The problem is, when you find a client that doesn't quite fit the policy, so you try to mould the policy to fit the situations, then it opens up to the next one that comes in and it kind of

broadens and broadens and broadens until finally, there's really no point in even having the policy anymore.

These hierarchical power struggles amongst providers were heightened by feelings of those who resisted management being more closely aligned with the needs of clients.

Providers are often characterized by clients as 'bad' when they enforce clinic policies, and do so consistently. A provider is also seen as 'bad' if they react negatively to clients as one client describes:

I know we have personality clashes and we definitely, [provider] and I don't get along but under circumstances one is supposed to be the professional and if I had been treated by a professional, which she is supposed to be, then I would treat her in such a manner but she seems to, because we have this clash, put me on the bottom of the list, make me wait longer.

This quotation reflects an obvious use of power, but more subtly at times when providers are more cautious of clients whom they perceive as being deceitful and question their requests rather than taking them at face-value. Again, the focus of clients here is on the personal agency of the provider, versus questioning the informal clinic policies of resource management that the providers are enacting/enforcing. Clients, for the most part, do not appreciate being denied requests and at times personalize this denial as a lack of personal care. However, this personalization of denial creates a tension amongst providers as some of them, particularly the reception and nursing staff, serve as gate-keepers to other professionals in the clinic and therefore have to deny requests more frequently than others. Providers sense that denying requests impacts how clients perceive them, and are frustrated by this.

As will be further highlighted in exploring the characterizations of clients, there is variety in how providers perceive their role, with some tending to focus on altering client behaviours and controlling the use of limited clinic resources. When functioning in this manner, providers were seen by clients as being judgmental and therefore uncaring. One negative interaction between a client and a provider can greatly impact how clients perceive the clinic as a whole. As one client stated:

There are a lot of people out there that will not come [into the clinic] because they're already pre-judged.... I mean, I don't know what the other people that walk through the front door think except for the people that walk, that don't walk through the front door anymore, who've been discouraged. These are good friends of mine who won't walk through that front door anymore.

How providers characterize clients. Similar to client perceptions, providers tend to characterize clients as either 'bad' or 'good', dichotomizing and essentializing them. However, for providers these characterizations are less benign, and actually serve a disciplinary function in terms of controlling client behaviours. There also tends to be more agreement amongst providers than clients regarding who is 'good' and who is 'bad', with formal and informal client discussions serving to enhance agreement. Here, the judgment of 'good' or 'bad' again focuses on personal agency, and has much to do with behaviours that providers have observed and how closely clients conform with expected social norms. However, if clients have been coming to the clinic for many years and have well established relationships with providers, some of this focus on personal agency and behaviours can be negated, likely because of the personal context providers then have to understand behaviours they are observing.

An important component of being deemed a 'good' client is how much the client is willing to share personal stories, being open and honest about past traumas, diagnoses, and substance use if applicable. That is, one of the factors in establishing trust is mutual self-disclosure (Gantert, McWilliam, Ward-Griffin & Allen, 2009), although the client is expected to disclose much more than the provider. This is an experience of vulnerability for the client, to expose themselves to providers, but this creates a personal touch and exposes structures of oppression in clients' lives that helps providers in framing the context of behaviours deemed to be difficult. A client is 'good' when they are obedient in following both the clinic rules and complying with prescribed treatment regimens if receiving health care services:

Like if they are showing more respect and if they have been so compliant with rules and regulations and policy and things like that in the past, then we are more likely to help them out and get them that supply they need.

Clients are characterized as 'good' when they are passive, are not involved in verbal or physical altercations in the clinic, and even intervene with other clients to de-escalate tense situations:

I mean this, this may be obvious but it's easier to relate to a client when they are in...less of a state of crisis and harder to relate to a client when they are in a state of crisis.

Clients are characterized as good when they do not object to observed inconsistencies in the enforcement of clinic policies. As well, clients are good when they don't request too many clinic resources, whether this be personal supplies, or services of providers.

Lastly, clients are deemed ‘good’ when they are sober, they abstain from substance use and they behave in a manner consistent with expected social norms.

Conversely, clients are characterized as ‘bad’ if they demonstrate the potential for violence and are seen as a safety risk to providers and other clients. In the clinic, violence is often unpredictable and often related to a state of intoxication from substance use. Therefore, clients who use substances are more likely to be deemed as ‘bad’ clients. Similar to other studies looking at how care often hinges on compliance (Breeze & Repper, 1998; Henderson, 2003), clients are seen as ‘bad’ when they are perceived as being manipulative, seeking to utilize as many clinic resources as possible, even if they do not meet the clinic qualifications and are not perceived by providers as being truly in need:

What’s this client’s history, have they had a history of abusing their privileges at the clinic? Or if there’s somebody who’s maybe prone to fabricating their situation, and saying that they need things that they might not necessarily. Clients are ‘bad’ if they lie, they ask multiple providers the same question, or they “mooch” repeatedly until they have their needs met:

And if that person has been very rude and very disrespectful throughout the course of the day, prior to asking for something, that’s going to have a lot to do with [whether we give them supplies or not].

This quote highlights an overt (ab)use of power in how the provider is using personal offense to frame a client as deserving or undeserving, rather than following policies on distributing resources. Interestingly, other research has suggested that perceptions of clients have more to do with the expectations of providers, and it is when unspoken

expectations go unfulfilled that providers become hardened towards clients (Wilson, 2009). Visual cues are also important, and clients characterized as ‘bad’ are often intimidating in terms of their look and their physique. This demonstrates how unconsciously fear and concerns for safety can predispose providers to relate to clients in a certain way. This is likely based on the wisdom of past experiences, but can also lead to harmful stereotyping. As well, clients are ‘bad’ when they are rude to providers, make demands, do not say “please” or “thank you”, or display a sense of entitlement:

I find individuals that um, feel that they have a right to treat you and others as, not really a slave but not really with much respect either and more of, you’re there to serve them and...there’s no real respect in the way, there’s no ‘please’, there’s no ‘thank you’, that would be the client that I tend to have to breathe in through the nose, out through the mouth sort of thing.

This quote also illustrates how providers are set-up as givers, whereas clients acquire the role of takers. Interestingly, the term ‘client’ is used in the health clinic instead of ‘patient’ to remind providers that they owe a service to the clients and are paid by the public purse to do so.

The agency/structure dialectic. The above characterizations shed light on some of the personal and interactional factors that influence the client-provider relationship in this context. Similar to the articles discussed in the review of the literature (Hatton, Kleffel, Bennett & Nancy Gaffrey, 2001; Minick, et al., 1998), much of the focus in team meetings or provider interviews on improving interactions between clients and providers is on the agency of providers. That is, providers consider each other as just needing more experience, more empathy, or a better theoretical

understanding of vulnerable persons to avoid interpersonal difficulties. Yet this perspective neglects the role of formal and informal policies that structure client-provider relationships. For example, providers often find the position of having to manage resources and behaviours while demonstrating care and concern more or less untenable. Although providers demonstrate a relational focus through their conceptualizations of clients they cannot readily neglect their role of managing scarce resources, explicitly disciplining clients who break rules, or implicitly disciplining behaviour through rewarding conformity to social norms. This further reinforces critical theoretical assertions that personal agency must always be considered in light of the structures that enhance or impair one's ability to act as desired.

Within the agency/structure dialectic, the role of structures in shaping client-provider relationships often remains hidden. Within the clinic, the primary structures of interest are informal, enacted clinic policies and broader system-level social and health policies, which serve to enhance or impair a relational focus of practice. In this context, informal policies are most often rules and procedures that are verbally constructed within the team. These informal policies are continuously adopted and adapted in an attempt to enact what is assumed to be a shared consciousness amongst providers. The process of informal policy making occurs explicitly as part of weekly staff meetings at which all providers are expected to be present, but also implicitly in the practice of providers. In the weekly meetings concerns are raised and discussed, which most often involves debating current policies and practices. Unfortunately, as explored below, the providers expressed during participant observation and within interviews that this process has limitations in terms of creating consistency, a shared

value of both clients and providers. Part of the problem identified is that power imbalances are felt amongst providers, and some feel that the process is undemocratic:

So I don't feel like we as a team develop [policies] anymore.... When I started here...I felt like we developed policies together, but personally I don't think we do anymore.

Because there is no true buy-in to all policies from all providers, policies that are formed in meetings are not necessarily implemented:

...then when a situation happens again, nobody, everybody kind of says, 'Oh I don't remember what we discussed so I'm just gonna do it the way we always did it before,' and other people are saying, 'Well no, it was definitely this way.'

Rather than what is decided upon in the team meetings, the policies that tend to be consistently carried through are those that evolve informally through day-to-day practice. Clients and providers recognize that providers interpret and enact policies differently. One client stated:

And I was turned away for food and I went to [Provider 1]. And I said, '[Provider 1] I don't want to lie to you I've already spoken to another staff member who told me 'no', so I don't want you to think I'm going behind [Provider 2]'s back and talking to you but here's my situation.' And [Provider 1] sent us home with microwavable soup to eat.

While consistency was often expressed as the ideal within team meetings and by clients, providers and clients identified that flexibility is important when working in the clinic, using one's experiential knowledge to treat individuals according to individual needs.

This represents competing discourses of fairness and consistency, and client-centred care.

Structures and personal agency function dialectically, with structures never completely ruling out the role of personal agency (and vice versa). This can be seen in how some providers actively resist certain policies. As one provider stated:

And no matter what, if you make the system too tense or too tight, people will find a way around it. And we talk about clients finding a way around it, staff are just as good.

Finding that informal clinic policies can impair their ability to engage in relationships that promote health as they see fit, some providers resist these policies in relationship with clients by trying to make decisions without the involvement of management,

When we do our brainstorming, when it's just the staff, we get a lot more accomplished and there's a lot less of, you can't do that or why would you even think of doing that sort of thing...we find that we get so much more done when there's not management around.

However, while differing implementation of policy in practice is done for the purpose of improving relationships and meeting the requests of clients, these differences may at times negatively impact upon client-provider relationships. That is, when a provider bends the rules they are seen by clients as being more understanding and more caring, but those providers who do not bend the rules are then seen as not "getting it". Clients, in relationship with providers, similarly actively resist policies that they deem in the moment to be barriers to their needs. Clients express frustration that at times they feel forced to bend the truth in order to attend to a basic need such as hunger or

transportation. Clients expressed in the focus group that differing social locations from providers, in particular race, gender, and particular health concerns, such as having a difficulty with substance use, impact on whether they *work with* or *work around* providers. For example, one client experiencing a substance addiction spoke of the desperation of needing more substance, of trying to get bus tickets to help meet this need, and of feeling forced to disguise this as something else.

The provision of basic necessities. During data collection, much of the discussion on informal policy formation and enactment was centred around the management and provision of basic necessities. With a mandate to promote health reflective of the social determinants of health rather than just medical care, the clinic makes resources available to clients that address some of these determinants. This includes emergency food, water, clothing, toiletries, bus tickets, shoes and socks. Although policies are subject to change, the general rule is that all providers, including receptionists, health professionals and social workers, are involved in the provision of basic necessities to clients. According to clinic policies, clients are to register with reception to make a request for resources, but during participant observation it was seen that requests are also made directly to nurses and social workers. At times clients were then directed back to reception, at other times providers took these requests directly.

Many policy changes were made or negotiated around the provision of basic necessities during the three months of participant observation, and all were related to managing scarce resources. These include policies to directly limit resources, such as only providing a pre-packaged bag of food or limiting the provision of bus tickets to appointments booked through the clinic. These also include policies to track resource

usage in order to make a case to enhance resource availability, such as having social workers provide all clothing and charting this, or having all providers chart food distribution. Lastly, policies were put in place to limit use of resources by any one client that is seen by providers as excessive, particularly in recording the names of those who receive resources and challenging what is seen as excess requests. Notably, providers disagree at times with each other about how to conceptualize 'excessive requests' in the context of absolute poverty, though mostly they deferred to the opinion of the receptionists, who heard requests most often. As resource availability fluctuates throughout the budgetary month and budgetary year, so do the policies and the implementation of these.

Both clients and providers expressed that the provision of the basic necessities of life is the primary means by which providers demonstrate care. This coincides with other research that has looked at the importance of the provision of resources in decreasing social distance (Malone, 2003; Peter & Liaschenko, 2004). When resources are plentiful, policies are relaxed and providers are able to better meet the basic needs of clients. When resources are limited, policies are created or enacted to limit the provision of resources to only those deemed most deserving or most in need. As seen in the findings, the provision or withholding of resources is one of the most overt ways that the power differential between providers and clients is enacted, and has a large impact on whether providers are characterized as 'good' or 'bad'. However, similar to other work on providing charitable resources (Tarasuk & Eakin, 2003), having to refuse requests of clients due to a lack of available resources is a very painful experience for providers. As well, if access to basic necessities is limited, to gain access to these some

clients will display the kind of manipulative behaviours that leads providers to deem them as ‘bad’, creating a vicious cycle. Although there are other factors at play, in general, when resources are more available to providers, relationships tend to be less conflictual; when resources are limited, relationships tend to be more conflictual. Additionally, in the same way that an increase in resources leads to a relaxation in policy, the tightening of policy can lead to an increase in resources available.

System-level social and health policy. Thus far, only local policies have been considered, those formal and informal policies that were unique to the clinic. Building on the consideration of structures, and recognizing that clinic policy, resource management, and relational practice do not occur in a vacuum, it is important to also consider the impact of broader system-level policies. Budgetary decisions are made within the clinic, but the dollar-value of the budget is determined by the regional board, known in Ontario, Canada as the Local Health Integration Networks (LHINs). The LHIN is responsible for determining how the provincial healthcare monies are divided amongst the organizations within the region. Providers spoke to the reality that the clinic must compete with other organizations in their region for funding, necessitating the demonstration of positive health outcomes. The challenge arises in what is considered as health outcomes, and how these are measured. In the current political context, medical care is privileged over care that supports the social determinants of health, so services such as the provision of food and clothing are given lesser value in budgets. These services also produce less immediate, measureable results, although being essential for the health and well-being of clients over time. Therefore, budgetary

restrictions to the provision of resources, which lead to client-provider relationships being more distal, originate with system-level health and social policies.

Discussion

The primary limitation in this study is how data collection was conducted, with clients being interviewed separately from providers, and focus groups also separating clients and providers. By hearing the perspectives of clients and providers separately, there is a risk of highlighting differences in perspectives over similarities, as was evidenced in initial drafts of the findings. However, these differences have been somewhat tempered by the use of multiple sources of data collection, such as participant observation of client-provider interactions, and by discussing client and provider findings in focus groups.

The competing demands of providing care while simultaneously policing resources and behaviours puts providers in an untenable bind. These functions counteract each other to some extent, so that a focus on one of these functions, such as policing resources, is often at a loss of the other, such as providing relational care. Additionally, many providers choose this area of practice because of their passion for working with people experiencing homelessness, and are then thrust into a position of enacting behavioural control. Clients are in a bind as well where they are trying to meet both basic needs and needs for social support and caring human connections, but find themselves working around rather than working with providers at times.

We must be careful not to downplay the provision of the basic necessities of life, which serves as both an 'icebreaker' in the relationship and a tangible demonstration of caring for clients (Malone, 2003). People who are experiencing homelessness are often

disadvantaged across the social determinants of health (Daiski, 2007), and have an urgent need for these necessities. However, access to these resources in the clinic is limited, as there are finite budgets for things like food and bus tickets. Therefore, providers must also police the resources that they know are important for clients, placing them in a bind between honouring their clients and managing resources. In this way, rather than a collaboration among clients, providers and management, providers often find themselves working as a buffer between the financial imperatives of management, representative of broader systemic values, and the immediate needs of clients.

In seeking to address the gaps in knowledge around power relations and policy in the provision of health care with people experiencing homelessness, I conclude that the providers are serving as the humane face to an inhumane system. That is, poverty is a systemic issue, and the clients served in the clinic represent those who suffer most from the systemic oppression inherent in the current Canadian social and economic system. Providers play a role that meets the needs of the system in that they form meaningful relationships with clients and provide the basic necessities, enough so that the necessity of reforming the system is hidden. Clients, often seen as service recipients rather than participants in their care, are kept comfortable enough that they do not demand change in the broader structures. Similarly, the problems of the system are actually reframed as personal problems, so that rather than identifying structural reform in the form of policy changes, the personal agency of clients is seen as flawed.

It is possible that only broader structural change can solve the challenges to client-provider relationships in the clinic. For example, even if budgetary lines for the

necessities of daily living were increased ten-fold, there would still not be enough to meet the needs of all. If one city greatly enhanced its services for people who are experiencing homelessness, there would simply be a migration of more homeless people to that city. Additionally, health and social agencies are individually affected by the constant shifts in governmental philosophies, trickling down from the national to the municipal level (Boutilier, Badgley, Poland & Tobin, 2001). Change must come from the highest level, being national, or even international, if it is to be permanent and truly effective. Until broader structural change comes, in the form of refining health and social policies, clients and providers simply vacillate between conforming and resisting, and live in an untenable position knowing that they cannot adequately meet their own needs or the needs of those they serve. This call to structural change fits with the current discussion of health promotion as both being a relational process, and a process of engaging in creating healthier systems (Raphael, 2008). Unfortunately, in this study, some providers responded to this challenge by distancing themselves from clients so as to make the failure to meet client needs less painful.

What then can we recommend to the clinic? Preliminary findings were taken back to the providers in two focus groups, and their input was sought for refining the findings and for recommendations for the future. A primary recommendation that was put forward was that providers should find a better way to go about saying ‘no’ to client requests for basic necessities when resources were low or if clients did not meet the criteria. This was seen as a solution to some of the inconsistencies in policy implementation, thus addressing some of the labeling of providers as ‘bad’, by being more humane in refusing demands. However, I would suggest that this would only

continue the cycle and maintain providers in the bind of providing and policing, as resources will continue to be inadequate to meet the needs. Rather than finding more effective ways to defray requests of clients, broader change might be precipitated by clients and providers working together to identify structural constraints they function within. In this way, it is possible that clients and providers may develop an increased understanding of systemic limitations on meeting needs around the social determinants of health, and partner to work for broader systemic change; this partnership is a health promoting relationship. And, as suggested above, until all Canadians have access to basic shelter, food and clothing, the work of health care providers serving people who are experiencing homelessness can never be enough.

Although generalizability is not a necessary outcome in critical research, these results are relevant to most health clinics that serve people who are experiencing homelessness and that fall within the same systemic constraints. The delicate balance in providing care and policing resources, and the role of being a humane face of an inhumane system is something experienced by providers and clients in this sector across the country, and likely in most developed nations. What is most important for clients and providers is that they do not lose sight of the role that broader structures have in influencing the relationships they have with each other. Once this perspective is lost, clients and providers tend to look for flaws in themselves or each other to explain limitations of care. This also serves to remind providers that in their role of being promoters of health, they have a responsibility to be involved in advocating with clients for broader policy and structural change. Lastly, further thought needs to be given to making space for homeless persons to be involved in meaningful ways in directing their

care. In the words of an Australian aboriginal woman, “If you are here to help me, then you are wasting your time. But if you come because your liberation is bound up in mine, then let us begin” (Valverde, 1991, p. 4). Poland and Holmes (2009) speak to reconceptualizing the work of health care professions from ‘helping’ the other to ‘solidarity’ with the other. Until there is drastic change at both a local and systemic level, the number of individuals finding themselves homeless and accessing care at such clinics will continue to increase, and resources will be stretched thinner and thinner.

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Chapter 6: Promoting Health with People who are Experiencing Homelessness

In this chapter I present the conclusions from a dissertation study that explored client-provider relationships in community-based health care with people experiencing homelessness. This study addressed two main areas: uncovering power in the relationships, and the relational navigation of space and place. For power in relationships, the following research questions were posed: 1) How are client-provider relationships enacted within the culture of community care with people who are experiencing homelessness? and, 2) How do clinic-level and broader social and health policies shape relationships in this context? For the navigation of space and place, the following research question was addressed: How is ‘place’ experienced by clients and providers within a community health clinic for people who are experiencing homelessness? In this chapter I focus on conclusions, opening with a brief description of the study background, the pertinent literature, the methodology and methods, and a summary of the findings.

Homelessness, herein defined as both those who are absolutely homeless and those in other living situations that do not include renting or owning a residence, such as ‘couch-surfing’, is bad for one’s health. Not only do people who are experiencing homelessness have significantly higher morbidity and mortality rates than the general population (Daiski, 2007), but they also face many barriers to health care (Gray, Moulton, Frankish, & Ratzlaff, 2009). The primary barrier to care is negative attitudes of health professionals (Ensign & Panke, 2002; Lester & Bradley, 2001; Nickasch, 2009). Studies have shown that people who are experiencing homelessness often have unmet health care needs (Hwang, 2010), which is predicted in cases of housing

instability (Kushel, Gupta, Gee & Haas, 2006). These needs are unlikely to be met in a formal health care system when people experiencing homelessness face prejudice (Bhui, Shanahan, & Harding, 2006), discrimination (Baumann, 1993), and dehumanization (Lafuente, 2003). Although researchers have begun to address the issues of client-provider relationships in health care with people experiencing homelessness, some gaps remaining in the literature are outlined next.

Review of the Literature

Literature with relevance to improving relationships with people who are experiencing homelessness includes that which addresses the basics of health care relationships (Hudson, Nyamathi, & Sweat, 2008; McCabe, MacNee, & Anderson, 2001; Walsh, Rutherford, Sarafincian, Sellmer, 2010). One key piece that has been identified in this care context is the importance of providing basic necessities as a first step in the relationship (Christensen, 2009; Cohen, 1989). Negative attitudes as a barrier to relationships have been addressed at an educational level, based mostly on the contact hypothesis that stigma towards homeless people can be decreased through increased contact (Aberson & McVean, 2008; Lee, Farrell, & Link, 2004; Ugarriza & Fallon, 1994). Clinical placements that expose health care providers students to people experiencing homelessness have been found to have a positive effect on attitudes towards people who are experiencing homelessness (Buchanan, Rohr, Stevak, & Sai, 2007; de la Cruz, Brehm, & Harris, 2004; Minick, Kee, Borkat, Cain, & Oparah-Iwobi, 1998; Rose, Lyons, Swenson Miller, & Cornman-Levy, 2003; Zrinyi & Balogh, 2004).

Reflecting on attitudes is useful to practitioners, but may be of limited use if the concept of power is neglected from these reflections. This focus on power is growing

within health care research as power has been an important part of the ongoing move towards client-centredness. There is a growing recognition that health care is inherently based in relations of control (Cutcliffe & Happell, 2009), and that health providers need to move away from ordering and enforcing health behaviour changes, to working relationally with clients to meet their needs together (Marnocha, 2009). Addressing power is important, because even when power is well conceptualized, it doesn't necessarily mean that health care providers are willing to confront power differentials (Henderson, 2003). To address power in the health care relationship, Cleary (2003) suggests proactively demonstrating respect, providing information, and relating on a personal level. However, it should be noted that these techniques can as easily be used coercively and to secure compliance, as for creating spaces with clients where they can empower themselves. For example, Holmes, Perron, and Savoie (2006) offered a more nuanced exploration of power in client-provider relationships, looking at how nurses influence decision-making around dialysis in end-stage renal disease. Holmes and colleagues speak to the Foucaultian concept of pastoral power, or how nurses guide client self-regulation by formulating the desires of the client who then sees them as their own. In this way client autonomy becomes almost tokenistic, as their subjectivity has been formed by the nurse in how information is presented and explored.

Although some work has been done on power in health care relationships, this work is often limited in terms of also addressing the impact of the policy context on these relationships. As well, this issue of power has not been widely explored within the context of health care with people who are experiencing homelessness. In addition to gaps around power, health care relationships with people experiencing homelessness

have rarely been considered in the context of the space and place in which they are enacted. Taking health promotion to mean having increased control over one's health and the social determinants of health (WHO, 2005), physical spaces themselves can be more or less health promoting depending on the meanings attributed to them by clients and providers. Therefore, two specific gaps are identified in the literature around health care relationships with people who are experiencing homelessness. Firstly, there is limited research on both power and the role of policies on the enactment of client-provider relationships in this context. The role of policies is addressed in this study with a focus on the organizational culture in which health care is provided, as the policies that govern relational practices in health care are culturally created, enacted and resisted. Secondly, the dialectical relationship between space/place and social relations remains unexplored, space being physical structures and place being the meaning ascribed to these structures. To address these gaps, this study focused on two main areas: power in the relationships, and the relational navigation of space and place.

Theoretical and Methodological Perspectives

Situated within a critical theoretical perspective, in this study power is seen as a force that can be used positively and negatively (Foucault, 1977), and that arises from multiple social inequalities (Giddens, 1973), including but not limited to the assignment of the power of knowledge, position, and decision-making to professionals. Critical research has been seen as a means to facilitating positive change (Eakin et al., 1996) in part through the raising of critical consciousness (Habermas, 2001). Building on traditions of social justice, researchers in this paradigm are tasked with making space for alternative voices to be heard, in order to confront power structures that marginalize

certain individuals and populations. A critical ethnographic methodology is used, which fits with this paradigm of positive social change, but with a focus on culture, herein defined as both shared beliefs or values and “the lens through which we look at the world” (Poland, Lehoux, Holmes, & Andrews, 2005, p. 172).

The study was conducted at a health clinic for people experiencing homelessness in London, Ontario, a medium sized urban area in Canada. Data were collected using multiple qualitative methods of document analysis, participant observation, and in-depth interviews, and data analysis was enhanced with focus groups. Document analysis looked at written policies that addressed the client-provider relationship, of which few were found. Participant observation involved both general observation within the clinic over 3 months, as well as observation within examination rooms and offices. In-depth interviews involved 10 providers, representing the total provider population at the clinic, and 11 clients. Data analysis was guided by Lather’s (2007) conceptualization of validity, including being open to multiple realities, allowing contradictions to stand, and being willing to push the boundaries. Analysis was enhanced by separate focus groups with providers and clients when preliminary findings were brought forward and discussed. Ethics approval was obtained from the university at which the principal author (AO) was conducting his PhD studies (Appendix A), as well as approval from the health clinic.

Summary of Findings

Findings on the ways in which power relations manifested in client-provider relationships in health care with people experiencing homelessness include the ways in which both clients and providers tend to essentialize each other as “good” or “bad”.

Clients tended to characterize providers as “good” if they were willing to stretch the rules to help the client meet their perceived needs. Providers tended to characterize clients as “good” or “bad” depending on their compliance with formal and informal clinic policies, leading to conceptualizing certain clients as deserving or undeserving of assistance. That said, it must be recognized that there was much variation within both groups as to how these essentializations were made, or whether they were made at all. Similar to Tarasuk and Eakin’s (2003) study on managing scarce resources in food banks, much of how providers spoke of clients was about navigating informal policies of policing scarce resources. By informal policies, I refer to decisions that were made on a weekly basis in the clinic by providers on how to solve clinic management issues that were discussed, but never written into formal policy. The resources being policed were basic necessities that were given by providers to clients, such as toiletries, food, clothing, footwear, bus tickets, and other items. A power struggle was inevitable in this setting as the demand for these items was greater than the budget to provide them, so providers navigated meeting requests without running out of resources. Likewise, clients had urgent and immediate needs, and variously worked with or around providers to meet those needs. Although enacted on a very local level, this struggle was reflective of broader fiscal constraints on frontline services as well as system pressures to budget health care in a manner that demonstrates positive and immediate medical outcomes. Therefore, budgeting for something like bus tickets may actually be detrimental to the clinic if it takes away from something like influenza immunizations, which fit much better on metrics for determining health care effectiveness.

What was discovered about space and place in this study was very much consistent with general relational and resource struggles, but with a focus on how clients and providers sought to make place in a manner that met their needs. Clients very much asserted themselves in the clinic by finding ways to circumvent barriers and policies related to spaces. They made the place fit their needs by looking past ‘appropriate use policies’ and doing what they felt was appropriate. For example, although prohibited, drugs were used in washrooms, and people accessed washrooms by holding doors for each other rather than requesting access from providers. Conversely, providers attempted to manage behaviours and create a professional workplace that they termed as ‘safe’. This is similar to the findings of O’Byrne and Holmes (2007) that nursing assessment includes a process of defining risk, and subsequently managing behaviours to eliminate this perceived risk. That said, there was again much variation between and among clients and providers as some clients also actively sought to manage behaviours deemed inappropriate, and some providers assisted clients in circumventing physical barriers and policies. This contesting of space and place raises a major question of who makes decisions on the space. As place is the relationally-mediated meaning of space, it will always be intersubjectively created and recreated, and this may be more or less conflictual depending on how decision-making is or is not formalized. For example, if clients were involved in weekly clinic management meetings, informal policies may be more reflective of a diversity of needs, or may be more agreed upon and less contested. A key component of the contested nature of space was the narrative of ‘safety’, as it was used as a sort of ‘trump card’ by providers and management to justify top-down decision-making.

Study Implications

The findings have many implications for health and social care providers in terms of individual practice. As well, findings have implications in terms of how spaces in which health and social care occurs are configured and conceptualized, the policies that guide health and social care delivery, and overarching system policies.

Implications include specific examples from the findings, and focus first on individual practice, but it is important to note that this individual practice is conducted within the context of both local place and policies, and a health care system that is formed by politics, thus in some ways reflecting public will. Therefore, simply altering personal practices is only one strategy to address the challenges seen in this clinic, and as much or more effort needs to be put into structural changes that will facilitate health and social care providers practicing in the manner that they know is most health promoting. The implications discussed here include: (a) relationships with clients, (b) creating health promoting places, (c) refining local policies, and (d) refining system policies. However, it is important to note that these are inseparable, as relationships are a part of health promoting places, as supportive local policies are essential to creating health promoting places, and as local policies will be reflective of broader system policies.

Relationships with clients. The role of the provider in promoting the health of people who are experiencing homelessness is not a benign one. Too often the relationship has been considered as one where the provider must simply optimize the interaction with the client in order to engage them in the services that they are thought to require (Kelner, 2000). Rather, my findings demonstrate that although the provider does attempt to serve the needs of the client, they also serve the needs of the system,

limiting the use of resources and managing behaviours. In the context of the clinic, clients approached providers with many requests for assistance around basic necessities. At times clients were ‘gaming the system’ and were making requests that were framed by providers as deceptive, such as requesting a bus ticket to get to an appointment with a true intention of selling it. Although this is a behaviour that is common across the socio-economic spectrum, such as paying for services under-the-table or exploiting tax loopholes, and although clients were doing this in the context of meeting very basic needs, it was viewed harshly by staff. Adaptive responses by clients in a context to meet basic needs around an addiction, for example, were not considered appropriate health promoting requests. Similarly, behaviours that were considered deviant or risky were to be confronted, with punishments, including banning, being meted out with the intention of reforming behaviour. These are not benign interactions, and not only serve the needs of the providers, they also constitute a Foucauldian (1998) form of discipline, creating subjects that will ‘work well within’ (conform to) system needs and limitations. Although practising with the best of intentions of beneficence and in this context charity, providers are a part of this regulatory practice. Unfortunately, measuring the ethics of practice based on good intentions has limitations if unintended consequences are not also considered.

A critical perspective helps to push beyond work that highlights the importance of positive attitudes and respect in client-provider relationships with people who are experiencing homelessness (Buchanan, Rohr, Stevak, & Sai, 2007; de la Cruz, Brehm, & Harris, 2004; Minick, Kee, Borkat, Cain, & Oparah-Iwobi, 1998; Zrinyi & Balogh, 2004). Even when providers are highly skilled in demonstrating positive attitudes

towards people who are experiencing homelessness and engaging respectfully, they will be called upon to enforce clinic policies (Perron, Fluet, & Holmes, 2005) and limit the use of clinic resources. This is why any discussion of enhancing individual practice skills must coincide with addressing the local and system-level policies that frame this practice. That said, the appropriate response of the provider is not to surrender to the limitations of the policy context, but to be explicitly aware of the limitations, and find a way to work within them while simultaneously reforming them. In this setting, it serves the providers well to reflect upon their positioning within the system, and how conflict with clients is predetermined. Similarly, clients who understand the untenable position of providers as both care providers and ‘police’, are likely to respond differently to the denial of requests or the enforcement of rules. Providers in these contexts of working with people with multiple vulnerabilities often choose these workplace settings because of a deep rooted desire to help others (Gill, 2000), and will be disappointed or even burnt-out if they do not anticipate conflict with those they serve, and recognize it as having systemic components rather than simply being personal.

It was evident that some of the providers had built very positive rapport with clients in spite of structural limitations. One component of this positive rapport was having worked in the community for a number of years, having built long-standing relationships with the clients. More importantly, some of the providers were involved in the community beyond their role in the health clinic, and were recognized as a part of the broader community. This meant being active in various committees and agencies outside of the clinic, which often included working collaboratively with clinic clients. On a philosophical level, most providers practiced from a harm reduction based model,

focusing on meeting the clients where they were at, being non-punitive, and seeking to reduce harm rather than ‘fix’ people (Marlatt, 2002). Some providers were able to enforce clinic policies without damaging their relationships with clients. This is not to suggest that all providers who work with people experiencing homelessness must move into the neighbourhoods where they work, but it highlights that there is more to health promoting relationships, where power differentials are compressed, than just being non-judgmental and demonstrating respect. Positive relationships reflected what Poland and Holmes (2009) refer to as a shift from a root metaphor of ‘helping’ to one of solidarity. Solidarity, from the perspective of the provider, is demonstrating concern for clients beyond the need to earn a pay cheque, but having a vested interest in the community as a whole. For health professions, solidarity means shifting from thinking of ‘helping’ others where it is considered that the provider has what the client lacks, to thinking of co-learning with and working alongside others. Solidarity in the context of this study might involve being a partner with clients on a community action group or community coalition. This is where political action, discussed shortly, and excellence in clinical practice can come together.

The other important piece to note in a discussion of relating to clients is that much of the literature to date has framed the relationship as being largely or solely the responsibility of the provider (Kelner, 2000). That is, it has been suggested that the provider must: foster trust, demonstrate respect, be an active listener, and learn empathy (RNAO, 2006). It is important to note that consciousness-raising (Habermas, 2001) around the precarious position of front-line staff as the gatekeepers to system resources is beneficial for both providers and for clients. Considering the relationship as being

fully the responsibility of providers could be construed as disrespectful and disempowering to clients, and the means to create health promoting relationships and health promoting places will be limited if all parties are not involved. That said, it must also be noted that in the context of working with people experiencing homelessness providers are in a significantly privileged position with access to many resources (Hoffman & Coffey, 2008), including clinical experience in areas like fostering relationships. The positional privilege puts much of the onus of the relationship on the provider, but should not negate the role of the client. To date, mutuality has simply been considered one concept among a list of others that are necessary for a positive health care relationship (RNAO, 2006). Instead, to recognize the shared ownership of a relationship, all the concepts of the health care relationship, such as trust and respect, could be couched within mutuality and solidarity. This would build on the work of others to enhance relational health promotion in contexts that level power, such as ‘participatory action knowledge translation’ (McWilliam, et al., 2008), which created empowering spaces for home care providers to translate client-driven care into practice, or Berman’s (2009) work on creating spaces for girls who have experienced displacement to lead research processes.

Creating health promoting places. Reflecting on the mutuality of relationships leads into a discussion of health promoting places, where the focus is on ownership of space and creating true collaboration for decision-making, meaning more than just tokenistic involvement of clients on committees (Buck, Rochon, Davidson, & McCurdy, 2004). The nature of public services can be lost beneath the positional power attributed to health professionals (Hugman, 1991). That is, the positional power

afforded to and taken by physicians, nurses and other health professionals can eclipse the reality that health care is a public service, and that health professionals serve their clients, not vice versa. Although providers serving in a health care clinic do have multiple responsibilities towards their managers, their registration body, the tax-paying public, and the local community, their primary responsibility is towards those who they are mandated to serve. That said, it is important to note that this mandate for service sits more or less comfortably with the different professions due to historical conceptual differences. For example, Social Work may be more rooted in solidarity, Nursing more rooted in caring, and Medicine more rooted in treating illness. In this study context, the clinic is explicitly tasked with meeting the health promotion needs of people who are experiencing homelessness, and the client therefore in theory takes precedence. It is important to recall that the definition of health promotion according to the World Health Organization (WHO) is increased control over health and the social determinants of health (WHO, 2005). Therefore, in considering a health promoting place, in addition to addressing the social determinants of health, consideration must be given to how clients have ownership and control within the setting.

There is some precedent in terms of conceiving of health care spaces as being health promoting based on active ownership of decision-making processes by both clients and providers. In particular, in 1995 a Dutch law was passed that required all health care organizations to include client participation in decision-making (Van Gennip & Sillevius Smitt, 2000). For the most part, this has been enacted as 'Client Councils' that function at a parallel level to management, being required to approve considerations going forward to the Board (FEANTSA, 2006). Because our systems are

structured in such a way that can make participation in such activities a mis-fit for people who are experiencing homelessness, organizations can task a specific staff member with ensuring that meetings are timed and structured in a way that ensures participation by clients as desired (FEANTSA). This proviso is important as it is what separates tokenistic participation of clients, which fulfills the needs of the organization rather than the clients, from true collaboration (Buck, Rochon, Davidson, & McCurdy, 2004). Many management teams have seats for clients experiencing homelessness that remain unfilled, or that although filled, the individual has difficulty attending meetings. This as likely demonstrates a disconnect between the world of business and the world of the streets, as a lack of interest in involvement. If health clinics were not allowed to make management decisions without approval of a client council, it is certain that time and effort would be put into making sure that this council was fully active. This structured collaboration fits the tenets of anti-oppressive practice, including “acknowledging the assets of individuals/groups/communities that are marginalized” (Sakamoto, et al., 2008, p. 8), as well as health promotion. Although The Netherlands and Canada have different health care systems, there is no reason to believe that this same model would not work in Canada as client-driven care is already a concept included in current Canadian system reform (McWilliam, et al., 2008).

Refining local policies. The discussion of ownership and control of the clinic setting has many implications for formal and informal policies, formal being those that are recorded and informal being those that are held only verbally. Take for example one component of the clinic space that was particularly contested: the washrooms in the clinic were situated past a controlled access door, in the same area as staff offices and

medical examination rooms. Clients had to request permission to use the washroom and be let through the door. Although there were two washrooms, one was kept closed to only be used by those getting a sample for the physician or nurse practitioner. With public washrooms lacking in the neighbourhood, there were constant line-ups for the one open washroom, and this could become problematic if a client was in the washroom for an extended period of time. This happened often enough, and at times was simply because the individual was unwell, but at other times because they were using drugs. The management of the washrooms from the provider perspective was framed around the rhetoric of safety. This included preventing drug overdoses in the washroom, and was enacted as administrative staff keeping a close watch on the washrooms to prevent multiple people from using them at once, or to knock on the door of someone was using them for too long. Making only one washroom available both made observation easier, and made it more likely that someone taking a long time in the washroom would be reported by other clients who were waiting for a while.

Reframing the washroom discussion to consider the clinic as being a health promoting space and place for clients brings into question a number of the policy decisions: Should only one washroom be available? Should washrooms be behind a locked door? Should there be time limits on washroom use? It would be an error for me to answer these questions on behalf of the clinic in this dissertation. Rather, building on the idea of client control of decision-making, these questions should be addressed mutually by providers and clients. It is possible that the decision will be to maintain policies as they are, but there could be a sense of expanded ownership for that decision by all. And, the washroom was just one example of clinic policies that could

be up for re-consideration. Other policies should be re-considered, such as budgetary decisions and quantities of basic necessities available (ie. socks, shoes, bus tickets, food, toothpaste, etc.), the process of banning clients from the clinic, hours of operation, and the design of the space. It is important to consider that none of these policies were open to review by clients, and only some were open for discussion to all providers. Many decisions, particularly budgeting, were made in a top-down manner, and many providers had limited understanding of the clinic budget.

Building on the concept of a health promoting place, or one in which clients have control of their health or the determinants of their health, policy making stands to be much more inclusive. That said, there is no question that opening decision-making processes to all stakeholders will create complexity in terms of the diversity of needs and desires of both clients and providers. However, this complexity should not be a barrier to creating more health promoting places. Some work has already been conducted on client-designed health care services for people experiencing homelessness. In particular, the Health Care for the Homeless Clinicians Network (HCHCN) in a report outlined a collaborative model of care and detailed some design components (Bonin, et al., 2004). According to the HCHCN, programs adapted to the needs of people experiencing homelessness include outreach that brings health services to where people congregate. Client-designed services also tend to include the integration of basic needs and health care services, flexible services that allowed for walk-in appointments, assistance with eliminating barriers to other services, and incentives attached to any long-term programs. Client participation also tends to push considerations of client needs beyond those of the immediate clinic context, to a

continual reflection on the network of services that people experiencing homelessness use (Buck, Rochon, Davidson, McCurdy, 2004). That is, while providers tend to focus on needs and responsibilities within their own workplace, clients tend to see the broader picture and recognize the clinic as one piece of a bigger puzzle. These are some examples of policy implications, but each setting could come up with their own policy revisions based on uniqueness of the setting and clients with whom they work.

Collaborative decision-making on policies that affect the care of people experiencing homelessness represents an opportunity to bring together the lived experience and local knowledge of clients, and the insights into policy rationales and priorities of providers (Brunjes, 2010). This could be facilitated by principles of ‘dialogue across difference’ (Ellsworth, 1989) in order to make space for all voices to be heard.

Refining system policies. In this study, specific system policies that filtered down to create pressures on individual providers were not often unpacked. However, this has been done elsewhere, in particular, Shapcott (2005a) has painted a clear picture of how Canada has expanded its homeless situation through the step-by-step dismantling of national and provincial housing programs. One of the primary challenges faced by the clinic was the inability to meet all the needs of all the clients, and a big part of this is that they are constantly accepting new clients who are newly homeless, without being able to discharge current clients. This bottleneck in the system, represented by an increase in homelessness across the country, has much to do with the lack of social housing (OrgCode Consulting Inc, 2010). It has been demonstrated that homelessness can be ended by providing housing subsidies for those in need, and supportive housing for a small number of people with greater needs (Shinn,

2009). Figure 3 adapted from Sveri (2004), captures well the crucial role that housing plays in breaking the cycle of homelessness. It is the obtaining of a 'Dwelling' that is the piece missing for many of the clients of the clinic. In addition to re-housing, systemic policies that look to curbing homelessness need to include homelessness prevention (Roman & Culhane, 2009). Health and social care providers stand the best chance for affecting change at this level by working with existing professional groups such as provincial associations or national unions.

The goal is to break a vicious circle

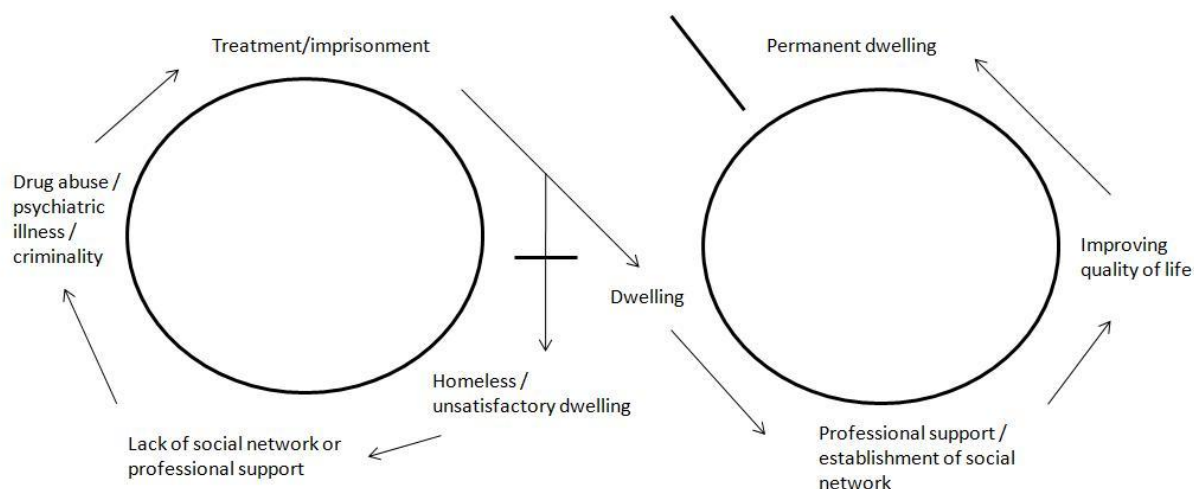


Figure 3: Housing as the break in the cycle of homelessness (Sveri, 2004).

These groups have experience in bringing issues forward to politicians and challenging or promoting platforms, so providers need to ensure that the issues are pertinent and appropriate to address client needs.

Although housing is an important public policy realm that can point to both causes of and solutions to homelessness, the push to refine public policies should not be exclusively limited to housing. Shapcott (2005b) also recommends increasing social assistance, enhancing social services, and increasing dollars for outreach and support. Similarly, the “Pathways into Homelessness” Report (Goering et al., 2002) found that 45% of primary causes of homelessness were financial, but also found 26.7% to be related to interpersonal conflict and abuse, 17.7% due to drug and alcohol use, and 3.7% due to mental illness. Therefore, using the factors that contribute to homelessness proposed by Frankish (2008), it can be suggested that in addition to housing policies, we need to consider health policies, social assistance policies, and other relevant public policies. Part of this diverse system picture will include a multitude of services, such as those for homeless veterans, youth-focused services, employment support programs, means of enhancing technology use (PATH, 2008), and many other programs that address unique populations or unique barriers to the social determinants of health.

Study Limitations

One limitation of this study that requires particular attention is the ethnicity of interview participants; further limitations specific to the research questions are discussed in Chapters 4 and 5 of this dissertation. Although participant observation included all individuals utilizing the clinic, in-depth interviews and focus groups were limited to those who volunteered/consented to participate. Recruitment for interviews included theoretical sampling where individuals were approached who were known to me to be very involved members of the community, but yielded little racial and ethnic diversity. That this targeted recruitment of community ‘leaders’ included no persons of

First Nations descent is likely reflective of systemic racism and the silencing of certain voices both within the broader community and within the community of people experiencing homelessness. This limitation was also in spite of also using open recruitment, with signs and flyers posted throughout the clinic. Non-Caucasian, non-aboriginals represent a very small proportion of the clinic, so it is not surprising that none were involved in the 11 interviews. However, people of visible First Nations descent were constantly present during participant observation, and one was involved in the client focus group. However, none requested an interview and two who were personally approached declined. The barriers to participation in research for First Nations peoples are discussed elsewhere (Meadows, Lagendyk, Thurston, & Eisener, 2003) and are beyond the scope of this paper, but it is worth noting that their unique perspective was not included in interview data. Beyond adding diversity, the lack of First Nations people, who are often at the receiving end of discrimination and exclusion, is a limitation in this study, particularly as the focus is to create positive social change. Much health promotion has historically benefited those who already have more access to resources and structural power, and excluding those most marginalized in the context of this study risks doing the same. Having a diverse group of researchers involved in data collection rather than a single individual may have made participation more welcoming to a broader selection of individuals.

Future Directions

In the context of this study, action on the findings resulted in the development of an action network, or community of practice, looking at issues around homelessness in London, Ontario. Known as the London Homelessness Outreach Network (LHON,

<http://www.londonhon.ca>), this network is a means by which many of the issues uncovered in this project, and other issues, can be addressed at personal, local, and political levels. The network came to fruition as the principal investigator of this study (AO) engaged in knowledge translation activities around the community, sharing the relational and structural challenges faced in promoting health with people experiencing homelessness. Other members of the community, mostly health professionals, expressed interest in taking further action on the findings. This included providers from the clinic involved in the research, and grew from 10 individuals to over 40 members at the time of publication. These members represent academics, service providers, concerned citizens and persons with lived experience. The network is both developing its own projects, and seeking projects from agencies and persons with lived experience. These projects are at any of three levels: political action, public perceptions, and personal engagement. This provides a means of refining personal practice, creating health promoting places, evolving local policies, and advocating for change on system policies. In terms of the clinic where this study was conducted, the network is providing an opportunity for providers to engage in work that they feel is meaningful, but is limited by the constraints of the clinic. As well, being non-institutional and community-based is key to what LHON might be able to achieve. Examples of projects already underway are: 1) creating a network of health professionals to provide voluntary street-level care; 2) enhancing creative arts groups for people experiencing homelessness and developing a publication from these that engages public perceptions of homelessness, 3) better connecting faith communities to agencies who work with people experiencing homelessness to mobilize human and financial resources, 4)

finding novel ways to promote health in the context of multiple vulnerabilities, and 5) finding ways to connect citizens in social relationships with people who are experiencing homelessness, such as having members attend a local drop-in.

Lessons from this study can also be utilized to enhance health and social care education, largely by corroborating directions already being taken in focusing more on social and political action. Most university programs already promote student involvement beyond the classroom, and push students to imagine working in the future beyond the workplace. This study provides support for educating health and social care providers with a strong background in social and political action so that they can effect positive change both in the workplace, but at a systems level as well. In particular, increased knowledge around health and social policies, policy development, and policy implementation would set students up for success in making change. In terms of relating with clients and individual practice, reflections on providers as the gatekeepers of public spending could enhance the current focus on establishing therapeutic relationships. As the relationship does not occur in a vacuum, but is influenced by local and social policies, suggestions to be a certain way with clients (ie. empathetic, respectful, trustworthy), must also include critical reflection on the limitations to these ways of being. The same is true of any workplace, for example in acute care, where increasing patient loads can make it impossible for providers to practice in the manner that they know is best.

Having addressed some of the gaps in the literature around considering relational health promotion with an eye to power, policy and place, more opportunities exist to continue to advance the field through further research. We have suggested here

that one component that has been under-looked is the value of creating spaces that reflect a philosophy of ‘power with’ versus ‘power over’. However, the literature shows that in doing this, there is a risk of tokenism (Buck, Rochon, Davidson, & McCurdy, 2004), a risk of simply divvying out small components of control rather than seeking mutuality. Therefore, although it was touched upon in this study, it would be informative to focus particularly on enhancing qualitative understanding of how some health providers are able to enact solidarity with clients in spite of systemic constraints. Using models of participatory action research (PAR), clients and providers could work collaboratively to enact ‘power with’ across large social distances. Similarly, work on anti-oppressive practices in the field of social work (Sakamoto & Pitner, 2005), could be merged into the health professions. This work could unpack particular social locations and their role in shaping client-provider relationships in this context, such as a gender-based analysis. In terms of health promoting places, more investigations needs to be done on how clients can be integrated into organizational decision-making in a manner that is truly collaborative rather than tokenistic (Buck, Rochon, Davidson, & McCurdy, 2004). This research might include exploring the outcomes of this process for both clients who are participating, and also clients who simply use the services, using a methodology that is attuned to process as well as outcomes, such as participatory action knowledge translation (McWilliam, et al., 2008). In regard to local policies, work needs to be done on novel program designs that seek to balance the increasing need for basics such as food, clothing, and transportation, with high cost health needs such as medication coverage and supplies. Are there ways in which health providers can ensure adequate transportation for people who are experiencing

homelessness, while still having the budget for rapid streptococcal pharyngitis tests and covering x-rays for those without health cards? Lastly, in terms of refining system policies, there is always room for participatory action research that engages communities in advocating for policy changes around those issues that affect them most. More knowledge needs to be disseminated on successful campaigns that have led to broad policy change, and health and social care providers should be a part of this.

Conclusion

To enhance our understanding of health promoting spaces with people experiencing homelessness, this study provided an in-depth exploration of the health care relationships and the space and place of a community-based clinic for people experiencing homelessness. As power has been under-studied in this context, the exercise of power in relationships was explored, as well as how space is contested and place is made. This process uncovered barriers to promoting the health of people who are experiencing homelessness, and in particular that these barriers exist both at the personal level, but also at the level of clinic and systemic policies. This provides those who work in these health care contexts with valuable questions and insights to enact relational health promotion, empowerment, client-driven care, or solidarity across vast social differences, while also being attuned to the necessity of social and political action to reform the broader context of health care. The onus for enhancing health promotion cannot be placed simply on individuals, but also lies on reforming public policies. Health and social care providers have a role to play in refining their personal clinical skills, but also in working in solidarity with clients to make their world a better place. This is no small task, but the passion that providers bring to the workplace, and the

unique skills of lived experience that clients have, means that in collaboration between and among people who are experiencing homelessness, practitioners, policy makers, and researchers, there are no limits to what can be achieved.

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Appendix A

Ethics Approval**Office of Research Ethics**

The University of Western Ontario
 Room 4180 Support Services Building, London, ON, Canada N6A 5C1
 Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
 Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice**Principal Investigator:** Dr. C. Ward-Griffin**Review Number:** 15305E**Review Level:** Expedited**Review Date:** July 9, 2008**Protocol Title:** Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography**Department and Institution:** Nursing, University of Western Ontario**Sponsor:****Ethics Approval Date:** September 11, 2008**Expiry Date:** August 31, 2009

Documents Reviewed and Approved: UWO Protocol, Letter of Information and Consent - Interview (Client), Letter of Information and Consent - Interview (Provider), Letter of Information and Consent - Focus Group (Provider), Letter of Information and Consent - Focus Group (Client), Participant Observation Letter (Provider), Participant Observation Letter (Client), Notice for Posting, Information Card.

Documents Received for information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- all adverse and unexpected experiences or events that are both serious and unexpected;
- new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Victor Han

Ethics Officer to Contact for Further Information			
<input type="checkbox"/> Janice Sutherland (jsuther@uwo.ca)	<input type="checkbox"/> Elizabeth Wambolt (ewambolt@uwo.ca)	<input checked="" type="checkbox"/> Grace Kelly (grace.kelly@uwo.ca)	<input type="checkbox"/> Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File

Appendix B

Letter of Information (Provider)

Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography

You are being asked to participate in a research study at the London InterCommunity Health Centre entitled “*Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography*”. This research study will explore the experience of power within the client-provider relationship in community care with people who are experiencing homelessness. If you agree to participate in the study, you will participate in an interview with the researcher. This interview will take approximately one hour to complete. There are no known risks associated with this study.

You may not participate in the study if you are not currently employed at the London InterCommunity Health Centre, or if you are unwilling to participate.

The knowledge gained from this study may help either yourself or other providers who work with people who are experiencing homelessness in providing optimal health care services.

Your participation in this study is entirely voluntary, and you may withdraw from the study at any time you wish. If you decide to discontinue your participation in this study, you will continue to be treated in the usual and customary fashion.

All study data will be kept confidential. However, this information may be used in nursing publications, subsequent focus groups or presentations, presented as group data.

If you sustain injuries from my participation in this research project, you will not be automatically compensated by the London InterCommunity Health Centre.

This letter is for you to keep. If you have any questions about this study, please call Abram Oudshoorn, the Principal Investigator at _____. If you have any questions about the conduct of this study or your rights as a research participant, please contact the Director, Office of Research Ethics, The University of Western Ontario, 519-661-3036, email ethics@uwo.ca.

Letter of Information (Client)

Client-Provider Relationships in a Community Health Centre for Homeless Persons:
A Critical Ethnography

You are being asked to participate in a research study at the London InterCommunity Health Centre entitled “*Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography*”. This research study will look at the experience of receiving health care as a person who is experiencing homelessness, with a particular focus on the client-provider relationship. If you agree to be involved in the study, you will participate in either a one-on-one interview with the researcher or in a group interview with other clients. This interview will take approximately one hour to complete. When you are done the interview, you will get \$20.00 for being involved. There are no known risks that come from this study.

You may not be involved in the study if you are younger than 25 years of age, you are not currently homeless, you do not speak or understand English, you are not a current client of the London InterCommunity Health Centre, or you do not wish to participate.

The information gained from this study may help either yourself or other people who are homeless receive optimal health care services.

Your involvement in this study is entirely by choice, and you may stop the study at any time you wish. If you decide to stop being involved in this study, you will continue to be treated in a respectful manner.

I understand that all study information will be kept private. However, this information may be used in nursing articles, focus groups or presentations, presented as group information.

If you are injured because of being involved in this research project, you will not necessarily receive any compensation from the London InterCommunity Health Centre.

This letter is for you to keep. If you have any questions about this study, please call Abram Oudshoorn, the Principal Investigator at _____. If you have any questions about the conduct of this study or your rights as a research participant, please contact the Director, Office of Research Ethics, The University of Western Ontario, 519-661-3036, email ethics@uwo.ca.

Appendix C

*Consent Form (Provider)*Client-Provider Relationships in a Community Health Centre for Homeless Persons:
A Critical Ethnography

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate in the research project "Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography". All questions have been answered to my satisfaction.

Participant (Print name)

Signature of Participant

Date

Individual Obtaining Consent (Print name)

Individual Obtaining Consent

Date

Consent Form (Client)

Client-Provider Relationships in a Community Health Centre for Homeless Persons:
A Critical Ethnography

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate in the research project "Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography". All questions have been answered to my satisfaction.

Participant (Print name)

Signature of Participant

Date

Individual Obtaining Consent (Print name)

Individual Obtaining Consent

Date

Appendix D – Notice for Posting

RESEARCH STUDY IN PROGRESS!

A research study entitled “*Client-Provider Relationships in a Community Health Centre for Homeless Persons: A Critical Ethnography*” is currently being conducted here in HOHP. This research study will explore client-provider relationships in community care with people who are experiencing homelessness.

Nurse Abe Oudshoorn is conducting this study, which involves observing interactions between staff and clients. Therefore, any interactions within the health centre may be included as data in the study.

If you do not wish to participate in the study, please inform Abe or other health centre staff immediately, your participation is entirely voluntary. All study data will be kept confidential, with pseudonyms used.

If you need to, you can contact **Abram Oudshoorn, RN, BScN, The University of Western Ontario, School of Nursing**, any time during the study. _____.

If you have any questions about your rights as a research participant or the conduct of the study you may contact **The Office of Research Ethics (519) 661-3036, email ethics@uwo.ca**.

Appendix E – Information Card

Side One

RESEARCH STUDY IN PROGRESS!

A research study entitled “*Client-Provider Relationships in Community-Based Health Care for Homeless Persons: A Critical Ethnography*” is currently being conducted here in HOHP. This research study will explore client-provider relationships in community care with people who are experiencing homelessness.

Side Two

Nurse Abe Oudshoorn is conducting this study, which involves observing interactions between staff and clients. Therefore, any interactions within the health centre may be included as data in the study.

If you do not wish to participate in the study, please inform Abe or other health centre staff immediately, your participation is entirely voluntary. All study data will be kept confidential, with pseudonyms used.

If you need to, you can contact **Abram Oudshoorn, RN, BScN, The University of Western Ontario, School of Nursing**, any time during the study. _____.

If you have any questions about your rights as a research participant or the conduct of the study you may contact **The Office of Research Ethics (519) 661-3036, email ethics@uwo.ca**.

Appendix F

Guide for Recording Fieldnotes

1. What is the atmosphere in the clinic today?
2. What interesting occurrences were there today?
3. What values were displayed today?
4. What behaviours were demonstrated today?
5. What beliefs were demonstrated today?
6. Describe client-client interactions.
 - a. Reflect on social locations.
 - b. Reflect on barriers.
 - c. Reflect on facilitators.
7. Describe client-provider interactions.
 - a. Reflect on social locations.
 - b. Reflect on barriers.
 - c. Reflect on facilitators.
8. Describe provider-provider interactions.
 - a. Reflect on social locations.
 - b. Reflect on barriers.
 - c. Reflect on facilitators.
9. Describe my interactions with clients.
 - a. Reflect on social locations.
 - b. Reflect on barriers.
 - c. Reflect on facilitators.
10. Describe my interactions with providers.
 - a. Reflect on social locations.
 - b. Reflect on barriers.
 - c. Reflect on facilitators.
11. Initial analysis of the client-provider relationship.
12. What was unsettling/challenging in what I saw today?
13. What were the paradoxes and contradictions in what I saw today?

Appendix G

Semi-Structured Interview Guide: Provider

1. What is it like to work here?
2. Can you think of any stories that typify to you what it is like to provide community care with people who are experiencing homelessness?

Probes:

What are the benefits?

What are the challenges?

Why did you choose to work in this setting?

What is your role? How would you change this role?

3. Tell me about a time when you felt good about an interaction with a client?

Probes:

Do relationships change over time? How?

What words would you use to describe your relationships with clients?

What constitutes a healthy relationship, what does it look like?

How do you decide on the care you provide with clients?

What helps your relationships with clients?

4. Tell me about a particularly challenging interaction with a client?

Probes:

Do you ever have disagreements with clients? How are these solved?

What hinders your relationships with clients?

5. What other factors impact client-provider relationships in this setting?

Probes:

What are personal factors, work environment factors, societal factors?

6. Tell me a bit about yourself?

Probes:

Educational background.

Financial background.

Family background.

Experiences with poverty/homelessness.

How long they have been working in this setting.

Racial/ethnic background.

7. Has my presence here impacted the setting? How?

Semi-Structured Interview Guide: Client

1. What is it like to come here?
2. Can you think of any stories that typify what it is like to receive health care at the London InterCommunity Health Centre?

Probes:

What is the quality of the care you are receiving?
 What changes would you make to your care?
 Why did you choose to come here for your care?

3. Tell me about a time when you felt particularly good about an interaction with a provider?

Probes:

Do relationships change over time? How?
 What words would you use to describe your relationships with providers?
 What constitutes a healthy relationship, what does it look like?
 How do you decide on the care you receive?
 What helps your relationships with providers?

4. Tell me about a particularly challenging interaction with a provider?

Probes:

Do you ever have disagreements with providers? How are these solved?
 What hinders your relationships with providers?

5. What other factors impact client-provider relationships in this setting?

Probes:

What are personal factors, community factors, societal factors?

6. Tell me about healthy relationships in your life?
7. Tell me a bit about yourself?

Probes:

Educational background.
 Financial background.
 Family background.
 Experiences with poverty/homelessness.
 How long they have been coming here.
 Racial/ethnic background.

8. Has my presence here impacted the setting? How?

CURRICULUM VITAE

1. Name: Abram Oudshoorn

2. Academic Preparation:

Degree	University	Department	Years
Doctor of Philosophy in Nursing – Health Promotion	The University of Western Ontario	Nursing	2005-2011
Masters of Science in Nursing – Health Promotion	The University of Western Ontario	Nursing	2004-2005 (Fast-track, Degree not conferred)
Bachelor of Science in Nursing	The University of Western Ontario	Nursing	2000-2004

3. Related Work Experience:

Date	Institution	Position
2009-Present	The University of Western Ontario	Lecturer, School of Nursing Year 4 Coordinator
2007-2009	The University of Western Ontario	Lecturer, School of Nursing
2004-2009	London InterCommunity Health Centre	Staff Nurse, Part-time
2003-2004, 2006-2007	The University of Western Ontario	Research Coordinator
Summer 2004	London InterCommunity Health Centre	Chart Auditor/Relief Nursing, Contract
2001-2003	The University of Western Ontario	Research Assistant

4. Honours and Awards:

2010 Canadian Homelessness Research Network, Travel Grant (\$500)

2009 Faculty of Health Sciences, The University of Western Ontario, Recognition of Excellence for an outstanding contribution to teaching.

2009 Canadian Nurses Foundation, AstraZeneca Urban Scholarship (\$6,000)

2009 National Initiative for the Care of the Elderly, Student Travel Assistance Grant (\$3,000)

2009 Faculty of Health Sciences, The University of Western Ontario, FHS Graduate Student Conference Travel Award (\$236.25)

2009 National Initiative for the Care of the Elderly, NICE Student Mentorship Program (\$1,000)

2009 Canadian Homelessness Research Network, Travel Grant (\$1,000)

- 2008 University Students' Council, The University of Western Ontario, Teaching Honour Roll Award of Excellence.
- 2008 Faculty of Health Sciences, The University of Western Ontario, Recognition of Achievement for an outstanding contribution to teaching.
- 2008 Canadian Association on Gerontology, Travel Grant (\$145)
- 2008 Ontario Graduate Scholarship (\$15,000)
- 2008 National Initiative for the Care of the Elderly, NICE Student Mentorship Program (\$1,000)
- 2007 Canadian Association on Gerontology, Travel Grant (\$306.60)
- 2007 Summer Program in Aging sponsorship, Canadian Institutes of Health Research – Institute of Aging.
- 2007 Jan Metcalfe Award, Registered Nurses Foundation of Ontario (\$1,000)
- 2007 Strategic Training Fellowship, Canadian Institutes of Health Research, Transdisciplinary Understanding and Training on Research - Primary Health Care (\$15,437.50)
- 2006 Canadian Association on Gerontology, Travel Grant (\$306)
- 2006 Nursing Education Initiative, Registered Nurses Association of Ontario (\$1,500)
- 2006 The Graduate Student Research Award, VP Research and Faculty of Health Sciences, The University of Western Ontario (\$330)
- 2006 People's Choice for Best Student Research Project, Ontario Gerontology Association, 2006 Annual Conference (\$100)
- 2006 Student Travel Award, School of Nursing, The University of Western Ontario (\$416.08)
- 2006-2007 Research Traineeship, "Client-Caregiver-Provider Relationships in Home-Based Dementia Care: A Critical Analysis", Alzheimer Society of Canada (\$5,000)
- 2006-2007 Doctoral Fellowship, Social Sciences and Humanities Research Council (\$40,000)
- 2006 Ontario Graduate Scholarship (Offer declined due to SSHRC Fellowship)
- 2006 The Dean's Award for Research Excellence for a second place oral presentation at the Western Research Forum, The University of Western Ontario (\$175)
- 2006 Educational Bursary, Community Health Nurses' Initiatives Group, Registered Nurses Association of Ontario (\$1,000)
- 2006 Doctoral Scholarship, Nursing Research Interest Group, Registered Nurses Association of Ontario (\$2,000)
- 2005 Nursing Education Initiative, Registered Nurses Association of Ontario (\$1,500)
- 2005-2006 Research Traineeship, "Double Duty Caregiving: Development and Validation of the DDC Scale", Canadian Institutes of Health Research (\$8,000)
- 2005 Extencicare Scholarship in Gerontology, Canadian Nurses Foundation (\$5,000)
- 2005 Canadian Association on Gerontology, Travel Grant (\$457)

- 2004 Nursing Education Initiative, Registered Nurses Association of Ontario (\$1,500)
- 2004-2005 Research Traineeship, "Understanding Client-Family-Nurse Relationships in Home-Based Palliative Care for Seniors", Canadian Institutes of Health Research (\$17,500)
- 2004 Outstanding Undergraduate Student, Sigma Theta Tau International Honor Society of Nursing, Iota Omicron Chapter
- 2004 Commissioner of Excellence Award, The University of Western Ontario
- 2003 Inductee, Sigma Theta Tau International Honor Society of Nursing, Iota Omicron Chapter

5. Publications:

1. Wilson, B., Harwood, L., **Oudshoorn, A.** & Thompson, B. (2010). The Culture of Vascular Access Cannulation Among Nursing in a Chronic Hemodialysis Unit. *Canadian Nephrology Nursing Journal*, 20(3).
2. McCleary, L., McGilton, L., Boscart, V. & **Oudshoorn, A.** (2009). Improving Gerontology Content in Baccalaureate Nursing Education Through Knowledge Transfer to Nurse Educators, *Canadian Journal of Nursing Leadership*, 22(3), 33-46.
3. Ward-Griffin, C., Martin-Matthews, A., Keefe, J., Kerr, M., Brown, J.B., **Oudshoorn, A.** (2009). The development and validation of the Double Duty Caregiving Scale (DDCS). *Canadian Journal of Nursing Research*, 41(3), 108-128.
4. McWilliam, C., Kothari, A., Leipert, B., Ward-Griffin, C., Forbes, D., King, M.L., Klosek, M., Ferguson, K. & **Oudshoorn, A.** (2008). Accelerating Knowledge to Action in Client-Driven Care: Pilot Study for a Social Interaction Approach to Knowledge Translation. *Canadian Journal of Nursing Research*, 40(2), 58-74.
5. McWilliam, C., Ward-Griffin, C., **Oudshoorn, A.** & Krestick, E. (2008). Living while dying/dying while living: Older clients' socio-cultural experience of home-based palliative care. *Journal of Hospice and Palliative Nursing*, 10(6), 338-349.
6. Leipert, B.D., Kloseck, M., McWilliam, C., Forbes, D., Kothari, A. & **Oudshoorn, A.** (2007). Fitting a round peg into a square hole: Exploring issues, challenges, and strategies for solutions in rural home care settings. *Online Journal of Rural Nursing and Health Care*, 7(2).
7. **Oudshoorn, A.**, Ward-Griffin, C. & McWilliam, C. (2007). Nurse-client relationships in home-based palliative care: A critical analysis of power relations. *Journal of Clinical Nursing*, 16(8), 1435-1443.

8. Ward-Griffin, C., **Oudshoorn, A.**, Clark, K. & Bol, N. (2007). Mother-Adult Daughter Relationships Within Dementia Care: A Critical Analysis. *Journal of Family Nursing*, 13(1), 13-32.
9. Ward-Griffin, C., Bol, N. & **Oudshoorn, A.** (2006). Perspectives of women with dementia receiving care from their adult daughters. *Canadian Journal of Nursing Research*, 38(1), 121-146.
10. **Oudshoorn, A.** (2005). Power and empowerment: Critical concepts in the nurse-client relationship. *Contemporary Nurse*, 20(1), 57-66.