Community Health Promotion
With People Who Are Experiencing Homelessness

Abram Oudshoorn RN PhD a, Catherine Ward-Griffin RN PhD a, Blake Poland PhD b, Helene Berman RN PhD a & Cheryl Forchuk RN PhD a

a The University of Western Ontario, London, Ontario
b University of Toronto, Toronto, Ontario


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Community Health Promotion With People Who Are Experiencing Homelessness

Abram Oudshoorn, RN, PhD and Catherine Ward-Griffin, RN, PhD
The University of Western Ontario, London, Ontario

Blake Poland, PhD
University of Toronto, Toronto, Ontario

Helene Berman, RN, PhD and Cheryl Forchuk, RN, PhD
The University of Western Ontario, London, Ontario

Homelessness is an experience of being displaced. Once removed from their personal places, homeless people are barred access to healthy places in which to be. Health clinics for people who are experiencing homelessness offer an opportunity to create health-promoting places. In this study, we explore how place is experienced within a community health clinic for people who are experiencing homelessness. A critical ethnographic methodology was used. Results illustrate how clients and providers contested the space of the clinic. Discourses of safety, health promotion, and privacy were enacted, altered, and resisted in a constant practice of culture-making. Physical components of the space became conceptual components of how place and power in place were understood by clients and providers. Results point to the importance of conceptualizing service users as the key stakeholders in their care, considering how places may be more or less health promoting, and rethinking how safety is conceptualized.

Homelessness is an experience of being displaced, 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 article, 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 both public and private places. Ultimately, by definition, they lack the primary private place in society, a home. Once finding...
oneself homeless, a person then faces being removed or banned 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). In being removed or moved along in public spaces, it becomes clear that there is a legitimate and illegitimate public (Kawash, 1998), meaning those who are or are not challenged for being present in public spaces. Being constantly uprooted, homeless individuals are forced to reinvent their sense of place (Vandemark, 2007).

In this article, place is considered to be a location that has meanings (Bender, Clune, & Guruge, 2007); 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). 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 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 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-centered care, and partnerships for health are taking precedence within health promotion research and practice. 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, 1996). Use of these perspectives is informative in terms of understanding health promoting and the idea of place.

Ultimately, 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 bearing their poverty bluntly and visibly, people who are experiencing homelessness work to assert themselves as legitimate public.
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. 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.

There is also a focus in the literature 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-Calio, 2004), but to recognize that people who are experiencing homelessness face some of the highest rates of morbidity within high-income nations (Daiski, 2007). To this end, Johnsen, Cloke, and May (2005) explored the development and inner workings of day centers 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 centers are truly offering spaces of care as alternatives. We found that day centers served service-users as a means both of accessing material resources, and of finding refuge, respite, and even empowerment. Day centers provided a space where certain behaviors were more tolerated than in other agencies, although this was balanced by a degree of policing and control. Service providers were not the only ones who controlled behaviors, as service-users policed each other and also self-policed. Consistent with St-Pierre and Holmes (2008), we highlighted how the day centers 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) explored how social deprivation is literally embodied by individuals and evidenced in health disparities. Similar to Johnsen and colleagues (2005), we 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 et al. described fear demonstrated in the actions of housed persons toward people who are experiencing homelessness. Building on Sibley’s (1995) “Geographies of Exclusion,” we suggest that being feared is used at times as a source of empowerment as displaced persons turn the tables and create spaces where the legitimate public feel uncomfortable and unwelcomed. Parr (2000) conducted an ethnographic study of a drop-in center in Nottingham, UK 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 center was a more accepting place, with wider social boundaries, the clients of the center were forced to live out their private identities within a public space. Like Johnsen and colleagues, Parr spoke to a Foucauldian disciplining of behaviors as there were still limits and norms in the center, 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 center]” (Parr, 2000, p. 234). Parr highlighted 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 article addressed the question of: How is place experienced by clients and providers within a community health clinic for people who are experiencing homelessness?

**Theoretical Perspective and Methodology**

This study falls within what has been referred to as a critical theoretical perspective (Campbell & Bunting, 1991). This perspective encourages academics and practitioners alike to seek social justice, hence the focus in this study on oppression and making spaces for positive change. A critical ethnographic methodology was employed to better understand the culture of a health center as it was experienced in the daily lives of the people who lived it (Crang & Cook, 2007). Poland, Lehoux, Holmes, and Andrew’s (2005, p. 172) understanding of culture was used:

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.

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. Building also on the focus within the critical paradigm of making spaces for positive change, the critical ethnographer is not content with developing a cultural critique, but engages with the culture of study to be a catalyst of change (Cook, 2005).

**METHODS**

The study was conducted in a community health center in a moderate-sized urban area in Ontario. This center 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.

Multiple qualitative data collection methods were used to develop a deep engagement with, and understanding of, the culture of the clinic. Data collection methods ran consecutively, and included participant observation, in-depth interviews, and focus groups. Participant observation involved 103 hr over the course of 3 months in the clinic waiting room and observations of seven client-provider dyads within examination rooms or offices. Participant observation played an important role in facilitating focused observations of a clinical area that was already familiar...
to the researcher. Field notes were recorded intermittently throughout the day in a private office so that they were recorded immediately and also unobtrusively (Groenkjaer, 2002). Observation also provided an opportunity to identify key individuals for in-depth interviews.

In addition to observation, 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). 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 men and women. As a group, participants did tend to be those who were more chronically homeless than would be representative of the clinic (M 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.

In analyzing the data, Lather’s (2007) work on understanding validity post-poststructuralism was used to enhance quality. Data analysis occurred as an ongoing process during participant observation as field notes 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 to try to capture the nuances of language in a manner most meaningful to those doing the analysis. A loose coding structure was created 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 field notes 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 article 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 results 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 results to be more meaningful to those most invested in the results.

RESULTS

The results section focuses on contesting space, looking at what is contested, and making place, looking at how clients and providers exert power to make place. There is an inherent structural tension to the clinic where multiple, and often divergent, accountabilities toward funders, the surrounding community, and clients must be balanced. Certain clients will present with some 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 clients and providers asserting themselves to create and recreate 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 center 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. Prior to the commencement of this study, clients had free access to all providers and to all facilities in the space of the clinic. 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 3 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. 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, behaviors 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’s 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 confront those who go through without permission. In this way, it is reasserted that the clinic is the clients’ place, and they should not, therefore, require permission to move through 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 recreate 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 considerable 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, the Wall was never going to be a popular change for all clients. However, three years after its construction, the majority of clients do not see The Wall serving the purpose that was suggested when it was built. 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.

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. There was 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 behavioral 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. Last, 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. The discussion is framed around three questions: (a) Whose space is it? (b) What constitutes a health promoting place? (c) 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 observed the implications of policy-setting being done by providers 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 aforementioned results 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 the use of this terminology was somewhat tokenistic (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 toward funders and the surrounding community, but, more important, 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 they felt the clinic to be 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 (World Health Organization [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 we 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 WHO (2005) definition of health promotion being to have increased control over one’s health and the social determinants of health, 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 behaviors (Kawash, 1998). Perhaps the clinic is not the appropriate space for this, but many clients identified the lack of these features as limitations. There is 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 et al. (2005) captured 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 results, there were some significant concerns around both clients and providers having been physically assaulted in the past. The question is, to what extent do health care providers enforce behavioral control before they create an unhealthy place?

Behavioral control is inseparable from a secondary question of safety. As well, behavioral control complicates the question of whether safety is solely the mandate of providers, or if clients have a role in it as well? In fact, clients worked hard to discipline the behaviors 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) highlighted well how the enforcement of rules upon a youth shelter to enhance safety and personal development was interpreted by the youth as uncaring, and the worst thing about the shelter. Insofar as 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 our 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 behaviors, 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 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 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, one moves 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 more health promoting must also be set 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 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 this study, clients were able to identify how agencies were doing in meeting their needs. 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 neighborhoods would benefit from utilizing a lens of space and place for identifying possible gaps or limitations in existing services. Last, much of the analysis in this study has focused on the clinic, but we are mindful that there are many opportunities to also explore how individual providers and clients work to create spaces of empowerment.

REFERENCES


