12-14-2015 12:00 AM

Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health

Sarah Benbow
The University of Western Ontario

Supervisor
Dr. Cheryl Forchuk
The University of Western Ontario

MOTHERS EXPERIENCING HOMELESSNESS:

SOCIAL EXCLUSION, RESISTANCE, AND HEALTH

(Thesis format: Integrated Article)

by

Sarah Benbow

Graduate Program in School of Nursing

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

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

ABSTRACT

Background and Purpose: Mothers experiencing homelessness in Canada are faced with unique challenges in achieving health. The purpose of this two-phase study was to critically examine the socio-political context, health needs, exclusionary and inclusionary forces, and strategies of resistance demonstrated by mothers experiencing homelessness. **Methodology**: This study falls under the critical paradigm informed by the theoretical perspective of intersectionality. Methodologies employed included critical narrative and critical discourse analysis. Data were collected at various homeless shelters and programs that provide services for women and mothers who are homeless in Southern Ontario. A purposive sample of women experiencing homelessness, and service providers participated in the study. Participants chose between individual and group interviews, based on their preference and comfort. In phase two, a critical discourse analysis of Ontario's Poverty Reduction Strategy was conducted. Phase two provided further context to research participants' narratives and insight in the current political will to address their needs.

Findings: Mothers (n=26) ranged from 18-58 years of age with an average age of 27.4 years. On average women had 1.6 children; the majority of children were under 5 years of age. Nineteen women self-identified as having or have had a mental illness. All service provider participants (n=15) were working with women who experienced homelessness. Based on study purpose and philosophical underpinnings, four overarching themes were identified: (a) exclusion from safety; (b) stigma: public surveillance and discrimination; (c) contradictory sources and systems of support; and (d) internal impacts of exclusion. Within phase two of the study, findings revealed that the needs of homeless mothers were not adequately represented or addressed in the policy, nor were their experiences of social

exclusion. Instead gender invisibility, neoliberal, and individualistic approaches to poverty reduction were dominant with minimal identification of timelines, concrete plans, and evaluation strategies.

Conclusions: The findings united individual realities with the macro structure of policy shaping the experiences of health, social exclusion, and homelessness for mothers. Implications for nursing practice, education, research, and policy with regards to the socio-political context of health, social exclusion, and resistance of mothers experiencing homelessness are identified.

Keywords: homelessness, mothers, health promotion, nursing, critical narrative, critical discourse analysis, social exclusion, intersectionality

CO-AUTHORSHIP STATEMENT

Sarah Benbow completed the following work under the supervision of Dr. Cheryl Forchuk, Dr. Helene Berman, Dr. Carolyne Gorlick, and Dr. Cathy Ward-Griffin, who will be co-authors of publications resulting from Chapters Two, Four, and Five.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF APPENDICES

CHAPTER ONE

INTRODUCTION

Mothers experiencing homelessness represent a unique and increasingly growing segment of the homeless population in Canada [Chambers et al., 2014; Human Resources and Skills Development Canada (HRSDC), 2010]. Shaped by complex systemic social, economic, and political factors, mothers experiencing homelessness are faced with a multitude of negative health consequences (Cheung & Hwang, 2004; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009). Intimate partner violence (Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007), mental health issues (Chambers et al., 2014), discrimination (Benbow, Forchuk, & Ray, 2011), trauma (Huey, Fthenos, & Hryniewicz, 2013; Torchalla, Linden, Strehlau, Neilson, & Krausz, 2015; Walsh, Rutherford, Krieg, & Bell, 2013), and acute and chronic health issues (Hwang, 2001; Hwang et al., 2009), are some of the complex circumstances that shape homeless mothers' experiences of health and relegate them to socially excluded positions in society.

Social exclusion is defined as "an expression of unequal relations of power among groups in society, which then determine unequal access to economic, social, political, and cultural resources" (Galabuzi, 2009, p. 254). Expanding on this, for the purposes of this study, social exclusion refers to the deeply embedded social processes whereby certain groups are prohibited from fully participating in and benefiting from social and political institutions and subsequently experience economic, political, social, and health inequities. Structural inequities shape social exclusion and arise out of the often intersecting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status and the like (Galabuzi, 2009). For homeless mothers, health is shaped by these socio-political contexts and exclusionary factors such as

poverty, or economic deprivation, among a variety of other influences such as gender and homelessness status (Raphael, 2007a, 2007b; Marmot, 2005). Homeless mothers are among those who are socially excluded from the full economic, social, and subsequently, health benefits of society (Labonte, 2009).

Statement of Research Purpose

The purpose of this study, theoretically informed by intersectionality, is to critically examine the socio-political context, health needs, exclusionary and inclusionary forces, and strategies of resistance demonstrated by women experiencing homelessness. Socio-political context refers to the material, economic, political, and cultural conditions shaping life experiences. This context is inclusive of public policies influencing everyday realities for these women.

Summary of Research Approach

The theoretical underpinnings of this study fall under the critical paradigm and are derived from the critical theory of intersectionality. Within this perspective, historical, political, and structural elements are recognized as important influences of one's lived reality (Carroll, 2004). Recognizing the structural and systemic issues contributing to homelessness among mothers, intersectionality provides a well-suited framework to address the socio-political factors influencing the social exclusion and health of homeless mothers (Hankivsky & Christoffersen, 2008). This study was comprised of two phases and two methodologies: Critical narrative methodology and critical discourse analysis.

In phase one, critical narrative methodology was employed and was theoretically informed by the work of a number of scholars (Chase, 2005; 2011; Labov, 1972; McCormack, 2000a; 2000b; 2004). With narrative inquiry, focus is placed on the story and the way in which stories are created, shared, and re-presented (Chase, 2005). Further,

critical narrative as a methodology emphasizes the creation of space for participants to tell their story (Chase, 2005). As a doctoral student researcher, I partnered with two organizations providing shelter accommodations to women in Southern Ontario. One organization provided services to pregnant and parenting young mothers experiencing homelessness; the other organization provided supports specifically to women fleeing domestic violence.

In phase two, a critical discourse analysis of *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019* (Government of Ontario, 2014), was conducted. The second phase provided a further understanding of the socio-political elements shaping participants' lives and served to bring the voices and perspectives of the participants into the critique of current policy. A more robust discussion of the theoretical and methodological underpinnings is presented in Chapter 3.

Positionality/Self-Reflexivity

Employing a critical orientation to narrative inquiry, or the exploration of "critical tales" (Van Maanen, 1988), provided a purposeful lens to illuminate larger social, political, and/or economic issues (Berman, 2009). Narrative inquiry recognizes the contextual and subjective nature of all knowledge and ways of knowing, including that of the researcher (Josselson & Lieblich, 2001). According to Tsekeris (2010), a researcher's engagement in reflexivity involves positioning, or locating, themselves in the contexts in which they study. In this process, how the researcher's social, cultural, and historical selves shape their perceptions is explored (Lather, 2007; Tsekeris, 2010). That is, the researcher is a "living, contradictory, vulnerable, evolving multiple self who speaks in a partial, subjective culture-bound voice" (Foley, 2002, p.474). The identification of the researcher's positioning does not invalidate findings, but rather it is a necessary

component of critical qualitative work and further enhances the rigour of the research by undermining value-free, objective research approaches (Foley, 2002; Lather, 1993; 2007) (see Chapter 3, pages 83-88, for a more in-depth discussion on reflexivity and rigour).

My worldview is congruent with the philosophical underpinnings of the study. The transparency in identifying the critical nature of the study, and in the application of intersectionality as a framework to the study, allows the reader to engage with the analysis process. I identify as a feminist woman, and thus I have a heightened awareness of, and interest in, issues of injustice and inequity. My feminism takes the form of feminist intersectionality in my worldview and understandings of life experiences. The transparency in research framing allows for recognition that the study interpretations and analysis were viewed through specific lenses, giving primacy to the social, economic and political structures of inequity shaping the health and lives of mothers experiencing homelessness.

Further, my professional background and experiences not only shaped the creation of the research study, but also provided specific insights, vulnerabilities, and contradictions that consistently required critical thought and reflection. For example, my background as a mental health nurse working in acute and tertiary health care settings shaped my interest in recognizing how homelessness can impact one's mental health, and likewise, how compromised mental health can lead to homelessness. I have worked with numerous individuals experiencing homelessness in this capacity. Working in these settings for seven years has brought to light the complexities individuals experiencing homelessness face, and the often-insurmountable injustices they experience. Likewise, I have engaged in research, as a research assistant for over a decade. I have been involved in research pertaining to mental health and homelessness, homelessness and diversity,

psychiatric survivors and social inclusion, and health literacy among criminalized women. Further, I was a volunteer street nurse with a local organization providing street-level care to individuals experiencing homelessness. Lastly, in 2009 I completed my Master of Science in Nursing Degree, where I examined issues of oppression and resistance in the lives of mothers with mental illness experiencing homelessness.

All of these experiences have further highlighted, to me, the structural challenges faced by certain groups in our society, and shaped my worldview and drive to expose such injustices. Women's stories of not being able to maintain custody of their children due to their own mental illnesses, homelessness status, criminalization and/or addiction issues were prominent in each of my professional experiences. Similarly, women having to choose between returning to an unsafe situation or becoming homeless was also far too common in the lives of the mothers with whom I have worked. The injustice of these situations continued to propel my interest in working with mothers (with and without physical custody of their children) experiencing homelessness to support their unique needs and shed light on the systemic issues impacting their health and well being. Throughout these experiences I have been in awe of women's strength, resilience, and action to overcome circumstances beyond their control.

In terms of my social positioning, I am a middle-class, married, Caucasian woman. At the time of data collection I did not have children and I was in my late twenties. My education privilege, privilege of safe employment and access to consistent income, as well as secure housing also shaped my positioning within this study. My personal social locations including my personal and professional background and philosophical worldview created ease in interacting and building relationships with service provider participants, as well as in partnering with agencies and key stakeholders.

We effortlessly engaged in discussion on the current culture of health and social care for vulnerable groups, long wait times for individuals with mental illness, and the great overlap in clientele we shared in our professional worlds. In addition to these aspects, I was able to connect with service providers based on interests, research, mutual colleagues, and worldviews.

Despite the varying nature of relationships participants had with service providers in this current study (as described in Chapter 4: Study Findings), I believe that my professional background as a nurse supported my partnership not only with service provider participants, but also with the mothers. With many of the participants there was an immediate trust in our relationship; this was especially noted after I shared my clinical experiences, study information, and philosophical worldview. However, in some interviews with younger mothers I was asked, on more than one occasion, if I worked for child protection services (Children's Aid Society), despite my introduction of my professional background. I had not considered the incredible impact that "age" would have in shaping my social locations and power in interactions with some participants. Further, the intersections of age and class of my social positioning undoubtedly reinforced imbalanced power relations. Prior to study commencement, I was blind to this inherent privilege and quickly recognized the powerlessness related to being young in age as some of the women experienced in their lives. This required more time for building trust in the research process, and often times it was within the follow-up interview or part way through the interview where some of the young mothers were more at ease and really began to share their stories. Further, in my attempts to diminish power relations, I engaged in the researcher-participant relationship in such a way that demonstrated genuine empathy, care, and invested interest in their experience. That is, I was not an

unattached and objective researcher.

Further, research participants shared a variety of ethno-cultural identities. While many women spoke freely about racialized issues and the challenges they experienced as newcomers, I acknowledged the potential influence of my ethno-cultural identity on participant ease, comfort and sharing of narratives. The participants were not homogenous and my social locations created various relations of power and privilege that I was mindful of and reflected on after each interview. In recognition of the inherent power the researcher brings into each interview, participant power and control was maximized through specific methods and within the overall intent of the research to provide spaces for women's voices to be heard (Duffy, 2007).

Lastly, I also have historical and current lived realities that influence my passion and worldview. I have experienced childhood poverty, housing instability and insecurity, and issues of safety. Likewise, family and close friends in my life continue to experience poverty, homelessness, mental illness, and victimization. These experiences have further shaped my perspectives on health, inequity, and injustice, as well as my compassion and passion for this study. During one interview, one young woman asked if I had any personal experience with low-income housing, outside of "work" experiences. I proceeded to share my experience of living in public housing. This connection and vulnerability seemed to enhance trust and openness between the participant and myself. In this way, self-disclosure not only ensured transparency, but it built collaboration and alliances (Josselson, 2007). Through my field notes and journaling I reflected on my interpretations and grounded my understandings in the theoretical underpinnings of the study. Further, I ensured that within each interview I sought validation and clarification to make meaning of participants' stories, not to silence my own voice, but to ensure that

the intent and meaning of participants' stories were shared (Caeilli, Ray, & Mill, 2003; Chase, 2011; Lather, 2007).

Background

Homelessness in Canada: The Historical and Current Political Context

Families, most often headed by single mothers (Weinreb, Buckner, Williams & Nicholson, 2006), are a significant and growing population of homeless persons in North America. Lack of affordable housing and poverty are leading causes of homelessness for single mothers; yet without governmental action, the crisis of homelessness will likely worsen (Khandor & Mason, 2007; Laird, 2007; Shapcott, 2009). In Canada, single mothers are considered to be one of the most vulnerable and poorest groups (Raphael, 2009; Shapcott, 2009), with 90% of single mothers under the age of 25 living in poverty (Czapska, Webb, & Taefi, 2008). Several researchers have identified that domestic violence is among the most common reasons for homelessness among mothers and their children (Sev'er, 2002; Tischler & Vostanis, 2007; Tutty et al., 2009; Van Berkum & Oudshoorn, 2015). Homelessness among women, particularly women with children, is particularly 'hidden' from mainstream discourses and public knowledge. In fact, homeless mothers are considered to be one of the least recognized groups of the homeless population (Anooshian, 2005), despite the fact that they are among the fastest growing groups of shelter users (Rahder, 2006; Tischler, Rademeyer, & Vostanis, 2007).

Housing is a key social determinant of health (Raphael, 2009). It is well documented that people experiencing homelessness have poorer physical health compared to the general population (Hwang, 2001; Hwang et al., 2009; Shanzer, Dominguez, Shrout & Canton, 2007). However, homeless women face a multitude of unique barriers to health. Not only are these women experiencing higher rates of

violence, trauma, mental illness, and substance abuse than the general population (Shanzer et al., 2007; Weinreb, Nicolson, Williams, & Anthes, 2006), but homeless women experience significant health consequences related to their homelessness, such as high rates of mortality, and multiple acute and chronic health conditions (Fazel, Geddes, & Kushel, 2014; Hwang et al., 2009). Evidence suggests that homeless mothers and their children suffer disproportionately from the negative health consequences of homelessness (Hatton, Kleffel, Bennett, & Gaffrey, 2008). In fact, Whitzman (2006) indicates that women experiencing homelessness in Canada encounter higher rates of almost every disease and have poorer health, when compared with the general female population in Canada.

Mothers experiencing homelessness live at the intersection of multiple compounding sources of inequity in a hierarchical society that devalues the lives of women (Neysmith, 1995). Exploring social exclusion can illuminate the structural factors that shape their lives and influence their health. In doing so, the multi-dimensional dynamics of health inequities can be exposed (Galabuzi, 2009; Raphael, 2007a; World Health Organization [WHO], 1986).

As noted, access to safe and adequate housing is recognized as an important social determinant of health (Raphael, 2009; WHO, 1986), and as a human right (United Nations, 1948). Yet, in Canada, countless individuals and families are homeless or precariously housed. It is difficult to estimate the actual number of people experiencing homelessness in Canada. Attempts to quantify the problem can only be done by using shelter data by not-for-profit agencies or municipalities, point-in-time counts, and are not consistent across the country. Such methods can be effective at providing a snapshot of the numbers of individuals residing in shelters. However, it is much more difficult to

identify the full scope of individuals and families experiencing homelessness, but who are not residing in shelters. That is, any current numeric representation of the crisis of homelessness is likely to be an underestimation of the true problem. Those who have attempted to identify both the hidden and visible homeless populations have attempted to take into account issues of underestimation, and project that 150 000 to 300 000 people in Canada experience homelessness annually (HRSDC, 2010; Laird, 2007; Shapcott, 2009). Researchers affiliated with the Homeless Hub, a Canadian web-based homeless research database, estimate that there are approximately 30,000 homeless people in Canada on any given night. This estimate includes 2,880 unsheltered persons, 14,400 staying in emergency shelters, 7,350 staying in violence against women shelters and 4,464 staying in temporary institutional accommodation, and another 50,000 hidden homeless persons who are precariously housed (Gaetz, Donaldson Richter, & Gulliver, 2013). Women with children, Aboriginal people, new immigrants, and individuals with mental illness are disproportionately represented in the homeless population (HRSDC, 2010).

 Although housing is acknowledged in Ontario Human Rights Code, housing is not recognized in the Canadian Charter of Rights and Freedoms, nor in the *Canadian Human Rights Act*. However, at the international level, Canada has signed the *International Covenant on Economic Social and Cultural Rights (ICESCR)* (United Nations, 2006), and the *Universal Declaration of Human Rights,* which recognizes that access to adequate housing is a fundamental human right. The Universal Declaration of Human Rights, (United Nations, 1948, Article 25) indicates that:

> Everyone has the right to a standard of living adequate for the health and well-being of himself [sic] and of his [sic] family, including food, clothing, housing and medical care and necessary social services, and the right to security in the

event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [sic] control.

While once praised for its progressive housing policies, the devastating nature of Canada's housing and homelessness crisis has been named a national emergency by the United Nations (UN). In a report for the United Nations, former UN Special Rapporteur Miloon Kothari outlined the Canadian Government's failure to meet international human rights obligations regarding the availability of affordable housing and declared an immediate need for a national housing policy (United Nations, 2007). Yet, Canada remains one of the only developed nations without a national housing policy.

The Federal Government by and large abandoned its responsibility to play a central role in housing policy through specific policy changes that took place in the 1980s and 1990s. Under the Canadian Constitution, both the Federal and Provincial Governments have jurisdiction to make laws and policies related to housing. Historically, the Federal Government's role has been to finance and allocate housing stock and ensure social housing needs of residents are met. The provinces and municipalities have played important roles in shaping and administering housing programs, often sharing costs of administering these programs with the Federal Government (Heffernan, Faraday, & Rosenthal, 2015).

The National Housing Act, introduced in 1944, consolidated all existing housing policies and gave the Federal Government a lead role in housing programs (The Canadian Mortgage and Housing Corporation [CMHC], 2015). CMHC was created two years later in 1946 to lead the nation's housing programs. These programs were predominantly focused on home ownership; for example, the CMHC played a key role in facilitating mortgage lending. In 1963, policy changes created a program requiring joint federal and

provincial funding to subsidize low-income housing units (Hulchanski, 2006). The National Housing Act was later amended in 1973 to create a National Housing Plan. In the decades that followed, the Federal Government financed over 600,000 low and moderate income housing units around the country (Heffernan et al., 2015).

However, reforms that began in the 1980s slowed funding to the construction of new rental units, and the National Housing Plan was eventually dismantled by 1993 (Gaetz, 2011; Shapcott, 2010). In 1996, the Federal Government transferred responsibility for social housing to the provinces, but also drastically reduced transfer payments to the provinces in order to reduce the federal deficit (Gaetz, 2010; 2011; Hulchanski, 2004). Consequently, the provinces radically reduced their own program spending, particularly in the spheres of housing and social welfare. Meanwhile, the Federal Government shifted its housing policy direction to programs that privileged homeownership, such as subsidies for homebuyers and access to loans, resulting in expanding socioeconomic inequity between homeowners and renters (Hulchanski, 2004). These policy changes, in conjunction with booming housing prices, trade liberalization and a polarizing distribution of income, hastened a large-scale "dehousing process" (Hulchanski, 2004, p. 226) and increased chronic poverty in Canada (Laird, 2007). Strangely, the dismantling of the federal National Housing Plan and cuts to transfer payments were executed by the majority Liberal Government, despite that just years earlier, in 1990, Liberal Members of Parliament, Joe Fontana and Paul Martin, released a report entitled *Finding Room: Housing Solutions for the Future: Report of the National Liberal Caucus Task Force on Housing* (Parliament of Canada, 1990), which called for the development of a national housing strategy. No such strategy was passed after this report; rather, the Liberal Government—with Paul Martin driving many of these changes

as Minister of Finance—implemented policy shifts that spurred and deepened the homeless crisis.

Housing activists, policy makers, academics, politicians, and concerned citizens from across the country have been advocating for a national housing strategy with legislative backing that would ensure that all Canadians have access to affordable, accessible, and safe housing (ACORN Canada, 2010; Benbow, Forchuk, & Ray, 2011; Canada Without Poverty, 2012; Canadian Federation of University Women, 2010; Centre for Equality Rights in Accommodation, 2010; Davies, 2009; Hulchanski, 2005; Layton, 2008; Raising the Roof, 2010; Red Tents, 2010; Shapcott, 2009). The last three decades have been such that politics, not legal or constitutional restraints, have governed housing and homeless policy (Hulchanski, 2004). A concrete strategy with legislative backing would give financial and political stability to homeless and housing initiatives.

Efforts to pressure the government to adopt a national strategy have also been undertaken at the political level. In 2001, New Democrat Member of Parliament, Libby Davies introduced a National Housing Bill of Rights. The draft was not debated but served as the basis of a private member's bill (Bill C-382, 2006), put forth in 2006 by New Democrat Member of Parliament, Irene Mathyssen (Bill C-382, 2006). Bill C-382 did not proceed past its first reading. However, in 2009, with a minority Conservative government, New Democrat Member of Parliament, Libby Davies put forth a similar private member's bill (Bill C-304, 2009), an Act proposed to ensure secure, adequate, accessible and affordable housing for Canadians (40th Parliament, 2nd Session). Bill C-304 had the support from Liberal, New Democratic, and Bloc Québécois Members of Parliament. After passing its second reading, it was sent to the Standing Committee on Human Resources, Skills, and Social Development and the Status of Persons with

Disabilities. Unfortunately, despite much political will and support, the bill died on the order paper with the May 2011 federal election, which resulted in the Conservative Party of Canada winning a majority government. In 2012, building on the work that was initiated nearly a decade ago, Bill C-304, subsequently labelled Bill C-400 (Bill C-400, 2012), was reintroduced by MP Marie Claude Morin. Despite strong organizational and grassroots support of the bill, it was defeated during its second reading in the House of Commons.

In response to Canada's relative lack of action on homelessness, a group of community members, including previously homeless persons, activists, lawyers and academics filed a lawsuit against the Governments of Canada and Ontario in 2010. The *Right to Housing* challenge argued that the Federal and Provincial Governments have failed to uphold their responsibilities under the *Charter of Rights and Freedoms* to safeguard social and economic rights. The Ontario Superior Court and Ontario Court of Appeal struck down the challenge, and the plaintiffs are currently appealing to the Supreme Court of Canada (Heffernan et al., 2015).

Although Canada lacks a national housing policy, the Federal Government has developed initiatives to support communities and individuals struggling with inadequate housing. In response to the homeless crisis observed in the 1990s and growing pressure from communities, the Federal Government implemented the National Homeless Initiative (NHI) (1999-2007), which invested nearly $1.2 billion over eight years to address homelessness. The initiative invested in emergency services for homeless populations, funded a "community-driven planning process to address longer-term needs and prevention", and implemented measures to help individuals facing homelessness to gain and maintain self-sufficiency (HRDSC, 2008, p. i). Despite such an investment,

there was "little or no appreciative improvements in the situation" (Gaetz et al., 2013, p. 10). However, several provincial governments have established integrated plans to end homelessness and several cities have seen reductions in homeless populations, particularly though Housing-First initiatives (Gaetz et al., 2013).

In 2007, the NHI was replaced with the Homelessness Partnering Strategy. The strategy supports 61 communities and partners with provinces, territories, communities, and organizations through funding housing-first options and community-based efforts to reduce homelessness (HRSDC, 2011). It also "carries out research to foster a better understanding of homelessness, and it collects and promotes best practices to help design the most effective responses" (HRSDC, 2011, para. 2).

In 2009, an evaluation of the Homelessness Partnering Strategy (HPS) documented the significant work and progress that has been initiated through this strategy. However, several limitations of the strategy were also identified. For example, community partners noted that the lack of sufficient funding and sustainable timeline had major impacts on the effectiveness of homelessness programs initiated (HRSDC, 2009). The limited funding is of particular importance, since the funding allotted for HPS has not increased since its inception despite an increasing prevalence of homelessness across the country, according to local enumerating efforts (HRSDC, 2009). Transitional housing programs and housing-first programs were found to be unable to keep up with demand, despite their effectiveness. Lastly, many community groups identified the lack of affordable housing as a key player in homelessness; however, affordable housing falls outside of the HPS mandate (HRSDC, 2009). While a key strength of both the NHI and HPS has been the emphasis on community-based solutions in addressing homelessness, neither provides broad, strategic approaches toward putting an end to homelessness. As

such, these initiatives have largely helped to manage the homelessness crisis, as opposed to addressing its root causes (Gaetz, 2010).

In light of the absence of a coordinated, national action strategy on homelessness, municipalities and other community-based initiatives have largely led the way (Gaetz et al., 2013; Shapcott, 2010). Despite many promising initiatives in cities across the country, the reliance on local efforts has often resulted in fragmented, short-term, *ad hoc* and downstream responses such as investment in emergency services instead of strategic, preventative measures (Gaetz, 2010). However, the provinces have worked toward filling the gap left by the national government on strategic action to address housing and homelessness. For example, in 2007 the Province of Alberta launched its Secretariat for Action on Homelessness, which released a plan the following year to end homelessness in the province in ten years (The Alberta Secretariat For Action On Homelessness, 2008), and the Province of Quebec released its *Plan d'action interministériel en itinérance* 2015-2020 (Interministerial Homelessness Action Plan 2015-2020) in 2014, pledging $52M to address homelessness in the province (Government of Quebec, 2014). The Provinces of British Columbia (2006), Manitoba (2009), New Brunswick (2010), Newfoundland (2009), Nova Scotia (2013), Saskatchewan (2013) all have released strategies or action plans on housing and homelessness in recent years.

The Province of Ontario released its first *Long-Term Affordable Housing Strategy* in 2010, and introduced the *Housing Services Act* in 2011, which required communities around the province to develop 10-year local housing and homelessness plans (Government of Ontario, 2015a). Recently, the province released its more ambitious poverty reduction strategy, *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019* (Government of Ontario, 2014), which sets out a commitment to

establish long-term goals to end homelessness in Ontario. To achieve this goal, the

province released an updated *Long-Term Affordable Housing Strategy* in the spring of

2015, and developed an expert panel for consulting and planning. Informed by this expert

advisory group, the Government of Ontario has committed to ending chronic

homelessness in 10 years (Government of Ontario, 2015b). Despite the improvements

made in several communities, and the aforementioned political will to end homelessness,

overall there has been no meaningful reduction in homelessness achieved at a national

level (Gaetz et al., 2013). Without improvements in the state of homelessness in Canada,

the significant impact of homelessness on health will only worsen.

Relevance

The impact of homelessness on health is significant. Leading to, and as a result of

homelessness, homeless mothers are at the intersection of multiple layered inequities.

The Canadian Nurses Association (2009) asserts that nurses must strive for social justice

by gaining greater insight into existing inequities that ultimately shape and are shaped by

one's health. That is, we have a moral and professional responsibility to understand and

address socio-political inequities impacting health (Benbow, 2009). The negative health

consequences experienced by homeless mothers have been well documented (Cheung &

Hwang, 2004; Hwang, 2001; Hwang et al., 2009), but there is a need shed light on the

socio-political influences of mothers' homelessness, and how their experiences of social

exclusion and homelessness influence their health. Moreover, when health ailments

among this population are identified, rarely are acts of resistance explored. A critical

narrative inquiry, in addition to a policy analysis was undertaken to provide insight into

the how the personal and political realms intersect to influence the health and health

experiences of these women. This study was developed not only to better understand

homeless mothers' experiences of social exclusion and health, but to also create empowering spaces for the women to share their truths and tell their stories. It is anticipated that the findings from this study will support ongoing efforts by health and nursing advocates in identifying how the health of this group can be promoted.

Dissertation Overview

This dissertation is organized in an integrated article format (as regulated by the School of Graduate and Postdoctoral Studies at Western University, London, Ontario) containing six chapters, three of which are stand-alone manuscripts to be submitted for publication. **Chapter One** serves as a brief introduction to this study with a summary of research purpose and approach, as well as a background to the context of homelessness in Canada. **Chapter Two** continues to serve as a background chapter, but is a stand alone chapter, focused on the concept of social exclusion and health and has been accepted for publication in the *Canadian Journal of Nursing Research*. In **Chapter Three**, relevant literature is reviewed pertaining to study purpose and an in-depth examination of this study's theoretical and methodological underpinnings are provided. **Chapter Four** is a stand-alone article of study findings from the first phase of this study. This article will be submitted to *Qualitative Health Research* for publication. **Chapter Five** is also a stand-alone article and the second phase of this study. In this article, a critical discourse analysis is employed to examine *Realizing Our Potential: Ontario's Poverty Reduction Strategy (2014-2019)* (Government of Ontario, 2014). **Chapter Six** provides a synthesis of the entire research study, with implications for nursing practice, policy, education, and research outlined. At times, there is repetition between chapters because of the integrated article format, particularly pertaining to the study purpose, literature review, and theoretical and methodological components. To avoid excessive repetition, the reader is

at times directed to a previous or upcoming section for further explanation.

References

ACORN Canada. (2010). *Red Tent goes national*! Retrieved from http: www.pivotlegal.
      Org/files/Pivot_Point5_Aug2010_Web.pdf

Alberta Secretariat For Action On Homelessness. (2008). *A plan for Alberta – Ending
      Homelessness in 10 years.* Retrieved from http://humanservices.alberta.ca/
      documents/PlanForAB_Secretariat_final.pdf.

Anooshian, L. (2005). Violence and aggression in the lives of homeless children. *Journal
      of Family Violence, 20*(6), 373-387. Doi: 10.1007/s10896-005-7799-3

Benbow, S., (2009). Societal abuse in the lives of individuals with mental illness. *The
      Canadian Nurse, 105*(6), 30-32.

Benbow, S., Forchuk, C., & Ray, S. (2011). Mothers with mental illness experiencing
      homelessness: A critical analysis. *Journal of Psychiatric and Mental Health
      Nursing, 18*(8), 687-695. Doi: 10.1111/j.1365-2850.2011.01720.x

Berman, H., Mulcahy, G.A., Forchuk, C., Edmunds, K.A., Haldenby, A., & Lopez, R.
      (2009). Uprooted and displaced: A critical narrative study of homeless,
      Aboriginal, and newcomer girls in Canada. *Issues in Mental Health Nursing, 30*,
      418-430. Doi: 10.1080/01612840802624475

Bill C-304. (2009). *Bill C-304: An act to ensure secure, adequate, accessible, and
      affordable housing for Canadians*. First Reading, Feb 10, 2009, 40th Parliament,
      2nd Session. Retrieved from http://www.parl.gc.ca/HousePublications/Publication
      .aspx? Pub=Bill&Doc=C-304_1&Language =&Mode=1&Parl=40&Ses=
      2&File=24

Bill C-382. (2006). Bill C-382: *An act to ensure secure, adequate, accessible, and
      affordable housing for Canadians*. First Reading, Nov. 11, 2006, 39th Parliament,
      1st Session. Retrieved from http://www.parl.gc.ca/LEGISInfo/BillDetails.aspx?
      BillId =2190114&Language=E&Mode=1

Bill C-400. (2012). *Bill C-400: An act to ensure secure, adequate, accessible, an
      affordable housing for Canadians*. First Reading, February 16th, 2012. 41st
      Parliament, 1st Session. Retrieved from http://www.parl.gc.ca/Legisinfo/
      BillDetails.aspx?Language= E&Mode=1&billId=5353445

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic
      qualitative research. *International Journal of Qualitative Methods, 2*(2). Article 1.
      Retrieved from http://www.ualberta.ca/~iiqm/backissues/pdf/caellietal.pdf

Canada Without Poverty. (2012). *Renewed call for a National Housing Strategy*. Retrieved from http://www.cwp-csp.ca/2012/02/renewed-call-for-a-national-housing-strategy/

Canadian Federation of University Women. (2010). *Homelessness: Its time for a national housing strategy*. Retrieved from http://www.cwp-csp.ca/2012/02/renewed-call-for-a-national-housing-strategy/

Canadian Housing and Mortgage Corporation (CMHC). (2015). *The History of CMHC*. Retrieved from https://www.cmhc-schl.gc.ca/en/corp/about/hi/

Canadian Nurses Association. (2009). *Ethics in practice: Social justice in practice*. Retrieved from http://www.cnanurses.ca/CNA/documents/pdf/publications/Ethics_in_Practice_April_2009_e.pdf.

Carroll, W.K. (2004). *Critical strategies for social research*. Toronto: Canadian Scholars' Press Inc.

Centre for Equality Rights in Accommodation. (2010). *Bill C304: A national housing strategy.* Retrieved from http://www.equalityrights.org/cera/?p=1015

Chambers, C., Chiu, S., Scott, A. N., Tolomiczenko, G., Redelmeier, D. A., Levinson, W., & Hwang, S. W. (2014). Factors associated with poor mental health status among homeless women with and without dependent children. *Community Mental Health Journal*, *50*(5), 553-559. Doi: 10.1007/s10597-013-9605-7

Chase, S. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (3rd ed.) (pp. 651-679). Thousand Oaks, California: Sage Publications.

Chase, S., (2011). Narrative inquire: Still a field in the making. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (4th ed.) (pp. 421-434). Thousand Oaks, California: Sage Publications.

Cheung, A.M., & Hwang, S.Q. (2004). Risk of death homeless women: A cohort study and review of the literature. *Canadian Medical Association, 170*(8), 1243-1247. Doi: 10.1503/cmaj.1031167

Czapska, A., Webb, A., & Taefi, N. (2008). *More than bricks and mortar: A rights-based strategy to prevent girl homelessness in Canada*. Vancouver: Justice for Girls.

Davies, K. (2009). *Libby's bill for a national housing strategy*. Retrieved from http://www.libbydavies.ca/parliament/speech/2009/04/01/libby-s-bill-national-housing-strategy

Duffy, M. (2007). Narrative inquiry: The method. In P.L. Munhull (Ed.), *Nursing research: A qualitative perspective* (pp. 401-421). Boston: Jones & Bartlett.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*, *384*(9953), 1529-1540.

Foley, D.E. (2002). Critical ethnography: The reflexive turn. *Qualitative Studies in Education, 15*(5), 469-90. Doi:10.1080/09518390210145534

Gaetz, S. (2010). The struggle to end homelessness in Canada: How we created the crisis, and how we can end it. *The Open Health Services and Policy Journal, 3*(21), 21-26.

Gaetz, S. (2011) *Plans to end youth homelessness in Canada - A review of the literature.* Toronto: Eva's Initiatives. Retrieved from http:// learningcommunity.ca/lcwp/wp-content/uploads/2012/12/Ending-Homelessness-in-Canada-backgrounder_April252011.pdf

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The state of homelessness in Canada.* Toronto: Canadian Homelessness Research Network Press. Doi: 10.2174/1874924001003010021

Galabuzi, G. (2009). Social exclusion. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed.) (pp. 252-268). Toronto: Canadian Scholars' Press Inc.

Government of Ontario. (2014). *Realizing our potential: Ontario Poverty Reduction Strategy, 2014-2019.* Retrieved from http://www.ontario.ca/home-and-community/realizing-our-potential-ontarios-poverty-reduction-strategy-2014-2019

Government of Ontario. (2015a). *Long Term Affordable Housing Strategy Update Consultation.* Retrieved from http://www.ontariocanada.com/ registry/view.do?postingId=18302

Government of Ontario. (2015b). *News release: Ontario commits to ending chronic homelessness in 10 years. Province releases report from expert advisory panel on homelessness.* Retrieved from https://news.ontario.ca/mah/en/2015/10/report-of-the-expert-advisory-panel-on-homelessness.html

Government of Quebec. (2014). *Plan d'action interministériel en itinérance.* Retrieved from http://publications.msss.gouv.qc.ca/acrobat/f/docum entation/2014/14-846-02W.pdf

Hankivsky, D., & Christoffersen, A. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, 18(3), 271-283. Doi:10.1080/09581590802294296

Hatton, D., Kleffel, D., Bennett, S., & Gaffrey, N. (2008). Homeless women and

children's access to health care: a paradox. *Journal of Community Health Nursing, 18*(1), 25-34. Doi:10.1207/S15327655JCHN1801_03

Heffernan, T., Faraday, F., & Rosenthal, P. (2015). Fighting for the right to housing in Canada. *Journal of Law and Social Policy, 24*(1), 10-45.

Huey, L., Fthenos, G., & Hryniewicz, D. (2013). "If something happened, I will leave it, let it go and move on": Resiliency and victimized homeless women's attitudes toward mental health counseling. *Journal of Interpersonal Violence, 28*(2), 285-319. Doi: 10.1177/0886.260512454717

Hulchanski, J. D. (2004). What factors shape Canadian housing policy? The intergovernmental role in Canada's housing system. In R. Young, & C. Leuprecht (Eds.). *Canada: The State of the Federation* (pp. 221-247). McGill: Queen's University Press.

Hulachanski, J. (2005). *Rethinking Canada's housing affordability challenge: A discussion paper prepared for the Government of Canada's Housing Framing Initiative*. Retrieved from http://www.chs.ubc.ca/archives/files/ Rethinking%20Canada's%20Housing %20Affordability%20Challenge.pdf\

Human Resources and Skills Development Canada. (2008). *Summative evaluation of the National homelessness Initiative*. Retrieved from http://publications.gc.ca/ collections/collection_2013/rhdcc-hrsdc/HS28-149-2008-eng.pdf

Human Resources and Skills Development Canada. (2009). *Evaluation of the homeless partnering strategy July 2009*. Retrieved from http://www.hrsdc.gc.ca /eng/publications_resources/evaluation/2009/ehps/page00.shtml

Human Resources and Skills Development Canada. (2010*). The homelessness partnering strategy*. Retrieved from http://www.hrsdc/gc.ca/eng/homelessness/index.shtml.

Human Resources and Skills Development Canada. (2011). *About the strategy*. Retrieved from http://www.hrsdc.gc.ca/eng/homelessness/about_us/index.shtml

Hwang, S.W. (2001). Homelessness and health. *Canadian Medical Association Journal, 164*(2), 229-233.

Hwang, S.W., Wilkins, R., Tjepkema, M., O'Campo, P.J., & Dunn, J.R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *British Medical Journal, 339*, b4036. Doi: http://dx.doi.org/10.1136/bmj.b4036

Josselson, R. (2007). The ethical attitude in narrative research: Principles and Practicalities. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry* (pp 537-566). Thousand Oaks, Ca: Sage Publications.

Khandor, E., & Mason, K. (2007). *The Street Health report*. Retrieved online from
   http://www.streethealth.ca/Downloads/SHReport2007.pdf

Labonte, R. (2009). Social inclusion/exclusion and health: Dancing the dialectic. In D.
   Raphael's (Ed.), *Social determinants of health* (pp. 269- 279). Toronto: Canadian
   Scholars' Press Inc.

Labov, W. (1972). The transformation of experience in narrative syntax. In W. Labov
   (Ed.), *Language in the inner city* (pp. 352-396). Philadelphia: University of
   Pennsylvania Press.

Laird, G (2007). *Shelter: homelessness in a growth economy: Canada's 21st century
   paradox.* Calgary: Sheldon Chumir Foundation for Ethics in Leadership and
   Gordon Laird. Retrieved from www.gordonlarid.com

Lather, P. (1993). Fertile obsession: Validity after poststructuralism. *The Sociological
   Quarterly, 34*(4), 673-93. Doi: 10.1111/j.1533-8525.1993.tb00112.x

Lather, P. (2007). *Getting lost: feminist efforts toward a double(d) science*. Albany: state
   University of New York Press.

Layton, J. (2008). *Homelessness: How to end the national crisis.* Toronto: Penguin
   Group.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, 365(9464),
   1099-1104.

McCormack, C. (2000a). From interview transcript to interpretive story: part 1- viewing
   the transcript through multiple lenses. *Field Methods, 12*(4), 282-297. Doi:
   10.1177/1525822X0001200402

McCormack, C. (2000b) From interview transcript to interpretive story: part 2—
   developing an Interpretive story. *Field Methods, 12*(4), 298 – 315. Doi:
   10.1177/1525822X0001200403

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview
   conversations. *International Journal of Social Research Methodology, 73*, 219-
   236. Doi:10.1080/13645570210166382

Neysmith, S.M. (1995). Feminist methodologies: a consideration of principles and
   practice for research in gerontology. *Canadian Journal on Aging, 14*(1), 100-118.

Parliament of Canada. The National Liberal Caucus Task Force on Housing. (1990).
   Finding Room: Housing Solutions for the Future. Retrieved from
   http://www.urbancentre.utoronto.ca/pdfs/home/Finding_Room_1990_by_Paul_M

Pavao, J., Alvarex, J., Baumrind, N., Induni, M., & Kimberling, R. (2007). Intimate partner violence and housing instability. *American Journal of Preventative Medicine, 32*(2), 143-146. Doi: 10.1016/j.amepre.2006.10.008

Rahder, B. (2006). The crisis of women's homelessness in Canada. *Women & Environments International Magazine, 70/71*, 38-39.

Raising the Roof. (2010). *Housing Again Bulletin, number 135*. Retrieved from http://hosted- p0.vresp.com/688376/dc812ec3bd/ARCHIVE

Raphael, D. (2007a). Addressing health inequalities in Canada: Little attention, inadequate action, limited success. In M. O'Neil, A., Pederson, S., Dupere, & I. Rootman's (Eds.), *Health Promotion in Canada: Critical Perspectives*. (2nd ed.), (207-221). Toronto: Canada Scholars' Press Inc.

Raphael, D. (2007b). Making sense of poverty: Social inequality and social exclusion. In *Poverty and policy in Canada* (pp. 85-111). Toronto: Canadian Scholars' Press Inc.

Raphael, D. (2009). *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto: Canadian Scholars' Press Inc.

Red Tents. (2010). *Art and activism meet with the help of a red tent.* Retrieved from http://redtents.org/blog/art-and-activism-meet-help-red-tent

Schanzer, B., Dominques, B., Shrout, P., & Canton, C.(2007). Homelessness, health status and health care use. *American Journal of Public Health, 97*, 464-469. Doi: 10.2105/AJPH.2005.076190

Shapcott, M. (2009). Housing. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed.) (pp. 221-234). Toronto: Canadian Scholars' Press Inc

Shapcott, M. (2010). *Precarious Housing in Canada.* Toronto: The Wellesley Institute, Retrieved from http://www.wellesleyinstitute.com/publications/new-report-precarious-housing-in-canada-2010/

Sev'er, A. (2002). A feminist analysis of flight of abused women, plight of Canadian shelters: another road to homelessness. *Journal of Social Distress and the Homeless, 11*(4), 307-313.

Tischler, V., Rademeyer, A., Vostanis, P. (2007). Mothers experiencing homelessness: mental health, support and social care needs. *Health and Social Care in the Community, 15*(3), 246-253.doi: 10.1111/j.1365-2524.2006.00678.

Tischler, V., & Vostanis, P. (2007). Homeless mothers: Is there a relationship between coping strategies, mental health and goal achievement*? Journal of Community and Applied Social Psychology, 17*(2), 85-102. Doi: 10.1002/casp.879

Torchalla, I., Linden, I., Strehlau, V., Neilson, E.K., Krausz, M. (2015). "Like a lots happened with my whole childhood": violence, trauma and addiction in pregnancy and postpartum women from Vancouver's Downtown Eastside. *Harm Reduction Journal, 12*(1), 1-10, doi: 10.1186/1477-7517-12-1.

Tsekeris, C. (2010). Reflections on reflexivity: Sociological issues and perspectives. *Contemporary Issues, 3*(1), 28-36.

Tutty, L. M., Ogden, C., Giurgiu, B., Weaver-Dunlop, G., Damant, D., Thurston, W. E., Solerno, J. (2009). *"I built my house of hope:" Best practices to safely house abused and homeless women.* Calgary, Alberta: RESOLVE Alberta.

United Nations (1948). *The Universal Declaration of Human Rights*. Retrieved from http://www.un.org/en/documents/udhr/

United Nations (2007). *United Nations special rapporteur on adequate housing, Miloon Kothari: Mission to Canada*. Retrieved from http://www.unhchr.ch/huricane/ 25arleton25.nsf/0/90995D69CE8153C3C1257387004F40B5?opendocument

United Nations Committee on Economic, Social, and Cultural Rights. (2006, May). *Concluding observations of the Committee on Economic, Social, and Cultural Rights – Canada.* Accessed from http://canadians.org/water/documents/ CESCR_Concluding_Observation_2006.pdf

Van Berkum, A. & Oudshoorn, A. (2015). *Best practice guideline for ending women's and girl's homelessness*. Retrieved from http://ywcacanada.ca/data/research_docs/00000347.pdf

VanMaanen, J. (1988). *Tales of the field*. Chicago: University of Chicago Press.

Walsh, C.A., Rutherford, G., Krieg, B., & Bell, M. (2013). Aboriginal women's voices: breaking the cycle of homelessness and incarceration: *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 11*(3), 377-394.

Weinreb, L. F., Buckner, J. C., Williams, V., & Nicholson, J. (2006). A comparison of the health and mental health status of homeless mothers in Worcester, Mass: 1993 and 2003. *American Journal of Public Health, 96*(8), 1444-1448. Doi: 10.2105/AJPH.2005.069310

Whitzman, C. (2006). At the intersection of invisibilities: Canadian women, homelessness and health outside the 'big city'. *Gender, Place and Culture, 13*(4), 383-399. Doi: 10.1080/09663690600808502

World Health Organization (1986). *The Ottawa Charter for health promotion*. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

CHAPTER TWO

SOCIAL EXCLUSION AND HEALTH:

DEVELOPMENT OF NURSING KNOWLEDGE[1]

Introduction

Health is not equally distributed among all members of society. Profound health inequities exist in Canada and elsewhere in North America, which are rooted in complex structures of injustice (Raphael, 2007a). As a result, some individuals, groups, and communities bear greater health burdens than others and experience unique health challenges. Health is influenced by socio-political and contextual forces and the deep-seated exclusionary processes shaping these forces. Addressing such injustices is consistent with the Canadian Nurses' Association [CNA] (2009) mandate. CNA asserts that nurses must strive for social justice in health and in promoting health. Based on the social, moral, and professional imperative to examine root causes of health inequities, nurses can address, examine, and advocate for equitable health and health care practices (CNA, 2009, 2010), in a variety of ways, such as through nursing research.

It has been proposed that the concept of social exclusion sheds light on some of the structural processes at the source of health inequity, and has been recognized as a social determinant of health[2] (Raphael, 2009, 2007b). Thus, social exclusion is an important and relevant concept in nursing and in the development of nursing knowledge.

---

[1] The original version of this chapter was published in the *Canadian Journal of Nursing Research.,* and the copyright belongs to McGill University.

[2] "Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries" (World Health Organization, 2014).

The significance of impact of the concept of social exclusion is increasingly evident in health literature especially related to understanding and promoting the health of vulnerable groups (Hyman, Mercando, Galabuzi, & Patychuk, 2014). However, it requires in-depth examination to determine its relevance and significance for a nursing science aiming to better understand and reduce health inequities.

The purpose of this chapter is to explore the relevance of the concept of social exclusion in the development of nursing knowledge, specifically for nursing research. Theoretical knowledge on the concept of social exclusion will be explored, its use in health research will be examined, and a conceptualization of social exclusion for the development of nursing knowledge will be proposed.

Conceptualizations of Social Exclusion: Historical and Political Context

Social exclusion is recognized as a key determinant of health (Raphael, 2009); however, in Canada, researchers and policy makers are only beginning to apply existing knowledge and further explore social exclusion in the health of Canadians. 'Social exclusion' emerged as an analytical concept in the social policy of France's socialist governments in the 1970s. The impetus for this was, in part, a concern for the exclusion faced by certain social groups who were unprotected by social insurance safety nets (Percy-Smith, 2000). Paul Lenoir, a French social policy analyst, known for first coining the concept of social exclusion in 1974, identified ten groups labelled 'les exclus', meaning, 'the excluded', referring to a select set of people who, due to social processes, were left on the margins of society (Lenoir, 1974; Silver, 1995).

In the 1980s and 1990s, the use of this term was taken up by the European Union which led to the creation of the Social Exclusion Task Force. Policy initiatives began incorporating social exclusion discourses into the political arena, often replacing or being

used interchangeably with terms such as poverty and most often associated with 'exclusion from employment' (Peace, 2001). There was a shift in conceptual understanding, which may be reflective of neoliberal[3] influences along with a real focus on participation in the labour market. Policies developed from this 'new' understanding of social exclusion were critiqued as actually excluding groups from the political discourses of social exclusion (Peace, 2001).

In the late 1990s and early 2000s, social exclusion discourse in Canada emerged, building upon the existing social exclusion discourse in Europe (Yanicki, Kushner, & Reutter, 2014). In Canada at that time, social and health policy emphasized neoliberal ideologies with responsibility placed on the individual unit with a decreased recognition of the social structures contributing to existing inequalities. With this came erosion of social safety nets, an increase in poverty, and growing inequities (Toye & Infanti, 2004). Likewise, individual rather than collectivist responsibility was also dominant in health discourses (Low & Theriault, 2008). With the surge of racialized newcomers in the late 1990s, the racialization of poverty and the overrepresentation of racialized people in low-end jobs reflected the growing inequities (Galabuzi, 2009). While once praised for progressive social and health policies, Canada remains the only developed nation to lack a national policy on poverty and social exclusion (Yanicki et al., 2014), as well as a national housing strategy ensuring access to safe and affordable housing for all.

Within this context, social exclusion discourse gained increasing popularity as evidenced in important documents by governmental and non-governmental organizations.

---

[3] Neoliberal ideology refers to the philosophical belief that values individualism and recognizes that individuals are "the fundamental basis of society" (Gill, 2000, P.3). Neoliberalism is associated with governmental withdrawal from policy areas such as social welfare, including the provision of housing and income security, optimizing conditions for market activity (Harvey, 2006; Raphael, 2007b).

Health Canada's 2002 definition of social exclusion emphasized the lack of participation in social relationships and construction of society (Health Canada, 2002). The focus on participation can be attributed to an individual's contribution to society, often marked by labour market participation, without critical examination of hegemonic structures of inequity. Health Canada (2001) also recognized that exclusion encompasses the inability of certain groups to exercise their social, cultural, and political rights. The importance of social belonging is recognized, emphasizing an individual's 'inability' without in-depth discussion of structural inequalities or political processes that create problems of social exclusion.

Around the same time, The Laidlaw Foundation, a nongovernmental organization, commissioned a series of working research papers entitled, "Perspectives on Social Inclusion" to refocus child and family policy (Freiler & Zarnke, 2002). The series of papers brought several researchers, perspectives, and foci to the forefront of social exclusion and inclusion discourse in Canada. They addressed issues related to inequity and the social structures that influence exclusion. In response to the current Canadian context, the Canadian Council on Social Development (2001) produced documents on social exclusion and inclusion. Social exclusion discourse has continued to emerge and evolve in governmental and nongovernmental documents (Canadian Mental Health Association, 2012; Noel & Fortin, 2012; Standing Senate Committee on Social Affairs, Science and Technology, 2013). It is important to note the terminology shift in governmental and nongovernmental discourse, from social exclusion, to social inclusion, now more commonly to 'inclusion/exclusion', as overlapping and interconnected concepts.

Prevailing Perspectives and Conflicting Ideologies

There is no one universally accepted definition of social exclusion. Discourses on the subject appear to be divided in terms of underlying ideologies of the concept or framework. Political and ideological elements influence the ways in which politicians, policy makers, academics, and researchers define the concept of social exclusion. While not always made explicit, it is important to consider how these influences impact the understanding and application of social exclusion in nursing and health research. In public policy discourse, social exclusion is at times used interchangeably with poverty (Percy-Smith, 2000), and is understood as a process of alienation from society, reinforcing deprivation and creating isolation from mainstream opportunities in society (Vleminckx & Berghman, 2001). Canadian scholars, Galabuzi (2009) and Labonte (2009), emphasize the structural processes and social inequalities as key elements of social exclusion. Galabuzi (2009) is most noted for his emphasis on the multidimensional nature of social exclusion, recognizing that poverty is only one of many contributing factors and/or outcomes of social exclusion. Galabuzi and Labonte (2002) propose this definition of social exclusion:

> Social exclusion describes the structures and dynamic processes of inequality among groups in society. Social exclusion refers to the inability of certain groups or individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political, and cultural resources. These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion (p. 1).

Labonte (2009) emphasizes the need for a 'critical eye' in exploring social exclusion to ensure the underlying root causes of exclusion, such as oppressive hierarchies, are challenged.

Despite the existing reference to social structures and institutions, its application in public policy terms primarily focuses on the individual as the unit of analysis and the site of intervention. There has been a great emphasis in Europe and in Canada to combat social exclusion through increasing and promotion of education and employment opportunities, in which alleged 'workless households' are targeted (Dobrowolsky & Lister, 2005).

Numerous authors recognize the dynamic and complex relationship between social exclusion and social inclusion (Guidlford, 2000; Labonte, 2009; Popay, Escorel, Hernandez, Johnston, Mathieson, & Rispel, 2008). Discussions on social inclusion, similar to those on social exclusion, must be examined by understanding the philosophical roots and political purposes influencing its use and understanding. Social inclusion is not simply the opposite of exclusion, and confusion and interchangeability among these terms results in further ambiguity of both concepts. Social inclusion literature places emphasis on the outcome of being included in community life with access to equal opportunities and well-being (Guildford, 2000; Sen, 2001). Inclusionary and exclusionary situations are often entangled and are not mutually exclusive (Caxaj & Berman, 2010).

Labonte (2009) argues that 'forcing' inclusion of groups into the society that has historically and politically excluded them, without critically examining the structures and hierarchies, may perpetuate existing oppressive hierarchies and worsen health inequities. Labonte (2009) points out that uncritical application of social inclusion discourse can divert attention away from hierarchies of exclusion and those who benefit from them. Galabuzi and Labonte (2002), Labonte (2009), and Raphael (2007b) warn that social inclusion conceptualizations must move beyond the rhetoric and acknowledge and

address the exclusionary processes and hierarchies of inequity that warranted a need for inclusion in the first place.

Canadian nursing scholars, Yanicki and colleagues (2014) provide a comprehensive review and synthesis of the literature on social inclusion/exclusion discourse in Canada. They identify three overarching discourses on social exclusion/inclusion: (1) the discourse on recognition, (2) the discourse on capabilities, and (3), the discourse on equality. They situate these discourses in an Integrated Framework for Social Justice. Within this framework, social inclusion/exclusion is recognized as both relational and structural concepts:

> As a relational concept, SI/SE [social inclusion/exclusion] involves experiences and dynamic relational processes enabling or constraining participation and (un)just social relations. As a structural concept, SI/SE involves structures that shape equitable or inequitable access to wealth, resources, rights, power and prestige, as well as the structures that sustain (in)equities, oppression and differential opportunities (Yanicki et al., 2014, p. 6).

Situating existing social exclusion discourse within a social justice framework politicizes the concept and makes clear note of the underlying structures, influences, and experiences of exclusion while simultaneously putting a call to action for nurses to promote health equity (Yanicki et al., 2014).

Several frameworks have been proposed in an effort to understand social exclusion. Being mindful of the purposes of this paper, discussion of relevant understandings used in health-related literature on social exclusion will be used. Social exclusion has been described based on four aspects: (1) exclusion from civil society; (2) exclusion from social goods; (3) exclusion from social production; and lastly (4)

economic exclusion (Galabuzi, 2009; Galabuzi & Labonte, 2002; Percy-Smith, 2000; Taket, Crisp, Nevill, Lamaro, Graham, & Barter-Godfrey, 2009). The first aspect, the exclusion from civil society, occurs as a result of institutional mechanisms such as discrimination based on social identities or categories. The second aspect, exclusion from social goods, refers to the denial of health care, education, housing, income or language services. While this aspect discusses social goods, some authors have interchanged social goods with human rights or basic human needs (Burchardt, Le Grand, & Piachaud, 2002; Galabuzi, 2009). The third aspect examines the denial of opportunities to contribute to and participate actively in society. Barry (2002) refers to the structural inequities that influence exclusionary processes, thus acknowledging the element of social injustice in the denial of opportunities. In the social exclusion literature, a focus on participation without an examination of exclusionary processes may actually perpetuate inequities and promote further exclusion. If individual responsibility is promoted while hegemonic systems of inequity are left unchanged, the hierarchical and exclusionary nature of political, social, and economic institutions goes uncontested. The fourth aspect is the lack of access to sufficient economic resources and opportunities (Galabuzi & Labonte, 2002; Percy-Smith, 2000).

Percy-Smith (2000) proposes a framework of understanding the creation of social exclusion in broader context. Percy-Smith (2000) notes how social exclusion is intrinsically shaped by broad societal forces. The local contexts such as local governments and particularities of place, combined with national contexts, such as social assistance, welfare programs and economic policy are influenced by globalization, resulting in social exclusion. Percy-Smith (2000) argues that defining social exclusion in a way that ignores the complexity of political elements of exclusion is not an adequate

definition and is morally problematic.

Research Exploring Social Exclusion and Health in Canada

In Canada, researchers are only beginning to explore social exclusion in the health of Canadians (Wilson, Eyles, Elliott, Keller-Olaman, & Devcic, 2007). Internationally, much headway has been made in research examining health and social exclusion. However, in Canada, researchers examining social exclusion and health tend to focus primarily on material deprivation and poverty (Stewart, Reutter, Makwarimba, Veestra, Love, & Raphael, 2008; Wilson, et al., 2007), while some are starting to expand beyond this and include a social determinant of health approach to understanding social exclusion (Chambers et al., 2014; Reid, 2004). Further, limited exploration by nursing scholars in Canada with discussion of nursing relevance and implications exist.

Research on social exclusion and health has traditionally focused on issues of economic disadvantage, primarily examining issues of poverty and material deprivation. Stewart et al. (2008) used a critical sociological perspective and a social determinants of health framework to examine the relational processes that lead to social exclusion and inclusion. Social exclusion was conceptualized broadly as the social processes that prevent full engagement in social institutions and result in economic, political, and social deprivations. The study consisted of two-phases exploring and comparing experiences of social exclusion among low-income and higher-income participants in Toronto, Ontario, and Edmonton, Alberta. The first phase employed qualitative individual and group interviews (n=119) and the second phase consisted of a quantitative comparative survey design (n=1167). A purposive sample was used for the first phase, and a cross-sectional telephone survey was used to collect data for the second phase. Data revealed significant relationships between health and social exclusion. The findings showed that limited

financial resources, poor health, and scrutinizing societal attitudes inhibited community involvement among lower-income participants.

Similarly, Wilson et al. (2007) explored relationships between social exclusion and health using a quantitative comparative design. Social exclusion was conceptualized as occurring when people do not participate in key social activities and experience material deprivation. Mixed-method research design was employed. Quantitative data were collected using a cross-sectional household survey (n=300) in two economically and socially-contrasting neighbourhoods in Hamilton, Ontario. In-depth qualitative interviews were also conducted with 40 randomly-selected participants from the initial quantitative phase. The purpose of the interviews was to further examine participants' engagement in neighbourhood activities, their relationships with neighbours, as well as their perceptions of their neighbourhood. The results revealed differences in the characteristics and experiences of social exclusion between the neighbourhoods, suggesting that the neighbourhood with lower-income participants experienced more aspects and higher levels of social exclusion than participants in the higher-income neighbourhood. While demographic information was collected related to education, employment status, and income level, other potential influences, such as racial and ethnocultural identities, on social exclusion were not discussed.

Social exclusion has also been explored as it relates to mental health. Benbow, Rudnick, Forchuk and Edwards (2014) used a social justice lens to qualitatively examine social exclusion and poverty among psychiatric survivors in Ontario. Specifically, the authors used a capabilities approach to social justice. Approximately 67% of participants had experienced homelessness at least once in their life. The majority of participants were single, never married, 50% were female (n=190), and 50% were male (n=190). Grade

school was the highest education level for the majority of the participants (47%). Based on thematic analysis, four themes emerged: (1) Poverty: 'You just try to survive'; (2) Stigma: 'People treat you like trash'; (3) Belonging: 'You feel like you don't belong'; and (4) Shared concern and advocacy: 'Everyone deserves housing'. Individual and community agency were acknowledged as important elements in understanding one's role in creating change, empowerment, and action (Benbow et al., 2014).

Reid (2004) used feminist action research to explore the relationship between exclusion, poverty and women's health with 30 women in British Columbia. Qualitative data were gathered from one-to-one interviews, participant observation, research team meetings, and field notes. Participants were women of low-income. Reid (2004) framed the research in a social determinants of health framework. Findings revealed exclusion at the cultural, institutional and material levels with an in-depth analysis within each of these levels. On a cultural level, the participants experienced exclusion in the form of stereotypes and labels. On an institutional level, exclusion took the shape of degradation and disrespect as systems failed to address their needs. On a material level, the participants experienced exclusion from access to basic needs. Reid's work is particularly notable for her multidimensional understanding and application of social exclusion, and the politicizing of health, social exclusion, and poverty of women experiencing low-income.

Towards Improvements in Social Exclusion Research in Canada

Overall, as aforementioned, social exclusion research in Canada, as it relates to health, is in its infancy. Even more notable, social exclusion research as it relates to nursing specifically is almost nonexistent. Nurses are able to draw on existing health literature; however, specific exploration and examination within nursing research is

needed. While the existing Canadian studies provide substantial understanding of the components of social exclusion and health, a dearth remains in academic literature. In striving for further development of the concept of social exclusion, it is important to note that social exclusion is at times vaguely, or narrowly, defined and conceptualized in research. When breadth of social exclusion is included in its conceptualization, its complexity often does not translate into research purpose and methods. The "measurability" using particular quantitative surveys designed for specific purposes may in fact trump theoretical understandings. There appears to be a disconnect between use of the concept of social exclusion in the theoretical literature and in the health-related research.

In the theoretical literature, structural inequity is identified as an important aspect of social exclusion, yet it is rarely discussed in research studies. Examination of the notion of agency within structures of inequity is also not thoroughly examined. However, there has been much work in the theoretical literature on social exclusion as it relates to health among a variety of groups, based on an examination of inequalities (Arthurson & Jacobs, 2004; Daly & Silver, 2008; Galabuzi, 2006; 2009; Martin, 2004; Morgan, Burns, Fitzpatrick, Pinfold, & Priebe, 2007; Peace, 2001). Situating research in the political context of a study through policy analysis research is also lacking from current social exclusion research in Canada.

Another important limitation within the current knowledge, is that the intersections among multiple dimensions of inequity are rarely explored. Often, when inequities are explored, examination is done in static silos, especially when examining health disparities as a form of social exclusion. In the absence of an intersectional understanding of inequity, the potential to exclude groups or experiences that 'fall

between the cracks' of siloed frameworks is likely. Internationally, increasing progress has been made in the social exclusion literature with recognition of its multiple dimensions (Macdonald & Marsh, 2002; Mumtaz, Sakway, Shanner, Bhatti, & Laing, 2011; Tong, Lai, Zeng, & Xu, 2011). Lastly, in building on current research, the recognition of social exclusion as a determinant of health requires an analysis of how such exclusion leads to changes in health status and how nurses can best promote health in this context.

Conceptualization of Social Exclusion for Nursing Knowledge

The theoretical exploration of social exclusion reveals the importance of providing a sound conceptualization is important in advancing the science of nursing. Thus, for the purposes of promoting health in the development of nursing knowledge, the concept of social exclusion must be clearly defined.

For the purpose of nursing research, I suggest a conceptualization of social exclusion that is situated within a social-justice framework. Social justice is recognized at the heart of social exclusion and inclusion discourses in Canada (Yanicki et al., 2014), as well as a foundation for nursing science (Canadian Nurses Association, 2010). Social justice has many varied understandings based on diverse philosophical underpinnings. According to the World Health Organization (WHO) (1986) social justice, a prerequisite for health, is the belief that social organization should be such that there is equitable distribution of benefits and equitable responsibility of burdens in society and that focus is on "changing social relationships and institutions to promote equitable relationships". Many nursing scholars have embraced a more multidimensional understanding of social justice. Yanicki and colleagues (2014), go beyond the WHO definition to offer a conceptualization of social justice for nursing practice and knowledge development that

takes into account:

> (a)power/powerlessness, (b) respect and valued recognition/ misrecognition, stigma and fear of difference; (c) capability development/ capability deprivation; and (d) equality and citizenship/social inequality and oppression, also making note of the concepts of participation, empowerment and globalization (Yanicki et al., 2014, p. 6).

Within a social justice framework for nursing science, social exclusion can refer to the deeply embedded social processes whereby people are prohibited from participating in and benefiting from social and political institutions and experience economic, political, social, and health inequities. These inequities shape social exclusion and arise out of the often intersecting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status and the like (Galabuzi, 2009). We are suggesting that social exclusion situates people, but does not deny them agency, in disadvantaged positions in society, which ultimately impacts health and well-being.

For instance, the increasingly growing subsection of homeless mothers and their children (Anderson & Rayens, 2004; City of Toronto, 2003; Gaetz, Donaldson, Richter, & Gullier, 2013), similar to other vulnerable groups, face a multitude of health challenges (Cheung & Hwang, 2004; Dashora, Slesnick, & Erdem, 2012). Intimate partner violence, the absence of a national housing policy, extreme poverty, and mental health problems, all of which are complicated by the inaccessibility of affordable childcare, are some of the compounding factors that can shape homeless mothers' experiences of health and situate them in socially excluded positions in Canadian society (Benbow, Forchuk, & Ray, 2011). For homeless mothers in Canada, health is shaped by these socio-political contexts and exclusionary factors such as poverty, and a variety of other influences such

as gender, and homelessness status (Marmot, Friel, Bell, Houweling, & Taylor, 2008; Raphael, 2007a, 2007b). As a result of, and contributing, to their homelessness, homeless mothers are among those who are socially excluded from the full economic, political, social, and subsequently, health benefits of society (Galabuzi, 2009; Labonte, 2009). Homeless mothers' position in Canadian society, similar to the positions of other socially excluded groups makes them susceptible to unique forms of social exclusion that influence their health in significant and debilitating ways. The examination of social exclusion in nursing research can lead to an understanding of both the process of becoming and the outcome of being socially excluded with emphasis on how health is impacted and can be promoted.

Nursing Research Implications and Future Directions

The proposed definition of social exclusion and our exploration of the literature, suggest significant implications for nursing research. Overall, we need further conceptual and methodological development of social exclusion and further exploration of the role of individual agency within exclusionary structures. Policy analysis, in addition to exploration of agency using various data collection methods, would deepen our understanding of how the processes of exclusion shape health in the Canadian context.

Intersectionality[4] as a guiding theory in social exclusion research would add to the current literature and provide rich insight into the multi-dimensional and interconnected nature of social exclusion. Nursing researchers seeking to better understand social

---

[4] Intersectionality is a theoretical framework, informed by several critical theories such as critical race theory and feminist theory. Intersectionality examines the 'crossroad' (Crenshaw, 1991), or intersection of multiple social identities and experiences of exclusion and marginalization. Sharing the central tenants of other critical theories, intersectionality serves as a lens to examine the cultural, historical, political, and social categories that interact to create systems of power, injustice, and social organization (Crenshaw, 1993).

exclusion and health can provide spaces to work with 'socially excluded groups' to explore structural inequalities shaping their health experiences, as initial efforts in nursing research aimed at promoting health. Through such research we will be able to question what is driving the creation of social exclusion and how nurses can work to respond to it.

Concluding Comments

If we accept the premise that a central aim of nursing is to promote health by addressing health inequities, it follows then that social exclusion is a concept that has a great deal of relevance. There is a need to develop clear definitions as well as transparency of the philosophical and political underpinnings framing the use of the concept. Increased clarity is something that is needed in all social exclusion discourse, but particularly if we embrace a perspective that recognizes power differentials and the importance of understanding health within a broad social and political context. We have suggested a conceptualization of social exclusion for nursing knowledge development that recognizes social exclusion as both a process and outcome of structural inequities, while also emphasizing the intersectional influences on experiences. This definition is highly congruent with a social justice-informed nursing practice. Social exclusion has great significance and relevance in addressing health inequities and in advancing the science of nursing. However, much work needs to be done to ensure advancement of this important area of knowledge development.

References

Anderson, D.G., & Rayens, M.K. (2004). Factors influencing homelessness in women. *Public Health Nursing, 21*(1), 12-23. doi: 10.1111/j.1525-1446.2004.21103.x

Arthurson, K., & Jacobs, K. (2004). A critique of the concept of social exclusion and its utility for Australian social housing policy. *Australian Journal of Social Issues, 39*(1), 25-40.

Barry, B. (2002). Social exclusion, social isolation, and the distribution of income. In J. Hills, J. Le Grand, and D. Paichaud (Eds.). *Understanding social exclusion.* (pp.13-29). Toronto: Oxford University Press.

Benbow, S., Forchuk, C., & Ray, S. (2011). Mothers with mental illness experiencing homelessness: A critical analysis. *Journal of Psychiatric and Mental Health Nursing*, 18(8), 687-695. doi: 10.1111/j.1365-2850.2011.01720.x

Benbow, S., Rudnick, A., Forchuk, C., & Edwards, B. (2014). Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors. *Disability and Society, 29*(7), 1046-1060. doi: 10.1080/09687599.2014.902359

Burchardt, T., Le Grand, J., & Piachaud, D. (2002). Introduction. In J. Hills, J. Le Grand, and D. Paichaud's (Eds). *Understanding social exclusion* (pp. 1-12). Toronto: Oxford University Press.

Canadian Council on Social Development. (2001). *Equality, inclusion and the health of Canadians: Submission to the commission on the future of health care in Canada.* Ottawa: Canadian Council on Social Development.

Canadian Mental Health Association. (2012). *Social Inclusion*. Retrieved from http://www.cmha.ca/public-policy/subject/social-inclusion/.

Canadian Nurses Association. (2009). *Ethics in practice: Social justice in practice*. Retrieved from http://www.cna-nurses.ca/CNA/documents/pdf/ publications/Ethics_in_Practice_April_2009_e.pdf.

Canadian Nurses Association. (2010). *Social justice: A means to an end, an end in itself,* (2nd ed.). Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/social_justice_2010_e.pdf

Caxaj, S., & Berman, H. (2010). Belonging among newcomer youths: intersecting experiences of inclusion and exclusion. *Advances in Nursing Science, 33*(4), 17-30. doi: 10.1097/ANS.0b013e3181fb2f0f.

Chambers, L.A., Greene, S., Watson, J., Rourke, S.B., Tucker, R., Koornstra, J., …The Positive Spaces Healthy Places Team (2014). Not just "a roof over your head":

The meaning of healthy housing for people living with HIV. *Housing, Theory, and Society, 31*(3) 310-333.

Cheung A.M. & Hwang S.Q. (2004) Risk of death among homeless women: a cohort study and review of the literature. *Canadian Medical Association Journal* 170, 1243–1247. doi: 10.1503/cmaj.1031167

City of Toronto. (2003). *Community social planning council of Toronto: Review of the literature from a Toronto perspective.* Retrieved from http://intraspec.ca/HOMELESSNESS_in_Toronto.pdf.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-1299.

Crenshaw, K. (1993). Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In D.K. Weisberg (Ed.), *Feminist legal theory* (pp.383-395). Philadelphia: Temple University Press.

Daly, M., & Silver, H. (2008). Social exclusion and social capital: A comparison and critique. *Theory and Society, 37*(6), 537-566. doi: 10.1007/s11186-008-9062-4

Dashora, P., Slesnick, N., & Erdem, G. (2012). "Understand my side, my situation, and my story:" insights into the service needs among substance abusing homeless mothers. *Journal of Community Psychology, 40*(8), 938-950). doi: 10.1002/jcop.21499

Dobrowolsky, A., & Lister, R. (2005). Social exclusion and changes to citizenship: women and children, minorities and migrants from Britain. In E. Tastsoglou and A. Dobrowolsky's (Eds.), *Women, migration and citizenship* (pp. 149-182).

Freiler, C., & Zarnke, P. (2002). Foreword. In N. H. Gilbert & Canadian Council on Social Development, *The Laidlaw Foundation's perspective on social inclusion.* Working paper series: Perspectives on social inclusion (pp. vii–x). Toronto: Laidlaw Foundation.

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The state of homelessness in Canada*. Toronto: Canadian Homelessness Research Network Press.

Galabuzi, G.E. (2006). *Canada's economic apartheid: the social exclusion of racialized groups in the new century*. Toronto, ON: Canadian Scholars' Press.

Galabuzi, G.E. (2009). Social exclusion. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed.) (pp. 252-268). Toronto: Canadian Scholars' Press Inc.

Galabuzi, G.E., & Labonte, R. (2002). *Social inclusion as a determinant of health*. Ottawa: Health Canada. Retrieved on October 13, 2009, from http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/overview_implications/03_inclusion_e.pdf

Gill, L. (2000). *Teetering on the rim: global restructuring, daily life, and the armed retreat of the Bolivian state*. New York: Columbian Press.

Guildford, J. (2000). *Making the case for economic and social inclusion*. Ottawa: Health Canada.

Harvey, D. (2006). *Spaces of global capitalism: towards a theory of uneven geographical development.* London: Verso.

Health Canada. (2001). *Population health newsletter: Social capital, social cohesion, social inclusion/exclusion*. Ottawa: Health Canada.

Health Canada. (2002). *Poverty as social and economic exclusion*. Ottawa: Population and Public Health Branch, Health Canada. Retrieved from http://www.hc-sc.gc.ca/hppb/regions/atlantic/work/e_c_1.html

Hyman, I., Mercando, R., Galabuzi, G.E., & Patychuk, D. (2014). A critical review of social exclusion and inclusion indicators: implications for the development of a Canadian framework. In Kenise Murphy Kilbride's (ed.) *Immigrant integration: research implications for future policy.* Toronto, ON: Canadian Scholars' Press.

Labonte, R. (2009). Social inclusion/exclusion and health: Dancing the dialectic. In D. Raphael's (Ed.), *Social determinants of health (2nd ed.)* (pp. 267- 279). Toronto : Canadian Scholars' Press Inc.

Lenoir, R. (1974). *Les Exclus : Un Francais sur Dix*. Paris : Editions du Seuil.

Low, J., & Theriault, L. (2008). Health promotion Policy in Canada : lessons forgotten, lessons still to learn. *Health Promotion International, 23(*2), 200-206. doi: 10.1093/heapro/dan002

MacDonald, R., & Marsh, J. (2002). Crossing the Rubicon: youth transitions, poverty, drugs and social exclusion. *International Journal of Drug Policy, 13*(1), 27-38. doi: http://dx.doi.org/10.1016/S0955-3959(02)00004-X

Marmot, M, Friel, S., Bell, R., Houweling, T., Taylor, S. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, *372*(9650), 1661-1669.

Martin, S. (2004). Reconceptualising social exclusion: A critical response to the neoliberal welfare reform agenda and the underclass thesis. *Australian Journal of Social Issues, 39*(1), 79-94.

Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V, & Priebe, S. (2007). Social exclusion and mental health: Conceptual and methodological review. *British Journal of Psychiatry, 191*, 477-483. doi: 10.1192/bjp.bp.106.034942

Mumtaz, Z., Salway, S., Shanner, K., Bhatti, A., & Laing, L. (2011). Maternal deaths in Pakistan: Intersection of gender, caste, and social exclusion, *BMC International Health and Human Rights, 11*(S4). doi:10.1186/1472-698X-11-S2-S4

Noel, A., & Fortin, S. (2012). *Poverty, inequalities, and social exclusion: What do we know and what can we do? CRDCN Research highlight*, *1*(4): Issue 1, Article 1. Retrieved from http://ir.lib.uwo.ca/cgi/viewcontent.cgi?Article=1003&context=crdcn_rccdr

Peace, R. (2001). Social exclusion: a concept in need of definition? *Social Policy Journal of New Zealand*, 16, 17-36.

Percy-Smith, J. (Ed.). (2000). *Policy responses to social exclusion: towards inclusion?* Buckingham, Philadelphia: Open University Press.

Popay, J., Escorell, S., Hernandez, M., Johnston, H., Mathieson, J., & Rispel, L. (2008). *Understanding and tackling social exclusion: Final report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network.* Retrieved from http://www.who.int/social_determinants/knowledge_networks/final_reports/sekn_final%20report_042008.pdf.

Raphael, D. (2007a). Addressing health inequalities in Canada: Little attention, inadequate action, limited success. In M. O'Neil, A., Pederson, S., Dupere, & I. Rootman's (Eds.) *Health Promotion in Canada: Critical Perspectives*. (2nd ed.). (pp. 207-221). Toronto: Canada Scholars' Press Inc.

Raphael, D. (2007b). Making sense of poverty: Social inequality and social exclusion. In *Poverty and policy in Canada* (pp. 85-111). Toronto: Canadian Scholars' Press Inc.

Raphael, D. (Ed.). (2009). *Social determinants of health: Canadian perspectives* (2nd ed). Toronto: Canadian Scholars' Press Inc.

Reid, C. (2004). *The wounds of exclusion: poverty, women's health, & social justice.* Edmonton AB: Qualitative Institute Press.

Sen, A. (2001). *Social exclusion: Concept, application, scrutiny.* Manila, Philippines : Asian Development Bank.

Silver, H. (1995). Reconceptualizing social disadvantage: three paradigms of social exclusion, in G. Rogers, C. Gore, and J.B. Figueiredo (Eds.), *Social exclusion: Rhetoric, reality, response* (pp. 58-80). Geneva: Institute of International Labour Studies.

Stewart, M., Reutter, L., Makwarimba, E., Veenstra, G., Love, R., & Raphael, D. (2008). Left out: Perspectives on social exclusion and inclusion across income groups. *Health Sociology Review, 17*(1), 78-94. doi: 10.5172/hesr.451.17.1.78

Taket, A., Crisp, B.R., Nevill, A., Lamaro, G., Graham, & Barter-Godfrey, S. (Eds.) (2009). *Theorising social exclusion.* New York: Routledge.

Tong, H.M., Lai, D.W.L., Zeng, Q., & Xu, W.Y. (2011). Effects of social exclusion on depressive symptoms: Elderly Chinese living alone in Shanghai, China. *Journal of Cross-Cultural Gerentology, 26*(4), 349-364. doi: 10.1007/s10823-011-9150-1

Toye, M., & Infanti, J. (2004). *Social inclusion and community economic development: Literature review.* Pan-Canadian Community Development Learning Network Project Framework. Victoria: Canadian CED Network.

Vleminckx, K., & Berghman, J. (2001). Social exclusion and the welfare state: an overview of conceptual issues and implications. In D. Mayes, J. Berghman, and R. Salais, (Eds.)., *Social exclusion and European policy* (pp. 27-46). Cheltenham: Edward Elgar.

Wilson, K., Eyles, J., Elliott, S., Keller-Olaman, S., & Devcic, D. (2007). Linking social exclusion and health: explorations in contrasting neighbourhoods in Hamilton, Ontario. *Canadian Journal of Urban Research, 16*(2), 126-148.

World Health Organization. (1986*). Ottawa Charter for health promotion*. Ottawa: ON: Canadian Public Health Association and Health and Welfare in Canada.

World Health Organization. (2014). *What are social determinants of health?* Retrieved from http://www.who.int/social_determinants/ sdh_definition/en/

Yanicki, S.,M., Kushner, K.E., & Reutter, L. (2014). Social inclusion/exclusion as matters of social (in)justice: a call for nursing action. *Nursing Inquiry, 22*(2), 121-133. doi: 10.1111/nin.12076.

CHAPTER THREE

LITERATURE REVIEW AND RESEARCH DESIGN

Current Literature

Empirical literature related to homelessness, homeless mothers, homeless women, homeless families, social exclusion, and health was searched and reviewed using several journal databases, including SCOPUS, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psych info, and Contemporary Women's Issues. Key search terms included: Social exclusion, homelessness, homeless, housing, resistance, health, women, mothers, female, as well a number of combinations of these words. Relevant articles cited or identified within pertinent articles, and/or recommended by experts in the field were also included. Literature was included from 2005 to present. Articles that were published prior to 2005 were included if they were deemed extremely pertinent, historical, or classic. A time period of ten years was chosen to keep the review focused on recent literature. Initially, studies conducted only within Canada were included; however, the literature review inclusion criteria was extended to include research conducted in the United States and the United Kingdom when pertinent articles were identified, with the review remaining primarily focused on Canadian literature. Five themes were used to organize relevant research retrieved: (1) homelessness and adverse health consequences; (2) violence and trauma: the gendered experience of homelessness; (3) unique challenges for mothers experiencing homelessness; (4) strengths and acts of resistance; and (5) social exclusion and health.

Homelessness and Adverse Health Consequences

Homelessness significantly influences health (Baggett, O'Connell, Singer, & Rigotti, 2010; Hwang, 2001; Notaro, Khan, Kim, Nasaruddin, & Desai, 2013), and

homeless women and mothers face a plethora of negative health consequences. Barrow

and Lawinski (2009) noted that homeless mothers share similar health characteristics

with other women living in poverty, as both have higher rates of depression, higher

instance of substance use, and are more likely to have experienced sexual and physical

abuse than the general population. However, health is further compromised and

threatened when living without a home. Researchers noted that homeless women

experience higher rates of violence, trauma, and substance use than do housed women

(Shanzer, Dominguez, Shrout, & Canton, 2007; Weinreb, Nicolson, Williams, & Anthes,

2007). Additionally, health disparities among homeless women include increased rates of

mortality (Fazel, Geddes, & Kushel, 2014; Hwang, Wilkins, Tiepkema, O'Campo, &

Dunn, 2009), acute and chronic health conditions (Hwang et al., 2009; Morris & Strong,

2004), poor birth outcomes (Arangua & Gelberg, 2007), increased rates of communicable

diseases (Hatton, Kleffel, Bennett, & Gaffrey, 2008; Khan et al., 2011), and worsened

and compromised mental health (C. Chambers et al., 2014; Tishler, Rademeyer,

&Vostanis, 2007), such as low self-esteem, mood disorders and psychosis (Finfgeld-

Connett, 2010; Strehlau, Torchalla, Li, Schuetz, & Krausz, 2012). In addition to higher

levels of health concerns, homeless populations may be further burdened by having

higher barriers to accessing and receiving appropriate primary health care (Shortt,

Hwang, Stuart, Bedore, Zurba, & Darling, 2008) and are much more likely than the

average population to use Emergency Department (ED) care (Doran et al., 2013).

In a study by Teruya et al. (2010), health and health care disparities were

examined among 1,331 homeless African American, Latina, and white women residing in

Los Angeles, California. The correlational study found that while all homeless women

faced major threats to their health and access to proper health care, a variety of

predisposing factors, including race/ethnicity, age, number of children, marital or partnership status, employment, conflict with the law, pregnancy, and social supports created further disparities within the homeless women population.

The relationship between homelessness and mental health has been shown to be complex and multi-directional; while mental health issues make women more susceptible to homelessness, homelessness itself can give rise to or exacerbate mental health problems, presenting more challenges to women trying to achieve housing stability (C. Chambers et al., 2014; Forchuk et al., 2007). C. Chambers and colleagues (2014) recruited 522 homeless women from shelters and meal programs in Toronto, Canada. Linear and logistic regression was performed identified factors related to mental health status. Data indicated that the participants experienced disproportionately higher psychiatric morbidity than the general population of Canada. Poor mental health was associated with limited access to social support, experiences of physical and sexual assault in the past year, presence of a chronic health condition, and presence of a drug use problem in the past month. Results show that homeless women, with and without dependent children, have poor overall mental health (C. Chambers et al., 2014).

Violence and Trauma: The Gendered Experience of Homelessness

The gendered experience of homelessness for women was noteworthy in the literature and included women's unique experiences of abuse, trauma, and/or violence (Khandor & Mason, 2007; Richards, Garland, Bumphus, & Thompson, 2010). Gender-based violence, such as sexual and physical violence, psychological abuse, violence in pregnancy, coerced sex/rape, sexual slavery, sexual harassment, and forced prostitution, was highly prevalent among pregnant and postpartum women from Vancouver's downtown eastside (Torchalla, Linden, Strehlau, Neilson, & Krausz, 2015). The purpose

of the qualitative study was to explore themes of trauma and gender-based violence from women who struggled with substance use during pregnancy and early motherhood (N=27). The majority of participants were involved in the sex trade, and experienced homelessness and gender-based violence. Key themes highlighted the pervasive existence of multiple and continuing forms of adversities and trauma from childhood to adulthood. Individual and environmental conditions intensified each other, preventing resolution of trauma-related symptoms and substance use. Implications emphasized the need to understand women's trauma in offering harm-reduction services. Similar findings of childhood trauma and abuse among homeless Aboriginal women have also been identified (Walsh, Rutherford, Krieg, & Bell, 2013).

Haldenby, Berman, and Forchuk (2007) examined the experiences of homeless adolescents with particular attention to the role of gender and public policy, health experiences, and barriers to health care. Six girls and seven boys participated in this critical narrative study conducted in Southwestern Ontario. Findings suggested shared and varied experiences of homelessness among participants. Although all of the participants had discussed being exposed to various types of violence while homeless, gender-based violence was especially identified by female participants in the form of harassment, abuse from a boyfriend, and women's involvement in the sex trade to seek shelter. As well, fears of getting pregnant were also expressed and the very practical concerns of accessing feminine hygiene products and birth control were unique to their experiences. Shared experiences among male and female participants included complex family situations, barriers to health care, challenges exiting homelessness, and difficulties navigating homelessness within the public policy context (Haldenby et al., 2007).

Differences among male and female youth experiencing homelessness were also

noted in a larger descriptive comparative study (N= 435) conducted in Vancouver, Canada, where 22% of street youth reported having gang involvement (Marshall, Debeck, Simo, Kerr, & Wood, 2014). The researchers investigated the relationship between early life traumatic experiences and gang involvement in a sample of street-involved youth. Of those street-involved youth, male and female participants yielded stark differences. Males reporting gang involvement were significantly more likely to have been in government care as a child, dealt drugs, experienced incarceration, and have perpetrated physical violence. In contrast, female participants with gang involvement were significantly more likely to have a history of childhood sexual abuse and have experienced physical violence. In this sample of Canadian street youth, the lifetime prevalence of gang involvement was higher than the general population (Marshall et al., 2014).

Sex work and the gendered experience of violence also intersect in unique ways. Duff, Deering, Gibson, Tyndall, and Shannon (2011) used a community-based prospective cohort study design to examine the individual, interpersonal, and work environment correlates and prevalence of homelessness among 252 women in street based sex work in Vancouver, Canada. Bivariate and multivariate logistic regression was used. Fifty-one percent of participants were Caucasian and 49% were non-Caucasian (Indigenous/Aboriginal or another visible minority). The lifetime prevalence of homelessness was 88% and findings suggested that many of the participants experienced the cyclic nature of homelessness throughout their lives. The findings indicated that factors related to younger age, sexual violence by non-commercial partners, servicing a higher number of clients, daily crack cocaine use, and servicing clients in public spaces were independently associated with sleeping on the street. The researchers noted that sexual violence by non-commercial partners is higher among homeless street-based

female sex workers suggesting that they lack access to safe, affordable spaces (Duff et al., 2011).

Unique Challenges for Mothers Experiencing Homelessness

Within the homeless population, mothers experience unique and varying challenges in their experiences of homelessness. Greaves, Chabot, Jategaonkar, Poole, and McCullough (2006) conducted a study with women (N=74) in shelters for abused women and children in British Columbia. They employed standardized questionnaires and qualitative interviews to examine alcohol and substance use, experiences of abuse, and levels and types of stressors. Eighty-eight percent of participants were mothers. Women's experiences of violence and substance use were interconnected in complex ways. Substance use was affected by a range of influences, such as financial concerns, mothering, relationships, levels of social support, and physical and mental health issues. Many mothers noted they had delayed leaving abusive partners because they feared losing custody of their children and/or feared for their children's safety if they left them with their partners. Some mothers had given up custody of their children in order to flee from their abusive partners while others left abusive partners in order to protect their children. The study found that substance use was often in response to relational issues, such as those pertaining to mothering, psychosocial and structural issues (Graeves et al., 2006).

In further examination of the mental health of homeless mothers, Zabkiewicz, Patterson, and Wright (2014) conducted a cross-sectional comparative study on a subsample of 713 women across five Canadian cities including Moncton, Montreal, Toronto, Vancouver, and Winnipeg. The relationship between parenting status and depression, as well as post-traumatic stress disorder (PTSD), varied by duration of

homelessness. Among women who had been homeless for less than two years, no relationship was found between parenting status and depression or PTSD. However, among women who had been homeless for two or more years, the incidence of depression was twice as high among parenting women compared with others. A similar relationship was found between parenting status and PTSD. Findings suggested that duration of homelessness elicited unique impacts for mothers experiencing homelessness.

Duff, Shoveller, Cherttiar, Feng, Nicoletti, and Shannon (2015) investigated the social and structural barriers to health and social services experienced by pregnant and parenting sex workers using a descriptive statistics and correlational design. Using baseline data from a larger study, of the 399 women who were pregnant or had a child, 35% reported experiencing a barrier to health and social services. The most common barriers cited were lack of financial support, fear of partner violence, lack of social support from family members, avoidance of services for fear of punitive measures regarding their children, such as child apprehension, and fear of stigma (Duff et al., 2015).

Swick and Williams (2010) explored the stories of four single-parent mothers who were homeless and residing in a transitional living situation in the southeastern United States. Researchers used qualitative approaches including participant-observation, interviews, and guided self-reports to investigate their major concerns. The participants felt that the major barriers to effective parenting were the lack of financial resources and a loss of self-control while in shelter. This study identified the impact of homelessness on the parent-child relationship. Similarly, Meadows-Oliver (2009) found that in a phenomenological study with eight women in the northeastern United States, participants described feeling overwhelmed by efforts to balance multiple roles and care for their

children in a shelter environment, such as being required to attend training programs, care for their children, find employment, and attend school. Children's behaviours of acting-out due to the high stress of being homeless and in shelter further complicated the participants' experiences. Mothering in a group setting also took a toll on these participants and created hostile situations with other mothers in shelter (Meadows-Oliver, 2009).

An additional body of research has focused on the experience of mothering within a context of parent-child separation. Barrow and Lawinski (2009) examined mother-child separations in homeless families with maternal mental health and/or substance use problems. The researchers used in-depth, semi-structured interviews with 61 homeless mothers in Westchester, New York. Most women were ethno-cultural minorities (48% Black, 21% Latina, 23% White, and 8% other). The women endured physical violence (74%) and sexual assault or molestation (53%). Forty-nine percent of the participants reported significant psychological distress. Of the mothers' 207 children, 143 (69%) had been separated, 64 (31%) had not. Separations ranged from one month to 17.8 years, inclusive of multiple separation episodes. Precursors of separation included housing loss, volatile partner relationships, substance abuse, mothers' institutional experiences (such as incarceration, hospitalization, and residential drug treatment programs), and children's needs (such as health needs and environmental needs). Women were often active agents by initiating separations to address their challenging circumstances and to protect their children (Barrow & Lawinski, 2009).

Prenatal health care was identified as a unique need for homeless mothers. Mill, Singh, and Taylor (2012) conducted an inductive qualitative study examining a peer-outreach program called "Women in the Shadows" in Edmonton, Alberta which provided

prenatal care for street-involved women. Seven program staff and five clients were interviewed. Most of the participants had experiences with child protective services. For some, their relationship with these agencies had begun in their own childhood. The experience of losing a child was devastating and painful, while the experience of regaining custody was described as motivational. The care received from the peer outreach workers provided a unique "in" to reaching the community and they were viewed as positive, supportive, and open (Mill et al., (2012).

Contrasting the positive experiences of working with peer outreach workers, other researchers have noted that staff and caseworkers working in shelters may perpetuate a disregard toward homeless mothers. Gültekin, Brush, Baiardi, Kirk and VanMaldeghem (2014), in a qualitative study involving 13 homeless mothers and five shelter caseworkers in Detroit, Michigan found that shelter staff sometimes lacked empathy or stereotyped homeless mothers, which often resulted in feelings of shame or belittlement. They reported that shelter workers' ideas of what homeless mothers needed was often misaligned with the women's own perceptions of their needs. For example, caseworkers felt that the women lacked proper work ethic or commitment to finding work, and were in need of "tough love" to overcome their homelessness. Mothers, on the other hand, reported being concerned with parenting and family cohesion. Many women reported wanting to work, but did not want to be stuck in low-paying, entry-level jobs, where shelter workers tended to espouse the attitude that "any job is a good job." (Gültekin et al., 2014).

Strengths and Acts of Resistance

While the literature emphasized that homeless mothers face significant challenges, research indicated that these women also enact resistance to the oppressive forces in their

lives. Wade (1997; 2007) noted the health-inducing and health-promoting function of resistance, as an opposing force to oppression, and challenged the traditional pathology-oriented meanings of the word. Resistance can be described as:

…any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence oppression (including any type of disrespect), or the conditions that make such acts possible… (Wade, 1997, p. 25)

It is important to note that resistance here is understood as being experienced and enacted in the presence of despair and marginalization (hooks, 1989). Bell hooks (1989) further indicates that it is imperative to understand marginality as the place of resistance, so not to silence pain, inequity, or oppression while recognizing the need for and place of resistance. Homeless mothers resist oppression in a variety of ways. Indeed, becoming homeless may itself be an act of resistance, as it may be a way for women to find respite while fleeing violence or other traumas in the home (Benbow, Forchuk, & Ray, 2011; Tischler, Edwards & Vostanis, 2009).

Studies suggested that women facing violence resist oppression using a variety of tactics. Anderson and Danis (2006) conducted a grounded theory study exploring the resistance and resilience in adult daughters of battered women (N=12). The researchers employed individual in-depth interviews with a semi-structured interview guide. The majority of participants were European American, highly educated, and heterosexual. A central finding was that the process of resisting oppression was the root of the participants' resilience. The women enacted a variety of resistance strategies to withstand or oppose their sense of powerlessness or oppression of themselves and their mothers. Examples of this included creating physical and mental escapes, building support

networks, creating order within family chaos, developing and executing safety plans, intervening with the batterer, and protecting and comforting mothers and siblings. Resilience evolved out of the process of resisting, and manifested in participants' commitment to breaking the cycle of violence (Anderson & Danis, 2006).

Benbow, Forchuk, and Ray (2011) explored oppression and resistance in the lives of 67 mothers with mental illness experiencing homelessness in Southwestern Ontario. They used a qualitative secondary analysis to examine seven focus group transcripts. The focus group transcripts were from two previous studies on diversity and homelessness among psychiatric survivors and mental health and housing. Findings revealed three overarching themes: (1) discrimination based on intersecting social identities; (2) being stuck in the cycle of oppression; and (3) we're not giving up: resistance through perseverance. Discrimination in the form of racism, sexism, classism, and ableism at various levels, shaped the participants' attempts to find safe and affordable housing and employment. Ongoing abuse, subpar housing, and insufficient financial supports were also reported. In addition to fleeing unsafe and violent situations and subsequently becoming homeless, mothers resisted oppressive forces by asserting their rights to safety and human dignity, and by attempting to regain custody of children who had been placed in foster care. Hope and perseverance in their ability to see past the present were also strengths that supported their resistance (Benbow et al., 2011).

Montgomery and colleagues (2014) also employed a secondary qualitative analysis on the sheltering experiences of Aboriginal women (N=21), in Southern Ontario. The participants included both service users and providers. Narrative analysis was employed to identify common experiences across study participants. Findings revealed stories of being "kicked" and "nurtured". The stories of being "nurtured" were in

response to stories of being "kicked". Stories of being "kicked" were comprised of multiple and compounding losses, whereas stories of being nurtured reflected the ways participants "lifted each other up", protected and restored each other in the face of such adversity (Montgomery et al., 2014).

Using participatory and interpretive methods, Cosgrove and Flynn (2005) explored the lived experience, strengths, and needs of 17 homeless mothers residing in two 'strengths-based' shelters in Northeastern United States. Seventeen mothers were interviewed and narrative analysis was used to analyze data. Participants' ages ranged from 20-32 years old with a mean age of 23 years 4 months. Forty percent were Latina/Hispanic, 27% were African American, 20% were White, and 13% were "multiethnic". Three central topics emerged: (1) the lived experience of parenting without a home; (2) participants' identification of their strengths and coping skills; and (3) participants' recommendations for social policy and shelter programs. While parenting without a home, the participants encountered negative stereotyping and expressed feeling stigmatized and judged based on their mothering ability and style. Despite these lived struggles, participants identified several personal strengths, such as being strong-minded, getting through the day, and setting goals for the future. The participants engaged in social change within the study by making suggestions for policy makers and shelter programs. The women were emphatic about the need to educate policy makers about the negative stereotypes of homeless mothers and the realities faced by homeless mothers (Cosgrove & Flynn, 2005).

The literature also described instances where homeless mothers found strength in their roles as mothers, which afforded them a sense of identity and stability (Gültekin et al., 2014). For example, a participatory research study that used photovoice to explore

strengths of young homeless mothers in Toronto (N=5) found that the women felt proud and positive about their role as mothers, which helped them to foster internal resiliency to their conditions, despite the judgment and criticism they often felt by others (Fortin, Jackson, Maher, & Moravac, 2015).

Social Exclusion and Health

Internationally, much headway has been made in research examining the many dimensions of social exclusion that shape health status. However, in Canada, researchers are only beginning to explore the relationship between social exclusion and health (Wilson, Eyles, Elliott, Keller-Olaman, & Devcic, 2007). Canadian researchers examining social exclusion and health tend to focus primarily on material deprivation and poverty (Stewart, Reutter, Makwarimba, Veestra, Love, & Raphael, 2008; Wilson, et al., 2007), while some are starting to expand beyond this and include a more multidimensional approach to understanding social exclusion (L.A. Chambers et al., 2014; Reid, 2004). Further, limited exploration of social exclusion by nursing scholars in Canada with discussion of nursing relevance and implications exist. Please refer to Chapter 2 (pages 34-38) for an examination of Canadian studies pertaining to social exclusion and health.

Summary of the Literature

Based on the review of the literature, there has been important research done with regard to homeless women and mothers, as well as in examining the concept of social exclusion. However, there is a need to further both of these bodies of literature. There is a particular need to examine the multidimensional nature of social exclusion and how it shapes the health of homeless mothers. Literature on social exclusion has tended to primarily focus on material deprivation and poverty, as well as issues related to mental

health and substance abuse. Rarely have intersections of inequity been explored and few researchers have focused on how the everyday experiences and the social processes of social exclusion shape the health of homeless mothers. As described in observations made by Morgan, Burns, Fitzpatrick, Pinfold, and Priebe (2007), social exclusion has often been vaguely defined and conceptualized. Data collection methods have primarily consisted of quantitative techniques. When the breadth of social exclusion is included in its conceptualization, its complexity often does not translate into research purpose and methods. The "measurability" of using quantitative surveys designed for specific purposes may in fact trump theoretical understandings due to practicality and feasibility.

Further, the negative health consequences experienced by homeless mothers have been well documented; however, health and health experiences are inseparable from the social, political, economic, and historical factors influencing mothers' health and are often not purposefully examined in studies. Thus, it is necessary to purposefully explore these cross-cutting factors to better understand homeless mothers' health experiences. Likewise, the concept of resistance is relatively new to the health sciences discipline and holds much potential in women's health promotion strategies in the face of oppressive forces. Lastly, there is a dearth of literature employing critical and intersectional approaches and analyses to examining the health experiences of mothers experiencing homelessness. Such an approach would offer a multidimensional and contextualized understanding of women's health and health experiences.

Statement of Research Purpose

The purpose of this two-phase study was to examine the socio-political context, health needs, exclusionary and inclusionary forces, and strategies of resistance demonstrated by mothers experiencing homelessness. Socio-political context refers to the

material, economic, political, and cultural conditions shaping life experiences. This context was inclusive of health and social policies influencing everyday realities for these mothers. The processes that relegate mothers experiencing homelessness to disadvantaged and marginalized positions within society, and how these positions shaped their health, were critically explored.

In phase one, a critical narrative methodology was employed and the following research questions were addressed:

1.   What are the socio-political contexts of mothers' experiences of social exclusion?

2.   How do the experiences of social exclusion and social inclusion shape their health?

3.   What are the strengths and strategies of resistance employed by mothers experiencing homelessness?

4.   How do these strengths and strategies influence their health?

Phase two further investigated the socio-political contexts explored in phase one and served to bring the voices and perspectives of the participants into the analysis of current policy. The following research questions were addressed:

1.   How are mothers experiencing homelessness and their health needs represented in *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019*?

2.   How does this policy address social exclusion experienced by homeless mothers as identified in phase one of the study?

Research Design: Methodologies and Methods

Theoretical Perspective

The critical theory of intersectionality was employed in both phases of the study. Within the critical paradigm there are numerous and diverse theories, all of which share the purpose of critiquing the existence of oppression, privilege, and imbalanced power

structures in society with the ultimate aim of creating change (Welch, 1999). The term, "critical", as a concept is coined from the work of left-wing scholars guided by social philosophy at the Frankfurt School in Germany during the 1920s and 1930s (Browne, 2000). Critical social theory lays the foundational underpinnings of most critical theories (Fontana, 2004).

Within this paradigm, attention is given to contextual elements shaping one's social positioning in society, and ultimately life experiences (Carroll, 2004). Contextual elements are inclusive of the historical, political, economic, and structural societal systems. Critical researchers use their work in attempts to challenge and transform the status quo, which is inherently shaped by power imbalances (Kincheloe & McLaren, 2006).

Critical scholars recognize that knowledge is not static and that knowledge is generated through an intersubjective process whereby the voices of both the researcher and the participant shape interpretation and meaning (Carroll, 2004; Guba & Lincoln, 2005). The subjective realities of the participant are valued and linked with the voice of the researcher to form an intersubjective understanding (Eakin, Robertson, Poland, Coburn, & Edwards, 1996). In this way, intersubjective research begins to deconstruct power imbalances in traditional health research.

Some theories that fall under a critical worldview include neomarxist, feminist, critical race theory, participatory action research, and queer theories (Lather, 1991). While critical theories are focused on the ways in which certain groups in society are privileged over others (Kincheloe & McLaren, 2005), many theories within the critical paradigm have been critiqued for essentializing and homogenizing certain groups. Essentializing is the act of neglecting diverse experiences of multiple social identities by

assuming a social group as unitary or the same (Calhoun, 2007; Hutchinson, 1999).

For example, critical race theory (CRT), which gained popularity in the 1970s, provided a framework to analyze and unveil discrimination and race domination based on the socially constructed notions of race (Delgado & Stefancic, 2007). The primary premise of CRT is to uncover unfair power dynamics manifested in racisms and race domination. The revolutionary nature of CRT has forever influenced legal studies pertaining to racialized groups and challenged the prominent main stream discourses which once negated the influence of racialization in society. Critiques of CRT shed light on its contributions to hierarchical thinking in relation to oppression (Crenshaw, 1993; Hutchinson, 1999). In such a hierarchy, issues pertaining to racialization are understood at the forefront of all experiences of domination. This is limiting in several ways. First, while injustices due to racialization are illuminated, the hierarchical thinking perpetuates exclusionary practices structured in power imbalances, by naming race and race domination as the 'most' influential social injustice. In doing so, the marginalization of certain groups is perpetuated. Hutchinson (1999) notes that CRT and other anti-racist theories negate oppressive issues related to patriarchy and heterosexism, with emphasis placed on the emancipation and justice of men of colour and failing to take into account diversities in racialized groups.

A similar critique can be made of feminist theories. Feminist theories, evolving from and driving forces for feminist movements give primacy to understanding and changing power differentials related to gender in the lives of women. Feminist inquiry, which gained increasing popularity in the 1960s and 1970s era of second wave feminism, promotes strategies for knowledge creation based on the social experiences of women which are often neglected in mainstream patriarchal discourses (Hesse-Biber, Leavy, &

Yaiser, 2004). Commonalities among feminist theories emphasize that women have been widely excluded from knowledge construction and experience oppression based on androcentric power structures (Hesse-Biber et al., 2004).

Despite the progressive contributions feminist theory has made in society, many feminist theories fall short of addressing issues related to gender for all women. According to Hill Collins (2000), second wave feminist theories, while attempting to address oppression based on gender, resulted in homogenous notions of all other social categories and were primarily emancipatory for white middle-class women. Generalizing needs based on the dominant and most influential women to all women forced race and class to be hierarchically situated as lesser axes of domination, if addressed at all (Reid, Pederson, & Dupere, 2007). Zack (2007) further criticizes the exclusionary nature of white feminists as symbolically rendering invisible the black woman's existence as a woman. In this sense, critical feminist theories perpetuated power differentials and further marginalized already excluded groups.

Intersectionality, informed by several critical theories such as CRT and feminist theories, provides a more comprehensive approach to examining power differentials and social injustices than the critical theories of its origin. Intersectionality, a term originally coined by Kimberlé Crenshaw, evolved out of a number of critical perspectives to promote a comprehensive understanding of women's multiple and compounding realities and the structural factors shaping them. Crenshaw (1993) first introduced intersectionality in response to the discrimination black women faced in the United States legal system. Intersectionality examines the 'crossroad' of multiple social identities in relation to the imbalance of power and the resulting oppression and privilege. Sharing the central tenets of other critical theories, intersectionality serves as a lens to examine the

cultural, historical, political, and social categories that interact to create systems of power, injustice and social organization (Crenshaw, 1991; 1993).

Intersectionality strives to reveal the multiple and layered social identities that interact on various levels to situate an individual's specific positions in society. It aims to unveil the structural inequalities of oppression and privilege in the lives of women (Davies, 2008). Intersectionality deconstructs homogenization and classification with the purpose to understand the complex and nuanced dimensions of privilege, inequity, and oppression and how these dimensions shape social positioning and ultimately health and well-being (Crenshaw, 1993; Hankivsky & Christoffersen, 2008; Knudsen, 2006).

Intersectionality draws attention to one's individual story as situated and contextualized within a larger system of inequity (Berman et al., 2009). While the theory of intersectionality originated as a way to expose the cross sections at which women of colour were oppressed, it has evolved to better understand how additional structures of inequity are symbiotically produced, and perpetuated. Recognizing the structural and systemic issues contributing to homelessness among mothers, intersectionality serves as a useful framework in understanding the unjust processes shaping their experiences. Intersectionality as a framework embraces the nuanced and layered experiences of oppression and privilege in the lives of these mothers.

Methodologies

Phase One: Critical narrative methodology. Critical narrative inquiry, or a critical orientation to narrative inquiry, was employed and was theoretically informed by the work of a number of scholars (Chase, 2005; 2011; Labov, 1972; McCormack, 2000a; 2000b; 2004). There is no one approach to undertaking narrative inquiry; however, several central tenets and key assumptions are shared (Berman et al., 2009). With

narrative inquiry, focus is placed on the story and the way in which stories are constructed, told, and represented (Chase, 2011). Stories reflect the storytellers' personal and outer world (McCormack, 2000b; Pitre, Kushner, & Hegadoren, 2011). 'Narrative inquiry' as a qualitative research approach has disciplinary roots in interpretative social sciences, literary criticism, and literary nonfiction (Patton, 2002), but the act of storytelling for social justice and emancipatory purposes extends far beyond these academic boundaries. That is, stories and the telling of stories have been central to social and political movements, in seeking justice, and in sharing truths. This is evidenced in memoirs, testimonials, poetry, art, graffiti, personal stories, and family narratives (Patton, 2002). Some specific examples include the role of 'slave narratives' which played a role in the civil rights movement, the resistance narratives of indigenous peoples (Guntarik, 2009), the personal narratives of women that played an important role in the feminist movement, and the 'testimonos' that have been associated with the work of Latin American activists in revolutionary movements (Chase, 2005). Thus, many narrative research approaches are informed by an overall interest in, and dedication to, social justice (Hodgson, 2009). The use of narratives emphasize "the moral force, healing power, and emancipatory thrust of stories" (Sandelowski, 1991, p.1). According to Duffy (2007), narrative inquiry is a vehicle in which the stories of the participants are heard and the value of their truth is reflected.

Following McCormack's (2000a; 2000b) approach of "multiple lenses", there is no one aspect or understanding of the story, but rather there are layered and intersecting lenses by which the story can be seen. The chronological ordering of events, as well as the socio-political meanings associated with those events, are central to methodological aims and purpose of narratives (Chase, 2005; 2011; Sandelowski, 1991).

Research Methods. *Sample and sampling strategies*. For the purposes of this study, a broad definition of homelessness was used. The definition of homelessness encompassed those residing in temporary shelters, community and group homes, those who were residing with family, friends, or acquaintances, those who were constantly moving between unstable living arrangements, and those living on the street or in abandoned buildings. Women of 18 years of age who self-identified as mothers, currently homeless or homeless in the past year were recruited for the study. Physical custody of children was not a requirement for participation in the study. While the majority of research with homeless mothers requires that participants have physical custody of at least one child (Cosgrove & Flynn, 2005; Meadows-Oliver, 2003; Tischler et al., 2007), such exclusionary criteria fails to include those mothers commonly struggling to regain custody of their children and those who have arranged for temporary care of their children with relatives or others for safety (Thrasher & Mowbray, 1995).

Participants were required to speak and understand spoken English to the degree necessary to participate in the interviews. Although requiring participants to speak English excluded non-English speaking mothers to share their stories; employing several translators able to translate current common languages within the homeless population was not feasible due to the cost required to hire multiple translators. Similarly, the accurateness of the translation would also have to be addressed to ensure concepts and stories were correctly represented.

Service providers were also included in the study. Service provider participants included those who provided some type of care to mothers experiencing homelessness. For instance, service provider participants included counsellors, volunteers, mental health

workers, and a social worker working within a variety of organizations. Initially, service

providers were not recruited; however, after initial interviews with mothers experiencing

homelessness, the instrumental and key role service providers played in women's

narratives and lives became apparent. Likewise, women participants suggested seeking

the input from service providers regarding the social and political context of "the system"

in which women were working and living within.

    I approached recruitment by initiating contact with several agencies that provide

services to women experiencing homelessness in Southern Ontario. I was then able to

build partnerships with two organizations operating three shelters and a variety of

programs and services. One organization was a shelter for pregnant and parenting young

mothers. The other organization was a women's shelter for women and children who

have experienced domestic violence. Both were in urban settings, but in different cities. I

had conducted research under supervision of my thesis supervisor with one of the

organizations prior to this study. These prior relationships helped to facilitate

collaboration, trust, and partnership. I was connected with the second agency through a

colleague who had passed on my contact information to a key stakeholder at a

conference. A social worker from the agency contacted me about my previous and

current research with mothers experiencing homelessness.

    While the agencies were not formally part of the research team, they were pivotal

in terms of gaining entry, gaining insight from service providers as key stakeholders (and

participants), and developing rapport and trust. Snowball sampling techniques

supplemented purposive sampling techniques which provided an opportunity for

individuals who were not using agencies, but who were experiencing homelessness, to

participate. Participants also passed on my contact information to individuals who they

thought might be interested. Interested participants either contacted me directly or arranged through staff within the organizations. Service provider participants self-identified as having provided care to mothers experiencing homelessness and were recruited primarily through key stakeholders within the partnering agencies.

In addition to this, based on my prior and current work experiences as a mental health nurse, as a nursing clinical instructor of students placed in a variety of agencies working with individuals experiencing homelessness, as a graduate research assistant working with women in conflict with the law, and with psychiatric survivors experiencing homelessness and housing insecurities, as well as a volunteer street nurse with a local organization, I was able to share study information with colleagues who passed on my contact information to women and service providers who they thought might be interested. I did not pursue contact with potential participants within my current places of work as I did not want to create any potential conflicts of interest while providing direct care to women.

Recruitment of mothers began within the partnering agencies where service providers promoted the study by displaying and distributing a flyer advertising the study, and discussing the research study during closed community groups. Secondly, the development of a website specific to the study was created (womens-health-research.org) where study flyers, letters of information, and contact information were included. The most effective form of recruitment was done through snowball sampling amongst participants and promotion among key stakeholders.

The sample size in qualitative studies is dependent upon multiple and differing techniques (Morse, 1999). Sample size was estimated based on similar studies, which used narrative inquiry (Kirkpatrick & Bryne, 2011; Mkandawire-Valhmu & Stevens,

2007; Pitre, Kushner, & Hegadoren, 2011; Reid, Berman, & Forchuk, 2005; Salmon, 2007). Three to four group interviews were estimated to take place with a range of 6-8 participants (Asbury, 1995). For individual interviews, it was estimated that 10-12 participants would be recruited. This estimation provided a total range of 28-44 participants. However, while this was an estimate, recruitment continued until data reflected the richness and complexity required to meet the study purpose, without obtaining an unmanageable amount of data (Sandelowski, 1995). There was a total of 26 participants comprised of mothers experiencing homelessness, and 15 service providers (N=41) who provided care to mothers experiencing homelessness.

Data collection. Methods to elicit narratives included conducting in-depth individual and group interviews, as well as photo elicitation to supplement the storytelling process. Participants were able to choose between individual or group interviews based on their preference, needs, and comfort. Offering choice of interview method as well as group interviews was purposefully included to help address the power differential and researcher privilege (Salmon, 2007). Further, the sharing of storied realties within a group can promote the collectivization of experiences (Berman, Ford-Gilboe, & Campbell, 1998). Of the 26 mother participants, 14 women chose to participate in individual interviews, while 12 chose to engage in group interviews. There was a total of three group interviews each consisting of two to four women. Service provider participants (n=15), also opted for both individual and group interviews, with a total of six individual interviews and one focus group consisting of nine service provider participants. Data collection took place over a period of seven months; the initial four months were heavily focused on initial interviews with mothers experiencing homelessness while the follow-up interviews and interviews with service providers

primarily occurred in the final months.

Ethics approval was obtained from the Research Ethics Board for Health Sciences Research Involving Human Subjects at the University of Western Ontario and Lawson Health Research Institute (Appendix A). Before consent was obtained, participants were given a letter of information (Appendix B). The letter of information was also read and discussed with the participants to minimize comprehension difficulties due to any potential literacy problems. Each interview lasted approximately 1.5 to 2 hours and was guided by a semi-structured interview guide, using open-ended questions with probes (Chase, 2005) (Appendix C). However, the guide was altered as necessary to meet the emerging needs of participants. The flexibility of the interview maintained the theoretical and philosophical valuing of this research that placed emphasis on creating a space for the participants' voices to be heard, as well as staying true to narrative inquiry whereby the story guides the interview process (Chase, 2011; Wuest, 1995). These semi-structured interviews were dialogic in nature. In this way, the researcher's voice was interactive and intertwined with the participant(s') (Chase, 2005). The interview process was not focused on the *retrieval* of knowledge, but emphasis was placed on the *construction* and *co-creation* of knowledge (Kvale, 1996). The researcher used probing, clarification, validation, interpretation, and reflection to facilitate and participate in the construction of knowledge (Simons, Lathlean, & Squire, 2008). A demographic questionnaire was also employed (Appendix D), but like the interview guide, it was altered to meet the needs of participants. For example, while the questions themselves were not altered, the manner in which I completed the interview changed. Initially, the demographic interview completed with the participant at the outset of the interview (Ponterotto, Casas, Suzuki, & Alexander, 2009); however, very quickly it became clear that many of the questions were

better answered once trust and rapport were developed. Thus, the process was altered to ensure comfort and ease of participants when disclosing stigmatizing aspects of their identities, such as mental illness.

Follow-up interviews were offered to the mother participants; however, less than half of the women (n=12) participated. This was primarily due to circumstantial barriers, such as changes in accessibility and extreme crises. During the follow-up interviews, the researcher shared further interpretations and synthesis of the data to deepen insight, understanding, and to ensure co-construction of knowledge and shared understandings were achieved (Chase, 2005; Duffy, 2007). Within the follow-up interviews consensus was not the goal, and convergent and divergent views were noted and welcomed. As the study progressed, even when follow-up interviews were not conducted, study interpretations, reflections, and analysis were shared during each of the interviews. Given that the service providers were interviewed at the end of the data collection phase, rather than scheduling a follow-up interview, the preliminary analysis was shared to propel the co-construction of emerging narratives. Service providers were encouraged to contact for follow-up if they chose to hear of study updates, ongoing analysis, or to add any further input. Study progress was shared with main contact persons within service provider groups and as requested by others. Several service providers remained in contact, curious about study progress and outcomes.

Photo elicitation was used as an alternative, supplemental, and additional way to illustrate and illuminate the mothers' storied experiences of health, social exclusion, and resistance. Arts-based narrative approaches are widely recognized and are successfully used within narrative inquiry to provide further richness of the participants' storied experiences (Duffy, 2007; Estrella & Forinash, 2007; Leavy, 2009). Berman, Ford-

Gilboe, Moutrey, and Cekic (2001) note that using photographs within a conversational setting can elicit rich information that may not be possible with traditional approaches. Further, such methods have been widely used in conducting research with vulnerable groups (Berman et al., 2001; Carlson, Engebretson, & Chamberlain, 2006; Castleden, Gavin, & Huu-ay-aht First Nation, 2008; Wilkin & Liamputtong, 2010).

After engaging in an initial interview, mothers were invited to participate in this method by taking pictures with a disposable camera. If interested, the women were given a disposable camera and were asked to take pictures of objects or locations reflective of their social and health experiences, consistent with approaches employed in other studies (Mkandawire-Valhmu & Stevens, 2007). There was discussion and preparation for camera use, at the end of the initial in-depth individual or group interview. Once developed, the participants engaged in "phototalk" (Berman et al., 2001, p. 29), the constructing and sharing of a narrative that emerges from the discussion of the photos. It was the *discussion* generated from the photo that was used for the unit of analysis. For individuals who chose to participate in the photography elements of this study, their follow-up interview consisted of further dialogic interviewing centered on the photographs. In this way, the photo provided a "fixed image that serve(d) as a catalyst…" for narrative discussion (Lykes, 2009, p. 275). Six women participated in the photography component of the research. These women also engaged in an additional follow-up interview (for a total of three interviews) to further reflect on interpretations and explore resonance of findings.

With the participants' consent, all interviews with mothers and service providers were digitally recorded and transcribed verbatim, while ensuring confidentiality (see Protection of Human Rights). For feasibility and in light of transportation and childcare

issues, interviews were made as convenient as was possible. Participants chose where the interviews took place. Several mother participants chose to participate in the interviews within their current residences of shelter, group home, or temporary place of accommodation. Several service provider participants opted for interviews within their current work place. This meant setting up an interview room within the organizations with whom I partnered. For those participants not residing within those organizations, or those who felt more comfortable elsewhere, other meeting places were arranged, including park benches, within their temporary transitional housing, at a friend's home, and in my car. Likewise, some service providers opted to meet in a coffee shop instead of their place of work. Childcare and transportation costs were offered to mother participants to decrease potential barriers to participation.

Mother participants were provided with a $20 honorarium for each interview. As the doctoral researcher, I recognized and considered the ethical dilemma posed by providing honoraria and the potential of it to unintentionally be an inducement for participation (Paradis, 2000). However, based on the philosophical underpinnings of the project, it was necessary to honour the time commitment required in participating in the study and the value of the women's knowledge. The literature shows a range in the amount of and form of honorariums provided when working with individuals experiencing homelessness. The amount chosen is consistent with the amount used in other research projects working with similar vulnerable populations in the same geographical location (see for example Forchuk et al., 2007; Forchuk et al., 2011). A $10 gift card was given as honorarium for service provider participants for their willingness and time to engage in the study.

Data analysis: Critical narrative analysis. Examining social exclusion through an

intersectional lens required that the focus of analysis be on the multidimensional and layered social processes that shaped the intensity and extent of the experienced marginalization (Galabuzi, 2009). Consistent with the methodological and theoretical underpinnings of this study, critical narrative analysis was used to analyze narrative data. The data consisted of the transcripts from all interviews. The content and meaning of the story and the way in which it was told is an important element of narrative analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998). Both micro and structural analysis were employed. This approach entailed that the stories be considered and analyzed in terms of their structural element, micro analysis of the text, and a retelling of the stories (Duffy, 2007; Riessman, 2002). This analysis was informed by the processes outlined by Labov (1972), McCormack (2000a; 2000b), and Riessman (1993). This narrative analysis has been referred to as a process of using multiple lenses and "storying stories" (McCormack, 2004, p. 220). Following McCormack's approach, narrative analysis was done in two intermingled stages that were neither sequential nor linear, they included: (1) viewing the transcript through multiple lenses and (2) developing interpreting stories (McCormack, 2000a; 2001b).

In viewing the transcript through multiple lenses, *active listening* was employed by immersing myself in the interview transcripts to identify the *narrative processes* used by the storyteller. Special attention was paid to the ways participants constructed and reconstructed their stories to give meaning to their lives (McCormack, 2000a). Narrative processes of stories, theorizing, argumentation, augmentations, and description (L.A. Chambers et al., 2014; McCormack, 2000a), are used by the storytellers to enrich their stories and get the meaning across to the listener. *Theorizing* is done when the storytelling becomes reflective and attempts to make meaning of experience.

Argumentation occurs when the storyteller adds an abstract element that may not be part of an already told story. *Augmentation* is done when a storyteller adds additional information to previous stories already told as the interview unfolds and a recollection of additional story pieces are added. Storytellers use *descriptions* to give detail of people, places, or things that are part of their story (McCormack, 2000a).

In addition to the narrative processes, narratives were analyzed through the lens of *language* which the storyteller uses to construct his/her reality. Analyzing the language used sheds light on the way in which the storyteller speaks of himself/herself (McCormack, 2000a). McCormack (2004) suggests that attention is paid to "what is said, how it is said, and what remains unsaid" (p. 225). Further, stories are shaped by contextual experiences and thus, the participants' stories were analyzed through the lens of *context*. This included the socio-political, cultural, historical, and structural conditions influencing the speaker's experiences and life. As well, the contextual elements of the interview itself were also included. Lastly, the transcript was analyzed to recognize significant *moments*, or turning points, in the interview that lead the speaker to discuss other stories or unexpected experiences. These were signified by key words or phrases and were epiphanies or moments of surprise, insight, puzzle, intense sadness, or joy (McCormack, 2000a; McCormack, 2004).

Developing an interpretive story involved identifying and examining the structures of the story (McCormack, 2000b); this required reading the transcript line by line and identifying the beginning, middle and end (Riessman, 1993). The beginning includes an orientation describing who, what, where, and when and an end brings the story to a close (McCormack, 2004). Within these boundaries includes an abstract, where the speaker summarizes the purpose of the story; an evaluation, which outlines the

meaning and implications of the story; and a series of events that are chronologically or thematically ordered (Duffy, 2007; Labov, 1972; McCormack, 2000b; 2004).

When engaging in this process, I read the electronic transcripts while listening to the audio recording of the interviews. This was a time-intensive process, but one that better served the analysis to re-orient me to voice tone, volume, and other non-transcribable features within an interview. While reading and re-reading I highlighted different stories within each transcript. I colour coded beginning and ends of stories within the electronic transcripts. I then highlighted the text with a different colour to identify each narrative lens within the story. I used the track changes function in Microsoft Word to add comments regarding my interpreted meaning from the story. My initial interpreted meaning was verbally discussed in each interview and was thus already in the transcript itself, as it was the interview itself where analysis began. Using the track changes comment function I added comments based on my reflections and any conflicting or contradictory information outlined in the lenses. I kept a research journal where personal assumptions, values, beliefs, feelings, and biases were explicitly explored and addressed. After each interview I wrote field notes and reflections. The use of reflexive journaling techniques and critical discussion were employed with the participants to explore reflections (Pini, 2003; Sprague, 2005). I then constructed a meaningful story by piecing together the highlighted story parts. I titled each story based on interpretation of meaning, and these 'titles' served as the initial codes, which were then refined, revised and collapsed into themes.

Transcripts, narratives, and themes were then shared with participants in follow-up interviews. According to Duffy (2007), "the researcher's obligation is to provide meaningful opportunities for the participants to review transcripts and the researcher's

retold stories" (p. 417). The purpose of feedback was not to seek one truth or meaning, but rather to continue the dialogue, reflection, and co-construction of knowledge. The dialogic and collaborative nature of analysis was congruent with the critical intent of the research (Chase, 2005). Data collection and initial analysis was co-constructed and validated in a reflexive and dialogic manner and based on the critical tenets of dialogue, reflection, critique (Berman et al., 1998). Collective and contradicting meanings of and within stories across study participants were examined while understanding how these realities were shaped by social and political systems (Berman, Irias Giron, & Marroquin, 2006).

Phase Two: Critical discourse analysis. During the iterative process within the qualitative methods employed in phase one, interview questions examined meaning and relevance of policy in shaping social exclusion, health, and in understanding participants' perspective of policy within a socio-political context. In further understanding the political structures shaping participants' lived realities, *Realizing Our Potential: Ontario's Poverty Reduction Strategy*, 2014-2019 (Government of Ontario, 2014), was analyzed as phase two of the study. This particular policy was chosen based on the centrality of poverty to the mothers' experiences, as identified in phase one study findings. Rationale will be further discussed below.

There are a number of ways of analyzing the discourse of policy. For the purpose of this analysis, critical discourse analysis (CDA) was employed, with the theoretical perspective of intersectionality. CDA was chosen for its applicability and the explicit marrying of micro, meso, and macro levels of analysis (Fairclough 1992, 1993). CDA is a form of analysis that can enable the examination of written and spoken texts. This methodological tradition is premised on the assumption that text can be interpreted in a

variety of ways, depending on the theoretical lens. CDA differs from other forms of discourse analysis, with its explicitly "critical" philosophical underpinnings. The overarching purpose of critical work, as aforementioned, is to unveil, critique, and challenge society's silencing and neglecting of oppressed groups (Fontana, 2004) and to uncover taken-for-granted and hidden assumptions related to the unequal distribution of power in society (Madison, 2005).

Critical discourse analysis involves investigating a form of discourse, such as a policy document, to examine and interpret the embedded ideologies and values within it (Duncan & Reutter, 2006). Discourse analysis is not only concerned with written text or spoken word, but how a certain text document interacts with and impacts the social world (Fairclough, 1995). While there are a variety of approaches to CDA, Van Dijk (1993) notes that CDA should "deal primarily with the discourse dimensions of power abuse and the injustice and inequality that results from it" (p. 252). It has been recognized that unequal social order is produced and reproduced through policy documents (Vavrus & Seghers, 2010) and thus CDA is a highly compatible methodology with which to analyze policy.

Fairclough's (1995; 2010) approach is said to be one of the most comprehensive frameworks of CDA (Sheyholislami, 2001). Fairclough's analytical framework combines theory and method, with emphasis of analysis at the macro, meso and micro levels of the document and social world. Fairclough and Wodak (1997) outline the main tenets of CDA as follows:

(1) CDA addresses social problems

(2) Power relations are discursive

(3) Discourse constitutes society and culture

(4) Discourse does ideological work

(5) Discourse is historical

(6) The link between text and society is mediated

(7) Discourse analysis is interpretative and explanatory

(8) Discourse is a form of social action.

Within Fairclough's (1995, 2010) analytical framework, analysis is focused on three simultaneously occurring dimensions: (a) *sociocultural practice, (b) discourse practice*, and (c) *text*.

Analysis of the social context, or at the *sociocultural practice* level, of the document is completed during this step. The purpose of this step is for the analyst to understand the factors taking place at a broader level in relation to power and ideology (Smith, 2007; Fairclough, 2010). In doing so, the analyst is able to link the other dimensions of the analysis to economic, political, and/or cultural environments shaping the document (Fairclough, 1995). Analysis of these environments is extremely relevant and significant to understanding the document (Fairclough, 1995, 2010). The sociocultural interests within the document affect the institutions discussed in the text (Smith, 2007).

Analysis at the *discourse practice* level requires that the production, distribution, and consumption of text be analyzed (Fairclough, 1992, 1995, 2010). Texts are produced in certain ways depending on the social context. Texts are also consumed differently in the varying social contexts (Fairclough, 1992). For example, when analyzing policy documents, this level of analysis would include an in-depth examination of the way the document was created, who it was created by, and who it was created for (Fairclough, 1992).

Analysis of *text* involves linguistic analysis where the semantics, style, structure, and/or vocabulary are analyzed for their purpose. Text analysis includes analysis of the content, with an examination of semantics and themes (Smith, 2007). It is at this level in which representations, relations, and identities are examined and analyzed (Fairclough, 2003). Content/thematic analysis of text is carried out at this level. CDA methodology requires the explicit examination of social context in which the policy was created and consumed while linking textual level analysis of language to these broader social contexts.

Research Methods. During interviews in phase one, policies and socio-political contexts of social exclusion and health were explored; thus, phase one and two were interdependent and mutually reinforcing phases. Interpretations of participant need and policy discussion were shared in interviews and focus groups in phase one. A spreadsheet was created, after initial data collection in phase one was complete, to identify the policies discussed throughout the interviews and to describe their impact on the participants' experiences of health, homelessness, and social exclusion. At times only one part of a policy was discussed, such as the Special Diet Allowance within the Ontario Disability Support Program. At other times policies were not named by participants, but referred to, for example, in one woman's reference to Ontario's social housing mandate (Government of Ontario, 2010), she discussed the "rules" that made her need for housing a priority on the social housing waitlist. In reviewing the policies identified and the way in which they were discussed, the central theme of poverty was exposed. Other themes relating to housing, food insecurity, and "rules" within shelters and government agencies were also brought forward, but could be collapsed into the most prominent theme of poverty.

Next, *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019*, (*OPRS*) (Government of Ontario, 2014), was identified as a current and relevant policy to meet the study purpose and was based on the emergent findings. Guided by the phase two research questions (outlined on page 61), *OPRS* was reviewed line-by-line to colour code and make notes of:

(1) the intended and unintended purpose(s);

(2) the ideology embedded in the text;

(3) the links between the *OPRS* and the experiences of research participants identified in phase one of the study;

(4) the problems within the strategy such as gaps, inconsistencies, incongruence of content with purpose;

(5) the chosen language;

(6) the accessibility and readability of the policy;

(7) the social context in which the document was produced and consumed (Burnett, 2012; Buse et al., 2012; Fairclough, 1995).

To achieve number three in the above list, I reviewed findings from phase one (outlined in Chapter 4), then read and re-read the policy document line-by-line and highlighted any aspects of the document that related to findings and participant voice. This was a process of systematically and simultaneously reviewing hardcopies of the study findings and the policy document while making links between them.

Further, each time I read the document I did so through the lens of intersectionality making note of how issues and people were framed and discussed. To illustrate, when an issue was presented, I examined how social locations and social

identities of people were represented and the ways in which social identities, such as race, class, and gender, mutually interacted and situated people and experiences in certain ways.

Study Rigor

The purpose of critical research, specifically critical research with women, is to question existing power differentials and recognize that women are experts of their own knowledge (Hesse-Biber et al., 2004). Meaningful discussion with groups whose voices have been silenced in mainstream discourse and exposure of unjust societal structures are the cornerstones of critical research (Mill, Allen, & Morrow, 2001), and congruent with the aims of this study. Consistent with the epistemological values of the critical paradigm, research analysis was co-constructed and validated in a reflexive and dialogic manner, as knowledge was jointly constructed. This study included two phases and employed two methodologies: Critical narrative methodology and critical discourse analysis. Both methodologies are consistent with the paradigmatic and epistemological underpinnings of the study. Phase two built on the work in phase one, by combining "talk and text", to apply participant perspective, as evident in research findings, to a relevant policy document. As well, analysis of phase two provided further insight into the socio-political context of mothers' narratives of social exclusion, a key aspect in doing critical work (Parker, 2004).

Patti Lather's (1995; 2007) transgressive validity was employed to further ensure study quality and rigor met standards relevant to feminist and critical methodologies. Lather (1995) identifies validity as a process of achieving rigour, as opposed to a static endpoint. Further, Lather (1995; 2007) problematizes the way in which researchers represent and interpret the voice of others and draws attention to the "crisis of

representation". She attends to the ethical considerations required of researchers through

the transgressive validity checklist, inclusive of four frames of validity: ironic,

paralogical, rhizomatic, and voluptuous validity (Lather, 2007). In the first frame, ironic

validity, Lather challenges the notion of one truth, or one objective reality. The

recognition of the multiple and layered realities within the findings is embraced and the

limitations of communication and representation through language are recognized. I

strived to incorporate ironic validity into our research process in purposefully choosing

an analytical approach which places emphasis on viewing narratives through multiple

lenses (McCormack, 2000a) and a theoretical perspective that requires unpacking taken-

for-granted truths. Employing narrative methodology inherently required the acceptance

of the existence of multiple realities, as I listened first to the voice within the narrative,

prior to listening across narratives (Riessman, 2008). I was mindful of the way in which

social locations and context of the researcher and participant interview can shape

dialogue and thus shared realities. Further, in recognition of the partial representations of

story elicited through language, supplemental data collection procedures were

incorporated to gain further insight into the nuanced lives of participants.

In achieving the second framing of paralogical validity, consensus forming was

problematized, and instead paradoxes, diverging views, complexities, and overall

"messiness" of data and findings were embraced (Lather, 2007). Under this frame, I

moved away from the need to neatly theorize, and instead offered immediate exposure to

and of voices (Fox & Saheed Bayat, 2007). In the findings, several contradictions and

complexities have been identified and the paradoxes and nuances served as a prominent

point of discussion as it related to the study purpose. In fact, the second theme in the

results includes "contradictions" in its title, thus making it clear that complexities were

embraced. At times it was challenging to resist wanting to present a "clean"

representation of data, for ease in understanding and displaying findings. However, it was

important to stay true to (a) the theoretical perspective of intersectionality, which values

the nuanced and fluid nature within one's social position, (b) the methodology of critical

narrative which purposefully investigates contradictions within and amongst narratives,

and (c) the participants, who are not a homogenous group and thus had varied and

divergent experiences, as well as shared and collective ones. Ensuring that each narrative

was situated within a context, of the story and interview, as well continuously

interrogating the preliminary findings and the interpretations through reflection,

diagramming, participant dialogue, and committee discussion, were methods used to

embrace the complexities and resist the urge for neat and tidy study results.

    The notion of generalizability was troubled, and emphasis was placed on

resonance and relevance of findings. This was attended to during the dialogic interviews

where my interpretations were shared in the moment for transparency as well as to ensure

my interpretations were reflective of the participant's meaning and purpose. Although

follow-up interviews were employed, the intent was not to ensure truth or consensus, but

rather to ensure co-construction of findings, as supported by the philosophical and

methodological underpinnings (Guba & Lincoln, 1989; 2005). During follow-up

interviews I shared findings and interpretations, gained further insight, learned of

resonance, and convergent or divergent perspectives, all of which supported further

engagement and reciprocal relationships (Lather, 1995). Study purpose was met with

richness and the depth necessary to create meaningful relevant results, thus embracing

complexity to address the research questions.

    An audit trail was employed to ensure that interpretations were grounded in

participant voice, research context, and philosophical underpinnings of the study (Crowe, 2005). The tracking consisted of recording key decision points and what was used to inform them allowing for a logical and transparent linking of data source and analysis. My advisory committee also provided guidance in the decision-making process and helped ensure that there was sufficient rational for analysis

Building on such complexity, rhizomatic validity was constructed. Within this frame, I was mindful of the multiple and nuanced ways the participants' agency intertwined with systems of power. In striving for rhizomatic validity, the theoretical perspective of intersectionality ensured a non-hierarchical understanding of the connections and interconnections between, within, and among constructs. That is, I purposefully unpacked the intersections of and societal response to race, age, gender, motherhood status, poverty status, homelessness status, and newcomer status to untangle complex webs of social exclusion. Multiple methods and choice for participant involvement in the research process were offered to maximize transparency, participant voice, and a deconstruction of power imbalances. Further, to link participants' lived realities with systems of power, an analysis of Ontario's Poverty Reduction Strategy (Government of Ontario, 2014) was employed. Connecting participant voice to the larger political structures was an important component of the research process and supported the rhizomatic validity of the study as a whole.

In the fourth frame of voluptuous validity, Lather spoke to the connecting of "ethics and epistemology together…via practices of engagement and self-reflectivity" (Lather, 1993, p. 686). Such an approach defies and transforms the traditional "pure" presence of the researcher into a fluid, positioned, explicit, and situated presence. My worldview was consistent with the theoretical perspective of the study. Transparency

through a thorough outline of theoretical underpinnings is incompatible with objectivity, and welcomed as a necessary and important element to qualitative critical research. Such transparency was also employed with participants in being transparent in my worldviews and that of the study. Further, my participant engagement and reflexive journaling incorporated my identities as a woman, health care worker, mental health specialist, as well as a nursing scholar. At times within my own journaling I found my perspectives as interplaying and contradicting with participants' voices. I journaled intensely on my privilege in my ability to leave the interview setting and "reflect" on the interview in the comfort of my own home, without fears of safety or financial insecurity.

Within this frame, the positionality of the researcher and its shaping on the research is not perceived negatively as to making the findings "invalid", but rather, it is necessary to recognize the explicit shaping and transparent process where the researcher's voice intertwines with the participants to create a discussion leading to findings. See chapter 1, pages 3-8, for a review of my positionality and engagement in self-reflectivity. Further to my positioning, reflexivity was an ongoing and pivotal component to the research process. Guba and Lincoln (1989) assert that reflexivity is the process of engaging in critical self-reflection maintaining the human as instrument. The power and privilege I brought into each space was thoughtfully unpacked in my field notes journal and reflected upon. After each interview I reflected on my interpretations, journaled my emotions, thoughts, reactions, diverging views, and perception of the participant-researcher relationship. Likewise, in the CDA I engaged in reflexivity in unpacking my initial interpretations and applications. I interrogated my thinking and reactions to identify when my own biases were surfacing and to re-orient my processing within the philosophical underpinnings of the study.

I was keenly attuned to the hierarchical relationship between myself and the research participants and recognized and reflected on how my social locations and purpose intertwined with theirs. For example, despite spending much time reflecting on how my social locations of being a middle-class, well-educated, partnered, able-bodied Caucasian women born in Canada could create an imbalance in power within the research interview prior to data collection, I had not anticipated the incredible privilege and power of age in shaping my own social location and in interacting with participants. In working with an agency providing services to young mothers, the imbalance of power associated with age became strikingly apparent and trust had to be achieved by consistently distancing myself from other adults they have worked, within positions of power. Further, I used reflexivity to ensure that while my role as a human instrument was apparent, I was cognizant of my positioning and worldview so as not to *impose* my voice (Lather, 1993), but rather situate it within the stated theoretical perspective. Journaling and diagramming also provided a space to constantly reflect on theoretical perspective and its shaping of interpretations.

Constructing voluptuous validity also entailed creating a space of true engagement with the participants. This was evident in the incredibly vulnerable and personal stories women shared, reflective of the trust and engagement we experienced. Within this engagement, the participants' "sensory world" was explored for those who participated in the photo elicitation component of the research. Lather (1993; 1995) identifies this aspect as distinct from the attainment of "hard data", as researchers move to recognize the multiple forms of data that can be derived from arts-based approaches, including visual arts, poetry, and photography (Crawford, Brown, Baker, Tischler, & Abrams, 2015).

Protection of Human Rights

Participants were informed of their right to withdraw from the study at any time, and the right to refuse to respond to a question at any time. Verbal consent was obtained at each phase of data collection. Confidentiality was maintained, and names were removed from all transcripts. The women choosing to participate in the photo elicitation component were advised that if they wanted to include photographs of people, consent had to be obtained. Original data were kept in a locked filing cabinet to which only the researcher had access. Furthermore, referrals and linking to agencies such as crisis services, or food banks were made at the participants' desire and need.

Ethical Issues that Arose

Issues of absolute confidentiality, in terms of recruitment and participation, were challenging when collecting data within an agency. As an outsider within the agencies, the service providers promoted the initial recruitment of participants and interactions between the participants and myself. In one agency, I was situated in an empty office space where meetings could take place. Some women participating were attending school on site and willingly participated in the research after informing their teacher of their participation. This was not necessary, as alternate times were offered; however, participants chose, out of convenience, to meet on-site during school hours and thus chose to inform their teacher of their whereabouts.

Further, two locations of data collection had locked entries for resident safety, and thus upon entry and request for a meeting room, as well as asking the front desk to notify the participant(s) of my arrival, confidential participation was not always guaranteed. However, this was discussed with the women, and alternative meeting places or meeting

protocols were offered. Once snowballing recruitment commenced, more diverse meeting

places were arranged and issues of confidentiality were reduced. However, many women

preferred to meet on site at the agency in which they were familiar attending, locating,

and residing, even if they were no longer utilizing the services. At other times, women

and service providers alike chose comfortable and convenient settings for themselves,

such as coffee shops. Ensuring their comfort and privacy were priorities, we physically

distanced ourselves from others in such settings to maintain confidentiality. Similarly,

focus group participation challenged the notion of absolute anonymity as well. Upon the

commencement and completion of each focus group, we discussed issues of

confidentiality and asked all present to respect and maintain the confidentiality of others.

Participants chose which interview format they preferred, based on their comfort.

Those who chose to engage in the photography component of the study faced

additional challenges in ensuring the privacy of those around them. Women residing in

shelter had to respect the rules of the organizations regarding photography, as a potential

safety issue. While key stakeholders did not think it would be an issue prior to study

implementation, we found that once women began taking photos it was difficult for them

not to include others, based on small and shared living quarters. While originally I was

going to keep one copy of the photos, we decided that to better meet safety procedures,

the participants would keep all photos. This did not impact analysis, as it was the "photo

talk" (Berman et al., 2001), or dialogue from the photo which was the unit of analysis,

not the photo itself.

Lastly, in employing critical narrative methodology we had to be mindful of the

challenge of anonymity within lengthy narratives where participant narratives would

include personal identifiers known within the community. Narrative researchers often

publish longer stories from individuals' narratives, which has the potential to increase

vulnerability and potential participant exposure (Chase, 2005). In striving to minimize the

potential for confidentiality to be breached, direct quotations were only long enough to

offer enough depth and richness to support analysis. This was discussed with women

participants during the informed consent process and was especially important given the

level of engagement of partnering agencies in seeking and valuing preliminary and final

reports. Further, specific agency names and locations were not included to further support

and maintain the confidentiality and anonymity of the women and service provider

participants.

References

Anderson, K.M., & Danis, F.S. (2006). Adult daughters of battered women: resistance and resilience in the face of danger. *Affilia, 21*(4), 419-432. doi: 10.1177/0886109906292130

Arangua, L., & Gelberg, L. (2007. *Homeless persons*. In R. M. Andersen, T. H. Rice, and G. F. Kominski, (Eds.), Changing the U.S. healthcare system (pp. 491–547). San Francisco: Jossey-Bass.

Baggett, T. P., O'Connell, J. J., Singer, D. E., & Rigotti, N. A. (2010). The unmet health care needs of homeless adults: a national study. *American Journal of Public Health, 100*(7), 1326-1333. doi: 10.2105/AJPH.2009.180109

Barrow, S.M., & Laborde, N.D. (2008). Invisible mothers: Parenting by homeless women separated from their children. *Gender Issues, 25*(3), 157-172. doi 10.1007/s12147-008-9058-4

Barrow, S.M., & Lawinski, T. (2009). Contexts of mother-child separations in homeless families. *Analyses of Social Issues and Public Policy, 9*(1), 157-176.

Benbow, S., Forchuk, C., & Ray, S. (2011). Mothers with mental illness experiencing homelessness: A critical analysis. *Journal of Psychiatric and Mental Health Nursing, 18*(8), 687-695.

Berman, H., Ford-Gilboe, M., & Campbell. J.(1998). Combining stories and numbers: A methodologic approach for a critical nursing science. *Advances in Nursing Science* 21 (1),1-15

Berman, H., Ford-Gilboe, M., & Moutrey, B., & Cekic, S. (2001). Portraits of pain and promise: A photographic study of Bosnian youth. *Canadian Journal of Nursing Research, 32*(4), 21-41.

Berman, H., Irias Giron, E., & Ponce, M. (2006). A narrative study of refugee women who have experienced violence in the context of war. *Canadian Journal of Nursing Research, 41(*1),144-165.

Berman, H., Mulcahy, G.A., Forchuk, C., Edmunds, K.A., Haldenby, A., & Lopez, R. (2009). Uprooted and displaced: A critical narrative study of homeless, Aboriginal, and newcomer girls in Canada. *Issues in Mental Health Nursing, 30*, 4 18-430. doi: 10.1080/01612840802624475

Browne, A. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, 32(2), 35-55.

Burnett, C. J. (2012). Examining the effects of policies on the delivery of shelter services to women who have experienced intimate partner violence" (2012). *Electronic Thesis and Dissertation Repository.* Paper 635. Retrieved from http://ir.lib.uwo.ca/etd/635/

Calhoun, C. (2007). *Sociology in America: A history.* Chicago: University of Chicago Press.

Carlson, E.D., Engebretson, J., & Chamberlain, R.M. (2006). Photovoice as a social process of critical consciousness. *Qualitative Health Research, 16*(6), 836-852. doi: 10.1177/1049732306287525

Carroll, W.K. (2004). *Critical strategies for social research.* Toronto: Canadian Scholars' Press Inc.

Castleden, H., Gavin, T., & Huu-ay-aht First Nation. (2008). Modifying photovoice for community-based participatory Indigenous research. *Social Science and Medicine, 66*, 1393-1405. doi:10.1016/j.socscimed.2007.11.030

Chambers, C., Chiu, S., Scott, A. N., Tolomiczenko, G., Redelmeier, D. A., Levinson, W., & Hwang, S. W. (2014). Factors associated with poor mental health status among homeless women with and without dependent children. *Community Mental Health Journal*, *50*(5), 553-559. doi: 10.1007/s10597-013-9605-7

Chambers, L.A., Greene, S., Watson, J., Rourke, S.B., Tucker, R., Koornstra, J., …The Positive Spaces Healthy Places Team (2014). Not just "a roof over your head": The meaning of healthy housing for people living with HIV. *Housing, Theory, and Society, 31*(3) 310-333.

Chase, S. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (3rd ed.) (pp. 651-679). Thousand Oaks, California: Sage Publications.

Chase, S. (2011). Narrative inquire: Still a field in the making. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (4th ed.) (pp. 421-434). Thousand Oaks, California: Sage Publications.

Cosgrove, L., & Flynn, C. (2005). Marginalized mothers: Parenting without a home. *Analyses of Social Issues and Public Policy, 5*(1), 127-143. doi: 10.1111/j.1530-2415.2005.00059.x

Crawford, P., Brown, B., Baker, C., Tischler, V., & Abrams, B.(2015). Practice-based evidence: Delivering humanities into healthcare. In *Health Humanities*, (pp. 120-136). New York: NY: Palgave Macmillan.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-1299.

Crenshaw, K. (1993). Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In D.K. Weisberg (Ed.), *Feminist legal theory* (pp. 383-395). Philadelphia: Temple University Press.

Davies, K. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory, 9*(1), 67-85. doi: 10.1177/1464700108086364

Delgado, R., & Stefancic, J. (2007). Critical race theory and criminal justice. *Humanity and Society,* 31, 133-145. doi: 10.1177/016059760703100201

Doran, K. M., Vashi, A. A., Platis, S., Curry, L. A., Rowe, M., Gang, M., & Vaca, F. E. (2013). Navigating the boundaries of emergency department care: addressing the medical and social needs of patients who are homeless. *American journal of public health*, *103*(S2), S355-S360. doi: 10.2105/AJPH.2013.301540

Duff, P., Deering, K., Gibson, K., Tyndall, M., & Shannon, K. (2011). Homelessness among a cohort of women in street-based sex work: the need for safer environment interventions. *BMC Public Health*, 11, 643-649. doi:10.1186/1471-2458-11-643

Duff, P., Shoveller, J., Chettiar, J., Feng, C., Nicoletti, R., Shannon, K. (2015). Sex work and motherhood: social and structural barriers to health and social services for pregnancy and parenting street and off-street sex workers. *Health Care for Women International*, 1-17, doi:10.1080/07399332.2014.989437

Duffy, M. (2007). Narrative inquiry: The method. In P.L. Munhull (Ed.), *Nursing research: A qualitative perspective* (pp. 401-421). Boston: Jones & Bartlett.

Eakin, J., Robertson, A., Poland, B., Coburn, D. & Edwards, R. (1996). Towards a critical social science perspective on health promotion research. *Health Promotion International, 11*(2), 157-165).

Estrella, K., & Forinash, M (2007). Narrative inquiry and arts-based inquiry: Multi-narrative perspectives. *Journal of Humanistic Psychology, 47*(3), 376-383. doi: 10.1177/0022167807301898

Fairclough, N. (1992). *Discourse and social change.* Cambridge, UK: Polity Press.

Fairclough, N. (1995). *Critical discourse analysis.* London: Longman,

Fairclough, N. (2003). *Analyzing discourse: textual analysis for social research*. London: Routledge.

Fairclough, N. (2010). *Critical discourse analysis: the critical study of language* (2nd ed.). London: Longman.

Fairclough, N. & Wodak, R. (1997). Critical discourse analysis: an overview. In Van Dijk (Ed.). *Discourse and interaction.* London: Sage, pp 258-284.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*, *384*(9953), 1529-1540. doi: http://dx.doi.org/10.1016/S0140-6736(14)61132-6

Finfgeld-Connett, D. (2010). Becoming homeless, being homeless, and resolving homelessness among women. *Issues in Mental Health Nursing, 31*(7), 461-469. doi: 10.3109/01612840903586404.

Fontana, J.S. (2004). A methodology or critical science in nursing. *Advances in Nursing Science, 27*(2), 93-101.

Forchuk, C., Jensen, E., Csiernik, R., Gorlick, C., Ray, S. L., Berman, H., ... & Joplin, L. (2007). Diversity and homelessness: Minorities and psychiatric survivors. *Canadian Journal of Nursing Research*, *39*(3), 191-193.

Forchuk, C., Richardson, J., Laverty, K., Csiernik, R., Edwards, B., Fisman, S., … Connoy, M. (2011). *Youth matters in London: Mental health, addiction, and homelessness.* Canadian Institute of Health Research.

Fortin, R., Jackson, S. F., Maher, J., & Moravac, C. (2015). I WAS HERE: young mothers who have experienced homelessness use Photovoice and participatory qualitative analysis to demonstrate strengths and assets. *Global Health Promotion.* Doi: 1757975914528960.

Fox, W., & Saheed Bayat, M. (2007). *A guide to managing research.* Lansdowne, Cape Town: Juta & Co Ltd.

Galabuzi, G. (2009). Social exclusion. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed.) (pp. 252-268). Toronto: Canadian Scholars' Press Inc.

Government of Ontario. (2014). *Realizing our potential: Ontario Poverty Reduction Strategy, 2014-2019*. Retrieved from http://www.ontario.ca/home-and-community/realizing-our-potential-ontarios-poverty-reduction-strategy-2014-2019

Greaves, L., Chabot, C., Jategaonkar, N., Poole, N., & McCullough, L. (2006). Substance use among women in shelters for abused women and children: Programming opportunities. *Canadian Journal of Public Health, 97*(5), 388-392.

Guba, E., & Lincoln, Y. (1989). *Fourth Generation Evaluation*. Newbury Park, CA: Sage

Guba, E., & Lincoln, Y. (2005). Paradigmatic controversies, contradictions, and

emerging influences. In N. Denzin & Y. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed.) (pp. 191-216).

Gültekin, L., Brush, B. L., Baiardi, J. M., Kirk, K., & VanMaldeghem, K. (2014). Voices From the Street Exploring the Realities of Family Homelessness. *Journal of family nursing*, *20*(4), 390-414. doi: 10.1177/1074840714548943

Guntarik, O. (2009). Resistance narratives: a comparative account of Indigenous dissent. *Narrative Inquiry, 19*(2), 306-327. doi: 10.1075/ni.19.2.06gun

Haldenby, A.M., Berman, H., & Forchuk, C. (2007). Homelessness and health in adolescents. *Qualitative Health Research, 17*(9), 1232-1244. doi: 10.1177/1049732307307550

Hankivsky, D., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271-283. doi:10.1080/09581590802294296

Hesse-Biber, S., Leavy, P., & Yaiser, M. (2004). Feminist approaches to research as a process: Reconceptualizing epistemology, methodology, and method. In S.N.

Hesse- Biber, S., & Yaiser, M. (Eds.), *Feminist Perspectives on Social Research* (pp. 3-26). New York: Oxford University.

Hill Collins, P. (2000). *Black feminist thought: knowledge, consciousness, and the politics of empowerment* (2nd ed.). New York: Routledge

Hodgson, N. (2009). Narrative and social justice from the perspective of governmentality. *Journal of Philosophical Education*, 43(4), 559-572. Doi: 10.1111/j.1467-9752.2009.00722.x

Hooks, B. (1989). *Talking back: Thinking feminist, thinking black*. Boston, MA: Southend Press,

Hutchinson, D.L. (1999). Ignoring the 96arleton9696ion of race: heteronormativity, critical race theory and anti-racist politics, *Buffalo Law Review, 47*(1), 1-115.

Hwang, S.W. (2001). Homelessness and health. *Canadian Medical Association Journal,*164(2), 229-233.

Hwang, S.W., Wilkins, R., Tjepkema, M., O'Campo, P.J., & Dunn, J.R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *British Medical Journal, 339*, b4036. doi: http://dx.doi.org/10.1136/bmj.b4036

Khan, K., Rea, E., McDermaid, C., Stuart, R., Chambers, C., Wang, J., ... & Hwang, S. W. (2011). Active tuberculosis among homeless persons, Toronto, Ontario,

Canada, 1998–2007. *Emerging infectious diseases*, *17*(3), 357.

Khandor, E., & Mason, K. (2007). *The Street Health report*. Retrieved from
http://www.streethealth.ca/Downloads/SHReport2007.pdf

Kincheloe J.L., & McLaren, P. (2005). Rethinking critical theory and qualitative
research. In N. Denzin & Y. Lincoln's (Eds.), *The Sage Handbook of Qualitative
Research* (3rd ed.) (pp. 303- 341).

Knudsen, S.V. (2006). Intersectionality – a theoretical inspiration in the analysis of
minority cultures and identities in textbooks. In E. Bruillard, B. Aamotsbakken,
S.V. Knudsen, & M. Horsley (Eds.), *Caught in the Web or Lost in the Textbook?*
(pp. 61-76).   Paris: Jouve. Retrieved on September 18, 2008 from:
http://www.caen.iufm.fr/colloque_iartem/pdf/knudsen.pdf. Thousand Oaks, CA:
Sage.

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*.
Thousand Oaks, CA: Sage.

Labov, W. (1972). The transformation of experience in narrative syntax. In W. Labov
(Ed.), *Language in the inner city* (pp. 352-396). Philadelphia: University of
Pennsylvania Press.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the
postmodern*. New York: Routledge.

Lather, P. (1993). Fertile obsession: Validity after poststructuralism. *The Sociological
Quarterly, 34*(4), 673-93.

Lather, P. (1995). The validity of angels: Interpretive and textual strategies in researching
the lives of women with HIV/AIDS. *Qualitative Inquiry, 1*(1), 41-68.

Lather, P. (2007). *Getting lost: feminist efforts toward a double(d) science*. Albany: state
University of New York Press.

Leavy, P. (2009). *Method meets art: Arts-based research practice*. New York: The
Guilford Press.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research, reading,
analysis and interpretation*. New York: Sage Publications.

Lykes, B.M. (2009). Creative arts and photography in participatory action research in
Guatemala. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research*,
(pp. 269-276). Thousand Oaks, CA.

Madison, D.S. (2005) *Critical ethnography: Methods, ethics, and performance.*
Thousand Oaks, CA: Sage.

Marshall, B.D.L., Debeck, K., Simo, A., Kerr, T., & Wood, E. (2014). Gang involvement among street-involved youth in a Canadian Setting: a gender-based analysis. *Public Health, 129*, 74-77. doi: http://dx.doi.org/10.1016/j.puhe.2014.10.017

McCormack, C. (2000a). From interview transcript to interpretive story: part 1- viewing the transcript through multiple lenses. *Field Methods, 12*(4), 282-297. doi: 10.1177/1525822X0001200402

McCormack, C. (2000b) From interview transcript to interpretive story: part 2— developing an interpretive story. *Field Methods, 12*(4), 298 –315. doi: 10.1177/1525822X0001200403

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. *International Journal of Social Research Methodology, 73*, 219-236. doi:10.1080/13645570210166382

Meadows-Oliver, M. (2009). Adolescent mothers' experiences of caring for their children while   homeless. *Journal of Pediatric Nursing, 24*(6), 458-467. doi: 10.1016/j.pedn.2008.06.007

Mill, J.E., Allen, M.N., & Morrow, R.A. (2001). Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research, 33*(2), 109-127.

Mill, J., Singh, A., & Taylor, M. (2012). Women in the shadows: prenatal care for street-involved women. *Canadian Journal of Urban Research, 21*(2), 68-89.

Mishler, E. G. (1999). Storylines. *Craftartists' Narratives of Identity*. Cambridge, Massachusetts: Harvard University Press.

Mkandawire-Valhmu, L., & Stevens, P. (2007). Applying a feminist approach to health and human rights research in Malawi: A study of violence in the lives of female domestic workers. *Advances in Nursing Science*, *30*(4), 278-289. doi: 10.1097/01.ANS.0000300178.25983.e1

Montgomery, P., Benbow, S., Hall, L., Newton-Mathur, D., Forchuk, C., & Mossey, S. (2014). Sheltering Aboriginal women with mental illness in Ontario, Canada: Being "kicked" and nurtured. *Nursing and Care, 3*(3), 164-169. doi: 10.4172/2167-1168.1000164

Montgomery, P., Brown, S., & Forchuk, C. (2011). A comparison of individual and social vulnerabilities, health, and quality of life among Canadian women with mental diagnoses and young children. *Women's Health Issues*, *21*(1), 48-56. doi: 10.1016/j.whi.2010.07.008

Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V, & Priebe, S. (2007). Social exclusion

and mental health: Conceptual and methodological review. *British Journal of Psychiatry, 191*, 477-483. doi: 10.1192/bjp.bp.106.034942

Morris, R., & Strong, L. (2004). The impact of homelessness on the health of families. *The Journal of School Nursing, 20*(4), 221-227.

Morse, J. (1999). Strategies for sampling. In J. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (2nd ed.)(pp. 127-145). Newbury Park: Sage.

Notaro, S. J., Khan, M., Kim, C., Nasaruddin, M., & Desai, K. (2013). Analysis of the health status of the homeless clients utilizing a free clinic. *Journal of community health, 38*(1), 172-177. doi: 10.1007/s10900-012-9598-0

Paradis, E. K. (2000). Feminist and community psychology ethics in research with homeless women. *American Journal of Community Psychology, 28*(6), 839-858.

Parker, I. (2004). Discovering discourses, tackling texts. In W.K. Carroll (Ed.), Critical strategies for social research. Toronto: Canadian Scholars' Press.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, California: Sage Publications.

Pini, B. (2003). On being a nice country girl and an academic feminist: using reflectivity in rural social research. *Journal Rural Studies, 20,* 169-179.

Pitre, N., Kushner, K., & Hegadoren, K. (2011). The search for safety control, and voice for mothers living with legacy of childhood violence experiences: A critical feminist narrative inquiry. *Advances in Nursing Science, 34*(3), 260-275. doi: 10.1097/ANS.0b013e31822723ed.

Ponterotto, J.G., Casas, J.M., Suzuki, L.A., & Alexander, C.M. (2015). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.

Reid, C. (2004). *The wounds of exclusion: poverty, women's health, & social justice.* Edmonton AB: Qual Institute Press.

Reid, C., Pederson, A., & Dupere, S. (2007). Addressing diversity in health promotion: Implications of women's health and intersectional theory, In M. O'Neil, A., Pederson, S. Dupere, & I. Rootman (Eds.), *Health Promotion in Canada: Critical Perspectives* (2nd ed.) (pp75-90). Toronto: Canada Scholars' Press Inc.

Richards, T., Garland, T., Bumphus, V., Thompson, R. (2010). Personal and political?: Exploring the feminization of the American homeless population. *Journal of Poverty, 14* (1),97-115. doi:10.1080/10875540903489496

Riessman, C. K. (1993). *Narrative analysis.* Newbury Park, CA: Sage.

Reissman, C.K. (2002). Analysis of personal narratives. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of interview research* (pp. 695-710). Thousand Oaks, CA: Sage.

Reissman, C.K. (2008). *Narrative methods for the human sciences.* Thousand Oaks. CA: Sage.

Rosenthal, G. C. (1993) Reconstruction of life stories. Principles of selection in generating stories for narrative biographical interviews. In R. Josselson and A. Lieblich (Eds.), *The Narrative Study of Lives* Volume 1, (pp. 59 – 91). Newbury Park: Sage Publications

Salmon, A. (2007). Walking the talk: How participatory interview methods can democratize research. *Qualitative Health Research, 17*, 982-993.

Sandelowski, D.J. (1991). Telling stories: narrative approaches in qualitative research. *Image: The Journal of Nursing Scholarship, 23*(3), 161-166.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18,* 179-183.

Schanzer, B., Dominguez, B., Shrout, P. E., & Caton, C. L. (2007). Homelessness, health status, and health care use. *American Journal of Public Health*, *97*(3), 464-469. doi: 10.2105/AJPH.2005.076190

Sheyholislami, J. (2001). *Critical discourse analysis*. Retrieved from http://www. 100arleton.ca/~jsheyhol/cda.htm

Shortt, S. E. D., Hwang, S., Stuart, H., Bedore, M., Zurba, N., & Darling, M. (2008). Delivering primary care to homeless persons: a policy analysis approach to evaluating the options. *Healthcare Policy*, *4*(1), 108. doi: 10.12927/hcpol.2008.20012

Simons, L., Lathlean, J., & Squire, C. (2008). Shifting the focus: sequential methods of analysis with qualitative data. *Qualitative Health Research, 18*(1), 120-132. doi: 10.1177/1049732307310264.

Smith, J. (2007). Critical discourse analysis for nursing research. *Nursing Inquiry, 14*(1), 60-70. Doi: 10.1111/j.1440-1800.2007.00355.x

Sprague, J. (2005). Qualitative shifts: feminist strategies in field research and interviewing. In *Methodologies for critical researchers: bridging differences*. CA: Altamira Press

Stewart, M., Reutter, L., Makwarimba, E., Veenstra, G., Love, R., & Raphael, D. (2008). Left out: Perspectives on social exclusion and inclusion across income groups. *Health Sociology Review, 17*(1), 78-94.

Strehlau, V., Torchalla, I., Li, K., Schuetz, C., & Krausz, M. (2012). Mental health, concurrent disorders, and health care utilization in homeless women. *Journal of Psychiatric Practice, 18*(5), 349-360. doi: 10.1097/01.pra.0000419819.60505.dc

Swick, K.J., Williams, R. (2010). The voices of single parent mothers who are homeless: implications for early childhood professionals. *Early Childhood Education Journal, 38*(1)*,* 49-55. doi: 10.1007/s10643-010-0378-0

Teruya, C., Longshore, D., Andersen, R.M., Arangua, L., Nyamathi, A., Leake, B., & Gelberg, L. (2010). Health and health care disparities among homeless women. *Women & Health, 50*(8), 719-736. doi: 10.1080/03630242.2010.532754.

Thrasher, S.P., & Mowbray, C.T. (1995). A strengths perspective: An ethnographic study of homeless women with children. *Health and Social Work, 20*(2), 93-101.

Tischler, V., Edwards, V., & Vostanis, P. (2009). Working therapeutically with mothers who experience the trauma of homelessness: An opportunity for growth. *Counselling and Psychotherapy Research, 9*(1), 42-46. doi: 10.1080/14733140802656198

Tischler, V., Rademeyer, A., Vostanis, P. (2007). Mothers experiencing homelessness: mental health, support and social care needs. *Health and Social Care in the Community, 15*(3), 246-253. doi: 10.1111/j.1365-2524.2006.00678.x

Torchella, I., Linden, I., Strehlau, V., Neilson, E.K., & Krausz, M. (2015). "Like a lots happened with my whole childhood": violence, trauma and addiction in pregnancy and postpartum women from Vancouver's Downtown Eastside. *Harm Reduction Journal, 12*(1), 1-10, doi: 10.1186/1477-7517-12-1.

Van Dijk, T.A. (1993). *Elite Discourse and Racism*. London: Sage Publications.

Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy*, 19(1), 23-39.

Wade, A. (2007). Despair, resistance, hope: Response-based therapy with victims of violence. In C. Flaskes, I. McCarthy, and J. Sheehan (Eds.), *Hope and despair in narrative and family therapy: adversity, forgiveness, and* reconciliation (pp.62-64).. Hover: Brunner-Routledge.

Walsh, C.A., Rutherford, G., Krieg, B., Bell, M. (2013). Aboriginal women's voices: breaking the cycle of homelessness and incarceration: *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 11*(3), 377-394

Weinreb, L., Nicholson, J., Williams, V., & Anthes, F. (2007). Integrating behavioral health services for homeless mothers and children in primary care. *American Journal of Orthopsychiatry, 77*(1), 142-152. doi: 10.1037/0002-9432.77.1.142

Welch, M (1999). Critical and feminist critique. In E.C. Polifroni & M Welch, *Perspectives on philosophy of science in nursing: An historical and contemporary anthology* (pp. 355-359). New York: Lippincott.

Wilkin, A., & Liamputtong, P. (2010). The photovoice method: researching the experiences of Aboriginal health workers through photographs. *Australian Journal of Primary Health, 16*, 231-239. doi: 10.1071/PY09071

Wilson, K., Eyles, J., Elliott, S., Keller-Olaman, S., & Devcic, D. (2007). Linking social exclusion and health: explorations in contrasting neighbourhoods in Hamilton, Ontario. *Canadian Journal of Urban Research, 16*(2), 126-148.

Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Nursing Research, 5*, 125-137.

Zabkiewicz, D.M., Patterson, M., & Wright, A. (2014). A cross-sectional examination of the mental health of homeless mothers: does the relationship between mothering and mental health vary by duration of homelessness? *British Medical Journal, 4*(e006174), 1-8, doi:10.1136/bmjopen-2014-006174

Zack, N. (2007). Can 3rd wave feminism be inclusive: intersectionality, its problems and new directions. In L. Alcoff & E. Feder Kittay (Eds.), *The Blackwell Guide to Feminist Philosophy* (pp. 193-207). Malden, MA: Blackwell Publishing.

CHAPTER FOUR

FINDINGS

Introduction

In Canada, mothers and their children are among the fastest growing segments of the homeless population (Rahder, 2006). Homeless mothers encounter significant obstacles in achieving health and experience unique challenges while parenting without a home. Intimate partner violence, lack of a national housing policy, extreme poverty, food insecurity, and mental and physical illnesses are some of the compounding factors that shape mothers' experiences of homelessness and health and relegate them to socially excluded positions in society.

According to Galabuzi (2009), "social exclusion is an expression of unequal relations of power among groups in society, which then determine unequal access to economic, social, political, and cultural resources" (p. 254). Social exclusion refers to the inability of certain groups, such as homeless mothers, to fully participate in Canadian life due to structural inequities (Galabuzi, 2009). These structural inequities result in multiple and varied health disparities among different groups. That is, health is not divisible from socio-political contexts. Socio-political context refers to the material, economic, political, and cultural conditions shaping life experiences. For example, policies affecting housing, childcare, education, employment and access to a reliable and sufficient source of income ultimately influence health (Raphael, 2007; World Health Organization, 2008). As a result of and contributing to their homelessness, homeless mothers are among those who are socially excluded from the full economic, social, and subsequently, health benefits of society (Labonte, 2009). The purpose of this study was to understand the socio-political contexts, health needs, exclusionary and inclusionary forces, and strategies of resistance demonstrated by mothers experiencing homelessness.

Homelessness in Canada: The Current Political Context

Access to safe and adequate housing has long been recognized as an important social determinant of health (Raphael, 2009; World Health Organization, 2008) and as a human right (United Nations, 1948). Yet, in Canada, countless individuals and families are homeless or precariously housed. It is difficult to estimate the actual number of people experiencing homelessness in Canada. Many attempts to quantify the problem can only be done by using shelter data by not-for-profit agencies or municipalities, and are not consistent across the country. Such methods can be effective at providing a snapshot of the numbers of individuals residing in shelters; however, it is much more difficult to identify the full scope of individuals and families experiencing homelessness, but who are not residing in shelters. Those who have attempted to identify both the hidden and visible homeless populations estimate that 150 000 to 300 000 people in Canada experience homelessness annually [Human Resources and Skills Development Canada (HRSDC), 2010; Laird, 2007; Shapcott, 2009]. Women with children, Aboriginal people, newcomers, and individuals with mental illness are disproportionately represented in the homeless population (HRSDC, 2010).

Literature Review

Homelessness and Adverse Health Consequences

It is well documented that homelessness significantly and negatively influences health (Baggett, O'Connell, Singer, & Rigotti, 2010; Hwang, 2001; Notaro, Khan, Kim, Nasaruddin, & Desai, 2013), and homeless women and mothers, among other homeless individuals, face a plethora of negative health consequences. Homeless women experience increased mortality rates (Fazel, Geddes, & Kushel, 2014; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009), health conditions (Hwang et al., 2009; Morris &

Strong, 2004), poor birth outcomes (Arangua & Gelberg, 2007), increased rates of communicable diseases (Khan et al., 2011), and worsened and compromised mental health (Chambers et al., 2014; Tischler, Edwards, & Vostanis, 2009). Additionally, individuals experiencing homelessness indicate a number of barriers to accessing necessary and appropriate primary health care (Shortt et al., 2008) and experience more visits to Emergency Departments than the general population (Doran et al., 2013).

Violence and Trauma: The Gendered Experience of Homelessness

The gendered experience of homelessness for women is noteworthy in the literature and often includes women's unique experiences of abuse, trauma and/or violence (Khandor & Mason, 2007; Richards, Garland, Bumphus, & Thompson, 2010). Gender-based violence, such as sexual and physical violence, psychological abuse, violence in pregnancy, coerced sex/rape, sexual slavery, sexual harassment, and forced prostitution, were highly prevalent among pregnant and postpartum women (N=27) from Vancouver's downtown eastside (Torchalla, Linden, Strehlau, Neilson, & Krausz, 2015). Further, Haldenby, Berman and Forchuk (2007) examined the experiences of homeless adolescents with particular attention to the role of gender and public policy, health experiences, and barriers to health care. Six girls and seven boys participated in this critical narrative study conducted in Southwestern Ontario. Although all participants had discussed being exposed to various types of violence while homeless, gender-based violence was especially identified by female participants in the form of harassment, abuse from boyfriends, and women's involvement in the sex trade to seek shelter.

Likewise, differences among male and female youth experiencing homelessness were noted in a larger correlational comparative study (N= 435) conducted in Vancouver, Canada, where 22% of street youth reported having gang involvement (Marshall, Debeck,

Simo, Kerr, & Wood, 2014). Of those 22%, male and female participants yielded stark differences. Males reporting gang involvement were significantly more likely to have been in government care as a child, dealt drugs, experienced incarceration, and perpetrated physical violence. In contrast, female participants with gang involvement were significantly more likely to have a history of childhood sexual abuse and have experienced physical violence (Marshall et al., 2014).

Unique Challenges for Mothers Experiencing Homelessness

Homeless individuals are not a homogenous group. Within the homeless population, mothers experience unique and varying challenges in their experiences of homelessness. Graeves, Chabot, Jategaonkar, Poole, and McCullough (2006) conducted a study with women (N=74) in shelters for abused women and children in British Columbia. Women's experiences of violence and substance use were interconnected in complex ways. Substance use was affected by a range of influences, such as financial concerns, mothering, relationships, levels of social support, and physical and mental health issues. Many mothers noted they had delayed leaving abusive partners because they feared losing custody of their children and/or feared for their children's safety if they left them with their partners (Graeves et al., 2006).

In further examination of the mental health of homeless mothers, Zabkiewicz, Patterson, and Wright (2014) conducted a cross-sectional comparative study on a subsample of 713 women across five Canadian cities including Moncton, Montreal, Toronto, Vancouver, and Winnipeg. The relationship between parenting status and depression, as well as post-traumatic stress disorder (PTSD), varied by duration of homelessness. Among women who had been homeless for less than two years, no relationship was found between parenting status and depression or PTSD. However,

among women who had been homeless for two or more years, the incidence of

depression was twice as high among parenting women compared with others. A similar

relationship was found between parenting status and PTSD. Findings suggest that

duration of homelessness elicited unique impacts for mothers experiencing homelessness

(Zabkiewicz et al., 2014).

Fear of child apprehension and the pain associated with mother-child separation

was also evident in the literature (Barrow & Lawinski, 2009; Mill, Singh, & Taylor,

2012). In a Vancouver-based study (Duff et al., 2015), social and structural barriers to

health and social services experienced by pregnant and parenting sex workers were

investigated using a descriptive statistics and correlational design. Using baseline data

from a larger study, of the 399 women who were pregnant or had a child, 35% reported

experiencing a barrier to health and social services. The most common barriers cited were

lack of financial support, fear of partner violence, lack of social support from family

members, avoidance of services for fear of punitive measures regarding their children,

such as child apprehension, and fear of stigma (Duff et al., 2015).

Strengths and Acts of Resistance

Homeless mothers face significant challenges; however, they also demonstrate

great strengths and enact resistance to the oppressive forces in their lives. Wade (1997;

2007) notes the health-inducing and health-promoting function of resistance, as an

opposing force to oppression, and challenges the traditional pathology-oriented meanings

of the word. Resistance can be described as:

…any mental or behavioural act through which a person attempts to expose,

withstand, repel, stop, prevent, abstain from, strive against, impede, and refuse to

comply with, or oppose any form of violent oppression (including any type of disrespect), or the conditions that make such acts possible… (Wade, 1997, p. 25)

It is important to note that resistance here is understood as being experienced and enacted in the presence of despair and marginalization (hooks, 1990). Although the strength and resistance mothers demonstrate in the face of homelessness is not as well documented as the challenges they face (Fortin, Jackson, Maher, & Moravac, 2015), mothers resist their experienced oppression in a variety of ways. Indeed, becoming homeless may itself be an act of resistance, as it may be a way for women to find respite while fleeing violence or other traumas in the home (Benbow, Forchuk, & Ray, 2011; Tischler et al., 2009). Likewise, maintaining hope and perseverance were central to strengths and resistance (Benbow et al., 2011).

The literature also describes instances where Aboriginal women giving and receiving shelter care found strength, protection, restoration in their support of one another, despite and in spite of their experiences of compounding losses (Montgomery et al., 2014). Further, researchers have described women finding strength in their roles as mothers, which afforded them a sense of identity and stability (Gültekin, Brush, Baiardi, Kirk, & VanMaldeghem, 2014). For example, a participatory research study that used photovoice to explore strengths of young homeless mothers in Toronto (N=5) found that the women felt proud and positively about their role as mothers, which helped them to foster internal resiliency to their conditions, despite the judgment and criticism they often felt by others (Fortin et al., 2014).

Social Exclusion and Health

Internationally, much headway has been made in research examining the many dimensions of social exclusion that shape health status. However, in Canada, researchers

are only beginning to explore the relationship between social exclusion and health (Wilson, Eyles, Elliott, Keller-Olaman, & Devcic, 2007). Stewart and colleagues (2008) examined and compared experiences of social exclusion between participants with low-income and high-income in Toronto and Edmonton. The first phase included qualitative individual and group interviews (n=119) and the second phase consisted of a quantitative comparative survey design (n=1167). The findings showed that limited financial resources, poor health, and negative societal attitudes impeded community involvement for participants of lower income (Stewart, et al., 2008). Similarly, Wilson et al. (2007) explored the experiences of social exclusion and health using a quantitative comparative study design in two contrasting neighbourhoods in Hamilton, Ontario. Social exclusion was defined as a lack of participation in social activities and experiencing material deprivation. The results suggested that those living in the low-income neighbourhood experienced more aspects and higher levels of social exclusion than the participants living in the higher-income neighbourhood.

Benbow, Rudnick, Forchuk and Edwards (2014) used qualitative methods to examine social exclusion and poverty as experienced by psychiatric survivors (N=380) in Southwestern Ontario. The authors applied a capabilities approach to social justice, informed by the work of Margaret Nussbaum. The analysis yielded four themes: (1) Poverty: 'You just try to survive'; (2) Stigma: 'People treat you like trash'; (3) Belonging: 'You feel like you don't belong'; and (4) Shared concern and advocacy: 'Everyone deserves housing' (Benbow, et al., 2014). The findings shed light on the multidimensional experiences of exclusion faced by psychiatric survivors. Similar findings were shared by low-income women in a study by Reid (2004) who used feminist action research to explore social exclusion and poverty in women's health in British

Columbia (N=30). A social determinant of health lens was employed and findings outlined women's experiences of exclusion at the cultural, institutional and material levels. Participants experienced social exclusion in the form of stereotypes and labels, not having their needs met by the system and their lack of access to basic needs (Reid, 2004).

Summary of the Literature

Based on the review of the literature, important research has been done with regard to homeless women and mothers, as well as in examining the concept of social exclusion. However, there is a need to further both of these bodies of literature. There is a particular need to examine the multidimensional nature of social exclusion and how it shapes the health of homeless mothers. Literature on social exclusion has focused primarily on material deprivation and poverty, as well as issues related to mental health and substance abuse. Rarely were intersections of inequity explored and few researchers focused on the everyday experiences and social processes of social exclusion in shaping the health of homeless mothers.

Further, the negative health consequences experienced by homeless mothers have been well documented. However, their health is inseparable from the social, political, economic, and historical factors influencing mothers' health and were not purposefully examined in the studies. Likewise, the concept of resistance as a health promotion concept is relatively understudied, and based on the review of the literature, it was not explicitly explored in the lives of homeless mothers. Lastly, there was a lack of literature employing critical and intersectional approaches in examining the health experiences of mothers experiencing homelessness. Such an approach would offer a multidimensional and contextualized understanding of women's health and health experiences.

Statement of Research Purpose

The purpose of this critical narrative study, informed by intersectionality, was to critically examine the socio-political context, health needs, exclusionary and inclusionary forces, and strategies of resistance demonstrated by mothers experiencing homelessness. The socio-political context was inclusive of the historical, cultural, and economic conditions as well as the public policies influencing everyday realities for these women. The contextual processes shaping mothers' experiences of social exclusion and homelessness, and how these experiences shaped their health, were critically examined. The following research questions were addressed:

1)   What are the socio-political contexts of mothers' experience of social exclusion?

2)   How do the experiences of social exclusion and social inclusion shape their health?

3)   What are the strengths and strategies of resistance employed by mothers experiencing homelessness?

4)   How do these strengths and strategies influence their health?

Research Design: Methodology and Methods

Theoretical Perspective

The theoretical underpinnings of this study fall under the critical paradigm and are informed by the critical theory of intersectionality. Within the critical paradigm there are multiple, diverse, and varied theories, which all share the central tenets of critiquing oppression and imbalanced power structures for the purpose of emancipation and changing society as a whole (Welch, 1999). From this perspective, attention is given to the historical, political, and structural elements shaping social positioning, life

experiences, and knowledge (Carroll, 2004).

Intersectionality evolved out of a number of critical perspectives to promote a comprehensive understanding of women's multiple and compounding realities and the structural factors shaping them. Crenshaw (1993) first coined the term "intersectionality" in relation to the gendered and racialized discrimination black women faced in the United States legal system. Intersectionality examines the "crossroad", or intersection of multiple social identities and experiences of exclusion and marginalization (Crenshaw, 1993). Sharing the central tenets of other critical theories, intersectionality serves as a lens to examine the cultural, historical, political, and social categories that interact to create systems of power, injustice and social organization (Crenshaw, 1991; 1993). Further, intersectionality draws attention to one's individual story as situated and contextualized within a larger nuanced system of inequity (Berman et al., 2009).

Methodology

Critical narrative inquiry, or a critical orientation to narrative inquiry, was employed and was theoretically informed by the work of a number of scholars (Chase, 2005; 2011; Labov, 1972; McCormack, 2000a; 2000b; 2004). With narrative inquiry, focus is placed on the story, the art of storytelling, and the co-construction of knowledge (Chase, 2005). Stories reflect the storytellers' personal world, outer influences, and provide a space to connect individual experience to the broader contextual aspects of society (McCormack, 2000a; 2000b; Pitre, Kushner, & Hegadoren, 2011). Through narratives, participants shared and provided meaning of their reality to the researcher and others (Sandelowski, 1991). Emphasis was placed on the contextual elements and the chronological ordering of events, as well as the meanings associated with those events (Chase, 2005; Sandelowski, 1991).

Research Methods

  Sample and sampling strategies. Data were collected at various homeless shelters and programs that provide services for women and mothers who are homeless, with a purposive sample of mothers in Southern Ontario. Specifically, the researcher partnered with two organizations operating three shelters and drop-in programs. One organization was a shelter for pregnant and parenting young mothers. The other organization was a women's shelter for women and children who have experienced domestic violence. Both organizations were in urban settings, but in different cities. Participants were sampled purposefully based on self-identified homelessness and motherhood status. Snowball sampling techniques were also used (see below). For the purposes of this study, a broad definition of homelessness was used, as homeless mothers and their children may not always reside in homeless shelters (Bhui, Shanahan, & Harding, 2006). The definition of homelessness encompassed those residing in temporary group homes or homeless shelters, those doubled-up with family or friends, those constantly moving between unstable living arrangements, and those living on the street or in abandoned buildings and is consistent with Canadian definitions of homelessness (Gaetz, Donaldson, Richter, & Gulliver, 2013). Women who self-identified as mothers, over the age of 18, who were experiencing homelessness or who had experienced homelessness in the past year, were included in the study. Women with or without physical custody of their children were included. Participants had to be able to speak and understand spoken English to the degree necessary to participate in the interviews. Sampling continued until data reflected the richness and complexity required to meet the study purpose (Patton, 2002; Sandelowski, 1995).

Sample demographics. Participants who were mothers (n=26) ranged from 18-58 years of age with an average age of 27.4 years. On average women had 1.6 children; the majority of children were under 5 years of age. Most mothers had physical custody of at least one of their children, while six did not. Nineteen mothers self-identified as having or having had a mental illness, including depression, anxiety, post traumatic stress disorder, panic disorder, and addiction. Seventeen mothers were born in Canada. While ten mothers identified as Caucasian, mothers with a variety of racial and ethno-cultural identities participated in the study, including women self-identifying as Jamaican-Canada, biracial, African, Aboriginal, Indian, and Spanish. Twenty-one mothers were receiving social assistance in the form of financial support, primarily from Ontario Works (OW)[5] (n=17), but also from Ontario Disability Support Program (ODSP)[6] (n=2), and the Children's Aid Society (Child protection services in Ontario) (n=2). Five mothers reported having employment, three of which were involving sex work, one held a full-time retail position, and the other had a contract position in the food industry. Three mothers reported no source of income at the time of the interview. Eleven mothers did not complete high school, with one individual having only elementary education. Ten individuals had completed high school, and five had completed college or trade schools. All service provider participants (n=15) were women, working with women who were

---

[5] **Ontario Works** is a social assistance program that offers financial and employment support services to those who are in financial need. Financial supports are dependent on multiple variables; however, the maximum monthly financial benefits for (1) a single person is $626, (2) a single parent with 1 child is $1,041, (3) a single parent with 2 children is $1,194 (Government of Ontario, 2014a).

[6] **Ontario Disability Support Program** is a social assistance program that offers financial and employment support services to those with a disability and are in financial need. Maximum financial benefits given to (1) a single person with a disability is $1,086, (2) a single person with 1 child is $1,604, (3) a single parent with 2 children is $1,768 (Government of Ontario, 2013).

experiencing homelessness. The majority of service providers worked within the agencies

I had partnered with during the study (n=11). The service providers' roles included:

counsellors, including mental health, trauma, and addictions counsellors (n=10); housing

and community advocates (n=2); and nurse and social worker case managers (n=3).

Ethics. Ethics approval was obtained from the Research Ethics Board for Health

Sciences Research Involving Human Subjects at the University of Western Ontario, as

well as the Lawson Health Research Institute. Before consent was obtained, a letter of

information was provided to the participants and verbally reviewed ensuring that all

questions were answered to their satisfaction. Confidentiality was maintained, and

identifying names and locations were removed to ensure anonymity.

Data collection. In-depth semi-structured interviews were carried out. Women

were able to choose which method, individual or group interview, based on their needs

and comfort. Offering choice and group interviews may have helped to address the power

differential (Salmon, 2007). Sharing storied realties in groups promotes the awareness of

collective experiences and strengths (Berman, Ford-Gilboe, & Campbell, 1998).

Interviews lasted approximately 1.5 to 2 hours and were guided by a semi-structured

interview, using open-ended questions with probes; however, the guide was flexible and

was altered as necessary to meet the emerging needs of the participants.

Consistent with narrative inquiry, follow-up interviews were offered. Twelve

mothers participated in follow-up interviews. During the follow-up interviews, further

interpretations and synthesis of data were shared to gain further insight and to ensure co-

construction of knowledge and shared understandings were achieved (Chase, 2005;

Duffy, 2007). The purpose of follow-up interviews was not to establish consensus. In

fact, diverging and contradictory viewpoints were encouraged and welcomed. These

understandings were integrated into findings. For example, some mothers found incredible support through services they accessed, others identified the distrust they had of the system in general. When one participant's experience differed from another, the focus was placed on one's personal experience, but also the sharing and resonance of other participants' experiences. The emphasis was on richness of data, and to ensure this, interviewing techniques such as active listening, paraphrasing, and validation ensured that I, as the doctoral researcher, was able to understand the participants' meaning and intention.

Photography elicitation was also offered to supplement the initial narrative interviews with the participants. During the initial interview women were invited to participate by taking pictures with a disposable camera. Similar to the techniques used by Mkandawire-Valhmu and Stevens (2007), participants who expressed interest were given a disposable camera and asked to take pictures of objects or locations reflective of their social and health experiences. When women expressed interest, there was discussion and preparation for camera use, at the end of the initial narrative interview. Once the photos were developed, the participants engaged in "phototalk" (Berman, Ford-Gilboe, Moutrey, & Cekic, 2001, p. 29), or the constructing and sharing of a narrative that emerges from the discussion of the photos. It was this discussion that was used for the unit of analysis. Six women participated in this component of the research.

All interviews were digitally recorded and transcribed verbatim, while maintaining confidentiality. Mothers were provided with a $20 honorarium for each interview. Participants chose where the interviews took place. Childcare and transportation costs were offered to the participants to decrease potential barriers to participation.

Additionally, individual interviews and focus groups were held with 15 service provider participants. Service provider interviews and/or focus groups lasted 1.5 to 2 hours, were digitally recorded and transcribed verbatim. A $10 gift card was given as honorarium to each service provider who participated. A flexible semi-structured interview guide, with several probes, guided the interviews. During the interviews, service provider participants were asked to speak about their role and their experiences as a service provider for mothers experiencing homelessness. They were asked about their perceptions of health and homelessness for homeless mothers, system facilitators and barriers, acts of resistance, and suggestions for improvement in the health and social sectors.

Analysis

This analysis was informed by the processes outlined by McCormack (2000a; 2000b; 2004) which involved (1) viewing the transcript through multiple lenses, and (2) developing interpretive stories. In viewing the transcript through multiple lenses: I engaged in *active listening* by immersing myself in the transcripts to identify *narrative processes* used by the storyteller, paying special attention to the *moments*, *language* and *context* in which the text was produced. These are dimensions in which people construct and reconstruct their stories to give meaning to their lives (McCormack, 2000a). The lens of *moments* refers to epiphanies and significant moments in the narrative. McCormack (2004) suggests in viewing the transcript through the lens of *language,* attention is paid to "what is said, how it is said, and what remains unsaid" (p. 225). Further, through the lens of *context*, the socio-political, cultural, historical, and structural conditions influencing the speaker's experiences and life were analyzed.

The second stage of analyzing narratives included the development of an interpretive story, or the act of storying stories (McCormack, 2000b). Developing an interpretive story involved identifying and examining the structures of the story; this included reading the transcript line by line and identifying the beginning, middle and end (Riessman, 1993). I read digital files of the interview transcripts in Microsoft Word, while simultaneously listening to the audio recording of the interview. While reading and re-reading I began highlighting different stories within each transcript, colour coding identifiable beginning and ends to the stories. I then highlighted the text with a different colour for each narrative lens identified and used the track changes function to add comments regarding my interpreted meaning from the story. I pieced the highlighted story parts together to create a meaningful story. I then titled each story based on my interpretation of meaning, and the titles served as the initial codes, which were then refined, revised and collapsed into themes.

During follow up interviews, the participants and I discussed the emerging codes and participants were given the chance to review their transcript; however, participants preferred not to review the actual transcript and instead we focused on preliminary findings. The purpose of feedback was not to seek one truth or meaning, but rather to continue the reflection and co-construction of knowledge. The voices of the participants intertwined with mine, the researcher, during the interviews and analysis. The dialogic and collaborative nature of analysis is congruent with the critical intent of the research (Chase, 2005). Special attention was paid to collective and contradicting meanings of and within stories and across study participants, while understanding how these realities are shaped by social and political systems (Berman, Irias Giron, & Ponce, 2006). I kept a research journal where personal assumptions, values, beliefs, feelings, and biases were

explicitly explored. After each interview I journaled field notes and reflections.

Findings

Four themes were constructed, based on study purpose and consistent with philosophical underpinnings. The four overarching themes and subthemes included:

1. Exclusion from safety;

2. Stigma: Public surveillance and discrimination;

3. Contradictory sources and systems of support:

    a. "Until you hit rock bottom there's no support"

    b. "It's just not enough": Insufficient supports

    c. "Help comes with a price": Support with surveillance

    d. "Every shelter is so different": Organizational philosophies impacting support;

4. Internal impacts of exclusion:

    a. Internalized expectations and regulation

    b. Pushing back from the margins: sources of resilience and resistance

        i. Challenging injustice and seeking/providing support and help

        ii. Gaining strength through the act of mothering

        iii. Building alliances with service providers

Exclusion from Safety

The act of mothering while experiencing homelessness posed unique challenges for participants. Poverty, mental illness, newcomer status, and racialized identities added further complexity to participants' experiences of homelessness. Threaded throughout women's stories was their repeated concern for their personal safety and the safety of

their children. Childhood abuse, ongoing intimate-partner violence, and a lifetime history of trauma were central to mothers' stories. The cyclical nature of these experiences was prominent and debilitating. Women shared lifelong histories of violence shaped and compounded by poverty, newcomer status, and housing insecurities. One woman described her experience:

> Homeless from age 13 on…so it's just like living in and out, one person, that person, this person, that couch, this couch…I'm completely alone in Canada right now…I just moved here [shelter] a couple of months ago, and I was pregnant when I was living with a friend, so I went from a friend to a friend being pregnant, right, and it was actually kind of scary because I know my baby father has a lot of problems with people, so, wherever I went now, like it was just like, is your door going to get kicked off, am I going to get hurt? Like, am I safe here? I was always scared so I just picked up and went other places and stuff, so...It's just too much to deal with sometimes…it just happened overnight and it was like right back to where I started as a kid, you know. I feel like because I went through it as a kid I knew how to handle it, but when you have a kid involved in the situation, it's ten times harder.

This quote was from an 18 year-old woman who shared her life history of housing insecurity, lack of safety, and poverty. She came to Canada from Jamaica when she was a child and has had limited family contact. Prior to coming and upon arrival to Canada she experienced childhood abuse and neglect. She expressed concern with navigating homelessness as a young woman, and as a mother in terms of personal safety. Although she was familiar with the experience of being homeless, the added layer of caring for a child while homeless created even more challenges and concerns for safety. The

challenges were intensified by her status as a newcomer and the limited familial support systems available to her in Canada. The intersections of ongoing poverty, housing instability, gender, motherhood, and newcomer status contributed to her exclusion from many basic human needs, such as access to safety and housing.

Many women reported that their experiences of violence shaped their becoming and experiencing homelessness. As well, women noted that the cyclical nature of violence in their lives was further impacted by not having the economic resources to easily escape and/or prevent dangerous situations. Noting the intersections of mental health, trauma, gender, poverty, and housing instability, a mother stated:

> I have anxiety, post-traumatic stress, and depression… I'm still having a hard time dealing with being sexually assaulted as a young child. I'm still dealing with it…I'm in shelter because of spousal abuse, like umm, assault yeah I've been in here lots of times…. When you have just been in your pain and you are looking for housing, and sometimes it just, it takes so long, for you to get housing, so what are you going to do? Welfare doesn't give you enough money, and disability doesn't give you enough money, and how can you get someplace for that? How can you live on that [amount of money]? There's no housing for what I can afford, so I end up having to go back with him…. And I don't want to live in a dump. You send in your application for housing [and] you have a one to two year waiting list. I can't be in a shelter for one to two years! Where am I going to go?

She, like many participants, emphasized how persistent poverty and lack of affordable housing influenced her lack of choices for housing and often resulted in her having to return to the violent situation that she had fled. She went on to explain how her mental health has suffered as a result of the ongoing safety concerns and lack of stable

housing. She asked, "How can I heal when it's still happening?" referring to her post-traumatic stress disorder. The increased stressors and subsequent compromised mental health as a result of violence, poverty, and homelessness were central to many participants' experiences.

While residing in shelter, some participants expressed issues of safety when staying at co-ed shelters. Those who had resided at co-ed shelters indicated that they experienced fear, intimidation, aggression, and sexual harassment from men. One woman shared that she returned to her unsafe living situation and abusive partner to avoid the dangers of co-ed shelter. Another woman indicated she did not "last more than an hour" in a co-ed shelter, due to fear and intimidation. While homeless, one woman described anxieties in her admission to a mental health care unit which provided care to men and women. She reported that she had no control over who entered her hospital room, and felt frightened and unsafe due to her history of intimate partner violence. Consequently, she requested to be discharged against medical advice as her perceived lack of safety was further compromising her mental well-being.

Mothers reported that shelters and organizations specific for women, women and children, and/or women who have experienced domestic violence created more safety and decreased many stressors and potential dangers. One woman discussed a photo she took of two video cameras hanging outside the shelter doors and discussed her increased feelings of safety and protection while residing in a shelter for women and children. However, despite extreme safety measures in women-only shelters, some women continued to experience safety concerns, most notably outside the physical walls of the shelter. A newcomer woman from India expressed her concern about leaving the shelter during the day due to the fear of her husband and his family finding her, kidnapping her,

taking her child away, and continuing to abuse her. For this woman, being a newcomer in Canada played a role in her experience, as she was not familiar with Canadian laws around violence and women's rights. As well, she felt much isolation and did not have family support to guide her. She took a photo of an enclosed empty green space at the back of the shelter to further illustrate her story. She expressed that it represented many things to her including her own isolation, her loneliness, her feelings of safety, as well as her need to be protected.

A Caucasian woman, in her thirties with five children who was seeking refuge and shelter after experiencing domestic violence expressed her fears based on her children almost being abducted while previously residing in a shelter:

> I just came [to shelter] and my abuser found me. And child care was walking back to the shelter with them, and he jumped out of the van, at the child care people and started ordering my kids in the van and they were crying and running in different directions…and umm, I remember, that oh my God the counsellor, came up to me, and was like "he, like he found you, you have to get down there right away".

Participants clearly articulated their unique circumstances in experiencing homelessness as a woman, and as a woman with children. Many noted the need for safety was one of the primary factors that led them to reside in a shelter. Women commonly discussed violence experienced in unsafe neighbourhoods, as well as family violence, predominantly from male intimate partners (current and previous husbands, boyfriends, and fathers of children), and also from other family members such as parents, siblings, and extended family members. One young mother expressed her need to find a safe neighbourhood for her and her daughter, despite long waitlists for public housing:

> Living in any hood is not safe, not somewhere you want to live or be. How can
> you raise your children in housing projects? It doesn't make sense. It sucks
> because people go into these housing projects because they want their life to
> better, but they are putting their life at risk in some of these projects. Do I want to
> die for someone else's beef? No!

Lack of safe housing was exacerbated by lack of safe employment. One Caucasian
woman with an addiction and without custody of her children shared her involvement in
the sex trade and expressed the dangers in this form of employment:

> It's just the work, the way you have to go about getting it [money], like walking
> up the street getting called names, but they don't know what's brought me out
> there. You know what I mean, and it's just not fair. I've had people throw stuff at
> me out the windows. I've been shot with paint guns, it's not nice man. I'm on
> my own, I mean I have a lot of regulars, but I'm trying to build a clientele, so that
> I don't have to go on the street no more 'cause I don't like [it], it's not safe.

In this way, lack of safe housing and employment were experienced as processes that
prohibited women from inhabiting safe spaces. Exclusion from safety was experienced
before, after, and during homelessness. Mothering at the intersection of poverty, violence
and homelessness brought with it unique and complicated patterns of exclusion from
safety.

Stigma: Public Surveillance and Discrimination

Women reported experiences of public surveillance and discrimination based on
the intersections of their mothering status with other social identities, such as
homelessness status. Participants described the ways in which they felt the gaze of
society while mothering in public spaces. They expressed being judged and

discriminated against within the health and social systems, as well as by family, friends and the general public. One young mother reported:

> I've had a couple of challenges in the way of feeling discriminated but also undermined…when I walk out of here [shelter for young mothers] I usually take the sidewalk…and the looks I get from people. Even just that. I just know… "Oh she's coming from there", they stare at me. We do have stigmas attached to us…We have so many stigmas attached to us.

The "stigmas" she identified included societal stereotypes assuming that young mothers are promiscuous, that they "feed off the system and have no education", and that they lack knowledge as to how to mother.

Mothers experienced intersections of racism, classism, and ageism. One mother described this when she said, "When you're poor… people are gonna judge you, especially if you're young and black. Well when I got pregnant, they said 'Oh, she's pregnant.' But I finished school! … When I'm on buses I feel like people are looking". She and other participants described feeling watched, monitored, judged, and undermined based on their young age, race, homelessness, and poverty status. Many participants felt it was important to share with me why they did not fit the stereotypes pushed on them. They expressed efforts in trying to prove they did not warrant such public monitoring and judgement. For example in the above quotation the young woman emphasized that she completed her high school education. Others emphasized their prior employment, and "being clean", when they were no longer using drugs and alcohol. Young mothers reported that their mothering was monitored in unique ways and rejected judgments of promiscuity. One young Muslim woman stated:

> I know I was a virgin and I never was with anybody but him, so I know that he's

the father. Oh yeah, I know he thinks that I'm like a big whore or something when I was only with him, so I don't know …when I'm walking down the street some people will give me looks, like "you're a mom?", blah, blah, blah, like "why did she have a kid so young"… there is a thing for the teen moms, cause apparently all of us teen moms are bad or that we're like whores or sluts because I have a baby, but it's not like I've slept with a billion people and I don't know who my baby father is, like, you know? Yeah, and like guys think that if I, since I have a baby, that if I'm dating them or whatever, that I'm just going to have sex with them right away and it's like, no, I have a baby, but it's not like that, yeah.

This woman described how society regarded her as promiscuous because she is young and has a child. In telling her story it was important for her to reject notions of promiscuity and demonstrate that she defied existing stereotypes. This participant was not alone in her feeling stigmatized by her single motherhood status and the judgement that it entailed. Further, most of the women indicated that their child's father was not involved in the child's life; they noted the heavier burden, responsibility, blame, public scrutiny, and judgment placed on them as single mothers when compared to the children's fathers.

Moreover, women felt that their mothering was watched and monitored by shelter and agency staff. They expressed surveillance in having to justify their circumstances, choices, and at times, their "every move" to people who were "waiting for [them] to fuck up". They felt that the stigma associated with being a homeless mother resulted in their mothering abilities being automatically placed under scrutiny. The very experience of mothering without a home, often in public spaces dominated by health and social services' staff, excluded mothers from mothering without felt surveillance and without a gauging audience. One mother stated: *"you are constantly worried about staff, are they*

gonna think I'm a bad parent, are they going to call [child protection services]". Another mother who had an extensive history of trauma reported: "They don't even know me here, but they don't trust me with my child…they just constantly watch, but I haven't done anything wrong… don't assume that I don't know how to take care of my kid!" This 32 year-old Caucasian mother made note of the felt surveillance she experienced while residing in a homeless shelter and the stress it created.

Stigma also fuelled discrimination experienced by participants. Participants experienced judgment and discrimination based on income, employment, and mental health status. One community advocate working with young mothers identified challenges faced by young mothers receiving social assistance in the form of welfare or a disability support program:

> There's a lot of barriers. The barriers that these young women face, they're young. They're parents. Or they're pregnant. They're on Ontario Works, Ontario Disability, or some of them are getting their finances from the Children's Aid Society [child protection services]. So those are the barriers a lot of them face…I was looking at an apartment with a young woman and her partner. Then it came time she (the landlord) just happened to just generally ask while we were on the elevator on the way down what their source of income was and when that was disclosed you can see that, you know, she – her demeanour changed a lot and she then said, "… I have four other applications sitting on my desk from people who are working, like employed". You need to take a step back. That's not okay to stereotype this family. They have a right to a home.

Several mothers of all ages echoed this advocate's perspective in their reports of clear discrimination based on their income source: "Before I came here I went and saw a

few places and the landlords are like 'so what's your source of income', and you say 'Ontario Works' and they don't want us there". Service providers also noted the increased complexities newcomers and racialized women faced in accessing housing. One service provider reported that her client was denied housing as a result of discrimination based on her religious practices. Her client was told over the phone that there was an apartment available, yet once her client arrived, wearing a hijab, she was told there was no apartment to be viewed. The next day the same client returned without wearing her hijab and was successful in securing the same apartment she was denied the day prior.

Further, a woman with a life history of violence and trauma, who suffered from addiction shared her experience of discrimination in her interaction with the care providers in the health care system:

> [In the emergency room] The nurse told me that, why should I, why should she help me, she was talking to another nurse. Why should she help me when I tried to OD [overdose], like kill myself, right I was suicidal. "Why should we help people like this?" I then, I just like and I got up off the bed, and I said to her, "you know what I am right here, and if you need to talk about talk about me please talk about me to my face" And she just looked at me, gave me a dirty look and walked away. And I was like, I'm in a hospital.

This woman tearfully spoke to the ongoing stigma and maltreatment that people experiencing homelessness and who have mental illness face on a daily basis and how it prevents them from receiving proper care. She questioned, "did the nurse not even care what was so bad, so bad that I didn't want to live?".

While homeless, mothers reported experiencing multiple forms of public

surveillance and discrimination. Surveillance and discrimination were fuelled by societal stigma based on a number of compounding factors, including single motherhood status, young age, homelessness, and addiction.

Contradictory Sources and Systems of Support

Central to the women's experiences of mothering while homeless were their interactions with "the system". The system, as they discussed it, referred to the federal, provincial, and municipal policies, as well as organizational, institutional, and social support services accessed or attempted to be accessed by the women. The way in which women referred to the system, was as an interactive entity, an active participant in shaping their lives. Because all participants were experiencing homelessness, they expressed interaction with some aspect of the system. Among the systems with which they interacted were shelter, housing, social assistance, child welfare, and health care. The various social safety nets were described as necessary for women's survival. However, prominent in the women's stories of support were contradictory and interactive tensions of exclusion and inclusion. Women discussed many organizations that enhanced a sense of inclusion, and facilitated their feelings of empowerment by offering resources, a sense of community, and increased access to basic needs, such as food and housing. The women noted that they would not have survived without certain agencies such as shelters and drop-in centres. The contradictory nature of the system was further categorized into four subthemes: (a) "Until you hit rock bottom there's no support", (b) "It's just not enough": Insufficient Support, (c) "Help comes with a price": Support with surveillance, and (d), "Every shelter is so different": Organizational philosophies impacting support.

"Until you hit rock bottom there's no support". A predominant concern raised

by participants was the notion that "you are only let in when you're so far out" or that "until you hit rock bottom there's no support". This concern referred to the dire state one had to be in to be able to access necessary support for survival. Many women reported that the detrimental impacts of unavailable services noted that extreme crises could have been prevented had they been able to access supports sooner, in a more preventative fashion. As one mother shared:

> …it's unfortunate that it has to get to the point where you have to go to a shelter, instead of having a support system up before that…years ago I did call a shelter, but they're more, we can't really do much for you unless you come in here. So it's really unfortunate that there isn't more in the way of...what if I have a place to go for a night. It's a stepping stone. It's too bad that that there isn't more in the way of even just a safe place to go for an hour to talk to somebody to say this is what I'm going through. If, women have a place to go, a safe place to talk to somebody for that hour they would probably make healthy choices before it got to the point where they had to come here.

The women and service providers alike emphasized the magnitude of extreme crisis needed to access support, rather than the availability of adequate support to avoid crisis. Service providers made special note of the overwhelming demand and need for mental health support and services for women experiencing homelessness. They reported limited support available until the woman is in such extreme need that she requires emergency hospitalization for stabilization and safety. For example, in a focus group, service providers reported that a mother who desperately needed psychiatric care was unable to acquire the necessary supports until her illness was so severe that she attempted suicide; it was only then that she was able to receive the mental health care she needed.

"It's just not enough": Insufficient supports. Further, service providers often felt helpless to best support women due to broader system issues such as lack of available general and specialized mental health supports and lack of affordable housing. One service provider reported the challenges in supporting women to access housing:

Yeah, I'd say it [public housing wait list] is pushing the ten year mark. Five to ten years is kind of what they're saying. Priority, a few years ago, it used to be about four to ten months…for people who have lived with an abuser or have fled the home recently. But now it's sometimes, it's about two years... the waiting list is just so extreme…So then people are forced to go to slumlords or the private sector.

Service providers and mothers indicated that the support to get out of crisis was insufficient to help them thrive. The majority of the women were receiving financial support in the form of Ontario Works, Ontario Disability Support Program, or financial support from Children's Aid Society. However, prominent in women's stories and based on the accounts from service providers was the assertion that insufficient financial support was allotted to women. The struggles women experienced were worsened due to "the amount of money they are getting from Ontario Works. It's not enough for somebody to live on, so in terms of financially being able to afford to buy their food for the month, or whatever, you know it's just not enough money." No matter their current source of income, Ontario Works, Ontario Disability Support Program, Children's Aid Society, sex work and/or other forms of employment, their income was insufficient to meet basic human needs. Buying groceries and clothing, paying for electricity and transportation, and accessing safe housing were simply not possible.

One woman shared her perspective of Ontario Works:

Anything is better than nothing and it beats having to sell yourself on the streets, but I need more money for food and shelter…Ask any mom on OW, food is an issue. We don't have enough money. I have to ask my mom to bring me food, but I'm still left without.

Further, lack of sufficient supports played out in women's lives from one generation to another:

I've just witnessed it, I've seen it all over the place, you know what I mean, like a lot of my friends struggling, some of my friends can't even come to school cause moms working two or three jobs to get the bills proper, get the lights back on, and they're home watching baby sister and baby brother, missing school, so there you go, she's missing out on her education, moms trying to work and basically she's gonna end up in the same lifestyle her mom's doing, and it just keeps continuing, continuing, continuing. There's no help, you know what I mean?

This woman emphasized not only the responsibility placed on mothers to care for and provide for their children while living in poverty, but also the way in which the cycle of poverty easily perpetuates when insufficient financial and social support exist, placing responsibility on the child to support the family.

Common among many women's stories was some form of food insecurity, past, present, or in concern for the future. Many women noted their common experience of going without meals to ensure their children were fed. Women shared that "food was scarce" and "a really stressful and scary thing". One young woman residing in shelter spoke about a photograph of food that she took while in shelter. She emphasized that while she and her children were in shelter, she knew they would be fed. She contrasted this with her experiences prior to shelter residence, where she was never certain she

would have food for each meal. System inadequacies, such as insufficient income support, created enforced dependence for many participants while residing in shelter. Service providers and women both reported the great benefit to being in shelter in terms of access to resources and advocacy. Services providers noted:

> They do become healthier while they are here… we have nurses come uh, a nurse practitioner, and a public health nurse, once a week, so I mean that is good for women, they can access, if they don't have a doctor, it is a way they can get connected, and they don't have to leave the building…And they are both women…they are safe here, the service comes to them…And that's the thing too, with some women not wanting to go to a male doctor, whether it be cultural or otherwise, so to have two you know, female nurses come and be present to do so many of those things, so…access to pap tests, pregnancy tests…All things that women would have to get elsewhere, for women's health.

Women reported that while in shelter they had increased access to health care services, but many noted they only have access while experiencing homelessness. Women discussed their fear of leaving the shelter, because once they leave many shelter supports and resources are no longer available. Speaking about a photo she took of her addictions counsellor, one woman noted:

> I finally have the help I need here. I can see a counsellor everyday if I need to. My son sees a nurse and counsellor. They saved my life, well me mentally I mean. But when I leave we won't have them, you know. I trust them, you know? It just sucks.

Service providers expressed the increased complexity mothers with mental illness faced in accessing supports:

If you have children, women downplay their symptoms because they are afraid

their children will be taken, or arranging childcare you know, what to go to an

appointment or to sit in emerg [the emergency room], like we have had women

say, "I will not go to emerg because I don't have anyone to watch my child".

Recognizing the unique needs for mothers experiencing homelessness, a service provider

identified a gap in the current services whereby mothers struggling with mental health

issues are not able to pursue necessary health care supports easily with children:

…I've worked almost exclusively with women whose lives are at the intersections

of abuse, addictions and mental health. The relationship to their children is

different, or whether or not they have children. So, for instance, if a woman is

living with a situation where there is abuse going on, she might be struggling with

mental health, addictions, you know, the opportunities that are available to her are

different than a woman with children, so, even though we have ridiculously long

waits for substance abuse treatment, we certainly don't have them for women in

order to be able to take their children with them. So having to make the choice

between either leaving your children in an unsafe situation, or placing them in

care so that you can get the support you need in order to go back and be the parent

you want to be, isn't an option. Whereas if you're a single woman without

children, your options are different because you are not needing to, your own

feelings of inadequacy around "I failed my children", "I can't be a good mom",

"if I leave people will know…", like a stigma that's attached to being a mother,

and also grappling with homelessness, addiction, mental health, it's so much

greater [for mothers] than for women who are not mothers.

Community workers and women alike recognized the unique need for specialized

services for mothers experiencing homelessness at the intersection of many vulnerabilities.

"Help comes with a price": Support with surveillance. Women expressed the existence of a false sense of support within a system that is meant to be supportive. For example, a mother with two children residing in shelter noted: "… once you have the support you need, you have to constantly prove you need it". This was common when participants discussed gaining access to social assistance in the form of Ontario Works, mental health support, and access to housing. The requirement to prove that they needed and deserved the service builds on the public surveillance aforementioned where mothers' lives were gauged and monitored by others. Women had to demonstrate their worthiness of some services, despite the fact that such supports were basic human needs, such as access to a liveable income, or shelter.

The women also reported that often times "help comes with a price". For many, the cost was the relinquishing of a private life, with their affairs being placed under scrutiny. They feared what system interactions could bring, such as child welfare system involvement, increased stigma and discrimination, and increased surveillance. Women noted that some organizations, which were supposed to offer refuge, protection and support, did the opposite. Women expressed their experiences with these particular services as repeated "markers of mistakes", "jail like", controlling, provoking fear and judgment. The negative aspects added to the fear of system involvement, so much so that women were reluctant to seek much needed help and support.

An Aboriginal woman with a long history of homelessness described her frustrations of seeking help and the subsequent interaction with the child welfare system:

> …a couple of times we were in the shelter and [child protection services] was

called and we weren't doing anything. They [child protection service workers] just get out of college, fresh out of college, university, they get this job, they go out, they get a call, they come to a person who has like two or three kids, and somebody called on them, and they are going to apprehend their kids, and I just think, think about, like you, do you have any kids, do you understand, like, you have no clue what it is like to have to raise a child, and to go through struggles every day…how dare you look down your nose at me…it really bothers me that they take kids away, they apprehend kids, from mothers who are so trying.

This woman further discussed how she did not feel supported to maintain custody of her children, and spoke about the subsequent trauma of having her children apprehended. Women's interactions with the child welfare system were complex. Distrust in the child welfare system was common to the mothers' experiences of parenting without a home. Women expressed their fear of child welfare system involvement, rather than viewing it as a source of support and a resource. While a few women noted the positive help, guidance, and support they received from child welfare services for themselves as children and/or for their children, this was the exception and was not common to most women. Overall, the women expressed that compounding vulnerabilities, such as young age, living in poverty, experiencing mental health crises, and parenting without a home placed them in precarious and powerless positions when working with child protection services. One woman reported feeling targeted due to her age and lack of employment:

[Child protection services] picks on mothers, targets younger moms. If you don't have support they target you. I was 18 years old when I had my daughter. There was a social worker from [child protection services] assigned to me, she didn't

close my [child protection services] file. They harassed me for 3-6 months. Like, I

take care of my daughter. There is food for her in my fridge; there isn't a bruise

on her. I put my foot down- I said, "You guys have no reason to come here". If I

was a woman who was older and had a job they wouldn't have targeted me. They

shouldn't target us because we have no family or are in shelter. These moms

should not have their kids removed for things beyond their control what needs to

change is for women to be able to trust [child protection services]. [Child

protection services] needs to work with women to get therapy, rehab supports for

women who have problems. I thought [child protection services] was there to

support us? Well then support us!

Sharing this woman's concerns, one service provider challenged accepted social

norms regarding apprehension of children and supporting mothers and reiterated the

detrimental impact of late onset support:

I think that as a society, we would be much more comfortable with the notion of

taking women's children away from them, than providing the background

services that could, you know, that would facilitate that woman continuing on in a

mothering capacity. So we would rather redirect services towards this idealized

foster family situation that rehabilitates this poor child, than provide the same

amount of resources and background support to allow the children to maintain the

relationship with their parents, their mother, and I think that that's based on a real

damaging representation of what it means to be a good mom. And being a good

mom does not mean struggling with mental health or addiction or homelessness, it

means being the perfect middle class, white, educated, well employed, you know,

mom with the Labrador retriever. It's both the stigma and our unwillingness to

acknowledge that you know, as a society we've just given up or we'd rather go in

and apprehend…so they're in crisis, so it looks like they're incompatible with

parenting but it just has to be the place in which we've intervened is too late

because they're that much further off. Had we created a system with which

women could come forward at an earlier part in their pregnancies, or in parenting

and said "I'm in crisis, I need help", out of fear that their children would be taken

from them or that they would be shunned or shamed or all of a sudden involved in

a system that is disempowering, then we would really minimize the more

hazardous outcomes that come later.

"Every shelter is so different": Organizational philosophies impacting

support. At a shelter/organizational level, service providers noted that organizational

philosophies, values, policies, procedures, and regulations shaped women's interactions

with support services. For example, several women working in a shelter for women

experiencing domestic violence noted their organization's feminist intersectional

philosophical underpinnings, and the ongoing examination of current policies and

procedures to ensure the needs of women were met and power differentials addressed.

These service providers noted their women-centered values and discussed the ways in

which the organization was striving to ensure the values, voice, and autonomy of the

women they worked with were incorporated into their approaches to care. Other service

providers working within agencies not guided by feminist or intersectional philosophies

noted that a more explicit women-centered and anti-oppressive approach was needed to

better support women. Two service providers felt at times that their organization's

authoritative approach further inhibited women's power and control and created distrust

and less effective care. These service providers desired to work within an anti-oppressive

organization where the agency would be required to create and enact policies that challenged current power differentials and valued the inclusion of women's voices in shaping the care provided.

Many mothers noticed a difference in how they were treated within and across various agencies, indicating how the autonomy and treatment of clients varied from agency to agency. The underlying philosophies or intrinsic values of the agencies influenced women's desire to seek support and help, as well as either trust or distrust in the system. For example, a woman shared her fear of disclosing her drug addiction, out of worry that she would not be able to remain in shelter and that she would not be able to see her daughter. She discussed the negative interactions she had with multiple counsellors and service providers from a variety of agencies, who made her feel "like shit", about her addiction as a mother. She knew she needed help, but at the same time felt she had to hide her addiction so as not to compromise shelter access. After she accidentally overdosed, she was referred to a shelter that was inclusive of women suffering from addictions. Not only did this shelter allow her to stay, despite her addiction, but they were able to support her through her addiction. She emphasized that they treated her "like a person" and did not "talk down" to her. Within this agency she noted that she felt heard, valued, respected and supported. Service providers echoed the importance of inclusivity in services. They reported the struggle in either having turned women away from services, based on policies, due to addictions or sex trade involvement (and the subsequent inability for women to meet "curfew"), or not being able to locate adequate support for mothers due to the exclusion criteria within other agency policies.

In summary, the contradictory sources and systems of support reflected the tensions of inclusion and exclusion mothers experienced while navigating a variety of

services necessary for their survival. The "system" actively participated in women's lives

in shaping their experiences of health and homelessness. Despite the existence of

supports, available services were described as inaccessible until one was in dire need. As

well, once able to access the supports many women and service providers noted that

existing services were insufficient to meet the complex needs of mothers experiencing

homelessness. Furthermore, the women were required to carry the relentless burden of

needing to constantly prove themselves needy enough to receive certain supports.

Women noted that in seeking help, their vulnerabilities would be exposed and their lives

would be monitored. Lastly, women and service providers alike noted that various

agencies provided different approaches to care, based on agency purpose and

organizational philosophies.

Internal Impacts of Exclusion

Experiences of social exclusion shaped women's lives in monumental ways. Lack

of access to resources and services were examples of external forces of exclusion.

Subsequently, internal impacts of exclusion shaped women's experience through (a)

internalized expectations and regulation, and in their (b) pushing back from the margins:

sources of resilience and resistance.

Internalized expectations and regulation. In discussing experiences of social

exclusion, the women often shared the way in which experiences of poverty,

homelessness, domestic violence, and mental illness negatively impacted their feelings of

self-worth. Internalized gender norms and societal expectations of what it meant to be a

"good mother" inherently shaped their view of themselves. Participants shared notions of

themselves as subpar mothers and expressed feelings of shame and blame for their

current circumstances. Some women expressed feelings of being "bad mother(s)" when

discussing their experiences of housing instability and domestic violence and addiction. Other mothers noted the blame they felt from self and society regarding circumstances often beyond their control. One mother of three who was receiving treatment for addiction and was residing in a shelter for women experiencing domestic violence reported:

> It's hard for me. I have both my boys with me, and it makes me, it carries a lot, it puts a lot more blame on myself, you know as a mom... And then the kids blame you, you know, 'mommy we're living in a woman's shelter'… And things got really bad, and therefore it, it just makes it harder for me, because when I can't give any of that (referring to safety and housing) to my children. I left to get away from the drugs and abuse, right, I left to get out of the hole, and then just a year later to be in here (shelter), it just makes it feel like none of its worth it, like when I go to court, then you know, like. I'm here because I have to be. But then I go to court, and I go like, "well, I live at the woman's shelter" it's not going to reflect any better on me, and you know, and my ex-partner whether he was abusive or not for six years, he lives in a house, and he's you know this and that…And you know it's going to reflect badly on me.

This woman placed her mothering under scrutiny, felt blamed by others, and blamed herself for circumstances that were beyond her control, such as domestic violence, residing in shelter, and economic insecurity. Many women echoed her frustration, self-blame, and a sense of powerlessness. It was difficult for women to resist the pervasive dominant expectations of mothering and to resist gauging their mothering in relation to the unjust circumstances and experiences they faced.

In some cases, the mothers expressed feelings of extreme worthlessness,

powerlessness, and hopelessness when discussing their circumstances and suggested questioning whether life was worth living. One newcomer woman expressed emotional defeat and frustration in the face of never-ending cycles of poverty, domestic violence, homelessness, and child apprehension. She compared the current injustices she faced with those she experienced in her home country:

> …but that [civil war] was not the worst thing in my life… that's what I am saying, like I'm saying why did I survive? What's the point? To then be here at this shelter, dealing with everything… like, I should have just died there, you know, what's the point?

This woman described the extreme childhood trauma of civil war, and emphasized that what she was going through now was even more difficult. She expressed a sense of futility and emotional exhaustion, emphasizing that chronic instability made life seem not worth living.

Another mother, not residing in shelter, expressed how the consequences of homelessness and poverty made her feel like an inadequate mother:

> Moving from place to place, my cousin's house, friend's house, not knowing where we are going to live next week. He has changed schools 3 times already and he just started! It makes me feel like a bad mom…It makes me want to give up. I hit a really big low this past winter, I just couldn't do it anymore. I'm not like the other moms on welfare, you know…I'm working for a living...I mean at least I'm not prostituting myself…What am I doing here, my son deserves better.

There seemed to be a need for many women to differentiate themselves from those in further compromised or excluded positions in society. That is, the need to separate themselves from those perceived as "worse off". The women separated themselves from

the stigma associated with certain social statuses by reinforcing a hierarchy of exclusion. In this way, women internalized dominant discourses to resist being placed in the same category as "the welfare mom", "the prostitute", and "the addict", and other stereotypes of mothers experiencing homelessness. This was also apparent when women were discussing who was "deserving" of accommodation in the shelter system, who deserved to have custody of their children and who did not. Dominant discourses and societal stigmas around mothering and poverty, addictions, violence, and mental illness were apparent, and the women tried hard to separate themselves from such stigma.

Pushing back from the margins*:* **Sources of resilience and resistance.** While the women suffered detrimental impacts of exclusion, they constantly demonstrated resistance and resilience in the face of such adversity. The women pushed back from the margins by: (a) challenging injustice and seeking/providing support, (b) gaining strength through the act of mothering, and (c) building alliances with service providers.

Challenging injustice and seeking/providing support. While participants experienced exclusion from the many benefits of society, they demonstrated great agency in shaping their present and future. This was demonstrated in their challenging of the injustice of their current situation. In questioning their situation and witnessing others experiencing similar hardships, women were able to identify the existence and pattern of poverty, abuse, trauma, homelessness. They questioned how such travesties of injustice could occur. One woman, expressed her frustration regarding the perceived lack of understanding from those with political power:

> I don't think that the government really cares. I've said this about people suffering from addictions; I've said this about people who have suffered from homelessness. All it would take is one of those assholes experiencing what

we've gone through then things would start to change. Somebody up there would

be saying "no we need to make a stand and make it better for these people". We

are spending umpteen billions of dollars on an airplane [military plane], but yet

we can't contribute it to people that have a disease. You know scientists are

saying, and psychiatrists are coming forward saying it is a disease. Homelessness

is part of that disease. How do people not know it's a cycle? There are so many

different factors that contribute to mental health. Unless somebody experiences it

and makes an incredible inspiring movie about it, which I will write someday,

then nothing gets done about it…really.

The women also demonstrated their challenging of injustices by identifying the

immediate need for an increase in affordable and safe access to housing. The women

noted the dangers they faced as a result of lengthy waitlists for safe and secure housing.

Further, they expressed their anger that the current approaches to housing access were

futile, inadequate, and unacceptable for single mothers living in poverty. In questioning

the systemic influences of their situation they defied and challenged self-blame. Several

women demonstrated this in recognition that "the system has failed [them]", they

themselves had not failed. This discussion created and reinforced a renewed energy and

commitment in the women challenging broader societal injustices, and in their resisting

the dominant perspectives of individualistic blame overpower their thinking.

The women also demonstrated their resistance to forced exclusion by actively

seeking support and help from service providers and agencies. Women fleeing domestic

violence and seeking refuge and support demonstrated much strength, resilience, and

resistance. In seeking support, some mothers expressed that informal communal spaces

of support were developed with other women sharing similar experiences. In this way,

space was created where women collectivized their experiences during meal times, during group therapies, and daily activities within agencies and shelters. During focus groups of this research, woman shared deeply personal experiences with one another, and through their disclosure, supported each other. The women hugged each other, cried for and with each other, and challenged each other to show self-compassion. They told other women "you are such a good mother", and demonstrated a uniting of experiences. The supportive space created a bonding centered on shared hardships and resilience. The women noted that the sense of community gained from residing in a shelter helped to give them balance, friendship, and support. One woman took a photo of a quote posted by a peer in an agency she accessed, which read: "You are stronger than you know". The woman shared this photo and explained the positive companionship and encouragement she felt from other mothers experiencing homelessness. The women reported this encouragement, positive reinforcement, and camaraderie as a protective and necessary factor in supporting their mental well being.

Gaining strength through the act of mothering. The majority of women, especially those with contact and/or with custody of their children, noted that their ability and need to care for their children served as a source of strength and reaffirmed their perseverance. One young woman described returning to school and finding a safe neighbourhood in which to live after having her daughter and raising her as a single mother:

Having my daughter got me out [of unsafe neighbourhoods and a dangerous lifestyle]... Children can be a driving force! Before I had her I lived a carefree life, partying, no responsibilities, but with a child you can't, you have to be responsible. You have to make better decisions or they will follow the same road.

Now that I got out of it, I never want to go back there, I don't want to go back

there. I can't fuck up, there is no back up plan.

For another woman, the need to protect her daughter was her motivation to seek safety

and leave her abusive partner:

He put a knife to my daughter—she was only a year and half—to her chest, and

he put a knife to my throat…I told my sister to call the police, they surrounded

my house, oh so many cops. They arrested him. I have not seen that man since.

And I did not feel sorry…I did not. When he put the knife to my daughter's chest,

my one and a half year old daughter that was it! Like me maybe, if he had only

done something to me, but he put a knife to my daughter's chest. And I was done.

That was it.

This woman spoke about the difficulty she had in leaving her partner and the challenges

she faced prior to her child's safety being in jeopardy. The need to ensure safety for her

child gave her the strength she needed to escape. Mothers found strength to face and

overcome their daily and ongoing struggles and challenges. The women often shared the

notion that it's "all worth it" because of their children. One service provider noted:

It's amazing to see, I would say, most of the moms that we see use their children

as their motivation, and so whatever they are doing, the fact that they are here at

all, like this is for my kids, this is for my kids, so they will just go to extremes,

whatever that means, whether it's the resourcefulness, or whatever, because they

just, they don't want to be here, but umm, it's just that they are able to really, use

the motivation from their children to fight for things.

Building alliances with service providers. Despite many of the aforementioned

critiques of service providers, mothers noted the instrumental roles that particular

counsellors and advocates have had in their lives. Most of the service providers

interviewed identified ways in which they worked tirelessly alongside the women. The

service providers demonstrated passion as they recounted their commitment to support

mothers. In sharing their stories of supporting mothers experiencing homelessness several

service providers expressed emotions of deep frustration, sadness, and exhaustion

working within and challenging "the system". Women often noted that they sought help

from particular service providers who were working in agencies and shelters to advocate

for and with them in broader social and housing systems. Mothers often noted how

specific service providers helped them, "stood up for [them]" and made them feel safe,

deserving, and understood.

Women discussed the importance of having service providers to advocate with

them for their needs. One mother stated: "I would have never gotten my children back

without her [name of service provider]. I wouldn't have…She never gave up". One

service provider shared an example of when she was able to effectively use her voice, to

elevate the concerns of the mother she was working with:

> …boarded up windows, and moms begging, begging and having us write letters to
>
> help. I went to a family who was missing her door knob. Her door knob! Like
>
> there was a big hole because her ex had kicked in her door. And I wrote a
>
> scathing letter, scathing. And just said you have 24hrs, before I contact my local
>
> MP, and this MP is going to know that this is what you are saying is suitable for
>
> children. It was fixed! You know, again we use our voice, our power, whatever
>
> you want to call it, our advocacy.

The service providers interviewed recognized the power and responsibility they had in

supporting women to achieve safety, and minimize their experiences of exclusion. They emphasized that advocacy was inherent in their roles and noted that advocacy happened daily in seeking services, resources, and in supporting women to know their rights. Service providers discussed that due to limited funding many assumed multiple roles in supporting women, but central to all roles was advocacy.

The service providers discussed how advocacy often happens on an individual level, but there was also much discussion about the advocacy that happens on a broader political level. One service provider noted the power of voting in elevating the voice and needs of the women:

> Voting! This is how I'm going to use my voice to get this family what it needs. Like you said low-income housing, just the state of some of these [housing] units. That is of no fault, of no fault to these moms and kids. Because they are doing the best that they can on this meagre amount of money, with this lack of low income housing that we have or affordable housing.

Voting as a form of advocacy draws attention to the systemic factors at play in shaping women's lives. The service providers recognized the broader societal flaws and pathologies as the source of much of the forced exclusion women faced. They emphasized societal responsibility, and resisted placing blame on the women for their circumstances, while recognizing the great agency and strength women held in the face of such adversity. The service providers noted change is needed on so many levels and discussed several policy issues and recommendations to better support the health and well being of mothers experiencing homelessness. At the broad political level, service providers and mothers alike recognized the need to increase affordable and safe housing in Canada. Service providers recognized that there was a need to raise societal

expectations regarding standards of living, emphasizing that women cannot live safe, healthy lives at the current standards. Service providers spoke at length how this would be all-encompassing, creating change related to housing, food security, domestic violence and access to a liveable income.

Recognizing the need for change, the service providers interviewed were fully engaged in working to support women in achieving more equitable and safe lives. As previously captured, women did not always feel supported or trust certain service providers within and across services. By and large, women noted those service providers who treated them with respect, demonstrated they truly cared for the women, and used inclusive and non-authoritative approaches, made a significant difference in their lives in their fight for survival.

Overall, the internal impacts of exclusion highlighted the way in which the systemic forces of social exclusion impacted mother participants, as well as the way in which they resisted such exclusion. Mothers internalized gender norms and pervasive discourses of mothering, while they simultaneously resisted them and questioned the injustice of their circumstances. Women participants gained strength from their role as mothers and with service providers in their advocacy efforts to challenge their circumstances and injustices they faced.

Discussion

Through critical narrative inquiry, women's narratives of health, exclusion, mothering, and resistance were illuminated. Likewise, service providers shared their experiences in supporting mothers experiencing homelessness. The findings identified the tenuous nature of mothering while homeless; that is, of mothering in spaces of exclusion. Women experienced exclusion in many aspects of their lives. Prominent examples of

social exclusion experienced by participants included a) discrimination in seeking housing, health care, and social services, b) lack of access to a liveable income, c) cycles of violence and trauma, (d) food insecurity, (e) intergenerational poverty, (f) lack of access to safe and affordable housing, (f) insufficient health and social supports, (g) societal surveillance, and (g) societal stigma.

The participants expressed their view that the system played a monumental role in their lives. In this way, the system was a participant in their lives, drawing attention to the *structures* of exclusion that shaped participants' health experiences. Oudshoorn, Ward-Griffin, Forchuk, Berman, and Poland (2013) noted, "the problems of 'the system' are too often reframed as personal problems" (p. 325). Thus, highlighting the need to address neoliberal policies and philosophies perpetuating the pathologizing of "symptoms of the system" as personal flaws and faults. As Scott (2007) so eloquently stated "A sick system creates sick people" (p.57).

The contradictory nature of the system created an illusion of support, but in mothers' lived realities, it perpetuated experiences of exclusion in spaces ironically designed to enhance inclusion. While the women noted the necessity of existing supports to ensure their survival, the available services did far from help them to thrive. This raised questions from the participants about the true intention of such supports and how the system was enacted despite its inclusionary purpose- at least rhetorically. Fear of system interaction was also prominent in mothers' experiences of mental illness and homelessness. Particularly, women with children avoided seeking certain forms of help due to fear of child apprehension and system surveillance. Such experiences challenged the current system to achieve inclusivity and truly meet the needs of service users.

Further, the women's experiences of exclusion and feelings of self-worth were

impacted by dominant societal views of mothering and what constitutes a "good mother".

Some participants expressed feelings of shame and blame for their current circumstances

and shared their beliefs of feeling like subpar mothers in relation to their homelessness,

addiction, and domestic violence. Others noted the blame and shame they felt from

society in navigating the system. Dominant expectations of mothering were shaped by

mainstream normative discourses built on privilege (Park, 2013). These standards were

incompatible with, and unachievable for mothers experiencing homelessness. Women

living in poverty, receiving social assistance, suffering from addictions or mental illness,

involved with the criminal justice system, and/or who are young in age or unmarried do

not meet the dominant expectations of being a "good mother" (Rolfe, 2008). Such

dominant standards of mothering, perpetuated by neoliberal and patriarchal norms,

chastise and stigmatize these women and blame them for their existing plight without

understanding and challenging structural inequities and historical and contextual factors

shaping their experiences (Barrow & Laborde, 2008; Benbow, 2012). A need to

challenge dominant constructions of mothering has been identified in literature pertaining

to mothers with serious mental illness living in poverty (Montgomery, McCauley,

Mossey, & Hill Bailey, 2009), mothering within the context of past trauma (Berman et

al., 2014), mothering while using substances (Reid, Greaves, & Poole, 2008) and

mothering within the context of the child welfare system (Hughes, Chau, & Vokrri,

2015).

Women showed a great deal of agency within these structures of exclusion; they

worked, and at times fought, tirelessly for safety, housing, their children, and their human

rights. They actively demonstrated their agency and resistance within the webs of

exclusion they faced. Such personal agency has been identified in the literature as

strengths, engagement, and motivation (Fortin, et al., 2014; Tweed, Biswas-Diener, & Lehman, 2012), without explicit mention of the active nature of such work and the underlying injustices against which they are working. As previously identified, resistance is a relatively new concept within the health promotion literature, but one that has great purpose and potential, especially within an emancipatory lens, and in relation to women relegated to the margins of society.

Many participants expressed their feelings of inclusion and collectiveness within their experiences of exclusion, for example, in finding formal and informal support within the shelter system. The simultaneous experience of and the non-linear relationship between inclusion and exclusion was noted in the literature (Caxaj & Berman, 2010; Pease, 2009; Reid, 2004; Yanicki, Kushner, & Reutter, 2014). However, similar to the enactment of resistance *within* a context of oppression, participants expressed that experiences of inclusion existed *within* the circumstance of exclusion. In this way, exclusion and inclusion were inextricably linked, as is described in the literature; however, within the context of this study and in the lives of study participants, social inclusion was predominantly experienced only within spaces of exclusion. This was especially evident in the quote and theme: "You are only let in when you are so far out".

Other findings suggested that in striving for social inclusion, such as through employment, we must be mindful of reasons one was excluded in the first place, such as due to addiction issues, discrimination, and domestic violence. A focus on inclusion without first addressing why people were initially excluded begs the question of how they can be successfully included into a society that inherently excludes them. This reifies the dynamic and intertwined relationship held between inclusion and exclusion and further emphasizes that as proposals to encourage social inclusion are underway, it is imperative

to first address processes of exclusion.

Limitations

Limitations included: (1) restriction to an English-speaking population, (2) challenges of following up with second interviews due to changes in accessibility and complexity of life situations, and (3) recruitment primarily through two organizations. Although requiring participants to speak English effectively meant that non-English speaking mothers could not share their stories, employing several translators was not feasible due to the cost required to hire multiple translators. Secondly, less than half of the participants engaged in a follow-up interview. This was not surprising, given the well-documented complexity of conducting research with homeless populations (Nowak et al., 2014; Tochalla et al., 2015; Williamson, Abrahams, Morgan, & Cameron, 2014). Nevertheless, I was able to share my reflections and the analysis to date with each participant. Primarily recruiting participants within two organizations may have limited the inclusion of women experiencing homelessness who were not accessing those particular services, such as the hidden homeless, or those residing in other shelters, such as Aboriginal shelters, or shelters catering specifically to newcomer families. Such study limitations provide impetus for future research.

Implications and Conclusions

This research builds on the social exclusion and inclusion bodies of literature and contributes to the current knowledge related to health in the lives of mothers experiencing homelessness. Based on study findings, prominent implications to support health and health promotion include: (a) challenging dominant discourses and internal expectations of "good mothering", (b) shifting hegemonic cultures of power and control in health and social services, (c) promoting trauma-informed care, (d) advocating for a liveable

income, and (e) advocating for safe and affordable housing.

Whether working in the shelter system, social assistance system, or health care system, nurses and other service providers can create spaces to counter mainstream and dominant discourses of "good mothering". Berman and colleagues (2014) suggest, "this might mean engaging in discussion about the often unrealistic expectations that society holds regarding anyone's ability to be a perfect or perfectly attuned mother" (p. 9). We can work towards "changing the script" by supporting and understanding different representations of mothers and mothering. This could have far reaching implications in public health advertisements, violence-prevention programs, child-care supports, and overall health promotion strategies. Such strategies far too often reinforce negative stereotypes of mothering by decontextualizing mothers' experiences and focusing on the poor "choices" which are seen as antithetical to good mothering. In challenging this notion of mothering through contextualizing their experiences, service providers can employ an intersectional lens to gain an understanding and appreciation for how historical, political, economic, and social factors impact mothers' health and well being. Recognizing the incredible strength mothers found in the act of mothering to help them persevere, create change, and seek safety, it is important that we also challenge mothers' internal expectations of mothering by highlighting and reinforcing strengths and systemic injustices shaping their experiences of health.

Shifting dominant cultures of power and control within health and social systems is important (Oudshoorn, Ward-Griffin, Poland, Berman, & Forchuk, 2013), as identified by participants, to ensure that mothers, as a marginalized group, feel supported and heard in accessing care. Anti-oppressive philosophies are beneficial for social and health care organizations where power differentials often go unchallenged (Marrow & Wiesser,

2012). Such change can be undertaken by a wide range of services, from local drop-in centers for homeless women to provincial social assistance services. This approach requires the routine and explicit examination of power and control enacted through policies and regulation with inclusion of client voice. In this way, we can ensure supports, which are rhetorically intended to promote inclusion, are not exclusionary by the ways in which they are enacted. In advocating for their clients, service providers require an environment where advocacy and partnership are not only valued but expected.

Such a lens requires that service providers have an understanding of what has happened in women's lives, as well as recognizing their resilience, resourcefulness and resistance in challenging and coping with injustices they have faced. Service providers can further meet the needs of women by being aware of and sensitive to the complexity of women's lives and circumstance, as well as their experiences of discrimination and felt stigma from health and social professionals within the system. In doing so, service providers and policy makers can promote a reconceptualization of how services can be employed to better meet the need of mothers experiencing homelessness. For instance, fear of child apprehension was an identified barrier for seeking and accessing help they needed, particularly related to mental health and addiction services. As well, participants noted that mothers with addictions were often disqualified for utilizing some services, such as particular shelters, or drop-in centers. In reconceptualizing services and service work we can challenge exclusionary criteria in ensuring mothers' needs are truly met, and do so in a safe space where mothers do not feel monitored, gauged, or powerless. In our work with mothers, strengths-based approaches, including trauma-informed care, are imperative to further challenge internalized and unmet expectations of mothering.

Violence and trauma were central to women's experiences of health, mothering, and homelessness. Women's experiences of safety, or lack thereof, must be a priority no matter the care setting. Employing trauma-informed care recognizes the role that trauma has played, and continues to play, in women's experiences of health (Van Berkum & Oudshoorn, 2015). Specifically, trauma-informed practice can help to address the magnitude of trauma in mothers' lives, by recognizing, ensuring, and responding to women's emotional and physical safety needs. It also promotes an understanding of the manifestations and health sequalae associated with trauma, such as depression, anxiety, and addictions (Hopper, Bassuk, & Olivet, 2010). Advocacy for organizational policies and procedures inclusive of abuse and trauma screening assessments, as well as training for staff as to how to best support trauma survivors can be implemented in a variety of institutions. Organizational accountability can be fostered in the training and purposeful recruitment of staff with anti-oppressive and trauma-informed values.

Poverty and the lack of affordable housing were central to the way in which social exclusion was enacted in the participants' lives. Social assistance rates in Ontario, and throughout Canada, are dramatically insufficient to support basic human and health needs, such as access to food and shelter. Health and social professionals and groups, can advocate to promote health through political involvement and lobbying efforts to reduce poverty for homeless mothers and increasing social assistance to liveable rates (OCAP, 2014). In advocacy efforts, an intersectional lens can be employed in response to the high prevalence of poverty among single mothers, racialized individuals, and newcomers (Government of Ontario, 2014b), and in recognizing that gender, race, and other social identities differentiates the processes leading to poverty and the ways in which poverty is experienced.

Further, Canada remains without a national housing policy, despite the recognition of housing as a human right (Ontario Human Rights Commission, 2008; United Nations, 1948), and as an important determinant of health (Raphael, 2009). It is paramount that the Government of Canada adopts an inclusive National Housing Policy to meet the housing needs of diverse groups, including mothers experiencing homelessness. Access to safe affordable housing is a basic human need that when not met, compromises all other determinants of health and overall life functions. As identified in the findings, safety was a central concern in mothers' lives. Mothers experience homelessness within the context of multiple inequities: racism, gender-based violence, sexism, stigma, and discrimination. Included in such a policy must be plans, indicators, and evaluation strategies to ensure safe and affordable housing is accessible to all Canadians with special considerations for uniqueness of circumstance.

In sum, social exclusion faced by mothers experiencing homelessness is complex and all encompassing. This research offered an in-depth examination of the socio-political context of social exclusion in mothers' lives and the way in which resistance is enacted. As a social determinant of health, social exclusion impacts the health and well being of marginalized groups, such as mothers experiencing homelessness.

References

Arangua, L., & Gelberg, L. (2007). Homeless persons. In R. M. Andersen, T. H. Rice, and G. F. Kominski, (Eds.), *Changing the U.S. healthcare system* (pp. 491–547). San Francisco: Jossey-Bass.

Baggett, T. P., O'Connell, J. J., Singer, D. E., & Rigotti, N. A. (2010). The unmet health care needs of homeless adults: a national study. *American Journal of Public Health, 100*(7), 1326-1333.

Barrow, S.M., & Laborde, N.D. (2008). Invisible mothers: Parenting by homeless women separated from their children. *Gender Issues, 25*(3), 157-172.

Barrow, S.M., & Lawinski, T. (2009). Contexts of mother-child separations in homeless families. *Analyses of Social Issues and Public Policy, 9*(1), 157-176.

Benbow, S. (2012). Mothers experiencing homelessness in Canada: Intersections and strategies for support. In S. Lapierre & D. Damant (Eds), *Regards critique sur la maternité dans divers contexts sociaux*. Quebec: Presses de l'Université du Québec.

Benbow, S., Forchuk, C., & Ray, S. (2011). Mothers with mental illness experiencing homelessness: A critical analysis. *Journal of Psychiatric and Mental Health Nursing, 18*(8), 687-695. doi: 10.1111/j.1365-2850.2011.01720.x

Benbow, S., Rudnick, A., Forchuk, C., & Edwards, B. (2014). Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors. *Disability and Society, 29*(7), 1046-1060. doi: 10.1080/09687599.2014.902359

Berman, H., Ford-Gilboe, M., & Campbell. J.(1998). Combining stories and numbers: A methodologic approach for a critical nursing science. *Advances in Nursing Science* 21 (1),1-15.

Berman, H., Ford-Gilboe, M., & Moutrey, B., & Cekic, S. (2001). Portraits of pain and promise: A photographic study of Bosnian youth. *Canadian Journal of Nursing Research, 32*(4), 21-41.

Berman, H., Irias Giron, E., & Ponce, M. (2006). A narrative study of refugee women who have experienced violence in the context of war. *Canadian Journal of Nursing Research, 41(*1),144-165.

Berman, H., Mason, R., Hall, J., Rodger, S., Classen, C. C., Evans, M.K., … Al-Zoubi, F. (2014). Laboring to mother in the context of past trauma: the transition to motherhood. *Qualitative Health Research*. doi: 10.1177/10497323

Berman, H., Mulcahy, G.A., Forchuk, C., Edmunds, K.A., Haldenby, A., & Lopez, R. (2009). Uprooted and displaced: A critical narrative study of homeless,

Aboriginal, and newcomer girls in Canada. *Issues in Mental Health Nursing, 30*, 4 18-430. doi: 10.1080/01612840802624475

Browne, A. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, 32(2), 35-55.

Bhui, K., Shanahan, L., & Harding, G. (2006). Homelessness and mental illness: A literature review and a qualitative study of perceptions of the adequacy of care. *International Journal of Social Psychiatry, 52*(2), 152-165.

Carroll, W.K. (2004). *Critical strategies for social research*. Toronto: Canadian Scholars' Press Inc.

Caxaj, S., & Berman, H. (2010). Belonging among newcomer youths: intersecting experiences of inclusion and exclusion. *Advances in Nursing Science, 33*(4), 17-30.

Chambers, C., Chiu, S., Scott, A. N., Tolomiczenko, G., Redelmeier, D. A., Levinson, W., & Hwang, S. W. (2014). Factors associated with poor mental health status among homeless women with and without dependent children. *Community mental health journal*, *50*(5), 553-559.

Chase, S. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (3rd ed.) (pp. 651-679). Thousand Oaks, California: Sage Publications.

Chase, S., (2011). Narrative inquire: Still a field in the making. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (4th ed.) (pp. 421-434). Thousand Oaks, California: Sage Publications.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-1299.

Crenshaw, K. (1993). Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In D.K. Weisberg (Ed.), *Feminist legal theory* (pp.383-395). Philadelphia: Temple University Press.

Doran, K. M., Vashi, A. A., Platis, S., Curry, L. A., Rowe, M., Gang, M., & Vaca, F. E. (2013). Navigating the boundaries of emergency department care: addressing the medical and social needs of patients who are homeless. *American journal of public health*, *103*(S2), S355-S360.

Duff, P., Shoveller, J., Chettiar, J., Feng, C., Nicoletti, R., & Shannon, K. (2015). Sex work and motherhood: social and structural barriers to health and social services for pregnancy and parenting street and off-street sex workers. *Health Care for Women International*, 1-17, DOI:10.1080/07399332.2014.989437.

Duffy, M. (2007). Narrative inquiry: The method. In P.L. Munhull (Ed.), *Nursing research: A qualitative perspective* (pp. 401-421). Boston: Jones & Bartlett.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*, *384*(9953), 1529-1540.

Fortin, R., Jackson, S. F., Maher, J., & Moravac, C. (2015). I WAS HERE: young mothers who have experienced homelessness use Photovoice and participatory qualitative analysis to demonstrate strengths and assets. *Global Health Promotion.* DOI: 1757975914528960.

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The State of Homelessness in Canada.* Toronto: Canadian Homelessness Research Network Press.

Galabuzi, G. (2009). Social exclusion. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed.) (pp. 252-268). Toronto: Canadian Scholars' Press Inc.

Government of Ontario (1997). *Ontario Works Act*. Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_97o25a_e.htm

Government of Ontario. (2013). *Ontario Disability Support Program Income Support Directives.* Retrieved online from http://www.mcss.gov.on.ca/documents/ en/mcss/social/ directives/odsp/income_ Support/6_1.pdf

Government of Ontario. (2014a). *Ontario Works Directives.* Retrieved online from http://www.mcss.gov.on.ca/documents/en/mcss/social/directives/ow/0601.pdf

Government of Ontario. (2014b). *Realizing our potential: Ontario Poverty Reduction Strategy, 2014-2019*. Retrieved from http://www.ontario.ca/home-and-community/realizing-our-potential-ontarios-poverty-reduction-strategy-2014-2019

Greaves, L., Chabot, C., Jategaonkar, N., Poole, N., & McCullough, L. (2006). Substance use among women in shelters for abused women and children: Programming opportunities. *Canadian Journal of Public Health, 97*(5), 388-392.

Gültekin, L., Brush, B. L., Baiardi, J. M., Kirk, K., & VanMaldeghem, K. (2014). Voices From the Street Exploring the Realities of Family Homelessness. *Journal of family nursing*, *20*(4), 390-414.

Hatton, D., Kleffel, D., Bennett, S., & Gaffrey, N. (2008). Homeless women and children's access to health care: a paradox. *Journal of Community Health Nursing, 18*(1), 25-34.

Hooks, B. (1990). *Talking back: Thinking feminist, thinking black*. Boston, MA:

Southend Press.

Hopper, E.K., Bassuk, E.L., & Olivet, J. (2010). Shelter from the storm: Trauma informed care in homelessness services settings. *The Open Health Sciences and Policy Journal, 3*, 80-105. Retrieved from http://homeless.samhsa.gov/ ResourceFiles/ cenfdthy.pdf

Hughes, J., Chau, S., & Vokrri, L. (2015). Mothers' narratives of their involvement with child welfare services. *Affilia.* doi: 10.1177/0886109915574579

Human Resources and Skills Development Canada. (2010*). The homelessness partnering strategy*. Retrieved from http://www.hrsdc/gc.ca/eng/homelessness/index.shtml.

Hwang, S.W. (2001). Homelessness and health. *Canadian Medical Association Journal*, *164*(2), 229-233.

Hwang, S.W., Wilkins, R., Tjepkema, M., O'Campo, P.J., & Dunn, J.R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *British Medical Journal, 339*, b4036.

Khan, K., Rea, E., McDermaid, C., Stuart, R., Chambers, C., Wang, J., ... & Hwang, S. W. (2011). Active tuberculosis among homeless persons, Toronto, Ontario, Canada, 1998–2007. *Emerging infectious diseases*, *17*(3), 357.

Khandor, E., & Mason, K. (2007). *The Street Health report*. Retrieved online from http://www.streethealth.ca/Downloads/SHReport2007.pdf

Labonte, R. (2009). Social inclusion/exclusion and health: Dancing the dialectic. In D. Raphael (Ed.), *Social determinants of health* (2nd ed.) (pp. 269- 279). Toronto: Canadian Scholars' Press Inc.

Labov, W. (1972). The transformation of experience in narrative syntax. In W. Labov (Ed.), *Language in the inner city* (pp. 352-396). Philadelphia: University of Pennsylvania Press.

Laird, G (2007). *Shelter: homelessness in a growth economy: Canada's 21st century paradox.* Calgary: Sheldon Chumir Foundation for Ethics in Leadership and Gordon Larid. Retrieved from www.gordonlarid.com

Marrow, M., & Weisser, J. (2012).Towards a social justice framework of mental health recovery. *Studies in Social Justice, 6*(1), 27-43.

Marshall, B.D.L., Debeck, K., Simo, A., Kerr, T., & Wood, E. (2014). Gang involvement among street-involved youth in a Canadian Setting: a gender-based analysis. *Public Health, 129*, 74-77.

McCormack, C. (2000a). From interview transcript to interpretive story: part 1- viewing

the transcript through multiple lenses. *Field Methods, 12*(4), 282-297.

McCormack, C. (2000b) From interview transcript to interpretive story: part 2—developing an interpretive story. *Field Methods, 12*(4), 298 – 315.

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. *International Journal of Social Research Methodology, 73*, 219-236.

Mill, J., Singh, A., & Taylor, M. (2012). Women in the shadows: prenatal care for street-involved women. *Canadian Journal of Urban Research, 21*(2), 68-89.

Mkandawire-Valhmu, L., & Stevens, P. (2007). Applying a feminist approach to health and human rights research in Malawi: A study of violence in the lives of female domestic workers. *Advances in Nursing Science*, 30(4), 278-289.

Montgomery, P., Benbow, S., Hall, L., Newton-Mathur, D., Forchuk, C., & Mossey, S. (2014). Sheltering Aboriginal women with mental illness in Ontario, Canada: Being "kicked" and nurtured. *Nursing and Care, 3*(3), 164-169. doi: 10.4172/2167-1168.1000164.

Montgomery, P., McCauley, K., Mossey, S., & Hill Bailey, P. (2009). "Just breaks my heart": A mother's narrative. *Journal of the association for research on mothers, 11*(2), 21-32.

Morris, R., & Strong, L. (2004). The impact of homelessness on the health of families. *The Journal of School Nursing, 20*(4), 221-227.

Notaro, S. J., Khan, M., Kim, C., Nasaruddin, M., & Desai, K. (2013). Analysis of the health status of the homeless clients utilizing a free clinic. *Journal of community health, 38*(1), 172-177.

Nowak, C., Sharif, F., Eischen, S., Thomas, J., Qi Wang, M.S., Guo, H., … Okuyemi, K. (2014). Retention of homeless smokers in the power to quit study. *Nicotine & Tobacco Research 17*(11). doi: 10.1093/ntr/ntu210

Ontario Coalition Against Poverty. (2014). *Welfare and ODSP*. Retrieved from http://www.ocap.ca/node/38

Ontario Human Rights Commission (2008). *Right at Home – Report on the consultation on human rights and rental housing in Ontario.* Retrieved from http://www.ohrc.on.ca/en/resources/discussion_consultation/housingconsultationreport/pdf.

Oudshoorn, A., Ward-Griffin, C., Forchuk, C., Berman, H., & Poland, B. (2013). Client-provider relationships in a community health clinic for people who are experiencing homelessness. *Nursing Inquiry, 20*(4), 317-328. doi:

10.1111/nin.12007.

Oudshoorn, A., Ward-Griffin, C., Poland, B., Berman, H., & Forchuk, C. (2013). Community health promotion with people experiencing homelessness. *Journal of Community Health Nursing, 30*(1), 28-41. doi: 10.1080/07370016.2013.750204

Park, S. M. (2013). *Mothering queerly, queerly mothering*. Albany, NY: State University of New York Press.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, California: Sage Publications.

Pease, B. (2009). The other side of social exclusion : interrogating the role of the privileged in reproducing inequality*, in Theorising social exclusion*, pp.37-46. Abingdon, England: Routledge.

Pitre, N., Kushner, K., & Hegadoren, K. (2011). The search for safety control, and voice for mothers living with legacy of childhood violence experiences: A critical feminist narrative inquiry. *Advances in Nursing Science, 34*(3), 260-275.

Rahder, B. (2006). The crisis of women's homelessness in Canada. *Women & Environments International Magazine, 70/71*, 38-39.

Raphael, D. (2007). Making sense of poverty: Social inequality and social exclusion. In *Poverty and policy in Canada* (pp. 85-111). Toronto: Canadian Scholars' Press Inc.

Raphael, D. (2009). *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto: Canadian Scholars' Press Inc.

Reid, C. (2004). The wounds of exclusion: poverty, women's health, & social justice. Edmonton AB: Qualitative Institute Press.

Reid, C., Greaves, L., & Poole, N. (2008). Good, bad, 163arleton, or addicted?: Discourses of substance using mothers. *Critical Social Policy*, 28(2), 211-234. doi: 10.1177/0261018307087990

Richards, T., Garland, T., Bumphus, V., & Thompson, R. (2010). Personal and political?: Exploring the feminization of the American homeless population. *Journal of Poverty, 14* (1),97-115.

Riessman, C. K. (1993). *Narrative analysis.* Newbury Park, CA: Sage.

Rolfe, A. (2008). 'You've got to grow up when you've got a kid': Marginalized young women's accounts of motherhood. *Journal of Community & Applied Social Psychology,* 18, 299-314.

Salmon, A. (2007). Walking the talk: How participatory interview methods can

democratize research. *Qualitative Health Research, 17*, 982-993.

Sandelowski, D.J. (1991). Telling stories: narrative approaches in qualitative research. *Image: The Journal of Nursing Scholarship, 23*(3), 161-166.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18,* 179-183.

Scott, S., (2007). *All our sisters.* Peterborough, Ont: Broadview Press.

Shapcott, M. (2009). Housing. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed.) (pp. 221-234). Toronto: Canadian Scholars' Press Inc

Shortt, S. E. D., Hwang, S., Stuart, H., Bedore, M., Zurba, N., & Darling, M. (2008). Delivering primary care to homeless persons: a policy analysis approach to evaluating the options. *Healthcare Policy*, *4*(1), 108.

Stewart, M., Reutter, L., Makwarimba, E., Veenstra, G., Love, R., & Raphael, D. (2008). Left out: Perspectives on social exclusion and inclusion across income groups. *Health Sociology Review, 17*(1), 78-94.

Tischler, V., Edwards, V., & Vostanis, P. (2009). Working therapeutically with mothers who experience the trauma of homelessness: An opportunity for growth. Counselling and *Psychotherapy Research, 9*(1), 42-46.

Torchella, I., Linden, I., Strehlau, V., Neilson, E.K., Krausz, M. (2015). "Like a lots happened with my whole childhood": violence, trauma and addiction in pregnancy and postpartum women from Vancouver's Downtown Eastside. Harm Reduction Journal, 12(1), 1-10, DOI: 10.1186/1477-7517-12-1.

Tweed, R.G., Biwas-Diener, R., & Lehman, D.R. (2012). Self-perceived strengths among people who are homeless. *The Journal of Positive Psychology, 7*(6), 481-492.

United Nations. (1948). *The Universal Declaration of Human Rights*. Retrieved online from http://www.un.org/en/documents/udhr/

Van Berkum, A. & Oudshoorn, A. (2015). *Best practice guideline for ending women's and girl's homelessness*. Retrieved from http://ywcacanada.ca/data/research_docs/00000347.pdf

Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy*, 19(1), 23-39.

Wade, A. (2007). Despair, resistance, hope: Response-based therapy with victims of violence. In C. Flaskes, I. McCarthy, and J. Sheehan (Eds.), *Hope and despair in narrative and family therapy: adversity, forgiveness, and reconciliation* (pp. 62-64). Hover: Brunner-Routledge.

Welch, M (1999). Critical and feminist critique. In E.C. Polifroni & M Welch, *Perspectives on philosophy of science in nursing: An historical and contemporary anthology* (pp. 355-359). New York: Lippincott.

Williamson, E., Abrahams, H., Morgan, K., & Cameron, A. (2014). Tracking homeless women in qualitative longitudinal research. *European Journal of Homelessness, 8*(2), 69-91.

Wilson, K., Eyles, J., Elliott, S., Keller-Olaman, S., & Devcic, D. (2007). Linking social exclusion and health: explorations in contrasting neighbourhoods in Hamilton, Ontario. *Canadian Journal of Urban Research, 16*(2), 126-148.

World Health Organization. (2008). *Commission on Social Determinants of Health final report: Closing the gap in a generation.* Retrieved from http:// apps.who.int/iris/bitstream/10665/69832/1/WHO_IER_CSDH_08.1_eng.pdf

Yanicki, S.,M., Kushner, K.E., & Reutter, L. (2014). Social inclusion/exclusion as matters of social (in)justice: a call for nursing action. *Nursing Inquiry,* doi:10.1111/nin.12076.

Zabkiewicz, D.M., Patterson, M., & Wright, A. (2014). A cross-sectional examination of the mental health of homeless mothers: does the relationship between mothering and mental health vary by duration of homelessness? *British Medical Journal, 4*(e006174), 1-8. doi:10.1136/bmjopen-2014-006174

CHAPTER FIVE

A CRITICAL DISCOURSE ANALYSIS OF REALIZING OUR POTENTIAL,

ONTARIO'S POVERTY REDUCTION STRATEGY, 2014-2019

Introduction

Public policy represents "a guide to action, a plan, a framework, [or] a course of action or inaction designed to deal with problems" (Pal, 2001, p. 5). Public policy, its development and implementation, raises questions about what governments *ought* or *ought not* to do in response to such problems and represents a form of social contract (Simon, 2009). Public policy not only impacts people, but it creates the very social locations in which people exist (Hankivsky, Grace, Hunting, & Ferlatte, 2012). Policies are powerful narratives that shape public perspectives and governmental actions toward societal issues, such as poverty and homelessness, as well as the people who are impacted by such issues (Bryant, 2013). Analysis of policy in health and nursing research merges scholarship and advocacy in appraising governmental response to social and health problems and proposing recommendations to better meet identified needs (Duncan, Thorne, Van Neste-Kenny, & Tate, 2012).

This chapter represents phase two in a two-phase study examining experiences of health, social exclusion, and resistance among mothers experiencing homelessness. Given the centrality of poverty to the issues and policies identified by research participants in phase one, *Realizing Our Potential: Ontario's Poverty Reduction Strategy*, 2014-2019 (Government of Ontario, 2014) was analyzed. Analysis of policy can be *of* existing policy or *for* policy development (Buse, Mays, & Walt, 2012). This particular analysis falls under the retrospective purpose, *of* existing policy, in analyzing an existing policy for its purpose, content, and ability to meet its intended goals (Buse et al., 2012). The

analysis was completed from the critical perspective of intersectionality and employed a

critical discourse analysis (CDA) methodology. This analysis provides context to research

participants' narratives (from phase one), and insight into the current political will to

address their needs. This analysis was guided by the following questions:

(1) How are mothers experiencing homelessness and their health needs represented in

Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019?

(2) How does this policy address social exclusion experienced by homeless mothers as

identified in phase one of the study?

Study Background

Phase one of the research study utilized critical narrative methodology seeking to

elevate voices and find meaning in mothers' experiences of homelessness and social

exclusion. Social exclusion was defined as the deeply embedded social processes

whereby people are prohibited to fully participate in and benefit from social and political

institutions and experience economic, political, social, and health inequities as a result of

unequal power relations (Galabuzi, 2009). Study participants[7] (N=41) included mothers

(n=26) experiencing homelessness and service providers (n=15) working with them.

Participants who were mothers were 18-58 years of age with an average age of

approximately 27 years. The majority of the women self-identified as having or having

had a mental illness (n=19). The majority of mothers were born in Canada (n=17).

Mothers identified as Caucasian (n=10), as well as a variety of racial and ethno-cultural

identities, including women self-identifying Jamaican-Canada, biracial, African,

Aboriginal, Indian, and Spanish as their racial and ethno-cultural identity. Mothers were

---

[7] Throughout this document, **study participants** and/or **research participants** refers to
those who engaged in phase one of the study (see Chapter 4).

receiving social assistance in the form of financial support, from Ontario Works (OW) (n=17), Ontario Disability Support Program (ODSP) (n=2), or Children's Aid Society (Child protection services in Ontario) (n=2). Three women identified as having no source of income. Five women reported having employment, three of which were involving sex work, one held a full-time retail position, and the other had a contract position in the food industry. All service provider participants (n=15) were women, working with women who were experiencing homelessness. The service provider participants included: counsellors (n=10); housing and community advocates (n=2); and nurse and social worker case managers (n=3). During the iterative process within the qualitative methods employed, interview questions explored the meaning and relevance of policy in shaping social exclusion, health, and in understanding their perspective of policy within a socio-political context.

During the interview process, mothers were asked how policies impacted their lives and service providers were asked how such policies impacted the lives of their clients. Participants largely expressed inadequacy in access to resources, such as food and housing, based on and contributing to mothers' poverty status. Participants identified a number of policies that perpetuated experiences of poverty despite their intended purpose of providing financial supports, such as those relating to OW, Children's Aid Society, and ODSP. The mothers were homeless at the time of interview, and thus homelessness was a pressing issue for them. For some, lack of affordable housing, lack of financial security, lack of secure housing, and lack of safety were directly related to their homelessness. The majority of the mothers interviewed were on a waitlist for affordable housing, describing wait times ranging from 6 months up to 10 years. The policies discussed were recognized as paramount influences of mothers' experiences of health, social exclusion, and

homelessness.

Theoretical and Methodological Perspectives of Analysis

Policy represents a particular form of social discourse[8] representative of societal values, will, and desire for change (Bryant, 2013). There are a number of ways of analyzing the discourse of policy. For the purpose of this analysis, critical discourse analysis (CDA) was employed, with the theoretical perspective of intersectionality. CDA is increasingly prevalent in health and nursing-related analysis of policy (Burnett, 2012; Crowe, 2005; Smith, 2007). CDA was chosen for its applicability and the explicit marrying of micro, meso, and macro levels of analysis (Fairclough 1992, 1995). CDA differs from other forms of discourse analysis, with its explicit critical orientation. Thus, CDA was congruent with the critical narrative methodology employed in phase one.

The overarching purpose of critical work is to unveil, critique, and challenge society's silencing and neglecting of oppressed groups (Fontana, 2004) and to uncover taken-for-granted and hidden assumptions related to the unequal distribution of power in society (Madison, 2005). Through the lens of intersectionality, social positioning is recognized as being shaped by the interaction of multiple and layered social identities (i.e. the combination and interaction of race, class, age, gender, and motherhood status), while simultaneously being shaped by social, political, historical, and cultural factors in society (Knudsen, 2006; Thorne & Varcoe, 1998). Such a lens is of particular importance in understanding the multidimensional nature of mothers' experiences of social

---

[8] Discourse can be understood as "the different ways of structuring areas of knowledge and social practice through written and spoken text…discourses do not just reflect or represent social entities and relations, they construct or 'constitute' them". (Fairclough, 1992, p. 3).

exclusion, health, and homelessness. CDA consists of the examination and interpretation of the ideologies and values shaping particular issues within select policy documents (Duncan & Reutter, 2006). Recognizing that discourse (re)produces power relations (Parker, 2004), this form of analysis is interested in how the document under investigation interacts with and impacts the social world (Fairclough, 1995).

CDA is an emerging area of scholarship in nursing research, but is also highly applicable to analysis of policy in health and nursing research (Smith, 2007). Fairclough's (1995; 2010) approach is said to be one of the most comprehensive frameworks of CDA (Sheyholislami, 2001). Fairclough's analytical framework combines theory and method, with emphasis of analysis at the macro, meso and micro levels of the document and social world. Within Fairclough's (1995; 2010) analytical framework, analysis is focused on three simultaneously occurring dimensions: *sociocultural practice, discourse practice*, and *text*.

The purpose of analysis at the *sociocultural practice* level is for the researcher to understand the factors taking place at a broader level in relation to power and ideology (Fairclough, 2010; Smith, 2007).   At the *discourse practice* level, the production, distribution, and consumption of text is analyzed (Fairclough, 1992, 1995, 2010). Texts are produced and consumed in certain ways depending on the socio-political context. When analyzing policy documents, this level of analysis includes an in-depth examination of the way the document was created, who it was created by, and who it was created for (Fairclough, 1992). At the *text* level the semantics, style, structure, and/or vocabulary within the document are analyzed for their purpose. It is at this level in which representations, relations, and identities are examined and analyzed (Fairclough, 2003). Ultimately, CDA methodology requires the explicit examination of socio-political

context in which the policy was created and consumed while linking textual level analysis of language to these broader contexts. The sociocultural practice, discourse practice, and text are inseparable and mutually (re)enforcing.

Methods

The inception of this analysis began in phase one of the study during qualitative interviews where relevant policies and socio-political contexts were discussed. Some policies were not named by participants, but referred to. For example, in one mother's reference to Ontario's social housing mandate (Government of Ontario, 2010), she discussed the "rules" that made her need for housing a priority on the social housing waitlist. I then began by reviewing research findings (see Chapter 4), and field notes. A spreadsheet was created, after initial data collection in phase one was completed, to identify the policies discussed throughout the interviews and to describe their impact on the participants' experiences of health, homelessness, and social exclusion. In reviewing the policies identified and the way in which they were discussed as impacting mothers' health and social exclusion, the central theme of poverty was identified. Other themes relating to housing and "rules" within government agencies and shelters were also brought forward, but experiences related to the theme of poverty were most prominent and all-encompassing.

Next, in response to the prominent and shared emphasis on poverty, I reviewed poverty and income-related policy documents, such as social assistance policy directives for OW and ODSP (Government of Ontario, 2013), and the Poverty Reduction Act, 2009 (Government of Ontario, 2009) in attempts to locate the most fitting policy to meet the study purpose. *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019*, (*OPRS*) (Government of Ontario, 2014), was consequently chosen as a current and

relevant metapolicy to best address the study purpose.

Informed by Fairclough's (1992; 1995; 2003; 2010) approach to CDA, sociocultural, discoursive, and textual practices were inter-dependent and inseparable in the analysis. Analysis began at the textual level and included describing applicable content of the strategy as it pertained to the analysis purpose. Analysis at the discourse level required interpreting the described content, and lastly, analysis at the sociocultural level entailed explaining the ideologies and values shaping the content (Smith, 2007). Guided by the analysis questions (outlined on page 2), *OPRS* was reviewed line-by-line to colour code and make notes of (1) intended and unintended purpose(s); (2) ideology embedded in the text; (3) links between the *OPRS* and the experiences of study participants identified in phase one of the study; (4) problems within the strategy (gaps, inconsistencies, incongruence of content with purpose); (5) chosen language; (6) accessibility and readability of the policy; and (7) the social context in which the document was produced and consumed (Burnett, 2012; Buse et al., 2012; Fairclough, 1995). This approach merged the sociocultural, discursive, and textual practices, as outlined by Fairclough (1995). Further, each time I read the document I did so through the lens of intersectionality making note of how issues and people were framed and discussed. To illustrate, when an issue was presented, I examined how social locations and social identities of people were represented and the ways in which social identities, such as race, class, and gender, mutually interact and situate people and experiences in certain ways.

Findings

Ontario Poverty Reduction Strategy Background

Ontario's first poverty reduction strategy, *Breaking the Cycle: Ontario's Poverty*

Reduction Strategy 2008-2013, (Government of Ontario, 2008) was released in 2008 by

the Liberal Provincial Government. The first strategy was focused on child and youth

poverty and set the agenda for prioritizing poverty reduction in Ontario, with particular

emphasis on breaking the cycle of intergenerational poverty. The Liberal Government

was elected into power in 2003, following the Progressive Conservatives (1995-2002).

During the Conservative tenure, Ontario suffered substantial cuts to social welfare

programs, including a 21% reduction in social assistance rates (Government of Ontario,

2008).

Leading up to the release of the first poverty reduction strategy, Ontario had

further experienced increases in unemployment and poverty rates related to the global

recession and financial crisis of 2008-2009 and its particular impact in Ontario where

over 200 000 people lost their jobs (Fernando & Earle, 2011). A primary goal within the

first strategy was to reduce child poverty by 25% (Government of Ontario, 2008). While

the goal of reducing child poverty by 25% was not achieved, Ontario did experience a

decline in child poverty, from 15.2 % to 13.6%, (a 10.5 % decline) (Government of

Ontario, 2014). The Liberal Government marks this decline as notable given the loss of

jobs and financial hardships for many Ontarians as a result of the recession and the lack

of support from the Federal Government (Government of Ontario, 2014). From the first

poverty reduction strategy, Ontario's Poverty Reduction Act, 2009, was implemented,

reflecting a stated long-term commitment to poverty reduction by the Government of

Ontario (Government of Ontario, 2009). Within the initial poverty reduction strategy, and

Poverty Reduction Act (Government of Ontario, 2009), the Provincial Government urged

the Federal Government to engage in the poverty reduction process at a national level.

Specifically, the Provincial Government called on the Federal Conservative Government

to increase the Universal Child Care Benefit and the Working Income Tax Benefit, to increase eligibility for EI, as well as access to housing and childcare spaces (Government of Ontario, 2008; Government of Ontario, 2009). However, it has been noted that the Federal Government failed to provide substantial economic relief for those living in poverty and implemented no action on poverty reduction (Fernando & Earle, 2011; Taillon, 2010). According to Fernando and Earle (2011):

> The Federal Government does not address systemic problems but rather individualizes poverty and seeks to address it through individual tax credits and economic stimulus. The strategy and capacity of the Provincial Governments is dependent on the Federal Government and its spending power so this limitation translates into the restricted success of Ontario's poverty reduction strategy. Furthermore, the underlying premise of Canada's current structure is one that enables the disadvantage and poverty to flourish, and where austerity agendas create an individualization of problems and do not address systemic barriers in the system (p. 37).

Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019

The current strategy, *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019[9]*, was also put forward in 2014 by the Liberal Provincial Government and continues to build on the initial strategy released in 2008. Similar to the first Poverty Reduction Strategy, key stakeholders were consulted across Ontario and informed the content of the strategy. Members of the public participated through market research online surveys (n=> 2000 responses) and formal submissions (n=>65

---

[9] *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019* will be henceforth referred to as *OPRS*, the strategy, or the policy.

submissions) (Government of Ontario, 2014). As well, in research commissioned by the Provincial Government, public consultations were held at select community sites across Ontario (n= >800 people) (Government of Ontario, 2014). While a comprehensive and transparent report on research methods, participant demographics, and specific results, were not disclosed within the strategy, inclusion of community voice is presented as central to the aims of the strategy.

The strategy is a 52-page document available online to those who have access to the internet and a computer or internet-connected device, from http://www.ontario.ca/document/realizing-our-potential-poverty-reduction-strategy-2014-2019. The language within some sections is accessible and relatively free from academic and technical jargon. However, there are several points within *OPRS* in which comprehension may be challenging because of statistical or academic discussions, or because of the literacy level of the audience. Statistical inferences were required of the reader and not always explained within the document. For example, as aforementioned, within *OPRS* it is noted that there was a marked decline in child poverty, yet it does not identify the total percentage of decline, simply the before (15.2 %) and after (13.6%) statistics (Government of Ontario, 2014, p. 9). To some, this would appear as a small change, of less than a 2% difference, when in fact the decline is approximately 10.5%. Such lack of clarity requires enhanced numerical and prose literacy of the reader and decreases the accessibility, readability, and clarity of important elements of the *OPRS*.

As well, at times the information is overwhelming with numerous initiatives identified within each section and with clarity missing regarding how each initiative is connected to poverty reduction and to this specific strategy as a whole. There is an emphasis on successful community programs, many already implemented, with inclusion

of direct quotes of peoples' lived experiences. Overall, the language within the strategy is positive and hopeful; however, such language was distracting and created difficulty in understanding the exact significance of implementation and outcome. To illustrate, on page 18, the *OPRS* reads that in ensuring equity "all children and students will be inspired to reach their full potential, with access to rich learning experiences that begin at birth and continue into adulthood" (Government of Ontario, 2014, p. 18). It is not clear what this sentence means, or how the government sets out to achieve it. The glossing over of issues with broad positive and hopeful statements resulted in a lack of substance, at times, where the reader is unable to disagree, but also unable to fully comprehend certain points.

Further, pronouns used throughout the *OPRS* include "we", "us", and "our", emphasizing a uniting intent among citizens, readers, as well as between citizens and government. For instance, the title itself reads "Realizing *Our* Potential" and sets the tone for the entire strategy. Such language creates the feeling of collaboration, unity, and collectiveness. The strategy reads: "the collective spirit of the people of Ontario is at the heart of our new Poverty Reduction Strategy" (Government of Ontario, 2014, p. 8). Interestingly, this is contrary to many of the listed initiatives, which reflected a largely individualistic focus on one's *potential* to adequately participate in society.

Notably, gender was not explicitly discussed throughout *OPRS* as it relates to poverty. Instead gender neutrality, and thus indivisibility of gender-specific issues, was emphasized (Government of Ontario, 2014, pgs. 8, 9, 10, 19, 27, 30, 34). This was surprising given that women experience consistently higher poverty rates (Reid, 2008; Townson, 2005). In fact, single women caring for children are among those most likely to experience poverty in Canada (Yeo et al., 2015). The 'Vulnerable Groups' section (p.8)

lists various vulnerable groups, but does not include women, or single mothers. It lists Aboriginal peoples, newcomers, persons with disabilities, unattached individuals aged 45-64, and *lone parents* (Government of Ontario, 2014). Within the *OPRS,* the term "lone parents" is emphasized, as opposed to naming the primary leader of lone parents as women (Canadian Women's Foundation, 2011). Likewise, vulnerabilities experienced by the populations outlined in *OPRS*, such as newcomers, Aboriginal peoples, or persons with disabilities, are not explored in relation to gender, or each other, thus, making the assumption that gender does not add further complexity to one's poverty experiences. Overall, there is a siloed understanding as to how poverty impacts a variety of people, including mothers and their children, that does not take into account people's multiple social locations and identities.

Social identities, vulnerabilities, or demographics are often presented as characteristics of individuals; however, this is done without further discussion or examination of how such characteristics impact social positioning and experiences of health, poverty, and exclusion. For instance, in *OPRS,* newcomers are listed in the "Vulnerable Groups" list, yet their specific needs and challenges are not explicitly discussed. Women research participants in phase one of the study emphasized their experiences of being newcomers, racialized, receiving social assistance in the form of income support, and how it was at these intersections that health and poverty were experienced. That is, each of these "vulnerabilities" was not simply a characteristic, but rather a complex mesh of interrelated identities shaping social positioning and impacting experiences of exclusion and marginalization.

Aboriginal Peoples' needs were more thoroughly expanded on throughout the strategy. For instance several initiatives are discussed pertaining specifically to Aboriginal Peoples, such as the Aboriginal Education Strategy, Postsecondary Education

Fund for Aboriginal Learners, and the Aboriginal Economic Development Fund. While there is an invested focus in meeting the needs of Aboriginal Peoples, there was no discussion in the strategy about consulting with specific Aboriginal leaders and communities in creating and implementing the initiatives. Explicitly outlining consultation strategies is important in working with silenced and historically excluded populations, such as Aboriginals Peoples (Nadaline, Maar, Ashbury, & McLaughlin, 2013; Tuhiwai Smith, 1999).

Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019 has four main foci:

1)   Poverty Interrupted: Continuing to break the cycle of poverty for children and youth;

2)   Working against Poverty: Moving towards employment and income security;

3)   Right at Home: A long-term goal to end homelessness in Ontario; and

4)   Investing in what Works: Using evidence-based social policy and measuring success (Government of Ontario, 2014).

1. Poverty Interrupted: Continuing to break the cycle of poverty for children and youth. The first goal of the strategy is focused on breaking the cycle of poverty for children and youth. There is much emphasis on children being the most vulnerable to the effects of poverty (p. 12), and the most important focus of a poverty reduction strategy; however, it is often done without recognition of the families, particularly those led by single mothers. Perhaps this is related to the social construction and perspective of children as innocent and deserving of support (Thomas, 2010); however, in doing so, mothers remain invisible, or not as deserving of help, and the sources of poverty and the cycle go undetected and unchallenged. Yet child poverty is worse among those who are

historically disadvantaged such as those within a female-led lone parent family (Khanna, Rothman, & Forget, 2013), with monumental negative health consequences for the family as a whole (Collins, 2009). Further, other social identities, such as race, newcomer status, ability, and age further shape a family's access to resources, but are not discussed in the *OPRS* in relation to child poverty.

Under the first foci, several successes and programs are identified. The Ontario Childcare Benefit (OCB), which offers additional financial benefit to low-to-moderate income families, is recognized as the cornerstone of the first Poverty Reduction Strategy. Further adjustments for inflation have been made to the OCB, which has been increased to a maximum annual benefit of $1,336 per child (Government of Ontario, 2015a), with continued adjustments for inflation in the future. The increase from 2007 when the benefit totalled $250 per child per year is significant (Government of Ontario, 2014, p. 12). Despite the adjustment for inflation as outlined in the strategy, research participants continued to identify the extreme financial challenges they faced, including the perpetuation of the cycle of poverty, abuse, addiction, and homelessness. Regardless of the policy change, research participants made clear mothers' insufficient income and subsequent inability to access basic resources, such as food, housing and safety.

A number of other initiatives are outlined as part of this goal. The Ontario's Student Nutrition Program (OSNP) offers breakfast programs in elementary and secondary schools, and has expanded in number including on-reserve schools in First Nations communities (Government of Ontario, 2014, p. 13). Such programs are necessary given the current poverty status and have positive outcomes (Lam, 2015; Skinner, Hanning, Metatawabin, & Tsuji, 2012); yet such efforts do little to actually *reduce* poverty, and more to work within the reality of poverty while reinforcing the status quo.

Initiatives like the OSNP perpetuate the notion that food insecurity experienced by mothers or other adults is not a priority, as long as children are fed.

The Comprehensive Mental Health and Addictions Strategy: Open Minds, Healthy Minds and the expansion of the Tele-Mental Health service to Aboriginal, rural and remote communities are identified within *OPRS* (Government of Ontario, 2014, p. 15). Reflective of neoliberal ideologies[10] focused on individual responsibility and productivity, there is an explicit emphasis on Ontario's economy being negatively impacted "when people with mental health issues are unable to work" (Government of Ontario, 2014, p. 15). Such valuing does not prioritize health or a humanitarian orientation to poverty reduction, but rather, it prioritizes the ability and capability of an individual to contribute to the economy. The importance of early mental health intervention is justified as a means to prevent "further mental health issues and provide great prospects for stable health, *independence, and employment* later in life." (Government of Ontario, 2014, p. 15). The clear focus on one's economic worth, rather than quality of life, or right to health and health care, is explicit. From an intersectional lens, experiences related to gender and newcomer status are not discussed, and there is no systemic analysis of how intersections can create unique and varied complexities shaping poverty experiences in different ways and requiring tailored approaches.

Education initiatives are outlined in this section with the recognition of the role that education can play in shaping one's opportunities and access to resources. There is

---

[10] Neoliberal ideology "supports a radical notion of individualism, arguing that shared social and economic resources and supports should be reduced, state services should become privatized, and that there should be a greater reliance on the 'marketplace' to distribute goods and services" (Gaetz, & O'Grady, 2013, p. 254).

much discussion of previous progress, noting the programs and investments already in place, such as the implementation of full day kindergarten (fully implemented September 2014), Summer Learning Program, and the After School Program. Lack of clarity exists regarding which initiatives listed are already in place, and which initiatives are the results of this particular strategy. The plethora of initiatives identified is superficially impressive, despite the limited depth, but leaves the reader uncertain as to what is going to change as a result of this strategy, how such initiatives directly impact poverty reduction, and how the initiatives are comprehensively evaluated.

For the mother participants in the study, competing and complex challenges at home related to poverty, their mental health, and childcare, were the foci discussed, as opposed to lack of training or access to education. To illustrate, one participant shared that a common experience for those affected by intergenerational poverty was that as children, they had to work or take care of their siblings so their parents could work. Such responsibilities limit opportunities for education or training and were not recognized in the *OPRS*.

2. Working against Poverty: Moving towards employment and income security. The second goal of the strategy relates to increasing employment opportunities, training, supports, and overall income security: "…meaningful employment is the most effective and speediest way to exit poverty for good" (p. 23). Within *OPRS*, there are a number of training programs outlined for 'vulnerable groups', including individuals with disabilities, and youth outlined within the document, such as Women in Skilled Trades and Information Technology Training Program and the Ontario Youth Apprenticeship Program. However, there is no discussion on how such training will ensure employment, and whether such employment would ensure an on-going and liveable income. That is,

evaluation strategies are largely absent in understanding not just the employability of those entering training programs, but the effectiveness of such training programs at reducing poverty.

Throughout the strategy, and as noted in other areas of the strategy, a siloed understanding of poverty is presented, meaning that each "vulnerability" (Aboriginal identity, newcomer status, disability status, lone-parent status, and being an unattached adult) is presented as being experienced in isolation. However, there are two sentences recognizing that women are:

> …disproportionately affected by poverty, particularly Aboriginal women, newcomers, and single mothers. To help women living in poverty build a better future, Ontario has a number of programs that help low-income women, as well as abused women, gain new skills and access new career opportunities (p. 27).

The majority of participants from our research did not emphasize lack of training, or education as a current barrier in the mothers' lives. They did, however, identify discrimination, stigma, homelessness, single motherhood, lack of stable housing, mental health issues, and lack of safety not only as the daily reality of the mothers' lives, but as significant hurdles dramatically impacting their lives. The prevalence of stigma and discrimination among individuals experiencing poverty, homelessness, mental illness, and who are racialized, is increasingly high in Ontario (Benbow, Forchuk, & Ray, 2011; Benbow, Rudnick, Forchuk, & Edwards, 2014; Cornish, 2012; Forchuk, Nelson, & Hall, 2006; Galabuzi, 2009). Yet, in the *OPRS*, stigma and discrimination are not discussed as they relate to poverty and employment. Training opportunities for employment are identified within *OPRS*; however, emphasis on striving for "inclusiveness" without critical examination of how certain groups came to be excluded from the employment

market in the first place ensures that power dynamics go unchanged, and perpetuates the status quo.

As a result, employment-training opportunities may distract from the priority issues for homeless mothers who experience income insecurity. For instance, what would the suggested training opportunities look like for the woman experiencing homelessness who is fleeing domestic violence with three children, the woman with addiction issues waitlisted for rehabilitative housing, or the woman with severe and persistent mental illness and longstanding homelessness? For homeless mothers, escaping poverty is certainly complex, but based on study findings, training for employment is not the primary focus for these women. Instead simply surviving and experiencing some form of housing, mental, family, and/or health stability are prioritized. Women in the study identified that until you hit "rock bottom" there is insufficient support; yet when one is at "rock bottom" and experiencing the most extreme forms of marginalization and exclusion, employment and employment training are not priorities. In fact, many women are marginalized in such a way that they would be unable to benefit from the training at this particular point in their lives. The strategy focus remains on productivity, individual ability, and contribution to the labour market, which is not always a feasible or helpful option for mothers experiencing homelessness.

Moreover, discussion surrounding the importance of a *living* wage versus a *minimum* wage is absent from the strategy, but was identified as an important distinction by research participants and within literature on poverty reduction (Bruijns & Butcher, 2014; Cornish, 2012; Hennesey, Tiessen, & Yalnizyan, 2013). A living wage is the basic level of economic security required to lift people out of poverty (Bruijns & Butcher, 2014). This differs from a minimum wage, which is provincially mandated as the

minimum amount of money an employer can legally pay an employee. In Canada, a living wage:

> ….provides an estimate of what (a) family needs to earn in order to meet basic needs and participate in the civic and social life of their community. The calculation is not national, it's not provincial – it's done municipality by municipality to reflect real local living costs and the hourly wage required to meet those basic costs (Tiessen, 2015, p. 9).

Living wage differs from community to community and is based on the cost of living, inclusive of material needs such as food, housing, electricity, and childcare. To illustrate, the living wage in the Waterloo Region is approximately $16.00 per hour, based on the national living wage methodological framework (Bruijns & Butcher, 2014), whereas the living wage in the city of Toronto is higher at $18.52 per hour, based on the same framework (Tiessen, 2015). This reflects the differing costs of living in different areas. In Ontario the minimum wage is $11.25 as of October 1st, 2015, with commitment to increase based on inflation, and is notably the second highest in Canada (Government of Ontario, 2014). However, those earning minimum wage, "the working poor", continue to live in poverty, despite having employment (Hennessy, 2012). Thus, limiting the notion that all employability and employment are successful ways to reduce poverty.

The title of the section of *OPRS* is "*Working* against Poverty", suggesting that all employment will ensure escape from poverty, which is simply not the case. This is important to consider since not all employment ensures a *living* wage, yet within the strategy the focus remains on training programs and employment. An examination of what constitutes poverty, and how access to a living wage may be more impactful to

reducing poverty than pushing a training and employment focus. Despite the plethora of training initiatives identified, there is minimal discussion of the employment success rates of such programs, as well as what type of employment is the result of such training programs. Also not discussed is the recognition that women, Aboriginal peoples, racialized people, and people with disabilities are segregated into "low income job ghettos" (Cornish, 2012, p. 5), where patterns of pay inequity are prominent. That is, these groups, and those who are similarly systemically disadvantaged, do not earn as much as other people in Canada (Cornish, 2012). As a seminal form of social discourse, *OPRS* devalues the attainment of a living wage for Ontarians and perpetuates an ideology emphasizing individual responsibility to access sufficient income regardless of social location and power imbalance.

Building on this, it is noted that since 2003, social assistance rates have increased by a cumulative 17.2 % for those receiving Ontario Works (OW), and 24.4% for those receiving Ontario Disability Support Program (ODSP) benefits (Government of Ontario, 2014, p. 29). While improvements have been made, as a result of the first poverty reduction strategy, the total income for someone receiving OW, ODSP[11], and minimum wage still remains below low income thresholds, based on the low income measure (LIM)[12]. In fact, people receiving social assistance remain in deep poverty; their incomes are less than approximately 80% LIM. A single adult receiving OW receives less than

---

[11] **Ontario Works** social assistance programs provides support services to those who are in financial need. The maximum financial benefit for (1) a single person is $626, (2) a single parent with 1 child is $1,041, (3) a single parent with 2 children is $1,194. **Ontario Disability Support Program** social assistance program provides support services to those with a disability and who are in financial need. The maximum financial benefit given to (1) a single person with a disability is $1,086, (2) a single person with 1 child is $1,604, (3) a single parent with 2 children is $1,768 (Government of Ontario, 2013).

[12] **Low Income Measure (LIM)** measures the number of people living in households with incomes less than 50 per cent of the median adjusted household income (Statistics Canada, 2014).

40% of LIM. A lone parent receiving OW or a single adult on ODSP would receive less than 70% of LIM (Social Planning Network of Ontario, 2011). Thus, such an approach does little to lift people out of poverty.

In phase one, participants made it clear that mothers' incomes were insufficient to access basic needs, such as food and housing, despite the outlined increase in social assistance rates as outlined in *OPRS*. Some women had to resort to sex and drug trades to financially support themselves, while still experiencing homelessness; others returned to domestic violence as a result of financial stressors and lack of timely access to housing and sufficient income. Again, the gendered, newcomer, and racialized specific experiences of poverty cannot be negated, with recognition that these vulnerable groups experience the highest poverty rates in Ontario (Galabuzi, 2009; Government of Ontario, 2014). Although there have been improvements in minimum wage and social assistance rates, such increases are simply not enough to ensure access to basic life necessities, such as housing (Canadian Mortgage and Housing Corporation, 2014), to maintain good health (Wellesley Institute, 2013), and to truly reduce poverty.

3. Right at Home: A long-term goal to end homelessness in Ontario.
Extremely applicable to homeless mothers is the third goal of the strategy, which outlines the establishment of a "long-term goal to end homelessness in Ontario". A goal to end homelessness, put forth by the government of Ontario, is a milestone. Creating provincial change to reduce and eliminate homelessness is something that activists have long been advocating and working towards (Canadian Mental Health Association, 2014; Ontario Human Rights Commission, 2007; Wellesley Institute, 2013). In setting such a milestone, there is recognition of the role of government in ending homelessness. However, no specific strategies or target dates are identified in the document, noting that the

government "lacks the data to effectively tackle this issue". This rationale is curious given the multiple reports put forth by governmental and non-governmental organizations, as well as academic researchers across Ontario on housing and homelessness (see for example, Association of Municipalities of Ontario, 2015; Baker Collins, 2013; Gaetz et al., 2013; Gaetz & O'Grady, 2013; Ontario Non-Profit Housing Association, 2015; Yeo et al., 2015). In fact, in an open letter in response of the *OPRS*, the Inner City Health Associates (2014), "reject the conclusion (in the *OPRS*) that further research into the magnitude of homelessness is needed before action plans and timelines can be defined" (para. 2). Despite the important vision of ending homelessness, the document contains minimal substance of how this plan will be achieved, notably without a timeline of any kind. However, a panel of thirteen community and academic experts has been created and is moving forward in working towards this goal.[13] See http://news.ontario.ca/mah/en/2015/ 01/expert-advisory-panel-on-homelessness-members.html, for an overview of the expert panel participants.

Several ongoing and new initiatives aimed at tackling the many facets of homelessness are identified in the strategy. Building on progress, the government has dedicated an additional $42 million (totalling $294 million) to the Community Homelessness Prevention Initiative (CHPI), which uses a Housing First Approach allowing for municipal governments to flex program funding to best meet local and community needs without clear articulation of implementation and evaluation strategies. The *OPRS* outlines unique housing needs and initiatives geared towards individuals with

---

[13] On Oct. 28th, 2015, the Government of Ontario released a report from the expert advisory panel on homelessness, and identified the Province's commitment to ending chronic homelessness in 10 years (Government of Ontario, 2015).

mental illness, Aboriginals living off-reserve, and youth. There is also emphasis on continued affordable housing initiatives, such as the Affordable Housing for Ontario program, and the Community Homelessness Prevention Initiative.

While ending homelessness is an identified priority within the strategy, there are some areas that were not addressed or considered. Lacking from the discussion were the needs faced by certain groups within the homeless population, such as women and mothers experiencing homelessness. Again, common to the rest of the strategy, a gender-invisible lens is applied within this section. A number of "vulnerable groups" are discussed throughout this section, in a siloed manner, yet women and mothers are nonexistent. "Sole-support families" and "pregnant and parenting youth" (Government of Ontario, 2014, p. 33-34) are referred to when discussing the needs of certain groups of the homeless population, yet recognition of the overrepresentation of women within these categories is absent. The experience of homelessness and access to housing is unique for women, and single mothers with children. The very essence of experiencing homelessness while taking care of another person/people, or while trying to regain custody of children creates complexity.

Further, the relationships between poverty, housing and domestic violence were not discussed in the *OPRS*, but were prominent in study findings. Women and children fleeing domestic violence make up a large portion of female shelter users (Gaetz, Donaldson, Richter, & Gulliver, 2013), and while they are given priority on social housing waiting lists (Government of Ontario, 2010), their experiences of housing, homelessness and poverty are distinct and noteworthy for discussion and planning within the strategy. Likewise, *safe* housing was not discussed in the document. However, study participants emphasized access to safe housing was an important aspect for mothers

leaving shelter, and that safety within the home, within the complex/apartment building, and within the neighbourhood is a primary concern. The further complexities experienced by newcomers and racialized mothers in their living without a home and risk for homelessness were largely absent within the *OPRS*. The gender neutrality throughout the *OPRS* renders invisibility of the systemic oppression experienced by women, newcomer women, racialized women, Aboriginal women, women with disability, and young women, as evidenced in women's longstanding history of poverty, gender victimization, and overall social exclusion (Reid, 2004; Tutty, 2014; YWCA, 2009).

While study participants emphasized lengthy housing waitlists and lack of income security as barriers to achieving housing, many also noted the extreme stigma and discrimination they experienced, especially in the private housing sector in trying to secure housing. Currently, 168,711 households are waiting for public housing in Ontario (Ontario Non-Profit Housing Association, 2015). Women and service providers alike noted racism, ageism, and income discrimination in their attempts to seek housing. These findings are echoed in several research studies (Benbow et al., 2011; Mulroy & Lane, 2015; Ontario Human Rights Commission, 2007). Similarly, while newcomers are identified in the "vulnerable groups" list within the strategy, their unique needs are not discussed throughout the document beyond this categorization. This is particularly pertinent as the increasing prevalence of poverty among racialized groups is significant (Galabuzi, 2009). Experiences of exclusion among newcomer and racialized groups has been repeatedly identified in Ontario-based studies (Caxaj & Berman, 2010; Galabuzi 2009), and were emphasized among study participants. The positive language and hopeful goals employed in the *OPRS*, that deem gender and ethno-cultural identities invisible, distract from the social injustices central to the experiences of poverty.

Within the *OPRS*, it is reported that funding from the Federal Government for social housing will decline from nearly half a billion dollars to zero dollars by 2033 (Government of Ontario, 2014). This is particularly concerning given the national plight of homelessness, with approximately 150 000 to 300 000 individuals in Canada experiencing homelessness annually (Human Resources and Skills Development Canada, 2010). Canada remains the only G8 nation who has failed to adopt a National Housing Policy, with an immediate need to implement one (United Nations, 2007). The development of such a policy would be just the beginning step in the Federal Government's commitment to ending homelessness, one that would require a concrete implementation plan, timeline, and evaluation strategies.

4. Investing in What Works: Using evidence-based social policy and measuring success. Within the fourth, and shortest, section of the *OPRS*, the importance of measuring progress is identified, with the goal being to "spend money where it measurably improves the lives of people living in poverty" (Government of Ontario, 2014, p. 39). The section begins with evidence and a full-page dedication on page 40, articulating that "poverty costs us all…there is a strong financial imperative for our Province to break the cycle of poverty". This statement and emphasis echoes the *OPRS* fiscal impetus for poverty reduction, implicitly and explicitly identified throughout *OPRS*, without recognition of the humanitarian imperative of reducing poverty. Such a purpose is in line with the Liberal Government's historical and current focus, and guiding neo-liberal ideologies (Bryant, 2013).

This section sets out to identify strategies to measure success, target dates, indicators, and evaluation of initiatives; however, much of these elements are largely absent. A vision is presented without an actual concrete strategic plan, leaving the reader

unclear as to what the government's process actually entails. To illustrate, the document reads: "We're investing $50 million over five years to create a new Local Poverty Reduction Fund targeted at supporting local solutions to poverty" (p. 41). Recognizing the frustration stakeholders felt in short term funding, the government committed to "sustained funding" (Government of Ontario, 2014, p. 41). However, an investment plan as to how the large sum of $50 million will be distributed is absent, likewise target dates and concreteness are missing from the action of distributing "more sustained funding". The reader is left unclear and with many questions: What does "more sustained funding" look like? Who receives it? Is this systemic change or mere tweaks to the existing system? What are the evaluation strategies for such an investment goal, and how does this action directly relate to poverty reduction? Strategy, implementation, evaluation, and timelines are missing from this section, as a whole, without explanation of evidence and measurement of success.

To monitor the progress of reducing poverty, the government will continue to track seven indicators from the first poverty reduction strategy, including: (1) birth weights, (2) school readiness, (3) educational progress, (4) high school graduation rates, (5) Low Income Measure, (6) depth of poverty and (7) Ontario Housing Measure[14]. Expanding on the already existing data-sources, as a result of this strategy, youth education, employment and training, long-term unemployment, and poverty rates of vulnerable populations will be further monitored (Government of Ontario, 2014). Birth weights of infants are listed as an indicator of successful poverty reduction; yet, birth

---

[14] "The Ontario Housing Measure measures the percentage of households with children under 18 with incomes below 40 per cent of the median household income and paying more than 40 per cent of their income on housing" (Government of Ontario, 2012b).

weights are not discussed in the current strategy (Government of Ontario, 2014). Such an indicator is inextricably linked with mothers' health and well-being thus reifying the importance and necessity of supporting and addressing the needs of mothers living in poverty. Regardless, this was the first mention of this indicator, without elaboration on the statistical analysis accompanying it, and its relationship to poverty and poverty reduction. Throughout this section there is minimal identification and explanation of measurement methods. Perhaps such ambiguity is necessary given the limited implementation strategies identified throughout the strategy; however, to move beyond a vision, concrete strategies to implement and evaluate are necessary.

Vulnerable populations identified to be monitored include Aboriginal people living off-reserve, newcomers, persons with disabilities, unattached individuals aged 45 to 64, and female lone parents (Government of Ontario, 2014, p. 46). Notably, female lone parents *are* listed in this section, explicitly, which stands in contrast to the gender neutrality and invisibility employed in previous sections (Government of Ontario, 2014, pg. 8, 9, 10, 19, 27, 30, 34). Further, evaluations of the several initiatives outlined throughout the document, such as specific training programs, raise in minimum wage, and social assistance, are not discussed as to methods to measure their success at actually preventing or lifting people out of poverty. This is significant and raises the question of implementation effectiveness, purpose, and success of the dozens of initiatives identified in the *OPRS*. For example, the effectiveness of poverty reduction from the incremental raise in social assistance rates, using the LIM, would demonstrate that despite such initiatives, those individuals receiving social assistance remain living in poverty. Perhaps the known lack of effectiveness in this regard explains why such a correlation evaluation is not included, but raises important questions about all initiatives presented and overall

intent of the policy. Ultimately, to comprehensively reduce poverty, each initiative's

effectiveness must be monitored and evaluated in relation to poverty and poverty

experiences; yet there is no evidence suggesting this approach will be employed.

Discussion

The *OPRS* offered an important political discourse on poverty, and poverty

reduction in Ontario. McKeen (2012) notes the importance of having narratives of women

living in poverty represented in policies affecting them. To better understand the needs of

mothers experiencing homelessness and how such needs are represented in relevant public

policy, an analysis of Ontario's Poverty Reduction Strategy was conducted. Poverty

affects 1.57 million Ontarians annually (Government of Ontario, 2014). Within this

population, single mothers are overrepresented, and according to Statistics Canada LIM,

single mothers have the second highest rate of poverty among vulnerable groups with

high rates of poverty (Government of Ontario, 2014). However, the gender-neutral lens

and lack of intersectional focus within the strategy minimizes the commitment and

relevance that this strategy could have on mothers experiencing homelessness. Further,

lack of an intersectional lens negates the compounding way in which women's social

location is shaped by their multiple and layered social identities. For example, a racialized

newcomer woman who is a single mother of three children experiences poverty

differently than a white woman receiving ODSP and who has mental illness. Both

examples fall under the "vulnerable groups" list; however the siloed understanding

reflected in *OPRS* does not accurately and comprehensively represent women's lived

realities of poverty. Such differences are based on social inequities and require

recognition to address the structures creating disparity. That is, while the mention of

particular groups is evident, it is done so without acknowledging how these groups are

systemically disadvantaged.

The clear neo-liberal underpinnings, within the strategy, with a focus on productivity and labour market participation leave little room for an understanding of poverty reduction from a human rights perspective and the non-economic causes and solutions to poverty (MacKinnon, 2013). This is notable and speaks to the broader philosophical and societal beliefs grounded in fiscal and economic values trumping humanitarian, social welfare, and health (Fernando & Earle, 2011; MacKinnon, 2013; Reid, 2004). Further, within the strategy, there is an assumption that all training *guarantees* employment and that all employment frees one from poverty, which simply is not the case, particularly for women (YMCA, 2009).

Poverty is seen as both a contributor and outcome of social exclusion (Raphael, 2007); and has significantly negative health consequences (Hyman, Mercando, Galabuzi, Patychuk, 2014; Raphael, 2009; Reid, 2004). Within the *OPRS,* there is minimal discussion on how poverty reduction relates to health and what this looks like for the identified "vulnerable" populations. Likewise, there is no discussion on how the most excluded, such as those living in extreme poverty and experiencing homelessness, can be lifted out of poverty, now or in the near future. Despite the progress in poverty reduction, research participants were clear on their inability to access housing, food and other basic necessities, as well as access to safety. Moving to a living wage focus would better ensure the reduction of poverty and the access to basic life necessities (Richards, Cohen, Klein, Littman, & Hajer, 2009; Tiessen, 2015). Absent from this strategy was also a recognition of the discrimination and stigma compounding experiences of poverty and exclusion. Comprehensive poverty and poverty reduction policies would benefit from a coexisting strategy to address systemic stigma and discrimination experienced by those

living in poverty. Such experiences not only fuel and perpetuate poverty, but they contribute and compound experiences of social exclusion (Benbow et al., 2014). Inclusion of stigma reduction strategies would challenge public opinion and thus the public will to address it.

Further, based on this analysis, several concerns are raised regarding the potential effectiveness of the *OPRS*. Specifically, due to the minimal transparency of the research methods employed in the creation of the policy, readers are unable to critique methods used or apply relevant findings. Further absent from the *OPRS* are concrete implementation strategies for each program, goal, and initiative presented. Such exclusion leaves the reader uncertain as to what next steps are required in meeting poverty reduction goals, and who is responsible for creating these strategies and facilitating the implementation process. Likewise, minimal discussion of evaluation methods is presented. This is prominent, as many of the programs outlined may not in fact lift people out of poverty, as the policy suggests. For example, the identified raise in minimum wage and social assistance will not change poverty rates, based on the LIM (Statistics Canada, 2014), as is used in the *OPRS*. Without scientifically-sound evaluation strategies, such initiatives, may not meet the ultimate goal of poverty reduction. The significance of the evaluation process in policy work cannot be understated and is necessary to determine the effectiveness and the impact of the policy and its associated programs (Buse et al., 2012). Notably, throughout the strategy were the lack of deadlines, target dates, and thorough action and evaluation plans. While having a vision is important, action is even more important, especially for those living in poverty (Campaign2000, 2014). Such absence troubles whether poverty reduction is truly a priority for the government, and society as a whole.

Conclusion

This analysis served to bring the voices and perspectives of the mothers and service providers into the critique of current policy. It promoted a further understanding of the political and social factors in shaping their health and homelessness experiences. In nursing, analysis of policy is an emerging form of scholarship, one that draws attention to the "macro" levels influencing of health and health promotion, such as the social determinants of health, and the policies that impact them. Reutter and Kushner (2010) assert that examination of the social determents of health, such as poverty and housing, is most significant, as they influence health directly and indirectly. Rather than focusing on reform at the individual level, attention must be paid to the structures that systemically create and enforce social exclusion. Analysis of policy is one such way nurses can engage in understanding and addressing systemic forces of inequity.

References

Association of Municipalities of Ontario. (2015). *Strengthening the foundation for housing in Ontario*. Retrieved from https://www.amo.on.ca/AMO-PDFs/ Reports/2015/Strengthening-the-Foundation-for-Housing-in-Ontari.aspx

Baker Collins, S. (2013). Childhood stress and mobility among rural homeless youth. In Gaetz, S., O'Grady, B., Buccieri, K., Karabanow, J., & Marsolais, A. (Eds.), *Youth Homelessness in Canada: Implications for Policy and Practice* (53-74). Toronto: Canadian Homelessness Research Network Press. Retrieved from http://www.homelesshub.ca/resource/why-don%E2%80%99t-you-just-get-job- homeless-youth-social-exclusion-and-employment-training-homeless# sthash.I067809z.dpuf

Benbow, S., Forchuk, C., & Ray, S. (2011). Mothers with mental illness experiencing homelessness: A critical analysis. *Journal of Psychiatric and Mental Health Nursing, 18*(8), 687-695. Doi: 10.1111/j.1365-2850.2011.01720.x

Benbow, S., Rudnick, A., Forchuk, C., & Edwards, B. (2014). Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors. *Disability and Society, 29*(7), 1046-1060. Doi: 10.1080/09687599.2014.902359

Bill 152. (2009). *Bill 152, Poverty Reduction Act, 2009.* Royal Assent received, Chapter number: S.O 2009 C.10. Retrieved from http://www.ontla.on.ca/web/bills/ bills_detail.do?locale=en&BillID=2147

Bruijns, L., & Butcher, L. (2014). *Calculating a living wage for the Waterloo Region*. Toronto: Canadian Centre for Policy Alternatives-Ontario. Retrieved from https://www.policy alternatives.ca /publications/reports/calculating-living-wage- waterloo-region.

Bryant, T. (2013). The politics of poverty: Shifting the policy discourse. *Social Alternatives, 32*(1), 43-48.

Burnett, C. J. (2012). Examining the effects of policies on the delivery of shelter services to women who have experienced intimate partner violence" (2012). *Electronic Thesis and Dissertation Repository.* Paper 635. Retrieved from http://ir.lib.uwo.ca/etd/635/

Buse, K., Mays, N., & Walt, G. (2012). *Making Health Policy,* 2nd ed. Berkshire, UK: Open University Press, McGraw-Hill education.

Campaign2000. (2014). *2014 Report card on child and family poverty in Ontario.* Retrieved from http://www.campaign2000.ca/anniversaryreport/ ONRC2014EN.pdf

Canadian Mental Health Association. (2014). *Housing and mental health.* Retrieved from http://ontario.cmha.ca/public_policy/housing-and-mental-health/

Canadian Women's Foundation. (2011). *Submission to the Commission for the Review of Social Assistance in Ontario September 2011*. Retrieved from http://www.mcss.gov.on.ca/documents/en/mcss/social/commission/A-E/Canadian%20Womens%20Foundation.pdf

Caxaj, C.S., & Berman, H. (2010). Belonging among newcomer youths: intersecting experiences of inclusion and exclusion. *Advances in Nursing Science, 33*(4), 17-30. Doi: 10.1097/ANS.0b013e3181fb2f0f

Collins, L. (2009). The impact of good insecurity on women's mental health: How it negatively affects children's health and development. *Journal of the Association for Research on Mothering, 11*(1), 251-262.

Cornish, M. (2012). *A living wage as a human right. .* Toronto: Canadian Centre for Policy Alternatives-Ontario. Retrieved from https://www.policyalternatives.ca/publications/reports/living-wage-human-right

Crowe M. 2005. Discourse analysis: Towards an understanding of its place in nursing. *Journal of Advanced Nursing* 51,55–63.

Duncan, S. & Reutter, L. (2006). A critical policy analysis of an emerging agenda for home care in one Canadian province. *Health and Social Care in the Community*, 14(3), 242-253.

Duncan, S.M., Thorne, S., Van Neste-Kenny, J., Tate, B. (2012). Policy analysis and advocacy in nursing education: The Nursing Education Council of British Columbia framework. *Nurse Education Today, 32*(4), 432-437. Doi:10.1016/j.nedt.2011.03.009.

Fairclough, N. (1992). *Discourse and social change.* Cambridge, UK: Polity Press.

Fairclough, N. (1995). *Critical discourse analysis.* London: Longman,

Fairclough, N. (2003). *Analyzing discourse: textual analysis for social research*. London: Routledge.

Fairclough, N. (2010). *Critical discourse analysis: the critical study of language* (2nd ed.). London: Longman.

Fairclough, N. & Wodak, R. (1997). Critical discourse analysis: an overview. In Van Dijk (Ed.). *Discourse and interaction.* London: Sage, pp 258-284.

Fernando, S., & Earle, B. (2011). Linking poverty reduction to economic recovery: Supporting community responses to austerity in Ontario. *Canadian Review of Social Policy, 65/66*, 31-44.

Fontana, J.S. (2004). A methodology or critical science in nursing. *Advances in Nursing Science, 27*(2), 93-101

Forchuk, C., Nelson, G., & Hall, G.B. (2006). "It's important to be proud of the place you live in": housing problems and preferences of psychiatric survivors. *Perspectives in Psychiatric Care, 42*(1), 42-52. Doi: 10.1111/j.1744-6163.2006.00054.x

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The state of homelessness in Canada 2013: A homeless Hub research paper*. Retrieved from http://www.homelesshub.ca/ResourceFiles/SOHC2103.pdf

Gaetz, S., & O'Grady, B. (2013). Why don't you just get a job? Homeless youth, social exclusion and employment training. In S. Gaetz, B. O'Grady, K. Buccieri, J. Karabanow, & A. Marsolais (Eds.), *Youth Homelessness in Canada: Implications for Policy and Practice. Toronto: Canadian Homelessness Research Network Press,* (pp. 243-268). Retrieved from http://www.homelesshub.ca/resource/why-don%E2%80%99t-   you-just-get-job-homeless-youth-social-exclusion-and-employment-training-homeless#sthash.I067809z.dpuf

Galabuzi, G. (2009). Social exclusion. In D. Raphael's (Ed.), *Social determinants of health* (2nd ed) (pp. 252-268). Toronto: Canadian Scholars' Press Inc.

Government of Ontario. (2008). *Breaking the Cycle: Ontario's Poverty Reduction Strategy.* Retrieved from https://dr6j45jk9xcmk.cloudfront.net/documents/3367/breaking-the-cycle.pdf

Government of Ontario. (2009). *Bill 152: An Act respecting a long-term strategy to reduce poverty in Ontario.* Retrieved from http://www.ontla.on.ca/bills/bills-files/39_Parliament/Session1/b152ra.pdf

Government of Ontario. (2010). Ontario's Long-Term Affordable Housing Strategy. Retrieved from http://www.mah.gov.on.ca/Page9187.aspx#Strategy

Government of Ontario. (2012). *Local plans and accountability.* Retrieved from http://www.mah.gov.on.ca/Page9184.aspx

Government of Ontario. (2014). *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019.* Retrieved from http://www.ontario.ca/document/realizing-our-potential- poverty-reduction-strategy-2014-2019

Government of Ontario. (2015a). *Ontario Ministry of Children and Youth Services: The Ontario Childcare Benefit.* Retrieved from http://www.children.gov.on.ca/htdocs/English/topics/financialhelp/ocb/howmuch.aspx.

Government of Ontario. (2015b). *News release: Ontario commits to ending chronic homelessness in 10 years. Province releases report from expert advisory panel on homelessness.* Retrieved from https://news.ontario.ca/mah/en/2015/10/report-of-the-expert-advisory-panel-on-homelessness.html

Hankivsky, O., Grace, D., Hunting, G., & Ferlatte, O. (2012). Why intersectionality matters for health equity and policy analysis. In O. Hankivsky's(Ed.). *An Intersectionality-Based Policy Analysis Framework.* Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University. Retrieved from www.sfu.ca/iirp/ibpa.html

Hennessy, T. (2012). *What if minimum wage was living wage?* Toronto: Canadian Centre for Policy Alternatives-Ontario. Retrieved from https://www.policyalternatives.ca /publications /commentary/what-if-minimum-wage-was-living-wage

Hennessy, T., Tiessen, K., & Yalnizyan, Y. (2013). *Making Every job a Good Job: A bench- mark for setting Ontario's minimum wage.* Toronto: Canadian Centre for Policy Alternatives-Ontario. Retrieved from: http://www.policyalternatives.ca/ sites/default /files/uploads/publications/Ontario%20Office/2013/11/Making% 20Every%20Job%20a%20Good%20JobFINAL.pdf

Human Resources and Skills Development Canada. (2010*). The homelessness partnering strategy*. Retrieved from http://www.hrsdc/gc.ca/eng/homelessness/index.shtml.

Hyman, I., Mercado, R., Galabuzi, G., & Patychuk, D. (2014). Chapter 6: A critical review of social exclusion and inclusion indicators: Implications for the development of a Canadian framework. In K. M. Kilbride (Ed.), *Immigrant Integration: Research implications for future policy* (pp. 85-102). Toronto, ON: Canadian Scholars' Press Inc.

Inner City Health Associates. (2014). *ICHA's response to the Ontario Government's pledge to end homelessness.* Retrieved from http://www.icha-toronto.ca/about-us/advocacy/ichas-response-ontario-governments-pledge-end-homelessness

Khanna, A., Rothman, L., Forget, R., (2013). *Campaign 2000: Report card on child and family poverty 2012.* Retrieved from http://www.campaign2000.ca/reportCards/ national/C2000ReportCardNov2012.pdf

Knudsen, S.V. (2006).*Intersectionality—A theoretical inspiration in the analysis of minority cultures and identities in textbooks. Caught in the Web or lost in the textbook?* In E. Bruillard, B. Aamotsbakken, S.V. Knudsen, & M. Horsley (eds.), *Caen: IARTEM, Stef, Iufm* (pp.1-76). Retrieved from http://www.caen.iufm.fr/ colloque iartem/pdf/200arleto.pdf.

Lam, M. (2015). *Assessing the sustainability of Manitoba School Breakfast Programs: A qualitative approach.* University of Manitoba: Electronic Theses and Dissertation. Retrieved from http://mspace.lib.umanitoba.ca/bitstream/handle/1993/30630/ Lam_Maxine.pdf?sequence=3&isAllowed=y

MacKinnon, S. (2013). The politics of poverty in Canada. *Social Alternatives, 32*(1), 19-23.

Madison, D.S. (2005) *Critical ethnography: Methods, ethics, and performance.* Thousand Oaks, CA: Sage.

McKeen, W. (2012). Seen but not heard. *Canadian Woman Studies, 29*(3), 107-123.

Mulroy, E. A. & Lane, T.S. (2015). Housing affordability, Stress and single mothers: Pathway to homelessness. *The Journal of Sociology & Social Welfare ,19*(3), Article 4. Retrieved   from http://scholarworks.wmich.edu/jssw/vol19/iss3/4

Nadalin, V., Maar, M., Ashbury, F., McLaughlin, J. (2013). Issues in the Recruitment and Retention of Aboriginal Health Research Participants in Canada. In J. While, J. Peters, P., Dinsdale, D. Beavon (Eds.), *Volume 9: Health and Well-Being in the Aboriginal Policy Research Series*, Thompson Educational Publishing, Inc. Retrieved from apr.thompsonbooks.com/vols/APR_Vol_9Ch10.pdf

Ontario Human Rights Commission. (2007). *Consultation paper: Human rights and rental housing in Ontario.* Retrieved from http://www.ohrc.on.ca/sites/default/ files/attachments/Consultation_paper%3A_Human_rights_and_rental_housing_in _Ontario.pdf

Ontario NonProfit Housing Association. (2015). *FocusON*. Retrieved from https://www.onpha.on.ca/onpha/web/Policyandresearch/focusON/Content/Policy AndRes earch/focusON.aspx?hkey=d3c8d411-40bf-413e-9ec7-36c77af84228

Organisation for Economic Co-operation and Development (2011). *Divided We Stand: Why Inequality Keeps Rising*. Retrieved from http://www.oecd.org/els/soc/ 49170768.pdf

Pal, L. A. (2001). *Beyond policy analysis: Public issue management in turbulent times* (2nd ed.). Scarborough, ON: Nelson.

Parker, I. (2004). Discovering discourses, tackling texts. In W.K. Carroll (Ed.), Critical strategies for social research. Toronto: Canadian Scholars' Press.

Prior, L. (2010). Document review in health research. In I. Bourgeault, R. Dingwall, & R. De Vries (Eds.), *The sage handbook of qualitative methods*. London: Sage.

Raphael, D. (2007). Making sense of poverty: Social inequality and social exclusion. In *Poverty and policy in Canada* (pp. 85-111). Toronto: Canadian Scholars' Press

Raphael, D. (2009). *Social determinants of health: Canadian perspectives* (2nd ed).
Toronto: Canadian Scholars' Press Inc.

Reid, C. (2004). *The wounds of exclusion: poverty, women's health, & social justice.*
Edmonton AB: Qual Institute Press.

Reid, C. (2008). Women's health and the politics of poverty and exclusion. In M.
Marrow, O. Hankivsky, and C. Varcoe (eds.), *Women's health in Canada,* (pp-
199-220). Toronto: University of Toronto Press.

Reutter, L., & Kushner K. E. (2010). Health equity through action on the social
determinants of health: Taking up the challenge in nursing. *Nursing Inquiry*,
17(3), 269-280.

Richards, T., Cohen, M., Klein, S., Littman, D., & Hajer, J. (2009). *The view from here:
how a living wage can reduce poverty in Manitoba.* Ottawa: Canadian Centre for
Policy Alternatives. Retrieved from http://www.policyalternatives.ca/sites/
default/files/uploads/ publications /reports/docs/The%20View%20
From%20Here%20_1_0.pdf

Sheyholislami, J. (2001). *Critical discourse analysis*. Retrieved from http://www.
202arleton.ca/~jsheyhol/cda.htm

Simon, C.A. (2009). *Public policy: Preferences and outcomes*. New York: Longman.

Skinner, K., Hanning, R.M., Metatawabin, J., & Tsuji, L.J.S. (2012). Impact of a school
snack program on the dietary intake of grade six to ten first Nation students living
in a remote community in northern Ontario, Canada. *Rural and Remote Health,
12*(2122). Retrieved   from http://www.rrh.org.au/articles/printviewnew.asp?
ArticleID=2122

Smith, J. (2007). Critical discourse analysis for nursing research. *Nursing Inquiry, 14*(1),
60-70. Doi: 10.1111/j.1440-1800.2007.00355.x

Social Planning Network of Ontario. (2011). *Human dignity for all: working for a
poverty free Ontario*. Retrieved from http://yrfn.ca/wp content/uploads/
2011/08/PovFreeOnt_ Presentation_BW.pdf

Statistics Canada. (2014). *Low income lines 2012-2013.* Catalogue no. 75F0002M
Retrieved from http://www.statcan.gc.ca/pub/75f0002m/75f0002m2014003-
eng.pdf

Taillon, P. (2010). Hard truths: Canada's social deficit. *Canadian Council on Social
Development.* Retrieved from http://www.ccsd.ca/home.htm.

Thomas, J. (2010). *Re-Constructing Children's Identities: Social work knowledge and
practice in the assessment of children's identities.* Unpublished PhD thesis,

Cardiff School of Social Sciences, Cardiff University. Retrieved from orca.cf.ac.uk/55064/1/U585453.pdf

Thorne, S., & Varcoe, C. (1998). The tyranny of feminist methodology in women's health research. *Health Care for Women International, 19*, 481-493. Doi: 10.1080/073993398246052

Tiessen, K. (2015). *Making ends meet: Toronto's 2015 living wage*. Toronto: Canadian Centre for Policy Alternatives- Ontario. Retrieved from https://www.policyalternatives.ca/publications/reports/making-ends-meet

Townson, M. (2005). *Poverty issues for Canadian women: Background paper*. Prepared for Gender Equality Consultations. Ottawa: Canada. Retrieved from http://www. Rapereliefshelter.bc.ca/sites/default/files/imce/Poverty%20Issues%20for%20 Canadian%20Women%20-%20Background%20Paper.pdf

Tuhiwai Smith, L. (1999). *Decolonizing methodologies: Research and Indigenous peoples*. London: Zed Books.

Tutty, L. (2014). Does gender matter in violence prevention programmes? In J. Ellis & R. K. Thiara (Eds.), *Preventing violence against women and girls: Educational work with children and young people* (pp 45-63). Bristol: Policy Press.

United Nations. (2007). *United Nations special rapporteur on adequate housing, Miloon Kothari: Mission to Canada*. Retrieved from http://www.unhchr.ch/huricane/ 203arleton203.nsf/0/90995D69CE8153C3C1257387004F40B5?opendocument

Vavrus, F., & Seghers, M. (2010). Critical Discourse Analysis in Comparative Education: A Discursive Study of "Partnership" in Tanzania's Poverty Reduction Policies. *Comparative Education Review*, 54(1), 77-103. Doi: 10.1086/647972

Wellesley Institute. (2013). *Poverty is a health issue: Wellesley Institute Submission on the Poverty Reduction Strategy*. Retrieved from http://www.wellesleyinstitute. Com/ wp-content/uploads/2013/09/Poverty-Reduction-Strategy-2013.pdf

Yeo, S., Ratman, C., Paradis, E., Oudshoorn, A., Nessa, B., Moser, J…Aguila, K. (2015). *A framework for ending women's and girls' homelessness.* Retrieved from http://www.homelesshub.ca/resource/framework-ending-womens-and-girls'- homelessness

YMCA Canada. (2009). *A turning point for young women.* Retrieved on August 26, 2015 from http://ywcacanada.ca/data/publications/00000006.pdf

CHAPTER SIX

STUDY SYNTHESIS AND NURSING IMPLICATIONS

The purpose of this study was to critically examine the socio-political context, health needs, exclusionary and inclusionary forces, and strategies of resistance demonstrated by mothers experiencing homelessness. The contextual processes shaping mothers' experiences of social exclusion and homelessness, and how these experiences influenced their health, were critically examined. This study included two phases. In the first phase, critical narrative methodology was employed in interviewing 41 participants, consisting of mothers experiencing homelessness (n=26) and service providers (n=15). Themes included:

1. Exclusion from safety;

2. Stigma: Public surveillance and discrimination;

3. Contradictory sources and systems of support:

    a. "Until you hit rock bottom there's no support"

    b. "It's just not enough": Insufficient supports

    c. "Help comes with a price": Support with surveillance

    d. "Every shelter is so different": Organizational philosophies impacting support;

4. Internal impacts of exclusion:

    a. Internalized expectations and regulation

    b. Pushing back from the margins: sources of resilience and resistance

        i. Challenging injustice and seeking/providing support and help

        ii. Gaining strength through the act of mothering

        iii. Building alliances with service providers

The second phase of this study extended the first phase by applying participant perspectives to political structure with a policy analysis. Specifically, a critical discourse analysis of *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019* (*OPRS*) (Government of Ontario, 2014) was conducted. Findings revealed that the needs of homeless mothers were not adequately represented or addressed in the policy, nor were their experiences of social exclusion, as identified in the first phase of the study. Instead gender invisibility, neoliberal, and individualistic approaches to poverty reduction were dominant with minimal identification of timeliness, concrete plans, and evaluation strategies. The results of phase two troubled the notion of governmental commitment to poverty reduction for socially excluded populations, such as mothers experiencing homelessness. Findings from phase two also provided a further understanding of the political structures shaping the health of mothers experiencing homelessness.

The findings from phase one and phase two united individual realities with the macro structure of policy shaping experiences of health, social exclusion, and homelessness. Cross-cutting findings from phases one and two problematized structures of support, and facades of inclusion within exclusionary systems. In phase one, despite the plethora of supports participants utilized, they were inadequately supported to address social exclusion. Likewise, poverty reduction strategies should ideally promote inclusion, yet based on phase two study findings, the exclusion experienced by marginalized groups such as mothers experiencing homelessness is not adequately addressed, and thus, systems of exclusion remain, despite the illusion of increased support and "inclusionary" plans. In this way, exclusionary spaces extended into and evolved out of the policy realm and reinforced experiences of social exclusion. Further, mothers were fully aware of the injustices they faced and were engaged in questioning their plight from a systems-level

perspective. However, dominant neoliberal ideologies and societal views on mothering, which are incompatible with mothering while homeless, young, or living in poverty, infiltrated mothers' thinking, creating blame and shame as internalized impacts of social exclusion.

Limitations

Despite the rich data and contributions to knowledge development, the study also included several limitations. First, the sample was restricted to an English-speaking population. This was due to the lack of feasibility in hiring multiple translators. Second, there were several challenges in employing follow-up interviews with all participants. This was largely due to changes in participant accessibility and the increasing complexity of life situations. Nevertheless, I was able to share my interpretations and the current preliminary analysis with each participant. Third, while phase two of the study was initiated during phase one, analysis of the *OPRS* was conducted after research findings from phase one were solidified. Thus, research participants did not further engage in the co-construction of knowledge throughout the policy analysis. Additionally, primarily recruiting through two organizations, with three agencies, limited the bulk of study participants to those who utilized those services. Thus, while partnering with these agencies enhanced recruitment and trust among participants, women who were not accessing those particular services, such as the hidden homeless, or those residing in other shelters, such as shelters catered to newcomer women and Aboriginal women, were not easily accessible. Likewise, service provider participants were largely limited to those working within local agencies. Although richness of data was achieved, such study limitations provide impetus for future research.

Methodological Challenges and Insights

Since the inception of this study key stakeholders were consulted on the research process. Photo elicitation, individual interviews, and group interviews were determined as potential data collection methods. However, the photo elicitation component created several challenges. We had initially planned to build on the "photo talk" (Berman, Ford-Gilboe, Moutry, & Cekic, 2001) by incorporating photos in knowledge exchange activities to increase awareness and elevate their voice. Despite consultation with agency partners and participants, issues of anonymity and safety emerged; living in shared spaces and capturing others and children in their photos posed safety risks and ethical challenges, even with consent of those being photographed. Ensuring that the research process and engagement met the participants' and agency needs, the method of photo elicitation was altered to ensure that only the participant kept the photos once developed. Subsequently, knowledge translation activities were also adjusted. This flexibility was imperative as knowledge dissemination strategies cannot be given primacy over participant anonymity (Josselson, 2007).

Issues of anonymity were further challenged in employing critical narrative methodologies, while constructing and sharing of research findings, reports, and summaries with partnering agencies and key stakeholders. These strategies raise the question for narrative researchers: How do we maintain anonymity of research participants while engaging in local knowledge exchange processes? Flexibility of the researcher and research process to meet the needs of the participants trump all else. Thus, participant stories were stripped of all identifying information, and were only so long as to ensure richness of data without life stories being fully revealed and easily identified within known communities (Josselson, 2007; Saunders, Kitzinger, & Kitzinger, 2014).

This also resulted in the decision to not use pseudonyms. While pseudonyms protect participants' names and hold important use in narrative work, participants could be easily identified within the community when multiple quotations from the same participant were included (Saunders et al., 2014). Ensuring anonymity was key in meeting with both mothers and service providers, in the development of trust, and in the sharing of incredibly sensitive and vulnerable information (Josselson, 2007). Some narrative research is designed to purposefully include participants' names based on preference of the participant (Grinyer, 2002). Inclusion of identity, based on choice, can be a potentially powerful tool for participant engagement in social action (Chase 2005). As critical researchers we must always ensure the needs of the participants are reflected in the needs of the research; thus, flexibility and understanding of vulnerability are identified as strengths within the research processes of this study.

In exposing, addressing, and challenging social injustices, critical researchers working with marginalized groups are immersed in participants' stories of extreme injustice, lived realities of unspeakable violence, trauma, and victimization, while simultaneously bearing witness to the resilience and resistance people enact. In engaging in empathetic interviewing, researchers' participation in the research process and invested interest in the participants' experience can create emotional distress for the researchers themselves (Coles, Astbury, Dartnall, & Limjerwala, 2014). While this has implications for researcher voice and interpretations, the challenge faced within this research was in creating space to cope with the emotional impacts of hearing the stories of 26 mothers experiencing homelessness and 15 service providers caring for them, beyond the traditional reflecting and interpreting processes of qualitative and critical work.

The emotional impact was not a new phenomenon in my work as a nurse or as a researcher; however, conducting doctoral work can be more isolating than other work (Matthiesen & Binder, 2009), such as being a nurse within a health care team, or a research assistant collecting data alongside others. Being the primary interviewer, transcriber, coder, report writer, and presenter of findings meant I was constantly immersed in the talk and text of women's lives, beyond the interview itself, and the incredible injustices they faced (Connolly & Reilly, 2007; Matthiesen & Binder, 2009).

My prior and concurrent work certainly prepared me for the emotional investment and toll; such investment fuelled my passion and dedication to the research process. However, it is important for researchers to have conversations about the emotional impact of our work. At times, it seems, that as a result of our positions of privilege we inherently feel guilt admitting the emotional toll we face, in thinking we do not deserve to *feel* our own pain because we get to return to our privileged lives. Creating opportunities for the emotional support of researchers is an important component of the research process (Coles et al., 2014), that often gets over looked. In response to this emerging need, I was able to connect with an informal network of doctoral students employing critical qualitative methodologies and who were working with marginalized groups. While no confidential information was shared, we created time and space to exchange and normalize feelings of sadness, outrage, powerlessness, and guilt. Further, recommendations identified by Coles and colleagues (2014) to engage in elements of self-care were followed. For example, on days that I was working as a mental health nurse, I would not book research interviews before or after my shift. This approach reduced the potential for emotional exhaustion and allowed for recovery time between such emotional work. The emotional impact of the research was important, and it was

required in carrying out empathetic interviewing and critical research. However, managing the impacts and acknowledging the toll cannot be minimized. Similar to the limitations of the study, the methodological issues provide enhanced motive for future studies with the lessons learned from this project.

Implications

Implications for Nursing Practice

While research participants spoke of their interactions with a variety of health and social service providers, these findings and implications are extremely relevant for nurses, as nurses are the main contact points to the health care system for individuals experiencing homelessness (Pauly, 2014). As well, literature suggests that nurses, and other members of the health care team, hold stigmatizing views towards individuals experiencing homelessness (Oudshoorn, Ward-Griffin, Forchuk, Berman, & Poland, 2013; Pauly, 2014), individuals with mental illness (Ross, 2009), and individuals with addiction issues (Danda, 2012), and that such stigma and discrimination creates barriers for access to health care (McGibbon, Etowa, & McPherson, 2008). While this is certainly not representative of the perspectives of all nurses, it is an important consideration in challenging social exclusion and in promoting the health of mothers experiencing homelessness.

In promoting health, nurses can embrace health promotion approaches aligned with the Ottawa Charter for Health Promotion, with ideological underpinnings of social justice and health equity (World Health Organization, 1986). In doing so, nurses can engage in health promotion practices that challenge the status quo and the entrenched ideologies that historically and currently marginalize and exclude certain populations. Nurses can begin this anti-oppressive practice by recognizing the role they may play as

actors within the system by directly or indirectly reinforcing and perpetuating social exclusion. Nurses can begin by engaging in critical reflection and challenge any stigma or discriminatory values held or enacted in providing care for marginalized groups, such as mothers experiencing homelessness. Nurses are not immune to dominant societal views; however, we have a professional responsibility to engage in critical reflection and challenge exclusionary ideologies, such as those based on stigmatizing or discriminatory values (Canadian Nurses Association, 2009).

As part of the reflection process we can evaluate the ways in which we enact, provide, and reproduce power in our client relationships. Participants reported feeling policed while receiving services and having to prove their worthiness of such services. In noting the power relations between nurses, or other service providers, and clients, nurses can work hard to create safe spaces fostering partnerships and alliances. We must strive to be the humane face in an inhumane system (Oudshoorn et al., 2013), by creating solidarity with clients and destabilizing authoritative hierarchies. In providing services to individuals experiencing homelessness, Oudshoorn, Ward-Griffin, Poland, Berman, and Forchuk (2013) suggest that health and social professionals can ask: "Whose space is it" (p. 39), to challenge cultures of power and control. Further, an examination of power within provider-client relationships can help to identify misuse of power and an examination of the ways in which we are perpetuating voicelessness and oppression. At the practice level we can contextualize the care we provide, in truly understanding life circumstances, injustices faced, and resilience.

In further challenging stigma and oppressive ideologies, nurses can counter mainstream discourses of "good mothering". Working within a health and social system that often blames mothers for circumstances beyond their control and their subsequent

health experiences (MacLennan-Peters & Aston, 2014), nurses must push to shift what it means to be a "good mother", while emphasizing the incredible strengths mothers demonstrate. Berman and colleagues (2014) suggest that we can work towards shifting societal expectations by supporting and understanding representations of mothers and mothering that vary from traditional and exclusionary perceptions of good mothering. This could have far reaching implications in a number of health promotion strategies such as in public health advertisements, violence-prevention programs, and child-care supports, which often reinforce negative stereotypes of mothering (Smyth, 2012).

In challenging this notion of mothering, nurses can contextualize mothers' experiences and understand the broader socio-political factors at play. That is, we can employ an intersectional lens to gain an understanding of how historical, political, economic, and social factors impact mothers' health and well-being. Such an approach must also foster spaces where the internalized expectations held by mothers experiencing homelessness can be challenged and a strengths-based approach employed. This is particularly important, as participants clearly identified the strength they found in mothering. In recognizing the incredible strength gained from peer support, nurses can work with mothers to facilitate informal and formal networks of peer support. Creating spaces to recognize and build on their resourcefulness, protectiveness, and resistance can help to challenge their internalized negative perceptions of their mothering.

Building on this, life histories of trauma were prominent in women's stories. Nurses can also promote trauma-informed care in recognizing and responding to the role that violence and trauma have in shaping women's current situation and health needs. According to Hopper, Bassuk, and Olivet (2010):

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (p. 82).

In employing trauma-informed care, nurses can recognize the role that trauma has played, and continues to play, in women's experiences of health and health experiences. Aligned within an anti-oppressive lens, a trauma-informed lens requires that those providing care have an understanding of what has happened in women's lives that brought them to this point, as well as recognizing their incredible abilities in challenging the injustices they have faced.

Implications for Policy

Service providers and policy makers can promote a reconceptualization of how services can be employed to better meet the needs of mothers experiencing homelessness. Many service provider participants expressed frustration in their inability to adequately or comprehensively support their clients, due to organizational and governmental policies and the lack of available services. Likewise, the mothers reported inadequate and unattainable supports within the system. For instance, fear of child apprehension was an identified barrier to seeking and accessing support services, particularly related to mental health and addiction services. In attempting to access the necessary services, women were often waitlisted or turned away.

In reconceptualizing services and service work, health and social professionals can challenge tangible and intangible exclusionary criteria in ensuring mothers' needs are truly met, and do so in a safe space where mothers do not feel monitored and

undermined. Organizational accountability in creating and revising policies to better reflect inclusive and anti-oppressive values is needed. Service users can provide input during routine evaluations to organizational processes to promote dialogue and address ongoing exclusion. Such an approach destabilizes power relations and can be employed in a variety of centers that cater to mothers experiencing homelessness, as well as in hospital settings, child protection services, and public health agencies, where power relations often go unchallenged (Marrow & Wiesser, 2012).

Organizational accountability can be fostered in the training and purposeful recruitment of staff with anti-oppressive and trauma-informed values to best meet the needs of mothers experiencing homelessness. Examination of how such policies are enacted, and ensuring that service providers, as actors of the policy, are supported and required to uphold anti-oppressive values in their practice. Routine practice reflections and peer and client evaluations can help to identify and counter current power relations. Advocacy for organizational policies and procedures inclusive of abuse and trauma screening assessments, as well as training for staff as to how to best support trauma survivors must be implemented in social and health institutions.

Based on study findings, there is also a need for governments to reconceptualize the social safety net to employ anti-oppressive philosophies. Such an approach would challenge the current entrenched societal ideologies of neo-liberal, individualistic, and policing philosophies deeply embedded in our social and health systems (Gelberg & Arangua, 2009). These systems, with the façade of support, are unable to comprehensively meet the needs of marginalized groups, such as mothers experiencing homelessness. Inclusion of women with lived experience of homelessness in decision-making and policy development would further support the reconceptualization of

organizational and governmental policies. Nurses can participate in political action through the voting process, engaging in activism, and holding political office in challenging ideologies negatively impacting marginalized groups (Burnett, 2012), and perpetuating social exclusion. Creating policy briefs, engaging in community policy-based workshops, and collaborating with policymakers in translating findings are further effective methods for nurses to engage in policy work (Ward-Griffin et al., 2015). Further, in recognizing the deep seated exclusion faced by mothers experiencing homelessness, policies promoting inclusion, whether at governmental or nongovernmental levels, must be critically examined to identify how structural inequities and social exclusion can be addressed. That is, activist, professional, and agency bodies can seek to examine current and prospective policies in examining who remains excluded and the ways in which such exclusion is addressed in promoting inclusion.

Poverty was central to the way in which social exclusion was enacted in the mothers' lives. Participants expressed the lack of sufficient access to basic human needs, such as access to food, safety, and shelter, due to extreme poverty. Social assistance, in the forms of Ontario Works and Ontario Disability Support Program, are unfathomably inadequate to meet basic human and health needs. Health and social professionals, as well as professional and activist groups, must continue advocacy through political involvement and lobbying efforts to reduce poverty and increase social assistance to liveable rates (OCAP, 2014). An intersectional lens can be employed when creating and critiquing poverty-related policy in response to the high prevalence of poverty among single mothers, racialized individuals, and newcomers (Government of Ontario, 2014), and in recognizing the mutual interaction of gender, race, and other social identities in shaping poverty.

Further, in developing poverty reduction strategies, governments must be pressured to simultaneously develop stigma and discrimination reduction strategies. In doing so, the systemic forms of discrimination, and their relationship to poverty experiences can be exposed and addressed. Findings revealed that Ontario's current poverty reduction strategy did not take these aspects into consideration in identifying circumstances perpetuating and reinforcing poverty, such as discrimination in preventing employment or access to housing.

Lastly, Canada remains without a national housing policy, despite pressure from the United Nations (United Nations, 2007), Members of Parliament (Bill C-382, 2006; Bill C-304, 2009; Bill C-400, 2012), and activist organizations (ACORN Canada, 2010, Canada Without Poverty, 2012, Heffernan, Faraday, & Rosenthal, 2015). Homelessness has detrimental effects on all other determinants of health and its existence is reflective of extreme social injustice. Nurses have a role in advocating for a national housing policy, ensuring access to affordable housing for all, inclusive of special considerations for specific populations, such as mothers experiencing homelessness. Nurses, as part of larger nursing bodies, such as Canadian Nurses Association, and the Registered Nurses Association of Ontario (RNAO), hold incredible advocacy power (Duncan, 2015). These bodies have streamlined access to public marketing tools, lobbying efforts, and familiarity with policy change, and political action. RNAO's position statement on homelessness and health, promoted awareness amongst nurses, demanded action at a political level, and clearly identified that we can no longer understand and promote health, without talking about homelessness (RNAO, 2004). We can engage in advocacy efforts within our associations to unite our voices in advocating for access to affordable housing in Canada.

Implications for Nursing Research

Several implications for future research stem from study findings. Policy analysis research is an emerging form of scholarship in nursing research (Smith, 2007) and has great impetus for connecting health and health promotion to the broader political institutions. A comparative policy analysis of philosophies within shelters might shed light on potential limitations, implications, and effectiveness of current models of care delivery. This could begin with a shelter-to-shelter comparative study, but would also have relevance for other services mothers experiencing homelessness utilize, such as mental health units, public health agencies, and child protection services.

Within these comparative studies, an examination not only of the policies but also the way in which the policies are enacted, with input from service providers and service users would have great implications in addressing exclusionary processes. Further, a shift in health promotion research to routinely include policy analysis would foster necessary politicized understandings of health. Health promotion researchers can employ techniques such as incorporating policy advisory committees, comprised of research participants, to explicitly link health research and policy, and destabilize traditional research hierarchies. Uniting individual realities with broader political contexts is necessary to identify and counter the multifaceted aspects shaping social exclusion and health for mothers experiencing homelessness.

This study laid the foundation for further research understanding the unique needs of mothers experiencing homelessness. For instance, the spreadsheet of policies discussed during study interviews included over 30 elements of governmental and organizational policies. However, poverty was the common and most prominent concern across discussion of policies and health experiences. Extending this work, policy analyses

pertaining to specific policies impacting the health and social exclusion experienced by subgroups within this population, such as Aboriginal mothers or newcomer mothers, can be conducted. This is particularly important as these subgroups face additional compounding and unique challenges (Van Berkum & Oudshoorn, 2015).

Researchers can examine service providers' enacted values, commitment to social justice, and potential stigma and discrimination to foster an understanding of how to improve the care provided and relationships created. Further, research examining the relationships between child protection services and mothers experiencing homelessness can be examined to address power imbalances, as identified by participants. Lastly, future studies can create opportunities for children residing with their mothers while homeless to participate in the research process to further our understanding of social exclusion, health, and health promotion as enacted in their lives.

Implications for Nursing Education

The socio-political context in which health is created and the role of nurses in supporting health within this context must be emphasized in nursing curriculum. Health and public policy courses offered at undergraduate and graduate levels can further promote a commitment to understanding, examining, and challenging policy in understandings of health. Such courses can offer opportunities for students to employ policy analysis research and/or engage in political action. At the graduate level, policy work and policy research can be integrated into all streams of graduate level nursing education. Courses and practicums offering opportunities for students to engage in policy work can further support this need.

At the undergraduate and graduate levels, nursing curriculum must include social justice as a goal in nursing care in all settings and the opportunities to use and develop

strategies, such as policy work, to ensure its attainment (O'Mahony Paquin, 2011).

Nursing clinical and research placements employing an application of social justice in

practice can help to create awareness, compassion, and understanding of health inequities

and how nurses can promote health through practice, research, and subsequent policy

work. For example, placements in shelters, drop-in centres, and outreach services can

provide opportunities for students to bear witness to the ways in which social

determinants shape health and to gain an increased awareness of the lived realities of

such marginalized groups (Benbow, 2009). Inclusion of course concepts such as social

justice and health inequity in undergraduate and graduate courses can serve to illuminate

the role that stigma and discrimination can play in shaping health and health care access

(McGibbon et al., 2008).

Knowledge Translation and Exchange

As central components of critical research, engagement in advocacy and activism

efforts are warranted and necessary (Chase, 2005; Lather, 1991). The uniting of

individual perspective and political structure supported the action-oriented nature of

critical research. Further, based on study findings and participant voice, preliminary

findings with recommendations from participants were shared with partnering agencies

with a full report and presentation to be shared upon completion. In fact, one agency was

able to use the research report in helping to apply for and secure funding for their centre.

In sharing the findings using easy-to-understand language and summarizing key points to

ensure anonymity, agencies were able to apply relevant findings, as they desired. This

ensured that I, as the researcher, was not the sole "holder of knowledge", but rather that

findings were of use to the participants and their agencies based on their needs.

Likewise, I plan to share study findings and exchange knowledge with academic

audiences, including health, nursing, and social professionals, as well as community-based audiences; I will present findings at multiple local, provincial, national, and international conferences. As well, manuscripts developed from Chapters 2, 4 and 5, will be submitted for publication in journals for nurses, health professionals and researchers, as well as policy analysts and developers.

I will work with professional nursing bodies, such as the RNAO; activist bodies, such as Ontario's Women Health Network; and agencies providing care to mothers experiencing homelessness, such as Safe Space and women's shelters in Southern Ontario, to share key findings and dialogue as to ways to continue the action components of this research. Interactions with each group will result in varying involvement and advocacy. For example, a research to policy translation may be presented to Ontario's Women's Health Network to further support their lobbying efforts in policy change, whereas my work with agencies providing services to homeless mothers may include a dialogue about ways specific policies and procedures can be examined and/or revised. I will offer summaries of phase two of the study to prominent women's groups and poverty-related blogs and organizations, such as End Poverty Now. I will consult with key decision makers within the organizations in planning and executing the most feasible methods for effective knowledge exchange (Wathen, Sibbald, Jack, & Macmillan, 2011).

Further, as a Professor within a School of Nursing there is much potential to incorporate findings into a number of ongoing curricular and program developments with far-reaching implications. I am involved in the development of new Certificate programs, such as an Advanced Mental Health Nursing Certificate, where I plan to create modules inclusive of the needs specific to caring for mothers experiencing homelessness. Likewise, in my role as an educator I have many opportunities to incorporate research

findings into dialogue and discussion with students around social justice and health, community health promotion, social determinants of health, and psychiatric mental health nursing.

Conclusion

This study united individual realities of mothers with the broader social and political structures influencing their health, homelessness, and experiences of social exclusion. Through critical narrative inquiry, mothers' narratives of health, exclusion, mothering, and resistance were examined. Likewise, service providers shared their experiences in supporting mothers experiencing homelessness. The socio-political factors shaping mothers' health and homelessness were further exposed through a critical discourse analysis of Ontario's Poverty Reduction Strategy (Government of Canada, 2014). Gender invisibility and neoliberal ideologies dominated discussion on poverty reduction and troubled the Provincial Government's commitment to poverty reduction. Findings from the entire study identified the tenuous nature of mothering while homeless and problematized systemic structures of support. As a social determinant of health, social exclusion is inextricably linked to health. In our advocacy efforts to promote health, nurses have an opportunity and obligation to challenge current practices, policies, and philosophies to better address social exclusion experienced by mothers experiencing homelessness.

References

ACORN Canada. (2010). *Red Tent goes national*! Retrieved from
    http://www.pivotlegal.org
    /sites/pivotlegal.org/files/Pivot_Point5_Aug2010_Web.pdf

Benbow, S., (2009). Societal abuse in the lives of individuals with mental illness. *The
    Canadian Nurse, 105*(6), 30-32.

Berman, H., Ford-Gilboe, M., & Moutrey, B., & Cekic, S. (2001). Portraits of pain and
    promise: A photographic study of Bosnian youth. *Canadian Journal of Nursing
    Research, 32*(4), 21-41.

Berman, H., Mason, R., Hall, J., Rodger, S., Classen, C. C., Evans, M.K., … Al-Zoubi, F.
    (2014). Laboring to mother in the context of past trauma: the transition to
    motherhood.   *Qualitative Health Research*. doi: 10.1177/10497323

Bill C-304. (2009). *Bill C-304: An act to ensure secure, adequate, accessible, and
    affordable housing for Canadians*. First Reading, Feb 10, 2009, 40th Parliament,
    2nd Session. Retrieved from http://www.parl.gc.ca/HousePublications/Publication
    .aspx? Pub=Bill&Doc=C-304_1&Language
    =&Mode=1&Parl=40&Ses=2&File=24

Bill C-382. (2006). *Bill C-382: An act to ensure secure, adequate, accessible, and
    affordable housing for Canadians*. First Reading, Nov. 11, 2006, 39th Parliament,
    1st Session. Retrieved from http://www.parl.gc.ca/LEGISInfo/BillDetails
    .aspx?billId   =2190114&Language=E&Mode=1

Bill C-400. (2012). *Bill C-400: An act to ensure secure, adequate, accessible, and
    affordable housing for Canadians*. First Reading, February 16th, 2012. 41st
    Parliament, 1st Session. Retrieved from http://www.parl.gc.ca/
    Legisinfo/BillDetails.aspx?Language= E&Mode=1&billId=5353445

Burnett, C. J. (2012). Examining the effects of policies on the delivery of shelter
    services to women who have experienced intimate partner violence" (2012).
    Electronic Thesis and Dissertation Repository. Paper 635. Retrieved from
    http://ir.lib.uwo.ca/etd/635/

Canada Without Poverty. (2012). *Renewed call for a National Housing Strategy*.
    Retrieved from http://www.cwp-csp.ca/2012/02/renewed-call-for-a-national-
    housing-strategy/

Canadian Nurses Association. (2009). *Ethics in practice: Social justice in
    practice*. Retrieved from http://www.cnanurses.ca/CNA/documents/
    pdf/publications/Ethics_in_Practice_April_2009_e.pdf.

Chase, S. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. Denzin & Y. Lincoln (Eds.). *The sage handbook of qualitative research* (3rd ed.) (pp. 651-679). Thousand Oaks, California: Sage Publications.

Coles, J., Astbury, J., Dartnall, E., & Limjerwala, S. (2014). A qualitative exploration of researcher trauma and researchers' responses to investigating sexual violence. *Violence Against Women, 20*(1), 95–117. doi: 10.1177/1077801213520578 vaw.sagepub.com

Connolly, K., & Reilly, R.C. (2007). Emergent issues when researching trauma. *Qualitative Inquiry, 13*(4), 522-540. doi: 10.1177/1077800406297678

Duncan, S.M. (2015). Collective nursing advocacy. In P.S. Wise & L.G. Grant (Ed.), *Leading and managing in Canadian nursing.* Toronto: Elsevier Canada.

Gelberg, L., & Arangua, L. (2009). Homeless people. In B.S. Levy & V.W. Sidel (Eds). *Social injustice and public health*. New York: Oxford University Press.

Government of Ontario. (2014). *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019.* Retrieved from http://www.ontario.ca/document/realizing-our-potential- poverty-reduction-strategy-2014-2019

Grinyer, A. (2002). The anonymity of research participants: Assumptions, ethics, and practicalities. *Research Social Update*, Issue 36. Retrieved from http://sru.soc.surrey.ac.uk/SRU36.html

Heffernan, T., Faraday, F., & Rosenthal, P. (2015). Fighting for the right to housing in Canada. *Journal of Law and Social Policy, 24*(1), 10-45.

Hopper, E.K., Bassuk, E.L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Sciences and Policy Journal, 3*, 80-105. Retrieved from http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf

Josselson, R. (2007). The ethical attitude in narrative research: Principles and Practicalities. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry* (pp 537-566). Thousand Oaks, Ca: Sage Publications.

Kiyimba, N., & O'Reilly, M. (2015). The risk of secondary traumatic stress in the qualitative transcription process: a research note. *Qualitative Research*, doi: 1468794115577013.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.

MacLennan-Peters, J., & Aston, M. (2014). Don't blame low-income mothers! Understanding low-income mothers' social-ecological circumstances in relation to health status. *Journal of the Association for Research on Mothering, 11*(2), 97-11.

Marrow, M., & Weisser, J. (2012). Towards a social justice framework of mental health recovery, *Studies in Social Justice,* 6(1), 27-43.

Matthiesen, J. & Binder, M. (2009). *How to survive your doctorate education.* What others don't tell you. New York, NY: Open University Press.

McGibbon, E., Etowa, J., & McPherson, C. (2008). Health-care access as a social determinant of health. *The Canadian Nurse, 107*(7), 23-27.

O'Mahoney Paquin, S. (2011). Social justice advocacy in nursing: what is it? How do we get there? *Creative Nursing, 17*(2), 63-67.

Ontario Coalition Against Poverty. (2014). *Welfare and ODSP*. Retrieved from http://www.ocap.ca/node/38

Oudshoorn, A., Ward-Griffin, C., Forchuk, C., Berman, H., & Poland, B. (2013). Client-provider relationships in a community health clinic for people who are experiencing homelessness. *Nursing Inquiry, 20*(4), 317-328. doi: 10.1111/nin.12007.

Oudshoorn, A., Ward-Griffin, C., Poland, B., Berman, H., & Forchuk, C. (2013). Community health promotion with people experiencing homelessness. *Journal of Community Health Nursing, 30*(1), 28-41. doi: 10.1080/07370016.2013.750204

Patton, M.Q. (2015). *Qualitative research and evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage Publications Inc.

Ponterotto, J.G., Casas, J.M., Suzuki, L.A., & Alexander, C.M. (2015). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.

Registered Nurses Association of Ontario. (2004). *Position statement: Homelessness*. Retrieved from http://rnao.ca/policy/position-statements/homelessness

Saunders, B., Kitzinger, J., & Kitzinger, C. (2014). Anonymising interview data: Challenges and compromise in practice. *Qualitative Research.* doi: 10.1177/1468794114550439

Smith, J. (2007). Critical discourse analysis for nursing research. *Nursing Inquiry, 14*(1), 60-70. doi: 10.1111/j.1440-1800.2007.003355.x

Smyth, L. (2012). *The demands of motherhood: agents, roles, and recognitions.* Basingstoke: Palgrave Macmillian.

United Nations. (2007). *United Nations special rapporteur on adequate housing, Miloon Kothari: Mission to Canada*. Retrieved from http://www.unhchr.ch/huricane/huricane.nsf/0/90995D69CE8153C3C125738700 4F40B5?opendocument

Ward-Griffin, C., Dupuis, S., Klosek, M., McAiney, C., Orange, J.B., Ploeg, J. …Wong, C. (2015). Dementia care: It takes a community. Policy brief. Retrieved from http://www.agewell-nce.ca/wp-content/uploads/2015/07/CDC-KT-Policy-Brief-FINAL-June-4-2015.pdf

Wathen, C. N., Sibbald, S. L., Jack, S. M., & MacMillan, H. L. (2011). Talk, trust and time: A longitudinal case study evaluating knowledge translation and exchange processes in research on violence against women. *Implementation Science,* 6:102. doi:10.1186/1748-5908-6-102

World Health Organization. (1986). *The Ottawa Charter for health promotion*. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

APPENDIX A

Research Ethics Board Approvals

Use of Human Participants - Ethics Approval Notice

Research
Western

Principal Investigator:Dr. Cheryl Forchuk
File Number:102630
Review Level:Full Board
Approved Local Adult Participants:44
Approved Local Minor Participants:0
Protocol Title:Mothers experiencing homelessness: Social exclusion, resistance and health
Department & Institution:Health Sciences\Nursing,Western University
Sponsor:
Ethics Approval Date:June 19, 2012
Ethics Expiry Date:December 31, 2013

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Western University Protocol	Including all instruments listed in section 8.1	
Letter of Information & Consent		
Advertisement		

This is to notify you that the University of Western Ontario Health Sciences Research Ethics Board (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 HSREB 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 University of Western Ontario Updated Approval Request form.

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

The Chair of the HSREB is Dr. Joseph Gilbert. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Signature

Ethics Officer to Contact for Further Information

Janice Sutherland (jsutherl@uwo.ca)	Grace Kelly (grace.kelly@uwo.ca)	Shantel Walcott (swalcol@uwo.ca)

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

The University of Western Ontario
Research Development & Services
Support Services Building, Suite 5150 • London, Ontario • CANADA – N6A 3K7
PH: 519-661-2161 • F: 519-661-3907 • www.uwo.ca/research

Western 🛡️

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Cheryl Forchuk
File Number:102630
Review Level: Full Board
Approved Local Adult Participants:59
Approved Local Minor Participants:0
Protocol Title: Mothers experiencing homelessness: Social exclusion, resistance and health
Department & Institution: Health Sciences\Nursing,Western University
Sponsor:
Ethics Approval Date: November 08, 2012
Ethics Expiry Date: December 31, 2013

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Revised Western University Protocol	Revised study design, methods, inclusion criteria, sample size, study instruments and compensation	
Other	Service Provider Interview Guide	
Letter of Information & Consent	Service Provider	
Increase in number of local Participants	Increased to 59.	

This is to notify you that the University of Western Ontario Health Sciences Research Ethics Board (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 HSREB 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 University of Western Ontario Updated Approval Request form.

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

The Chair of the HSREB is Dr. Joseph Gilbert. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Signature

Ethics Officer to Contact for Further Information

Janice Sutherland (jsuther|@uwo,ca)	Grace Kelly (grace.kelly@uwo.ca)	Shaniel Walcott (swalcott@uwo.ca)

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

LAWSON HEALTH RESEARCH INSTITUTE

FINAL APPROVAL NOTICE

RESEARCH OFFICE REVIEW NO.: R-12-263

PROJECT TITLE: Mothers experiencing homelessness. Social exclusion, resistance and health

PRINCIPAL INVESTIGATOR: Dr. Cheryl Forchuk

DATE OF REVIEW BY CRIC: June 25, 2012

Health Sciences REB#:   102630

Please be advised that the above project was reviewed by the Clinical Research Impact Committee and the project:

Was Approved

PLEASE INFORM THE APPROPRIATE NURSING UNITS, LABORATORIES, ETC. BEFORE STARTING THIS PROTOCOL. THE RESEARCH OFFICE NUMBER MUST BE USED WHEN COMMUNICATING WITH THESE AREAS.

Dr. David Hill
V.P. Research
Lawson Health Research Institute

All future correspondence concerning this study should include the Research Office Review Number and should be directed to Sherry Paiva, CRIC Liaison, LHSC, Rm. C210, Nurses Residence, South Street Hospital.

cc: Administration

APPENDIX B

Letters of Information

Western
Arthur Labatt Family
School of Nursing

LAWSON
HEALTH RESEARCH INSTITUTE

Letter of Information
Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health

Sarah Benbow RN, MScN PhD candidate
Arthur Labatt Family School of Nursing
Western University
███████████████

Cheryl Forchuk RN PhD (Principal Investigator)
Arthur Labatt Family School of Nursing
Western University
███████████████

Introduction and Purpose of the Study
You are being invited to participate in a research study. The purpose of this study is to better understand the health and health experiences of mothers experiencing homelessness in Southern Ontario. We are interested in the skills and strengths that you demonstrate in order to ensure your health, wellbeing, and safety, as well as the barriers you face.

Study Procedures
Between 28 and 44 women over the age of 18, who have had children and who are currently experiencing or who have experienced homelessness within the past year are invited to participate in this study. You will be given the option to participate in either a traditional in-depth interview, or a photovoice interview, based on your preference.

Traditional In-depth Interviews: With your consent to participate you will be asked to take part in either an individual or group indepth interview, based on your choice and preference. In the interview you will be asked to talk a little bit about yourself. For example, you will be asked questions about your health, living arrangements, barriers that you are faced with, and suggestions for improvement. Interviews will take place at the most convenient location for you, while ensuring privacy.

Photovoice Interviews: With your consent, you will be provided with a disposable camera and will be asked to take photographs representing your experiences of health, living arrangements, barriers you are faced with, and positive things in your life. You will be encouraged to take as many photographs as you wish, up to a maximum of 24. If you are taking photographs of any people, please ensure that you obtain permission to do so. Once you have taken the photographs, the research team will develop two sets of photos: one set for the you and one set for the research team. With your consent you will be asked to take part in either an individual or group interview, based on your choice and preference, to discuss the meaning behind the photos you took.

The traditional and photovoice interviews will last 1.5 to 2 hours and will include a follow-up interview. The follow-up interview will last 30 minutes- 1hour and will take place at a convenient time for you within 3 months of your initial interview. The purpose of the follow-up interview is for the researchers to share their understandings and preliminary analysis with you, and for you to have the opportunity to review your interview and make any changes you find necessary. This will ensure that your experiences are accurately understood and represented. You will be asked to provide your contact information to arrange a time to meet for the follow-up interview. You will also be asked for information for secondary contact person for the purposes of contact for follow-up interview. If you do provide names of secondary contact people, please obtain permission to do so. In order to participate, you must be able to speak and understand spoken English to the degree necessary to

Page 1 of 3

participate in the interview. The interviews will be audio taped so not to lose valuable information. You will be compensated $20 for your participation and travel costs, and you will be reimbursed for childcare costs as necessary with receipts and up to a maximum of $20. Light refreshments will be provided. If you agree to participate in this study you will be asked to sign the consent form.

Voluntary Participation
Participation in this study is completely voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. Your decision of whether or not to participate in this study will have no effect on the services provided to you by any agencies or organizations that provide homeless mothers with assistance. If you would like to withdraw your information from the study, you may do so by contacting the researcher.

Privacy and Confidentiality
All information will be collected, reported and stored in a confidential manner. Your name will not appear in any report generated from this research, and will be combined with all research data. All data collected will be retained in a locked facility. Only researchers connected with this project will have access to the information. Data without identifying information will be kept to answer future research questions. With your permission, certain photos may be used for publication of study findings or in future studies.

While participation in this research may be of no direct benefit, it is hoped that the information collected will increase awareness and may inform health care practice and policies in the future, as needs and gaps will be identified. Discussing your life and health experiences may create emotional discomfort. As well, it may be a positive and empowering experience. However, should you experience any emotional discomfort or become uncomfortable during the interview due to the topics discussed, you will be provided with information about follow-up mental health services to further resolve any issues that may arise. This letter is yours to keep. If you have any concerns or questions, please contact:

If you have any questions about the conduct of this study or your rights as a research subject, you may contact Dr. David Hill, Scientific Director, Lawson Health Research Institute (519) 667-6649.

Letter of Information
Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health

Research Participation Consent Form

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 "Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health". Specifically I agree to participate in the:

Traditional In-depth Interview   YES   NO

Photovoice Interview   YES   NO

 All questions have been answered to my satisfaction.

Participant (Print name)

_____

Signature of Participant   **Date**

_____   _____

Individual Obtaining Consent (Print name)

_____

Individual Obtaining Consent   **Date**

_____   _____

Western Arthur Labatt Family School of Nursing

LAWSON HEALTH RESEARCH INSTITUTE

Letter of Information for Service Providers
Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health

Sarah Benbow RN, MScN PhD candidate
Arthur Labatt Family School of Nursing
Western University

Cheryl Forchuk RN PhD (Principal Investigator)
Arthur Labatt Family School of Nursing
Western University

Introduction and Purpose of the Study
As a service provider of women who experience housing insecurities, you are being invited to participate in a research study. The purpose of this study is to better understand the health and health experiences of mothers experiencing homelessness in Southern Ontario. We are interested in the skills and strengths that mothers demonstrate in order to ensure their health, wellbeing, and safety, as well as the barriers they face.

Study Procedures
Between 28 and 44 women over the age of 18, who have had children and who are currently experiencing or who have experienced homelessness within the past year are invited to participate in this study. As well, 5-15 service providers who provide some type of care to or for mothers who experience homelessness. If you choose to participate in this study, you will be invited to participate in an in-depth interview or focus group, based on your preference.

In the interview or focus group you will be asked to talk a little bit about your experience as a service provider for mothers experiencing (or who have experienced) homelessness within the past year. For example, you will be asked questions about their health, living arrangements, barriers that they are faced with, and your suggestions for improvement in this health and social sector.

The interviews will last 1.5-2 hours. In order to participate, you must be able to speak and understand spoken English to the degree necessary to participate in the interview. The interviews will be audio taped so not to lose valuable information. You will be compensated with a $10 gift card to Starbucks for your participation and time. Light refreshments will be provided. If you agree to participate in this study you will be asked to sign the consent form.

Voluntary Participation
Participation in this study is completely voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. Your decision of whether or not to participate in this study will have no effect on your employment. If you would like to withdraw your information from the study, you may do so by contacting the researcher.

Privacy and Confidentiality
All information will be collected, reported and stored in a confidential manner. Your name will not appear in any report generated from this research, and will be combined with all research data. All data collected will be retained in a locked facility. Only researchers connected with this project will have access to the information. Data without identifying information will be kept to answer future research questions.

While participation in this research may be of no direct benefit, it is hoped that the information collected will increase awareness and may inform health care practice and policies in the future, as needs and gaps will be identified. This letter is yours to keep. If you have any concerns or questions, please contact Sarah Benbow at ▮▮▮▮▮▮▮ or ▮▮▮▮▮▮ , or Dr. Cheryl Forchuk at ▮▮▮▮▮▮▮ or ▮▮▮▮▮▮▮ .

If you have any questions about the conduct of this study or your rights as a research participant, you may contact Dr. David Hill, Scientific Director, Lawson Health Research Institute (519) 667-6649.

Letter of Information for Service Providers
Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health

Research Participation Consent Form

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 "Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health".

 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 C

Interview Guides

Semi-structured interview guide

These are interview questions that will evolve throughout the study based on the responses, needs, and interests of the women as they relate to social exclusion, resistance, and health.

1. I am really interested in understanding your experiences of homelessness. Tell me what your everyday life is like?
Some possible prompts:
- What is it like living in a shelter/group home/with family/friends?
- What is it like being a woman in these environments?
- What is it like being a mother in these environments?/What is it like parenting in the these environments?
- What does a usual day consist of?
- What are some common difficulties or stressors you are faced with?
- Tell me about what life was like before experiencing homeless?
- Tell me about how you are treated given your homelessness status? What makes you feel different? What barriers are you faced with?
- Tell me about your access to basic needs, such as food, clothing, money, housing, health?
- What do you need access to, but do not have?

2. Tell me about your health?
Some possible prompts:
- What does health mean to you? What does being healthy look like to you?
- What factors influence your health?
- How do your living arrangements impact your health and the health of your children?
- How do you access health care?
- What are some barriers to achieving health?
- What helps you in maintaining your health?
- How you see accessing basic needs, such as housing, as impacting your health?
- How is your mental health supported? What supports are needed?
- What recommendations do you have for service providers to help you in achieving health?
- How do certain policies impact your well-being? Such as Ontario Works? Shelter policies? School policies? Child protection Policies? How do they/does it impact your health?
- How do you feel about the government's role/responsibility in relation to housing? In relation to food security? Income security? and health care access?

3. Tell me about times that you feel respected and valued?
Some possible prompts:
- What are some positive things in your life?
- What makes you feel proud?
- How are you supported?
- How do you overcome barriers you have faced?
- What are some of your strengths or the strengths of your living environment?
- Tell me about what you envision for the future?

Semi-structured interview guide for Service Providers

These are interview questions that will evolve throughout the study based on the responses, needs, and interests of the participants as they relate to social exclusion, resistance, and health.

1. Tell me about your role in providing care/service for mothers who are experiencing homelessness.
   - Tell me about some of the circumstances these women experienced prior to and leading to their homelessness?
   - What are some of the common stressors/difficulties there are faced with? What are some of their unique challenges?
   - Tell me about their access to basic needs such as food, clothing, money etc? What do they need access to but do not have? What factors influence this?

2. Tell me about their health?
Prompts:
   - What factors influence their health?
   - How do their living arrangements impact your health and the health of your children?
   - How do they access health care?
   - What are some barriers to achieving health?
   - What supports do you they have for mental health? What supports are needed?

3. Tell me about their strengths
Prompts:
   - What are some positive things in their lives?
   - What are some of the strengths of this population?
   -

4. What needs to change to improve the health of these women?
   Prompts:
   - What recommendations do you have in ensuring they achieve health?
   - How do certain policies impact their well-being? Such as Ontario Works? Shelter policies? School policies? Child protection Policies? How do they/does it impact your health?
   - How do you feel about the government's role/responsibility in relation to housing? In relation to food security? Income security? and health care access?

APPENDIX D

Demographic Questionnaire

1. What is your age:_____

2. How old are your children:

_____

3. What are your racial and ethno-cultural identities?

_____

_____

4. Where is your place of birth? _____

5. What is your source of income (circle one):
a) Employment
b) Ontario Works (OW)
c) Ontario Disability Support Program (ODSP)
d) Other
        If you circled 'other', please specify:
_____

6. Please indicate your education experience:
  a.   No formal schooling
  b.   Elementary school (grade 8 or less)
  c.   Some high school
  d.   High school diploma
  e.   College / Trade diploma
  f.   Some university
  g.   Bachelor's degree

  7. Have you been diagnosed with a mental illness?   YES   NO

  h.   What is your mental health diagnosis?

        _____

CURRICULUM VITAE

Name: Sarah Benbow

Post-secondary Education and Degrees:

Degree	Institution	Faculty	Dates
Doctor of Philosophy in Nursing – Leadership in Health Promotion	Western University	Faculty of Health Sciences, School of Nursing	2009-2015
Master of Science in Nursing – Leadership in Health Promotion	Western University	Faculty of Health Sciences, School of Nursing	2007-2009
Bachelor of Science in Nursing	Western University	Faculty of Health Sciences, School of Nursing	2003-2007

Honours And Awards:

1. **University of Western Ontario-University Student Council, Teaching Honour Roll,** Award of Excellence**,** 2013, 2012, 2011, 2010, 2009
2. **Recognition of Excellence in Teaching,** Faculty of Health Sciences, Western Ontario, 2013, 2012, 2011, 2010, 2009
3. **Ontario Graduate Scholarship Program (Total of $61 500),** 2010, 2011, 2012, 2013- with distinction
4. **Dr. Hildegarde E. Peplau Award ($1,000)** Registered Nurses Foundation of Ontario (RNFOO), Mental Health Nursing Interest Group, March 2012
5. **Travel Award** ($500) Faculty of Health Sciences, Western Ontario, 2011
6. **CNF Astra Zeneca Urban Scholarship ($6 000)**Canadian Nurses Foundation (for conducting nursing research to promote the health of marginalized urban groups in Canada), 2010
7. **Dr. Hildegarde E. Peplau Award ($1,000)**, Registered Nurses Foundation of Ontario (RNFOO)- Mental Health Nursing Interest Group, March 2010
8. **Clinical Nurse Specialist Education Award ($1,000)**, Registered Nurses' Association of Ontario (RNAO)- Clinical Nurse Specialist Interest Group, 2010

9. **Graduate Scholarship in Nursing ($10,000),** Arthur Labatt Family School of Nursing, Western Ontario (for highest academic achievement upon entry into the doctoral nursing program), 2009
10. **B. Eileen Kirkpatrick Memorial Scholarship ($2,000)**, Registered Nurses' Foundation of Ontario (RNFOO) (for pursuing graduate nursing research with focus on mental health nursing [MScN thesis]), 2009
11. **Graduate Scholarship in Nursing ($4 000)**, Joseph and Vera Byrne 125th Anniversary Alumni, Western Ontario (for highest academic achievement upon entry into the MScN program), 2008
12. **RNAO Nursing Education Initiative ($1,200)**, Registered Nurses' Association of Ontario (RNAO), 2008

Related Work Experience:

Dates	Organization/Institution	Department	Position
2015-present	Fanshawe College, London, ON	School of Nursing	Professor
2012-2015	Southwest Centre for Forensic Mental Health Care, St. Joseph's Health Care-St. Thomas	Forensic Psychiatry	Clinical Nurse Specialist; Officer-In-Charge
2007-2013	London Health Sciences Centre	Adult Mental Health Inpatient Unit	Registered Nurse (casual)
2008-2012	Western University	School of Nursing	Limited Duties Part-Time Lecturer
2007-2011	Regional Mental Health Care-London St. Joseph's Health Care	Specialized Adult London; Moods and Anxiety	Registered Nurse (casual)
2007-2012	Western University	School of Nursing	Graduate Research Assistant
2005-2007	Western University	School of Nursing	Research Assistant

Publications:

1. **Benbow, S.** (2009). Societal abuse in the lives of individuals with mental illness. *Canadian Nurse, 105*(6), 30-32.
2. **Benbow, S**., Forchuk, C., & Ray, S. (2011) Mothers with mental illness experiencing homelessness: A critical analysis. *Journal of Psychiatric and Mental Health Nursing.* doi: 10.1111/j.1365-2850.2011.01720.x
3. **Benbow, S.,** Hall, J., Heard, K., & Donelle, L. (2013). Conducting research with criminalized women in an incarcerated setting: the researcher's perspective. *Canadian Journal of Nursing Research, 45*(3), 80-91.
4. Montgomery, P., **Benbow, S.,** Hall, L., Newton-Mathur, D., Forchuk, C., & Mossey, S. (2014). Sheltering Aboriginal women with mental illness in Ontario Canada: Being "kicked" and nurtured. *Journal of Nursing Care, 3(*3). doi: 10.4172/2167-1168.100016
5. **Benbow, S.,** Rudnick, A., Forchuk, C., & Edwards, B. (2014). Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors. *Disability and Society, 29*(7), 2046-1060.
6. Donelle, L., Hall, J., & **Benbow, S.** (2015). A case study of the health literacy of a criminalized woman. *International Journal of Health Promotion and Education. 53*(4), 192-203.
7. **Benbow, S.,** Forchuk, C., Gorlick, C., Berman, H. & Ward-Griffin, C. (2015). Social exclusion and health: Nursing knowledge development. *Canadian Journal of Nursing Research, 47*(3), 56-72.

Book Chapters:
1. **Benbow, S.** (2012). Mothers experiencing homelessness in Canada: Intersections and strategies for support. In S. Lapierre & D. Damant (Eds.), *Regards critique sur la maternité dans divers contexts sociaux.* Quebec: Presses de l'Université du Québec.
2. **Benbow, S**., Terp, M., Ta'an, W., Haslap, M., & Forchuk, C. (in press). Mental health nursing standards: a global perspective. In E. Yearwood and V. Hines-Martin (Eds.), *Global Mental Health Nursing,* London: Routledge.