Involving Homeless Persons in the Leadership of a Health Care Organization

David S. Buck
Donna Rochon
Harriett Davidson
Sheryl McCurdy
Members of the CHANGE Committee of
Healthcare for the Homeless–Houston (HHH)

Consumer advisory boards (CABs) are a way of involving patients in their health care. To engage the homeless in the administration of a health care organization for the homeless, a service agency formed such a board comprising homeless and formerly homeless individuals. The purpose was to integrate experiences of homelessness into programmatic design and research efforts of the organization, and to promote participatory research among the homeless. A content analysis and member checking revealed four distinct themes relating to committee goals, identity definition, power, and issues and needs of the homeless. Findings indicate that participatory research provided a useful structure in which the CAB could improve self-sufficiency and self-efficacy, and contribute to the direction of the health care agency.

Keywords: *homeless; health care; participatory action research; qualitative analysis*

Historically, the low rates of participation of disadvantaged populations in community projects have been attributed to their lack of financial resources, which effects poor motivational levels (Boyce, 2001). Boyce has suggested that the tendency toward victim blaming, particularly of homeless individuals, has created structural influences and constraints on the participation of these groups. Some in the public health sector have proposed community participation as a means or a process leading to improved health status (Cohen & Syme, 1985; House, Landis, & Umberson, 1988); others have suggested that participation is a valued end or health outcome in and of itself (Oakley, 1989; Vuori, 1986). To achieve a productive level of participation, many organizations have begun to rely on the input of consumers to

AUTHORS' NOTE: This research was supported in part by an Advanced Research Training grant awarded to Dr. Buck from the American Academy of Family Physicians. We would like to acknowledge Stephen Pierrel, Ph.D., for his invaluable contribution as facilitator of the CHANGE Committee meetings and Pamela Paradis Tice, E.L.S.(D.), for her skillful editing of and feedback about the manuscript; both are with the Department of Family and Community Medicine, Baylor College of Medicine. We would also like to acknowledge Dr. Ann C. Macaulay's generous guidance and support during formulation of this project.

QUALITATIVE HEALTH RESEARCH, Vol. 14 No. 4, April 2004 513-525
DOI: 10.1177/1049732303262642
© 2004 Sage Publications

guide service provision. Although the degree of participation and input into the daily operations of community-based agencies, health care providers, and mental health agencies varies, community or consumer advisory boards (CABs) are now a common vehicle by which the community's interests in program decisions and direction can be conveyed to governing boards.

As CABs can closely reflect the views of the communities they represent, attention to members' differences in sociodemographic and health care experiences with the community might strengthen their role even more (Conway, Hu, & Harrington, 1997). CABs can ensure continued and systematic evaluation of health services, treatment programs, and staff effectiveness (Morrison, 1978). Particularly since the advent of the AIDS epidemic, CABs have even begun to offer advice on the research agendas and clinical trials conducted by major federal health agencies and large pharmaceutical companies (Cox, Rouff, Svendsen, Markowitz, & Abrams, 1998).

Despite the large body of research on the involvement and mobilization of consumers in their health care and social service delivery, not all researchers have embraced CABs, nor have CABs been entirely successful in every setting. Boote, Telford, and Cooper (2002) identified seven main areas in which objections have arisen: representativeness, quality, bias, influence, consumers' expectations, increased cost and length of research, and overlapping roles. Similarly, Goode and Harrisone (2000) identified several "significant barriers" that arose when launching participatory groups among minority populations. First, some members of racially and ethnically diverse groups shunned participation in research studies because of historical mistrust due to past experiences with racism, bias, or exploitation in health care delivery systems. Second, some diverse communities have not benefited equitably from their participation in research. Third, differing values and social, cultural, religious, and spiritual beliefs related to health might have inhibited or prevented certain individuals and groups from participating in research protocols and studies. As a far more disenfranchised group, community participation of the homeless as consumers of services has been limited to their involvement as peer counselors in health promotion, health education, or mental health programs (Chinman, Rosenheck, Lam, & Davidson, 2000; Henman, Paone, Des Jarlais, Kochems, & Friedman, 1998; Lyons, Cook, Ruth, Karver, & Slagg, 1996).

Most researchers agree that objections to and the shortcomings of CABs can be addressed by initiating systematic research into the effectiveness of consumer involvement in the research process (Boote et al., 2002). A study from the consumer's point of view delineated three issues that appear to be important for successful participatory interactions: trust between the consumer and researcher; reward for the consumer's involvement; and sharing of research findings with the consumer group (Davis, 1990).

PARTICIPATORY ACTION RESEARCH

PAR is a process that incorporates "systematic inquiry, with collaboration of those affected by the issue being studied, for the purpose of education and taking action or effecting social change" (Green et al., 1995, p. 4). The three primary features of PAR are collaboration between the researchers and the community, mutual education, and the production of local knowledge to improve interventions or practices

(Green et al., 1995). The goal is to facilitate the ownership of the research process by the community so that its members can use the results to improve their quality of life (Israel, Schulz, Parker, & Becker, 1998).

As an empowerment tool, community participation entails both the development of management skills in consumers and the ability to make decisions that affect their own lives (Boyce, 2001). Boyce has cited Segal, Silverman, and Temkin (1995) as suggesting that "the concept of empowerment assumes an element of equity with respect to participation in the social issue at hand and is also tied to specific activities, rather than being generalized in an 'empowered state' " (p. 1553). Especially in disadvantaged communities, PAR helps with self-empowerment by removing barriers and promoting environments within which communities can increase their capacity to identify and solve their own problems (Macaulay, Commanda, et al., 1999).

Traditionally, health care providers have used a strictly clinical framework to evaluate a patient's illness in relation to his or her individual behavior. By drawing on the experiences of the affected population, AR provides a way to respond to health issues within a social and historical context (Macaulay, Commanda, et al., 1999). PAR tries to include the community in every aspect of the undertaking, from determining what the problem is, to evaluating the solutions, to eventually disseminating information about it. This type of research increases the likelihood that health programs will be successful over time, improves the cultural appropriateness of the intervention, promotes socioeconomic development, and transfers relevant skills and knowledge to community members (Macaulay, Delormier, et al., 1998).

PURPOSE OF THE STUDY

Recognizing the need for drastic improvements in the delivery of health care to the homeless in Houston, Texas, local homeless service agencies began meeting on a regular basis in May 1999 and formed a consortium of 26 organizations and health care providers dedicated to the provision of comprehensive, coordinated health care for the homeless. Known as Healthcare for the Homeless–Houston (HHH), this consortium coordinates primary health care services at local homeless shelters using a biopsychosocial model that includes psychiatry and mental health counseling, health education, and information about and referral to other homeless service providers.

The people who benefit directly from the comprehensive health care services offered by and through HHH are the homeless men, women, and children of Houston. The primary focus is to reach homeless individuals who have no other resources (money, insurance, city or county services, Medicaid, or other benefits) and to provide health care while assisting them in connecting or reconnecting with established sources of care, for which many are eligible. In 2002, approximately 2,655 unduplicated clients were cared for at HHH sites, for a total of 15,518 patients' visits during the same year. Most patients were African American men (56%) between the ages of 30 and 44 years. Most (32%) had at least a high school diploma or higher, and many (60%) were currently single. Eighteen percent were veterans. Their most common medical conditions were upper respiratory infections, hyper-

tension, fungal infections, and diabetes, most of which require regular, uninterrupted treatment. Between 34% and 40% of the patients also had substance abuse problems and severe mental illness.

In this descriptive study, we summarize the preliminary findings of a program in which the homeless were involved in the administration of HHH. The purpose of the program was to integrate experiences of homelessness into programmatic design and research efforts, and to promote community-based PAR among the homeless in Houston. This article contributes to the literature on the homeless by expanding our understanding of the role of the homeless in the political process and explaining how one might involve the homeless in an active, participatory project with tangible outcomes.

METHOD

In 2001, the leadership of HHH approached its advisory council to identify appropriate homeless individuals who could serve on a CAB. Clinicians were also asked for names of patients they thought might be interested in serving. The CAB's proposed function was to serve in an advisory capacity to the HHH board of directors with the same standing as the board's executive, finance, and development subcommittees. Its overall purpose was to make recommendations to the board about direct client services and to guide the research agenda of HHH.

The first meeting occurred in October 2001, and any homeless person who attended that meeting became a de facto member. The medical director–president of HHH and a clinical psychologist facilitated this and subsequent meetings to keep the group focused. Breakfast was supplied at each meeting as a small incentive. Five of the original members were homeless individuals who were still on the street or were staying in a transitional living facility; two had found housing and jobs. Of the 7 persons who regularly attended meetings over the 8-month period, there were 2 African American men, 2 African American women, and 3 White men.

CONTENT ANALYSIS

Three independent qualitative researchers (a historical ethnographer, a nurse, and a public health researcher) performed a content analysis on the CAB meeting agendas, minutes, and transcripts. Discourse analysis, in which documents are read and reread so that important issues can be highlighted (Holloway, 1997), began with a verbatim transcription of committee meetings proceedings and a close examination of other related documents (i.e., agendas and minutes). Inductive analysis involved the derivation of themes and constructs from the data without imposing a prior framework. In keeping with this methodology, the researchers coded the committee meeting transcripts, looking for relationships and regularities in the content that arose during eight meetings that occurred between October 2001 and May 2002. We decided to begin data analysis after only 8 months, because the CAB had reached a point of self-sufficiency and had made several sound organizational decisions. We were confident that future meetings could be conducted without focusing on administrative detail.

As a way of examining the data from different perspectives, we triangulated the results of the coding process with agendas and minutes, as well as with members of the CAB, to validate the findings. The final phase of the analysis involved cross-checking with the CAB members to verify the findings and interpretations of the researchers, a method commonly referred to as member checking. This gave members the opportunity to comment and indicate whether they recognized their own experiences in the analysis.

This project was submitted to the Baylor College of Medicine Institutional Review Board and approved. The CAB adhered to the proposed guidelines for PAR as delineated by Green et al. (1995) and as described above. There was active collaboration between the researchers and the homeless community: CAB members acknowledged on tape at the start of every meeting that they were aware that the meetings were being audiorecorded, that the transcripts of the meetings would be analyzed for research purposes, and that they would be given the chance to provide further feedback.

RESULTS

Based on the content analysis and the triangulation of committee documents, several patterns emerged that directly reflect the goals of successful PAR, namely that the individuals involved actively participate in the process and that concrete, measurable outcomes occur. Four distinct themes surfaced. The first three (Committee Goals and Member Roles, Identity Definition, and Power Issues and Power Hierarchy) relate to process, whereas the last (Issues and Needs of the Homeless) addresses more directly the purpose of the CAB and outcome issues.

Committee goals and member roles. As would be expected, much of the time spent in the initial CAB meetings was devoted to establishing the rules and practices by which this new committee would operate. This process included such things as setting meeting times and location; determining the committee's mission and goals; and formulating the criteria for committee size, attendance, and membership. As early as the second meeting, CAB members had agreed that in their role as a standing HHH committee, they should do the following: critique and give feedback to the Advisory Council; present homeless issues to the board and the public; offer suggestions and ideas for improvement; serve as a voice for the homeless; and advocate for change in the service delivery system. Within 6 months (by March 2002), members had further refined the administrative details about who would be responsible for taking minutes and preparing the agenda; the choice of a homeless representative for the HHH executive committee and a decision to hold longer meetings came during the eighth meeting. The CAB seemed particularly capable of making significant organizational decisions in a timely manner, an occurrence that struck the researchers as unusual, given that the homeless tend to lack experience serving in leadership roles and are considered to be a generally disempowered group, with little structure in their lives because of transience and mental instability (Burt, Aron, Lee, & Valente, 2001).

CAB members quickly recognized that one of their long-term goals should be to try to facilitate the integration of all social services for the homeless to improve

access to available services and health care. They also agreed that it would be necessary to work with service providers to expand the options for health, housing, training, and job placement for homeless persons. Short-term goals included finding a way to motivate the homeless to return for follow-up health care appointments after making a "quick fix" visit for their immediate problems. One CAB member suggested that obtaining supplemental financial support would ensure that "a task is followed through," that is, that increased funding for care and case management services would provide the infrastructure necessary to improve follow-up rates. Another CAB member recommended that it would be helpful to have someone available to answer questions for those who return for follow-up and pointed out that these patients want to believe that "someone is out there to help them."

The general overriding principle, articulated at the first meeting by one of the eventual "leaders" of the group, was to "focus on today through tomorrow," a directive to the assembled group to refocus their efforts to plan for the future rather than living only for the present. As was expressed repeatedly throughout these meetings, many homeless individuals often feel defeated, that "they are always going to be homeless," that they have no future. The ongoing challenge for the CAB was to show other homeless persons that "you don't have to stay there [remain homeless]. If you choose to stay there, if you don't have goals to move from this, you won't move from it." They believed that by focusing on today, taking small steps, and accomplishing attainable goals, one could move toward the future. In keeping with this idea, committee members agreed, after several months of discussion, to call themselves the CHANGE Committee. The acronym stands for Compassion, Hope, Achievement, New life, Greatness, and Excellence.

Identity definition. As a result of participating in the committee, and possibly as an effect of the participatory process, CAB members have begun to develop a new identity for themselves, both as individuals and as a group. In the early meetings, there was considerable discussion among members about whether they should speak for all homeless people or only for those who had changed their circumstances. The debate centered on the fact that most of the individuals serving on the CAB had, in some way, improved their situation and were working to enhance their living conditions. Given this fact, many of the CAB members felt that it would be inappropriate to present themselves as experts on homelessness, because that would involve speaking for those individuals who remained homeless and might not actively seek to "get off the street." One of the members expressed this feeling by asking, "Are we experts on homelessness or are we homeless persons?" Most agreed that they were simply homeless persons and that identifying themselves as experts would be misguided.

Another recurrent theme was the fear of being identified forever as a homeless person. CAB members were, for the most part, quick to separate themselves from those individuals who were less proactive about changing their status. Members agreed that the "homeless" label could create a self-perpetuating cycle that would be difficult to leave behind. For example, if staff at the various clinics and service providers continually remind clients seeking services that they are homeless—through innuendo, comments, or attitude—it can create a feeling that is best summarized as "once homeless, always homeless." To mitigate this, the members

believe that clients must be made to feel that there is someone who is willing to listen to what their immediate problem is and to help them find ways to remedy it.

Bolstering the argument for PAR, the CAB members reiterated several times at the meetings that they did not want to be research subjects. As one member said, "The less this group feels like test subjects, the better the results. [There should be] interaction with a specific and small group of researchers. Don't bring in the resident of the week." After years of being studied, these homeless people stressed that they "are tired of being guinea pigs" and being made to feel that their contributions to these studies have been ignored.

Power issues and power hierarchy. From the researchers' viewpoint, the most interesting theme to surface from the transcript analysis was the issue of power. This particular group of previously homeless individuals organized the currently homeless into a two-tier classificatory system: those who want to change their status and those who want to remain homeless. Within the group who want to remain homeless, there is a self-imposed hierarchy in which the homeless grade each other. Contained within the homeless population of Houston, there are the chronically homeless, those individuals who have been homeless for a long time and make no attempts to change their circumstances; the newly transient, people who were domiciled or employed, and have only recently become homeless; and the transitory, those people who were either domiciled, employed, or chronically homeless but who now move around continuously from shelter, to street, to shelter. According to CAB members, the chronically homeless rank the lowest in this classificatory system. The unspoken implication is that those individuals who do not fit into any of these three categories are at the top of the tier, because they have moved out of the cycle of homelessness.

CAB members' attitudes about these differences over class structure extended into a debate over who should be recruited to participate on the committee and who would be considered an inappropriate nominee. If an individual is chronically homeless, as characterized by CAB members through a fairly arbitrary set of criteria, then that person "most probably won't have any interest in coming to this committee or getting involved with any board or with any staff beyond what they have to." Furthermore, this type of person might be interested in promoting only those services and programs that make it easier to remain homeless (e.g., soup kitchens, a laissez-faire attitude about dumpster diving, or infrequent enforcement of vagrancy laws).

Although there had been several discussions during previous meetings about the attitudes of staff at shelters and service agencies and the way they treat homeless people, labeling shelter staff as "the enemy" emerged only during the last meeting. The sentiment was strong: CAB members agreed that agency personnel do not know how to talk to people. Even though some staff have come from situations in which they were homeless or have stayed in shelters, they seem to have "forgotten where they came from." One member felt that although some staff are not good at interacting with homeless clients, "that kind of limits you, because if that's the enemy, how can you go to them and say 'I need help' . . . Because they know that you look at them as the enemy, they are already on their guard." The eventual consensus was that shelter staff needs to know how the other side—the currently homeless—

feels, and service providers need to be educated or reminded about the issues faced by homeless people to change these prevailing attitudes.

Issues and needs of the homeless. The most relevant category with respect to primary health care for this population that emerged during 8 months of meetings was a long list of specific needs and issues that directly affect the homeless and are common to most health care delivery programs. In terms of services, CAB members cited the need for more clinics in different parts of the city and outside the city limits; extended clinics hours, including evenings and weekends; and transportation to and from clinics, shelters, and service agencies.

The topic most often mentioned was the need for respect from clinic, shelter, and agency staff. One member, referring to comments he had heard from other homeless individuals, said, "They have been treated so badly and so dehumanized." Because of this prevailing attitude, many homeless persons have maintained that they would rather not seek care or go to a shelter. CAB members also expressed the requirement for homeless people to feel that they have a voice with which to express their concerns and request adequate care. One member suggested that the committee go to shelters "so that we can have some interaction with them [the homeless]. . . . We would get out there and come back with what we've learned." CAB members also noted a need for a balance between security and freedom, that is, feeling safe from abuse and violence, as there is a high incidence of both among people living on the streets.

In addition, the homeless who access services and use shelters want to have some freedom to move around and not be constrained by numerous restrictive rules. For example, some of the shelters require residents to stay through the night, and if someone leaves, he or she cannot reenter the shelter that evening; others require residents to attend religious services. One member commented that individuals "don't like being locked up or whatever and they're not going to go to that type of place." Another suggested, "Instead of [the shelters] forcing them to go to the chapel for two hours, why don't you give them an hour for the clinic?"

Organizational outcomes. CAB members produced a mission statement during their fourth meeting. The consensus was "to provide insight into the needs of the homeless, their priorities and the relationship between those needs/priorities and health care services." They decided that the first project to be coordinated and carried out by members of the group would be to disseminate information about services for the homeless at area shelters. To that end, they decided to construct, with the help of an Eagle Scout volunteer and his troop, wooden display boards on which such information can be displayed at shelters, agencies, and clinics throughout the city.

In a collaborative effort, CAB members have given the researchers feedback on various projects and proposals undertaken by HHH. In addition to comments on this PAR project, they provided advice on a city-funded bus route with service to homeless service agencies and helped design information boards to publicize the availability of clinic services. They also commented on the content and style of a poster presented at the National Health Care for the Homeless Conference in Chicago and suggested that the importance of mental health services for the homeless receive greater attention. They provided input on intervention specifics for a

federally funded health care grant and suggested a study on the prevalence of West Nile virus among Houston's homeless population. As part of an effort to contribute to the direction of major research and clinical efforts, they have offered suggestions for better goal-directed care through the health clinic at HHH.

Substantial administrative outcomes made by the CAB during their first 8 months of operation include (a) the drafting of a mission statement, (b) the decision to hold longer meetings, (c) the establishment of prerequisites and guidelines for committee membership, (d) assuming responsibility for minute taking and agenda setting, and (e) the creation of an orientation package for new committee members. Member actions that constituted participatory action, as observed by the researchers and experienced by the CAB members, included (a) an increased comfort level in giving and receiving opinions, (b) development of inquiry skills, (c) improved proficiency in planning actions and in managing relationships, (d) developing the ability to introduce issues and frame problems, and (e) achieving proficiency in modeling the inquiry process. As a result of these things, HHH and the researchers agree that this initial attempt to build a CAB using the principles of PAR has been successful.

DISCUSSION

The use of PAR concepts and methodology by the CAB and HHH has provided a useful structure for the creation and continuation of a CAB. Each of the three criteria for a successful outcome was met:

- Collaboration between the researchers and the community was achieved through member checking to confirm the data interpretation. This fostered communication and helped build trust between CAB members, the research team, and the HHH staff.
- Mutual education occurred when members became better informed about how governing boards operate and what research projects entail. HHH is learning about the specific needs of the homeless population.
- The production of local knowledge to improve interventions or practices was initiated by designing placards with information about services for the homeless.

What has become evident is that in this case, the CAB is part of the solution to the problems of the homeless in Houston rather than merely being consumers of services. This suggests that participation in a CAB created within a PAR framework can improve homeless individuals' self-efficacy and self-sufficiency.

The main limitation is that these results are not generalizable to all homeless populations, because this study was conducted in a large urban center in the southwestern United States. Selection bias might also be a factor, because the CAB members, by their very participation, are probably not representative of all homeless people. It is possible that they are more empowered to begin with than other homeless people. Nevertheless, Macaulay, Commanda, et al. (1999) have suggested that certain results from a PAR project—for example, new findings and procedures for developing CABs and partnerships—are transferable and applicable. At the very least, such a project would increase local knowledge, self-empowerment for the homeless, improved health outcomes, and community planning.

The process of member checking revealed a potential shortcoming in PAR methodology, namely, that it can lead to disparate conclusions. CAB members reviewed the researchers' findings based on personal recollection, not on verbatim transcriptions of the meetings. The issues that they remembered as being important for the homeless were different from what actually emerged during the content analysis of the taped conversations. For instance, mental illness is considered by researchers to be a major problem for homeless individuals. Many people are homeless because they suffer from some form of mental illness, and they remain homeless because their mental health problems go untreated. The problem of mental illness was alluded to at different times and in a general sense in the CAB meetings; reference was regularly made to someone who was "crazy" or "had a lot of mental problems." Mental illness as a specific topic, however, was not mentioned explicitly during any of the meetings and, therefore, did not emerge as a recurrent theme in the content analysis.

This gap between the clear patterns that emerged during the content analysis versus what CAB members thought to be important resulted because the analysis was based on actual conversations, not on ideas or concepts. This disparity is significant, because it typifies the shortcomings of member checking (Holloway, 1997). First, it is difficult for participants to be objective about the interpretations made by the researcher. Second, participants rely on their memory and might not remember or recognize the meaning that they assigned to a discussion a particular time. Recall, in this context, might be a matter of thinking retrospectively in broad concepts rather than about specific issues as they were addressed at a particular time. Finally, because some time usually elapses between data collection and member checking, participants might give a different interpretation to the phenomenon under study. Ultimately, there are layers of involvement that produce different explanations. In this case, the layers involve the homeless, the clinicians who treat them at the clinics, and the researchers who conduct the analysis.

The final intriguing development is that interest in CAB meetings by homeless persons seemed to wane over the 8-month period we studied. At times, attendance dropped to as few as two of the original members, and input of ideas and suggestions was low. We questioned members about why they had missed a meeting, and they cited the following as barriers to participation: (a) difficulty paying for transportation to the meeting site; (b) inflexibility because of new job requirements; (c) competing needs of food and shelter; (d) residency in a shelter outside of the city limits; and (e) child-care responsibilities. Time was spent in several meetings discussing methods for encouraging attendance. In addition to breakfast, which we provided each time, members suggested offering monetary incentives, posting notices on the bulletin boards of service agencies, and e-mailing members if they had computer access through the shelters. The HHH staff assistant routinely called the agencies from which CAB members were receiving services and left reminder messages about meeting times and dates.

This flux in meeting attendance might be another indication that the principles of participatory action are working. After living with the sense of failure and shame that is intrinsic to homelessness, participants have had the opportunity to develop their personal and professional skills and have assumed a certain amount of responsibility for the actions of the group. These qualities and processes have directly affected their self-confidence, not only during the CAB meetings but also in other areas of their lives. In fact, several members have found jobs, and others have found

stable housing. One male CAB member managed to save enough money to get an artificial limb, which has given him the ability to walk again. Because the ultimate purpose of any PAR program is to empower individuals to take control of their lives, we can conclude that some members of the CAB feel that they no longer have as great a need for the positive reinforcement and associative experience that committee membership provided.

IMPLICATIONS

Because homelessness is a social problem often confounded by health problems, identity issues, and the need for a comprehensive treatment model, providing health care to the homeless must be considered from a complex, multidimensional perspective. Consumers of homeless services have experienced failure with most care systems and institutions to a degree unmatched by most other socioeconomic groups. For example, the most common precipitant of homelessness among women is abuse, and many homeless women have experienced the legal and health care systems as unresponsive. Veterans, the largest single group of homeless men, have access to a comprehensive health care system unavailable to other homeless individuals, but many homeless veterans experience it as inaccessible. In our study, we used PAR to bring homeless individuals into social roles in which they felt inept: They became part of a group (the CAB), which is part of an institution (HHH), which is part of the larger health care system.

Before 1996, homeless individuals were not considered to be suitable participants for CABs (Policy Research Associates, 2001). The rationale was that they are disenfranchised, believe themselves to be powerless, and generally experience encounters with authority figures as unsuccessful. We believe that these are the very reasons why they should be sought after most vigorously. Participation would facilitate learning about group interaction, help develop planning skills, and allow the building of cooperative management expertise. Such skills would offer the homeless an opportunity to see how organizations work and how they can work within systems, thereby enhancing their self-efficacy.

The primary areas for intervention over the long term, as derived from the analysis of qualitative data, are the integration of health care and social services; the expansion of options for health, housing, and job placement; and the addition of more service providers who are more patient centered and sensitive to the health care needs of the homeless. Central to realizing these goals is the creation of more clinics with extended hours and a transportation program that would facilitate access.

CAB members enumerated two outcomes that might be attainable over the short term. The first is a better follow-up system that brings clients back to the clinic after their initial visit. This will be made easier with the launch of the new bus route and through the hiring of a case manager to track patients. The second is making clients feel that there are people who are willing and able to help them with their immediate problems, whether those problems are related directly to their health or indirectly to their quality of life. Goal-directed care, in which the patient decides with the clinician which health problem he or she wants to address, would afford the homeless patient some modicum of control over his or her own health outcomes.

In the case of quality of life, it is necessary to refer back to the identity and power issues that were such prevalent themes during committee meetings (i.e., chronic homelessness and the hierarchy of homelessness, disrespect from shelter staff, status as "experts" and research subjects). The apparent self-denigrating outlook on chronic homelessness might reflect the notion that committee membership offers power sharing and status, conditions that are inherent in the PAR model and that probably should materialize if the model is working. The negative attitudes of service providers can discount a homeless person's ability to make decisions, which, in turn, can affect a person's health if the decision is left unmade or is made late. Furthermore, the hostility between the homeless and service providers could reflect a level of inherent resentment that some homeless individuals have toward staff because of the power that the latter now have over their clients. This antagonism can fairly easily be remedied, and at a reasonable cost, through the provision of staff education programs and in-services, as well as cultural sensitivity training on the experiences of the homeless.

Although it is certainly true that more research is required on the needs of the homeless and on which outcomes should be targeted, it is important to remember that the homeless, like many disenfranchised populations, have come to feel like nothing more than research subjects in an arena with few outcomes. As a countermeasure, PAR can keep research practical, focused, and intimate, and prevent participants from feeling like guinea pigs. Action research should be not researcher driven but collaborative. By continuing with the analysis of committee meeting transcripts, member checking at every step, and increasing the advocacy roles of the members, homeless consumers will have the opportunity to develop a greater sense of ownership in the overall research process and can feel proud of their role in and responsibility for any successful outcomes.

REFERENCES

Boote, J., Telford, R., & Cooper, C. (2002). Consumer involvement in health research: A review and research agenda. *Health Policy*, *61*(2), 213-236.

Boyce, W. F. (2001). Disadvantaged persons' participation in health promotion projects: Some structural dimensions. *Social Science & Medicine*, *52*(10), 1551-1564.

Burt, M., Aron, L. Y., Lee, E., & Valente, J. (2001). *Helping America's homeless: Emergency shelter or affordable housing?* Washington, DC: Urban Institute Press.

Chinman, M. J., Rosenheck, R., Lam, J. A., & Davidson, L. (2000). Comparing consumer and non-consumer provided case management services for homeless persons with serious mental illness. *Journal of Nervous & Mental Disease*, *188*(7), 446-453.

Cohen, S., & Syme, S. (1985). *Social support and health*. Toronto, Canada: Academic Press.

Conway, T., Hu, T. C., & Harrington, T. (1997). Setting health priorities: Community boards accurately reflect the preferences of the community's residents. *Journal of Community Health*, *22*(1), 57-68.

Cox, L. E., Rouff, J. R., Svendsen, K. H., Markowitz, M., & Abrams, D. I. (1998). Community advisory boards: Their role in AIDS clinical trials. *Health and Social Work*, *23*(4), 290-297.

Davis, A. (1990). Who needs user research? Service users as research subjects or participants: Implications for user involvement in service contracting. In M. Barnes & G. Wistow (Eds.), *Researching user involvement* (pp. 33-46). Leeds, UK: Nuffield Institute for Health Services Research.

Goode, T. D., & Harrisone, S. (2000). *Cultural competency in primary care: Partnerships for a research agenda* (Policy Brief 3). Washington, DC: Georgetown University Center for Child and Human Development, National Center for Cultural Competence.

Green, L. W., George, M. A., Daniel, M., Frankish, C. J., Herbert, C. J., Bowie, W. R., et al. (1995). *Study of participatory research in health promotion*. Ottawa, Canada: Royal Society of Canada.

Henman, A. R., Paone, D., Des Jarlais, D. C., Kochems, L. M., & Friedman, S. R. (1998). Injection drugs users as social actors: A stigmatized community's participation in the syringe exchange programmes of New York City. *AIDS Care*, *10*(4), 397-408.

Holloway, I. (1997). *Basic concepts for qualitative research*. Oxford, UK: Blackwell Science.

House, J., Landis, K., & Umberson, D. (1988). Social relationships and health. *Science*, *241*(4865), 540-545.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Reviews of Public Health*, *19*, 173-202.

Lyons, J. S., Cook, J. A., Ruth, A. R., Karver, M., & Slagg, N. B. (1996). Service delivery using consumer staff in a mobile crisis assessment program. *Community Mental Health Journal*, *32*(1), 33-40.

Macaulay, A. C., Commanda, L. E., Freeman, W. L., Gibson, N., McCabe, M. L., Robbins, C. M., et al. (1999). Participatory research maximises community and lay involvement. *British Medical Journal*, *319*(7212), 774-778.

Macaulay, A. C., Delormier, T., McComber, A. M., Cross, E. J., Potvin, L. P., Paradis, G., et al. (1998). Participatory research with native community of Kahnawake creates innovative code of research ethics. *Canadian Journal of Public Health*, *89*(2), 105-108.

Morrison, J. K. (1978). The client as consumer and evaluator of community mental health services. *American Journal of Community Psychology*, *6*(2), 147-155.

Oakley, P. (1989). *Community involvement in health development: An examination of the critical issues*. Geneva, Switzerland: World Health Organization.

Policy Research Associates. (2001, April 17). *Client participation in HCH governance yields responsive programs*. Retrieved March 17, 2003, from http://www.hchirc.com/newsletter/july_98_a.asp

Segal, S. P., Silverman, C., & Temkin, T. (1995). Measuring empowerment in client-run self-help agencies. *Community Mental Health Journal*, *31*(3), 215-227.

Vuori, H. (1986). Community participation in primary health care—A means or an end. In H. Vuori & J. E. F. Hastings (Eds.), *Patterns of community participation in primary health care* (pp. 1-17). Copenhagen, Denmark: World Health Organization Regional Office for Europe.

David S. Buck, M.D., M.P.H., is an assistant professor of family and community medicine, Baylor College of Medicine, Houston, Texas.

Donna Rochon, M.A., is a research associate in family and community medicine, Baylor College of Medicine, Houston, Texas.

Harriett Davidson, M.A., is an associate professor at Texas Woman's University, Houston, Texas.

Sheryl McCurdy, Ph.D., is an assistant professor at University of Texas Health Science Center Houston School of Public Health, Houston, Texas.