Advances in Applied Sociology
2013. Vol.3, No.1, 61-68
Published Online March 2013 in SciRes (http://www.scirp.org/journal/aasoci)
http://dx.doi.org/10.4236/aasoci.2013.31008

Outside the Cage: Exploring Everyday Interactions between Government Workers and Residents in a Place-Based Health Initiative

Naomi Sunderland
School of Human Services and Social Work, Griffith Health Institute, Griffith University, Meadowbrook, Australia
Email: n.sunderland@griffith.edu.au

Received October 15th, 2012; revised November 20th, 2012; accepted November 30th, 2012

This paper presents an ethnographic case study of the daily lived experience of place by government health and community workers in a place-based chronic disease initiative (PBI) located in a disadvantaged peri-urban area in Australia. The case study focused on the place at which the PBI staff members interfaced with the community informally as opposed to the deliberate interactions described in the formal community engagement strategy. Subtle social phenomena, such as social positioning and the contrasting cultures of bureaucracy and community, generated outcomes that were the antithesis of those sought by the PBI. If these characteristics of place are not attended to during the development of PBIs, we risk recreating existing social divides and jeopardizing the potential of these initiatives to build community capacity. This case study provides an important conceptual-theoretical understanding of the place-based approach, which can augment existing empirical studies of place. The findings are also relevant for those who are exploring the physical co-location of diverse professional groups in socially disadvantaged neighbourhoods. It also exposes the inherent complexity of "place" and the futility of poorly designed bureaucratic responses.

Keywords: Place-Based Initiative; Bureaucracy; Community; Culture; Habitus; Proximity; Ethnography; Lived Experience

Introduction

The district manager of the government health district is sitting working in his office. He hears a commotion and yelling from outside the eastern wall of his office which is made entirely of glass and partially covered by blinds. He looks out to see a man smashing his female companion's head against a brick wall on the walkway outside the office. The district manager runs outside through the secured sliding glass doors of the building to intervene. A female colleague who worked in the office at the time said, "There was nothing else he could do!"

A female researcher and a female government employee are walking to their car following a meeting at the government office, which is located in the same building as several community services (i.e., child protection, probation and parole, rehabilitation, and employment services). As they walk to their car, they see a group of young men in "street" clothing leaning against a brick wall talking. The young men do not look at the women. They keep talking to each other as the women approach. The government employee says to the researcher, "Should we cross the road, these guys might be chroming[1]".

Program leaders and the Manager of a place-based health coalition are having a formal monthly team meeting inside the government building. The program leaders are all employees of the government health department. They are wearing semi-formal corporate style clothing suitable for office work and public meetings. The meeting room features a long boardroom table. An eastern wall made entirely of glass overlooks a walkway that circles the building and contains entrances to the various community services in the building. There is a commotion and swearing outside the meeting room. The PBI Manager says, "Are those unhappy people outside?" Another of the meeting participants leans over and closes the blinds. Several of the people outside stare into the meeting room as he closes the blinds.

A female researcher, a government health promotion officer and the PBI Manager are conducting formal interviews for a team leader position in the PBI when a child screams. The screaming continues and intensifies, "Daddy, Daddy, I don't want to go". Looking out the boardroom window, the occupants watch as a child safety worker carries the screaming child into the office next door and locks the security doors. Two other child safety workers hold back the father who eventually throws up his hands and walks away. The boardroom is silent for a few more minutes, followed by some discussion about how this is a regular occurrence. The interviews continued.

Increasingly it is clear that people's health and wellbeing is determined not by individual actions alone but by complex individual, social, political, economic, and environmental determinants of health (CSDH, 2008; Marmot et al., 2010; Schulz & Northbridge, 2004). Strategies for addressing these complex "social determinants of health" (SDOH) have been recognised internationally both as a way of preventing ill health in the future and addressing pervasive health inequities between people who experience positive social circumstances and those

[1]"Chroming" is a colloquial term for sniffing substances in aerosol cans.

who do not (CSDH, 2008; Marmot et al., 2010). Researchers have shown that health advantage or disadvantage tends to cluster in distinct geographical areas due to localised social and environmental factors such as the affordability of housing and other services such as transport; cultural, socio-economic, and physical mobility; and the presence of supportive social networks and relationships (see for example, Baum & Palmer, 2002). As a result, policy makers have developed a string of government funded "place-based" initiatives (PBIs) or "health action zones" (see for example, Bradford, 2005) that are designed to tackle place based SDOH. These PBIs attempt to effect positive change across complex SDOH such as healthy public policy, built environments, pollution, access to facilities and services, income and employment, crime, and social inclusion (Schulz & Lempert, 2004; Schulz & Northbridge, 2004).

While there is growing support for PBIs internationally, there is less acknowledgement of the inherent complexity of implementing PBIs in neighbourhoods that experience significant social and economic disadvantage and diversity. In particular, there is little discussion of the challenging nature of place based work for health promotion workers. The purpose of this article is hence to examine the nature and reality of PBIs from the perspective of the health promotion workers who implement them. To do this, I present an ethnographic case study of interesting and unexpected social interactions and boundaries between government PBI workers and local community members at a government service building in a peri-urban PBI targeting chronic disease in Australia. I draw on a range of theoretical concepts from existing literature to aid in interpreting the phenomena encountered during the case study that may in turn usefully inform future PBIs (Farmer, Munoz, & Threlkeld, 2012: p. 185).

Background

In parallel with international PBI policies and investments, researchers across the fields of social geography, urban and community studies, sociology of health, and health promotion have developed innovative theory and methods to examine the deterministic relationship between place and health (see for example, Brodsky, 1996; Carpiano, Kelly, Easterbrook, & Parsons, 2011; Caughy, O'Campo, & Patterson, 2001). Farmer and colleagues (2012) for example, adopted social geography theory to emphasise the heterogeneity and dynamism of places that health planners and researchers often label using misleading static and homogenising categories such as "peri-urban", "regional", and "remote". Farmer et al. (2012) argue instead for a dynamic conception of place and health that understands "place" as the crossing in time and space of various forces and flows (including people, economic opportunities, natural resources, social assets, politics, cultural mix, infrastructure and history), and so as defined not only by the local but also by relatedness to other places.

Such a conception of place and health is obviously amenable to the complex SDOH view of health in international policy. Following Massey (2005), Farmer et al., (2012) further emphasise the "throwntogetherness" of place that "unites a host of human and nonhuman features in time" including "people and health services, and also family, work and social networks, local and distant community and business organisations, government, policy and regulatory arrangements" (p. 187).

Broader literature on space and place emphasises that people participate in places and spaces for different reasons and with differing levels of familiarity and connection (Tuan, 1977: p. 6). Likewise, the social relations that comprise places "are never still; they are inherently dynamic" (Massey, 1999: p. 2). As such, people may have both complex and ambivalent feelings about place (Tuan, 2005: p. 7). In shaping and being shaped by our experiences, places become interwoven with individual and collective identity and belongingness where "people collectively imbue physical space with meaning that transforms it into a socially and emotionally significant location—a "place" (Hochschild Jr., 2010: p. 622). Likewise, place identities are created and recreated through "meaningful social interaction and interconnectedness at the locale" (Hochschild Jr., 2010: p. 622). "Cultures of place" then are not universally shared experiences for all people who frequent a place but, rather, general *patterns* of relating and experience that lead to shared meaning making (Martin, 2002: p. 112).

Despite the "throwntogetherness" of place, place participants produce and reproduce known expectations for experience *within that place* and "observable social orders" for specific activities such as how to line up for buses or wait for appointments (Sharrock, 1995; McHoul, 2009: p. 18). Health researchers have also identified that class related SDOH cluster within specific geographic areas and places. Singh-Manoux and Marmot (2005), for example, identified intergenerational class socialisation and resulting "habitus" and social positioning as key SDOH that determine health outcomes across many generations of families. Singh-Manoux and Marmot (2005) applied Bourdieu's theory of habitus to explain the way that "social structures, through the processes of socialization, come to be embodied as schemes of perception that enable individuals to live their lives, leading societies to reproduce existing social structures" (Bourdieu, 1984; Singh-Manoux & Marmot, 2005: p. 2129). They contend, as a result, that "norms on healthy behaviour" are conditioned through socio-economic contexts throughout our life course (Singh-Manoux & Marmot, 2005: p. 2129). The social environment is hence paramount in defining and perpetuating class-related health behaviours, attitudes, and beliefs that are available to individuals. In order to "belong" to a certain social class and related social places, then, individuals exhibit—both consciously and unconsciously—the material cues (such as dress and habits) and dispositions that identify them as part of the relevant social group (see also Weyers, Dragano, Richter, & Bosma, 2010).

Health researchers have sought to document the complexity of place and health outlined above using a range of innovative methods including: geographical information systems mapping of relevant SDOH and health outcomes statistics (see Dennis Jr., Gaulocher, Carpiano, & Brown, 2009; Gudes, Kendall, Yigitcanlar, Pathak, & Baum, 2010); systematic observational studies that document physical environments (see Caughy et al., 2001; Cohen et al., 2000; Craddock, 2000; Raudenbush & Sampson, 1999); narrative studies of place based experience of health and wellbeing (see Dennis Jr. et al., 2009; Parry, Mathers, Laburn-Peart, Orford, & Dalton, 2007); and ethnographic studies of the lived experience of local SDOH (see Burbank, 2011; Schulz & Lempert, 2004; Sunderland, Bristed, Gudes, Boddy, & Da Silva, 2012). Despite the significant above mentioned advances, current literature under-represents one of the key factors that influences how a PBI is enacted: namely the preparedness or otherwise of health workers to operate collaboratively

and *in situ* with the communities that experience significant disadvantage (see Broadhead & Fox, 1990: p. 323; Moore, 2009). PBIs typically involve the generation of a partnership or coalition among providers in the government, non-government, local council authority, and community sectors. Although this connection to local organisations is a defining feature of PBIs (i.e. based *in* and *with* place as opposed to being imposed *upon* place), the connection to the local community can often be limited to formal (i.e. deliberate and controlled) bureaucratic modes of engagement. As shown in this study, this focus on formal partnerships leaves an intensely under-recognised spectrum of informal and incidental engagement that occurs continuously as a result of the physical proximity of PBI workers to their local communities.

Case Study

Background

Given the nature of place outlined above, PBIs are inherently complex social interventions. As Massey (2005), indicated, cultures of place encompass various cultures of ethnicity, organisations, families, language groups, and professions that are "thrown together" in space and time. This case study occurred as part of my research with a complex PBI targeting chronic disease prevention in an intensely diverse health service district in Australia. The PBI district is classed as experiencing significant "socioeconomic disadvantage" (ABS, 2006) and residents experience complex interlocking SDOH such as low income, unemployment, crime, violence, and relatively high incidence of preventable chronic disease. It is one of the most culturally and linguistically diverse health service districts in its state and is known to function as a first "port" for refugees and migrants to Australia (ABS, 2006). The Australian Bureau of Statistics attributes net migration into the area to the availability of relatively low or unskilled employment in the area, low income housing, and pre-existing culturally and linguistically diverse communities in the district (ABS, 2006). I was part of an interdisciplinary research team that worked with the PBI team as collaborators over a period of four years. Our research was funded by a combination of Griffith University and Australian Research Council (ARC) funding.

The venue for this particular case study was the PBI central administration office and the community services building within which it is located. It was a venue worthy of study for at least two main reasons. First, it was chosen by the founding employees of the PBI so they could be located in close physical proximity to the "community" with which they would be working. They made this decision in an attempt to break down perceived divisions and tensions between the central funding agency for the PBI (a state government health department), and local non-government health and community service providers who were voluntary partners in the PBI. Second, the venue is worthy of study because of the significantly personal (private and potentially sensitive) nature of the services that are provided to community members in the building and the resulting culture that surrounds them. In addition to the PBI central administration office, the building houses: Adult Mental Health Services; Legal Aid; Probation and Parole; Employment services; Hearing services and equipment providers; Child safety services; Indigenous youth employment services; and State multicultural services.

I was initially invited to observe regular PBI team meetings at the case study venue to document knowledge sharing across the PBI's teams and networks as part of the broader ARC and Griffith University funded research. This included a focus on how the PBI engaged with local communities. This case study of the PBI office building emerged somewhat unexpectedly from my observations of these meetings after I observed significant "insider-outsider" incidents and dynamics—such as those described in the preface to this paper—between PBI team members and local community members at the case study venue. Case study participants hence opportunistically included the three male and five female state government health department employees who participated in the observed meetings and who were located in the central PBI administration office (n=8). These participants were not engaged in direct service provision and did not have direct professional contact with local community residents as part of their daily tasks. Their contact with external parties was almost solely comprised of contact with other service providers in the district. Hence their only regular contact with community members was through daily incidental interactions at the case study venue.

Approach

The overarching aim of this case study was to document and interpret government health workers' daily lived experiences of implementing a PBI in a known area of socio-economic disadvantage. In particular, I wanted to explore the PBI office building as an interface between PBI workers and local community members. The case study method aligned with interpretive approaches to research which frame both the building itself and the social relationships enacted within it as meaningful discursive resources upon which human agents both draw and contribute to in making sense of their experiences (Pink, 2007a). All elements of the social interaction can be seen as active and dynamic "meaning-making" resources including, for example, signs, documents, clothing, hairstyles, facial features, expressions, language, and general demeanour (see Goffman, 1959). Pink's (2007a, 2007b) visual ethnography informed data collection, emphasizing the role of visual data in creating durable representations of the meaning-making resources present at a given time in a given social space. This method was ideal for investigating the ways in which built environments interacted with social relationships to create and recreate shared meaning and experience.

I initially conducted data collection during my observation of monthly PBI team meetings over a period of 12 months between 2008 and 2009 (approximately 24 hours of meeting observation in total). Once I observed an initial "insider-outsider" dynamic between PBI staff and community members outside the building during team meetings, I began to conduct additional unstructured observations and interviews with meeting participants opportunistically before or after meetings to ask them about the dynamics I was observing. I was already in a routine of taking semi-structured field notes during and after every meeting I observed and extended this for the purposes of the case study. I routinely shared my notes with the Chair of the meeting via email to gather her feedback on my observations and provide insider knowledge and explanations wherever she saw fit. If the Chair responded to my observations via email, I copied and pasted her response into my original observations document and referred to them as part of my ongoing collection

of research data. I also began to take a small camera with me to meetings and took random photographs of public spaces in and around the building to create a "personal record of spatial and social relationships" (Knoblauch, Baer, Laurier, Petschke, & Schnettler, 2008). I later took additional purposive photographs that expressed particular observed patterns of interaction or meaning making.

I adopted a theory-driven approach to interpret the phenomena I observed during the case study. This consisted of me attempting to explain the phenomena using theoretical concepts from the existing literature and then coding observation notes and photographs in reference to these concepts (see for example, Carpiano et al., 2011; Ryan & Bernard, 2003; Singh-Manoux & Marmot, 2005; Snow, Morrill, & Anderson, 2003). I then applied a series of more structured analysis questions during this process including: What is observable about social interactions within this place? Do the photographs support, contradict or complement the perspectives observed in meetings? Can these patterns be explained using any thematic concepts (i.e. theoretical concepts that are applicable to observed phenomena)? Based on the outcomes of this questioning, I identified the key "thematic concepts" (i.e. the most frequently coded) that could be used to describe and interpret the observed social phenomena at the case study venue. I discuss these key thematic concepts in the following section.

Outcomes

Three concepts from the existing literature effectively describe the insider-outsider dynamics I observed at the PBI office building. These include: 1) cultures of bureaucracy and community; 2) habitus and social positioning; and 3) proximity. In particular, I found that these concepts described both the social boundaries I observed between PBI workers and local community members at the case study venue and the broader dynamics—such as proximity—that PBI workers experience in significantly disadvantaged areas. I discuss the case study outcomes in reference to these concepts below.

Contrasting Cultures of Bureaucracy and Community

The first observable boundary that divided those inside and outside the window at the PBI building was the contradiction between the cultures of bureaucracy and community and resulting "insider-outsider" demarcations of space in the building. Scribner and colleagues (1999) usefully described this phenomenon:

> … it is useful to view community and bureaucracy as occupying opposite ends of the organizational spectrum. Within the Gemeinschaft/Gesellschaft theoretical framework (14), "community (Gemeinschaft) may be experienced through kinship, through living in the same neighborhood, or through gathering with others in community of the mind" (15)… In contrast to relationships experienced in community settings, Gesellschaft-type relationships are often contractual in nature, serve to achieve some goal or benefit, and are representative of relationships formed within bureaucratic organizations (Scribner et al., 1999: p. 135).

The symbolic features "inside" the PBI office were typical of bureaucracy and government within Australia (for example: office furniture, filing cabinets, desks, chairs, computers and partitions). The physical parts of the PBI office that were most visible to the outside world were the secure doors, warning signs, and meeting rooms or offices located on the walkway (see photographs). When community members looked through the glass, they saw a group of professional people in professional clothing engaged in discussions around a boardroom table, or sitting at a computer desk. The relationships community members witnessed inside the office were not of a social nature, although these may of course have been present. Rather, the relationships were systems-oriented, work-related, contractual in nature, largely conducted between the hours of 8 am to 5 pm from Monday to Friday.

By contrast, the symbolic features of the "outside" world were those of the local community or, at least, those sub-groups of local community that attended the building on a regular basis. The relationships among people who grouped together outside were those of friendship and family, in all their positive and negative forms, that were not limited to business hours and working days. They were relationships of place and kinship that endure and find their home in the geographic locations mapped by the PBI strategic documents. Although the PBI was designed to be finite in its duration and presence, these community relationships went on indefinitely. People from outside were not welcome in the PBI office unless they had an appointment to participate in some aspect of the *administration* of the PBI, which was rare.

The cultural cues for maintaining an insider-outsider culture at the building were clear. The sign shown in *Image "D"* hangs on the secure sliding doors into the PBI office and *Image "E"* hangs on the main public entrance to the building as well as on the toilet doors prohibiting members of the public from using the public toilets allegedly due to previous "vandalism". A formal letter from the building owner hangs on the toilet doors justifying and notifying of a decision not to allow public access to the toilets. All doors to the toilets and offices are protected by coded locks with passwords or buzzers that allow acceptable visitors to gain admission with approval from the PBI recaptionist. Although there are necessary safety and security justifications for restricting access to the building, these precautions reinforce the culture of place that keeps insiders and outsiders apart. The signs are notable because they are a powerful cue to *all* people entering the building that: 1) there have been some problems associated with people using the building as a public space; 2) that [some] people who frequent the building are the kind of people who vandalize public toilets; and 3) [some] people inside want to keep other people out.

A more complex history of the toilets at the building emerged through an informal interview with one of the team members. The team member stated that the "real" reason for securing the public toilets was because a community member had committed suicide in the toilets. The team member had performed cardio-pulmonary resuscitation on the community member with another colleague from the PBI office. The team member said that because the PBI office was labelled as a state health department office, the security officer had turned to the PBI for assistance when the community member was found unresponsive in the toilets. Others in the PBI office were present in the toilets and surrounding hallway until the ambulance arrived. A male team member independently reported the same incident, but added that it had happened within the first two weeks of the PBI moving into the building "just before Christ-

mas". The male participant said he had a feeling of "woah what a way to start" following the incident.

Habitus and Social Positioning

A second significant boundary between insiders and outsiders was habitus and social positioning. Habitus refers to the way in which a person's (or group's) access to social, economic, cultural, and other forms of capital are inscribed upon them in discernable ways (Bourdieu, 1990). According to Bourdieu, the social, political, economic, and cultural spaces of our present and past are evident the *dispositions* we display. Social positioning relates to social dynamics that reach beyond place. Lindemann's (2007) concept of social positioning further identified the categories of social stratification that are inscribed upon us, namely, "age, gender, ethnicity, education, status on the labour market and income". These categories all affect a person's perceived and lived position in social hierarchy. She argued that income, for instance, determines an individual's perceived sense of their position in social hierarchies. In her words, "[t]he subjective social position depends not only on the objective characteristics but also on how people experience society, the way they perceive their position in comparison with others, and what they imagine their position would be in future" (Lindemann, 2007: p. 54).

Although it is obvious that the people working in the PBI office were diverse in terms of their own experiences and origins, it was also clear that those outside the window differed substantially from those inside. The people inside the PBI office inhabited different social, political, economic, and cultural spaces to the people outside the office. There was little observable about the culture of the place that would allow either the insiders or outsiders to develop more than cursory impressions of one other.

As Goffman (1959) observed, when thinking about social positioning as a barrier to engagement and understanding, it is important to recognize that it is intertwined with stereotypes and lived experience—both positive and negative. If proximal engagement between people does not occur in a PBI setting, there is nothing to challenge the stereotypes that social positioning conjures. For example, when a community member punched the window of the meeting room, it provoked intensely negative engagement from the meeting participants. Neither those outside nor those inside moved any closer toward an appreciation of the other as a result of this interaction, or any other interactions. Hence, there is no conciliatory social or moral engagement despite the close physical proximity. The potential for social positioning to produce stereotyped and distant interactions was further evidenced when a female PBI employee came upon the group of young men talking and leaning against the fence. Her reaction was unexpectedly one of fear which prompted her to cross the street. She invoked a stereotype that the young men were chroming and would be dangerous, even though there was no indication to support this view.

Proximity

The suicide incident in the PBI building's toilets was a powerful and intense example of the extreme proximity between the government employees and community members in this venue. In this case, the team member who provided assistance to the community member had extensive clinical experience via which she could interpret and manage the experience. For most government employees engaged in bureaucratic work, the requirement to provide medical attention would be highly unusual and stressful. Team members who did not have clinical backgrounds also attended the scene but were unable to assist. Within the first two weeks of commencement, this incident was a direct and confronting example of the challenges that were faced by the communities at the centre of the PBI and the degree to which PBI team members would potentially be engaged in those challenges.

Other incidents and experiences reported by team members shaped their experiences of place in the PBI. For instance, team members reported during informal interviews that the health department had arranged for them to have physical self-defense training so they could disarm a threatening person if they moved into the building. Several building-wide "lock-downs" had occurred in response to threats of violence made toward child protection workers housed in the building. A bullet hole was once found in the window of the PBI meeting room and there had been several "ram raids[2]" on the building. Most significantly, there had been a murder around the corner from the building. An armed security officer patrolled the main public entrance to the building at all times. There was a secure area under the building used to transport children and others safely to and from the building without the need to interact with members of the public. After hearing about the range of incidents that occurred in the PBI building, and seeing the range of bureaucratic steps taken in response to those incidents, it became clearer how an inside-outside culture had developed. It also raised my awareness of the complex and often contradictory interplay between physical and moral proximity between staff and community members in PBIs. In short, physical proximity did not appear to invoke moral proximity (i.e. an appreciation of the "other"). In the above examples it appeared, rather, to create the opposite effect of creating moral distance and even fear.

Although it was often not acknowledged by the PBI team members themselves as meaningful or significant, I observed that the PBI team was *constantly* interacting with community members in informal and incidental ways within the shared spaces of the building (e.g. walkway) and via the permeable interface of the office windows. This was largely due to the physical layout of the building. The Eastern-facing walls of the office were made of glass, covered by blinds that were kept partially or fully open. The office was on the first floor of the building which featured a wrap-around walkway providing access to two public entrances. There was a relatively high amount of pedestrian traffic on the walkway consisting of community members who were accessing the range of services provided in the building as well as friends and family members who accompanied them. Almost every desk within the office had a view of the outside walkway. Community members often congregated in small groups on the walkway to wait for friends or family or appointments. There were smoking areas on the footpaths that surrounded the building.

As a result of the physical layout of the building, the community members, who were by all accounts the *raison d'être* of the PBI, were literally *just outside the window*. Introna (2001) observed that proximity to others in geographical and social space brings an unavoidable *obligation* to respond to them in

[2]Slang term used to denote the process of breaking into a building with a motor vehicle.

a moral way (see Introna, 2002, 2001; Levinas, 1998; Silverstone, 2003). Introna (2002) argued that our moral obligation to others becomes most visible and strongest when we come "face to a face" with another person in our physical and social settings (i.e., we are allowed to see that individual for who he or she is, in all of his or her vulnerability and humanness). In contrast, the further away we are from another person in physical and social proximity, the easier it is to ignore that person or people. Despite this "natural" obligation to others, I observed that there were many aspects of social life (e.g. stereotypes and prejudice) that prevented PBI workers and community members from coming "face to *a* face" with each other. During meetings, for example, significant social boundaries had been constructed to divide those inside the window from those outside. The only observed acknowledgement of the community members was negative verbal and non-verbal responses to perceived "antisocial" behaviors (e.g., swearing, shouting, physical violence, a community member punching the meeting room window). Through the artificial barriers created by the ability to close the blinds, the labelling of behavior and the solidarity of the "insiders", potential for mutual engagement and naturalistic understanding of local community based on physical proximity in place was lost.

Photographic observation of place—selected images

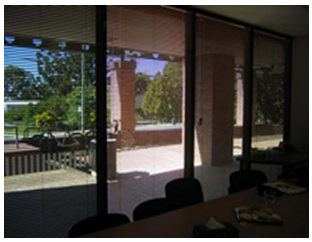
Image A. Main entrance to community services building in which PBI central administration office is located.

This image shows the main entrance to the PBI administration building which also houses several other community services including: probation and parole; child protective services; and employment services. The building itself is set high off the street. An armed security guard stands just inside the sliding glass windows at the top of these stairs. The windows display a number of A4 laminated warning signs to members of the public including Image "E" which advises community members that there is no access to toilets in the building due to vandalism. The image also shows community members sitting on the walls waiting which is typical of this venue.

Image B. Walkway and meeting area outside PBI office.

This image shows the walkway that surrounds the building and its proximity to the PBI offices. PBI staff members' desks are located against or facing the windows shown in this image. Groups of community members frequently congregate along these walkways while they wait for appointments. There are no waiting areas inside the building and only those with appointments are allowed inside. The meeting room pictured from inside the building in Image "C" overlooks this walkway just around the corner from where this image was taken. The bike pictured in Image "F" was located on the walkway during a subsequent photo-observation data collection.

Image C. PBI meeting room overlooking walkway. Bullet hole was found in this window.



This image shows the meeting room where program leader meetings were observed for 12 consecutive months in year one and the final quarter of years 2 - 3. The walkway outside is clearly visible through the windows and sound is audible through the glass from outside. During an unstructured interview, one participant told me that a bullet hole was found in this window during the early period of the PBI. This is also the window that a community member punched during one of the observed meetings. PBI staff can close off the view to outside by closing the blinds on the windows. It was notable that the blinds were kept open during meetings until the incidents reported in this paper occurred (e.g. community member punching window, verbal arguments outside, and so on).

Image D. "This is not a clinic" Sign displayed on secure sliding glass doors that lead into PBI office.

This sign is displayed on the sliding glass doors leading into the PBI office (Image "B") as another artefact of the insider-outsider culture that exists at the PBI building. The statement that "no bags or money are kept on these premises" infers that those outside looking in may be interested in knowing this fact (i.e. interested in stealing). Also the statement "this is not a clinic" indicates that because the government health department logo is displayed on the sign outside the PBI offices that some community member may have, or may be expected to have mistaken, the office for a medical clinic. Overall the message of this sign can be interpreted as "keep out" and "we are not here to help you".

Image E. "Due to constant vandalism there is "No" public toilets available in this building" Sign displayed on main entrance to building.

This sign was located at the top of the stairs pictured in Image "A". The sign is accompanied by a formal dated business letter from the building manager advising that toilet access is no longer available due to "repeated" acts of vandalism including "removal of toilet seats". The nearest toilets at Station Road were a considerable distance away. The building manager's prohibiting community access to the toilets then appeared to me as quite an extreme measure. The bureaucratic and authoritative tone of the letter was distinct and clearly positioned the building as being in control of those who are embedded in a formal bureaucratic way of operating. This is reinforced in the sign pictured above which refers in a general way to "constant vandalism".

Image F. "Which Bank? They're all bastards!" Sticker on bike parked on walkway outside PBI offices.

This bike is an example of the discursive resources on offer to both insiders and outsiders at the PBI building (i.e. "us versus them"). The "which bank?" sticker is an intertextual reference to an advertising campaign run by the Commonwealth Bank of Australia throughout the 1990s-2000s which posed the question "which bank?" to which people would enthusiastically answer "the Commonwealth Bank!". The alternate answer on this bike of "they're all bastards" echoed the almost stereotypical hostility that existed between some community members outside the PBI windows and those inside. It appeared that community members *automatically* identified PBI workers as "them". Note the spelling errors in the graffiti on the bike ("to rite" instead of "too right").

Conclusion

PBIs are complex endeavours because they join in collaboration those who live in and care about the place experiencing the intervention and those who do not. The social spaces within a place that are claimed by a PBI can be close, local, and familiar to some and distant, professionalised, and work-oriented to others. This means that participants' experience, use, and valuing of place and the PBI in general are inherently different even though all parties might be united under a common social aim or vision. Great degrees of variability, ambivalence, and ambiguity toward place can thus exist within a PBI.

This case study provided insight into the capacity of PBI staff members to connect with and understand local places and the people who inhabit them. Rather than promoting in-place engagement, the co-location of PBI staff members in this community service building [re]produced a defensive insider-outsider culture that limited opportunities for informal and incidental knowledge sharing. The culture at the building also precluded opportunities for PBI staff to move beyond their bureaucratic roles by reinforcing existing social boundaries and deflecting attention and appreciation *away from* the particularity of the immediate community in which they were embedded. These observations could be applied to the more appropriate and sustainable development of PBI interventions in future.

Although this study focused on the *patterns of experience* (i.e., culture) in a specific place (i.e., the PBI building), they are not likely to be contained to this venue. Rather, the dynamics revealed in this case study could potentially apply in any setting where professional workers who are embedded in cultures of bureaucracy meet local residents who are embedded in cultures of community, particularly when they also herald from substantially different social contexts and backgrounds. Indeed, a significant finding of the case study was that *fundamental* pre-existing social stratifications between "insiders" and "outsiders" were recreated (and in fact exacerbated) through the *medium* of this administration building. Ironically, the result of placing the PBI within the local community was the antithesis of the community engagement intentions of the PBI staff. The study has indicated the need for future research on PBIs to explore the role played by the concepts identified through this case study. Specifically, it is necessary for PBI organizers to more critically explore the place at which they intersect with the community, seeking and managing instances of insider-outsider cultures and divides created by social positioning. These concepts are likely to apply to *all* services placed in areas that are experiencing significant social disadvantage.

Acknowledgements

I would like to acknowledge the generous and insightful contributions of all participants and colleagues in the research. I would also like to acknowledge and thank Heidi Muenchberger and Elizabeth Kendall for editing and additional examples, and Stephanie Prout and Courtney Wright for editorial support.

REFERENCES

Australian Bureau of Statistics (ABS) (2006). *Census of population and housing*. Australian Bureau of Statistics. http://www.censusdata.abs.gov.au/

Baum, F., & Palmer, C. (2002). "Opportunity structures": Urban landscape, social capital and health promotion in Australia. *Health Promotion International, 17,* 351-361. doi:10.1093/heapro/17.4.351

Bourdieu, P. (1990). *The logic of practice*. Stanford, CA: Stanford University Press.

Bradford, N. (2005). *Place-based public policy: Towards a new urban and community agenda for Canada research*. Ottawa, ON: Canadian Policy Research Networks. http://www.rwbsocialplanners.com.au/spt2006/Social%20Planning/Place%20based%20public%20policy.pdf

Broadhead, R. S., & Fox, K. J. (1990). Takin' it to the streets: AIDS outreach as ethnography. *Journal of Contemporary Ethnography, 19,* 322-348. doi:10.1177/089124190019003004

Brodsky, A. E. (1996). Resilient single mothers in risky neighborhoods: Negative psychological sense of community. *Journal of Community Psychology, 24,* 347-363. doi:10.1002/(SICI)1520-6629(199610)24:4<347::AID-JCOP5>3.0.C

O;2-R

Burbank, V. K. (2011). *An ethnography of stress: The social determinants of health in Aboriginal Australia (culture, mind and society series)*. New York, NY: Palgrave Macmillan.

Carpiano, R. M., Kelly, B. C., Easterbrook, A., & Parson, J. T. (2011). Community and drug use among gay men: The role of neighborhoods and networks. *Journal of Health & Social Behavior, 52,* 74-90. doi:10.1177/0022146510395026

Caughy, M. O., O'Campo, P. J., & Patterson, J. (2001). A brief observational measure for urban neighbourhoods. *Health & Place, 7,* 225-236. doi:10.1016/S1353-8292(01)00012-0

Cohen, D., Spear, S., Scribner, R., Kissinger, P., Mason, K., & Wildgen, J. (2000). Broken windows and the risk of gonorrhoea. *American Journal of Public Health, 90,* 230-236. doi:10.2105/AJPH.90.2.230

Commission on Social Determinants of Health (CSDH) (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final Report of the Commission on the Social Determinants of Health. Geneva: World Health Organization.

Craddock, S. (2000). Disease, social identity and risk: Rethinking the geography of AIDS. *Transactions of the Institute of British Geographers, 25,* 153-168. doi:10.1111/j.0020-2754.2000.00153.x

Dennis Jr., S. F., Gaulocher, S., Carpiano, R. M., & Brown, D. (2009). Participatory photo mapping (PPM): Exploring an integrated method for health and place research with young people. *Health & Place, 15,* 466-473. doi:10.1016/j.healthplace.2008.08.004

Farmer, J., Munoz, S. A., & Threlkeld, G. (2012). Theory in rural health. *Australian Journal of Rural Health, 20,* 185-189. doi:10.1111/j.1440-1584.2012.01286.x

Goffman, E. (1959). *Presentation of self in everyday life*. New York, NY: Doubleday Anchor Books.

Gudes, O., Kendall, E., Yigitcanlar, T., Pathak, V., & Baum, S. (2010). Rethinking health planning: A framework for organising information to underpin collaborative health planning. *Health Information Management Journal, 39,* 18-29.

Hochschild Jr., T. R. (2010). "Our club": Place-work and the negotiation of collective belongingness. *Journal of Contemporary Ethnography, 39,* 619-645. doi:10.1177/0891241610378857

Introna, L. D. (2002). The (im)possibility of ethics in the information age. *Information and Organisation, 12,* 71-84. doi:10.1016/S1471-7727(01)00008-2

Introna, L. D. (2001). Virtuality and morality: On (not) being disturbed by the other. *Philosophy in the Contemporary World, 8,* 11-19.

Knoblauch, H., Baer, A., Laurier, E., Petschke, S., & Schnettler, B. (2008). Visual analysis. New developments in the interpretative analysis of video and photography. *Forum: Qualitative Social Research, 9.* http://www.qualitative-research.net/index.php/fqs/article/viewArticle/1170/2587

Levinas, E. (1998). *Otherwise than being: Or beyond essence*. Pittsburgh: Duquesne University Press.

Lindemann, K. (2007). The impact of objective characteristics on subjective social position. *TRAMES Journal of the Humanities and Social Sciences, 11,* 54-68.

McHoul, A. (2009). What are we doing when we analyse conversation? *Australian Journal of Communication, 36,* 15-21.

Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives. Strategic review of health inequalities in England post-2010.* London: University College London.

Massey, D. B. (2005). *For space*. London: SAGE.

Massey, D. B. (1999). *Space, place, and gender*. Minneapolis, MN: University of Minnesota Press.

Martin, J. (2002). *Organisational culture: Mapping the terrain*. Thousand Oaks, CA: Sage Publications.

Moore, D. (2009). Workers, "clients" and the struggle over needs: Understanding encounters between service providers and injecting drug users in an Australian city. *Social Science & Medicine, 68,* 1161-1168. doi:10.1016/j.socscimed.2008.12.015

Parry, J., Mathers, J., Laburn-Peart, C., Orford, J., & Dalton, S. (2007). Improving health in deprived communities: What can residents teach us? *Critical Public Health, 17,* 123-136. doi:10.1080/09581590601045253

Pink, S. (2007a). *Doing visual ethnography: Images, media and representation in research* (2nd ed.). The Hague: Mouton.

Pink, S. (2007b). Sensing cittàslow: Slow living and the constitution of the sensory city. *Sense and Society, 2,* 59-77. doi:10.2752/174589207779997027

Raudenbush, S. W., & Sampson, R. J. (1999). Ecometrics: Toward a science of assessment ecological settings, with application to the systematic social observation of neighborhoods. *Sociological Methodology, 29,* 1-41. doi:10.1111/0081-1750.00059

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods, 15,* 85-109. doi:10.1177/1525822X02239569

Schulz, A. J., & Lempert, L. B. (2004). Being part of the world: Detroit women's perceptions of health and the social environment. *Journal of Contemporary Ethnography, 33,* 437-465. doi:10.1177/0891241604265979

Schulz, A., & Northridge, M. E. (2004). Social determinants of health: Implications for environmental health promotion. *Health Education & Behavior, 31,* 455-471. doi:10.1177/1090198104265598

Scribner, J. P., Cockrell, K. S., Cockrell, D. H., & Valentine, J. W. (1999). Creating professional communities in schools through organizational learning: An evaluation of a school improvement process. *Educational Administration Quarterly, 35,* 130-160. doi:10.1177/0013161X99351007

Silverstone, R. (2003). Proper distance: Towards an ethics for cyberspace. In G. Liestol, A. Morrison, & T. Rasmussen (Eds.), *Digital media revisited: Theoretical and conceptual innovations in digital domains* (pp. 469-490). Cambridge, MA: MIT Press.

Singh-Manoux, A., & Marmot, M. (2005). Role of socialization in explaining social inequalities in health. *Social Science & Medicine, 60,* 2129-2133. doi:10.1016/j.socscimed.2004.08.070

Snow, D. A., Morrill, C., & Anderson, L. (2003). Elaborating analytic ethnography: Linking fieldwork and theory. *Ethnography, 4,* 181-200. doi:10.1177/14661381030042002

Sunderland, N., Bristed, H., Gudes, O., Boddy, J., & Da Silva, M. (2012). What does it feel like to live here? Exploring sensory ethnography as a methodology for investigating social determinants of health. *Health & Place, 18,* 1056-1067. doi:10.1016/j.healthplace.2012.05.007

Tuan, Y. (2005). *Space and place: The perspective of experience.* Minneapolis, MN: University of Minnesota Press.

Weyers, S., Dragano, N., Richter, M., & Bosma, H. (2010). How does socio economic position link to health behaviour? Sociological pathways and perspectives for health promotion. *Global Health Promotion, 17,* 25-33.