University of Alberta

Tuberculosis,
Adherence Behaviour & the Inner City

by

Pieter Francois de Vos 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Sciences

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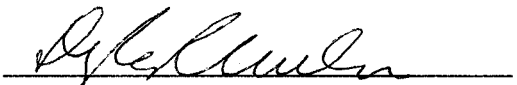

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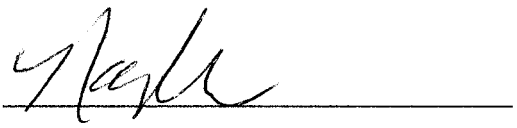

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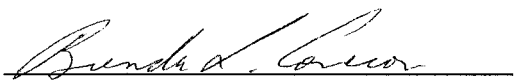

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"Even in a time of elephantine vanity and greed, one never has to look far to see the campfires of gentle people."

- Garrison Keillor

Abstract

Although tuberculosis is no longer considered to be a major threat to public health in Canada, it remains problematic for Aboriginal, immigrant and inner city populations. Non-adherence to TB treatment is a major obstacle to the control of TB. Treatment behaviour is a complicated phenomenon, and successful strategies to enhance patient adherence must address the barriers to treatment encountered by patients. The association between homelessness and TB is widely acknowledged, but few studies have examined how socio-cultural factors impact adherence to TB treatment in homeless populations. This study uses qualitative methods (including participant observation and ethnographic interviewing) to address this knowledge gap. Sixteen homeless individuals in Edmonton were tracked over a period of 18 months. Working from a social ecological framework, the study shows how socio-political realities play out in the lives of homeless people—shaping not only their attitudes towards personal health but also their notions of individual agency.

Acknowledgement

This document owes greatly to the contributions of many people. I am appreciative of the Bissell Centre, which provided the space and the infrastructural support necessary to complete this project. More importantly, I recognise the inputs of my colleagues—mostly notably the staff and vendors of Our Voice Magazine whose insights and perspectives greatly influenced this work. I am particularly indebted to Natasha Laurence, Ron MacLellan, Theresa McBryan, and Bruce Fox for their friendship, honesty and vision.

The photographs in this document were taken by me (Pieter de Vos) and have been previously published in Our Voice Magazine. Verbal consent was obtained before any photography occurred. No research participants are portrayed in any of these images.

Betty Nordin wrote the poems that appear in this thesis. In only a few words, she expresses ideas that took me paragraphs to articulate. I am grateful for her generous contribution.

Finally, I gratefully acknowledge the individuals who shared their personal experiences regarding poverty and homelessness. It is their powerful narratives and life histories that inspired this work. It is unfortunate that they must remain anonymous.

Dedication

This document is dedicated to the people who have quietly stood by me during this project—most notably, Ophelia Kwong and my parents (Pieter and Rea de Vos) who were pillars of strength throughout the process. I also owe a debt of gratitude to my thesis committee (Dr. Andrew Cave, Dr. Nancy Gibson, and Dr. Douglas Wilson) for their patience and unwavering support.

Table of Contents

List of Tables

List of Figures

1.0 Introduction

> Anyways, I was down in the boardwalk area...I'm going into this restaurant and was straight and I was on my days off. And anyways, there's this person sitting down outside and he's bleeding. I don't know if he fell down or got attacked or whatever. So anyways, people were just walking by, so anyways I had a handkerchief on me and I had taken First Aid and I told him to put his head back. Because I didn't know where the blood was coming from. It was just running down his face. And then I ran downstairs and told some guy to phone an ambulance and this guy says, "How come you're helping that guy? He's nothing but a low-life Indian." Anyways, I didn't have time to make a comment because it wasn't even worth commenting about. Until after I was done and anyways I said, "How would you like it if you were sitting out there and nobody was helping you?"
>
> *Research Participant*

In the spring of 1996, I ventured into Edmonton's inner city. I was nearing twenty-six at the time and my world was in chaos. Everything in my life had changed. Years earlier, I remember hearing a schizophrenic man describe the onset of his illness as "the day the earth shifted a quarter of a turn and stayed that way." Everything was out of kilter but still recognisable. The change in my life appeared in a similar way, fed by a growing awareness of the social inequities that exist in an otherwise affluent society.

I had just emerged from the comfortable womb of university, disoriented and ill-prepared for life's uncertainties. In the course of this confusion, I decided to channel my feelings into a constructive outlet, namely a photographic documentary of homelessness in Edmonton's inner city. A visual examination of our messy backyard, turned into a six-year exploration of a world that exists at the margins of mainstream society. In the course of this journey, I witnessed first hand the structural inequalities present in Edmonton. I have worked with troubled street youth, counselled young prostitutes, and have worked at **Our Voice**—a street paper that not only provides an income opportunity for people coping with poverty but also gives them a chance to express their concerns to a society from which they often feel excluded.[A] At times the juxtapositions of wealth and poverty were sadly comical. One glaring example is the newly constructed Winspear Centre, which is built on the site formerly occupied by the Boyle Street Community Co-operative, an agency that provides for the homeless. In the pursuit of urban renewal, those with the least resources have been pushed from the downtown area to the poorest regions of Edmonton—further evidence that they are unwelcome in the capital city. Economic and political marginalisation has been followed by geographical marginalisation. Other examples of the symbolic and material disenfranchisement of the poor are numerous.

Terms such as **skid row** and **ghetto** are constant reminders that our notions of the inner city are influenced by profoundly negative emotions. The **inner city** is part of our urban mythology. It's a kind of geographical boogieman. To the casual observer or the uninformed, it's hostile territory—a place where our fears of failure are personified in the cast-offs of society. In a sense, the inner city is a metaphor. It's a *city* within a *city*, but it's also part of our collective consciousness. For some, it represents a stern warning against sloth and other perceived failures of character; for others, it's the ultimate expression of human avarice, with small subsets of society hoarding the majority of the resources.

In an academic sense, the inner city provides graphic proof of how the individual body can be subordinated to the body politic. Fundamentally, poverty is rooted within a system that promotes the well-being of some members at the expense of others and thereby reflects the inability of sectors of society to gain adequate access to essential resources. Far too frequently, this disparity is reflected at the individual level in the psychological and physical correlates of anomie and ill health. Homelessness predisposes individuals to a plethora of acute health problems and exacerbates chronic health conditions, leading to further deterioration of health status.[1]

One illness that has been a particular scourge on the poor is tuberculosis (TB). In fact, based on the higher prevalence of the disease amongst the poorest in society, TB is a good indicator of where systemic inequalities lie. A review of the global epidemiology of tuberculosis indicates that TB remains the leading infectious cause of preventable deaths in the world.[2] "It is sufficiently shameful," notes one of the leading authorities on TB "that 30 years after the recognition of the capacity of triple-therapy...to elicit 95%+ cure rates, tuber-

culosis prevalence rates for *many* nations remain unchanged." (Pg. 735)[3] Even in some of the fortunate nations where TB mortality had steadily decreased throughout the century, these trends have reversed. In Canada, the number of cases of TB has steadily grown for the past fifteen years as immigration to this country has increased. These trends have been attributed to the lack of access to appropriate health care, the emergence of drug-resistant strains of TB, and to poor adherence[B] to treatment plans.[4] Also implicated in the resurgence, is the increasing incidence of HIV and TB co-infection.

Although TB is no longer considered to be a major threat to public health in Canada, it remains problematic for Aboriginal, immigrant and inner city populations. Increasingly, in developed countries TB has become an urban disease. In 1998, in the United States 75 percent of all TB cases were reported from metropolitan areas of 500,000 persons or more. During the same year 60 percent of all TB cases in Canada were reported from the nine metropolitan areas of Quebec City, Montreal, Ottawa-Hull, Toronto, Hamilton, Winnipeg, Calgary, Edmonton, and Vancouver. Within cities, people in lower socio-economic groups are at the highest risk of TB.[5] While incidence rates for Aboriginal people have declined in many parts of the country, they remain unacceptably high. The annual incidence rate for status Indians in 1996 (35.8 per 100 000 population) greatly exceeded that for Canadian-born people of non-Aboriginal descent, for whom the rate was less than 2 per 100 000 population, and for the population as a whole, for which the rate was 6.5 per 100 000 population. Because the prevalence of tuberculosis infection is much higher in Aboriginal communities than among Canadian-born non-Aboriginal people, and it is likely that TB will continue to pose a problem in these communities for the foreseeable future.[6]

In Edmonton, 6 out of the 36 documented cases of TB in 2001 occurred in Edmonton's inner city (Pop—10 000; rate 60).[7] Between December 2000 and the end of March 2001 seven (7) new cases were diagnosed in the inner city. Accordingly, a major contact investigation was conducted and 443 individuals were screened for TB, of which 94 were identified as candidates for Rifampin /Pyrazinamide (RZ) preventative therapy. Despite the extensive contact investigation, an eighth active case was identified in late December 2001.

Non-adherence to TB treatment is a major obstacle to the control of TB.[8, 9, 10, 11, 12] Low adherence to treatment regimens has serious consequences for individual morbidity and increases the likelihood of TB transmission and infection.[3] Moreover, discontinuous chemotherapy, as typified in cases of non-adherence, enhances the likelihood of acquired drug resistance.[8] A DNA fingerprinting study in San Francisco, found that the index cases of the three largest clusters, which together accounted for 14 percent of the cases of TB detected during the two-year study, were non-adherent and remained sputum culture positive for prolonged periods of time.[13]

Treatment behaviour is a complicated phenomenon, and successful strategies to enhance patient adherence need to address the barriers to continued treatment encountered by patients—not the least of which are the long dura-

tion, complexity and potential toxicity of anti-TB treatments.[14] Other possible barriers to treatment for individuals include the competing demands on their time, the contradictory norms or expectations of their families or cultural groups, and communication difficulties between patient and health care providers. Reported correlates of non-adherence to TB therapy include homelessness, alcoholism, injection drug use, unemployment and other sociomedical characteristics.[15]

The association between homelessness and TB is widely acknowledged, but few studies have examined how sociocultural factors impact adherence to TB treatment in homeless populations. This oversight is consistent with the lack of attention given to the sociocultural characteristics of high-risk populations. The persistence of TB in these populations indicates the inability of biomedical methods to overcome an otherwise preventable and treatable disease, and highlights the urgent need to complement the present chemically-oriented control methods with strategies that are grounded in the relevant sociocultural environments. Recently, directly observed therapy (DOT) has been widely employed to improve adherence to TB treatment, but as Fujiwara *et al* observe "DOT is not a panacea." (Pg. 147) It works because of the human bond that develops between the patient and the caregiver.[16] It depends upon the caregiver's insight into the patient's social situation and of the health beliefs of the community.[3] The use of DOT does not by itself ensure adherence to tuberculosis treatments. In Edmonton's inner city, for example, the completion rate for RZ preventative treatment was only 56.5 percent in 2001, despite the use of DOT.[7]

While past research has examined the sociocultural factors that impact adherence to TB treatment in such diverse environments as rural Ethiopia[17], Highland Chiapas[18] and Wardha India,[19] few studies have addressed the factors that effect the so-called 'sub-cultures' of society. This is probably due to the methodological challenges of studying *invisible* populations, but it also reflects the overall historical neglect of these populations. Several key knowledge gaps are apparent in the traditional epidemiological literature on tuberculosis. These include:

- Intra-cultural perceptions and responses to the health care system
- The understanding of the sociocultural responses to medical regimens
- Culture-specific experience of the disease process
- The effect of the social, economic and political context on intra-cultural responses.

Also conspicuously absent is any mention of the social conditions that localise TB to the poorest in society. The myopic focus on individual behaviour has come at the expense of examining the larger social processes that produce inequalities and lead to non-adherence in the first place. The literature has consistently overlooked that those least likely to adhere to TB treatments *are those least able to adhere.*

This study uses participatory qualitative research methods to address these

knowledge gaps. Drawing from my personal experiences in Edmonton's inner city, I will attempt to elucidate some of the connections between the socio-environmental context and the health behaviour of homeless individuals. It should be noted that, while some of the connections are substantiated by studies conducted in other contexts, the bulk of the analysis is based on participant observation and semi-structured interviews.

This study is an experiment of sorts. It is an attempt to meld the theory of health behaviour with the rich textures of the world in which individual behaviour is created and recreated. In doing so, the paper attempts to combine the rigor of scholarship with the emotion of prose. While these goals appear to be antithetical, I believe that from the perspective of Population Health they are entirely complementary. Population Health posits itself as a discipline grounded in the reality of community life. It sides with the disenfranchised and lends justice to their narratives. It attempts to slice through the layers of subterfuge and rhetoric to reveal the power relationships that structure everyday life. On the one hand, Population Health draws from the theoretical and methodological rigor of such disciplines as medicine, psychology and anthropology; on the other hand, it affirms the subjective nature of reality. In short, Population Health is both a science and an art.

In the following sections, I will present a social ecological description of Edmonton's inner city, including an overview of the socio-political climate that has contributed to the phenomena of homelessness. Once the macro context has been established, I will examine how micro-level factors such as addictions impact the willingness of homeless individuals to adhere to tuberculosis treatment. The analysis will attempt to move seamlessly from the macro to micro levels to show how socio-political realities play out in the lives of homeless people—shaping not only their attitudes towards personal health but also their notions of individual agency.

2.0 Literature Review

In 1993, the World Health Organisation declared TB a global emergency.[20] Despite this warning, 1995 brought with it the largest number of deaths at almost 3 million people.[21] In Canada, homeless people and Aboriginal people are two groups at risk of contracting TB.[22] The distinctiveness of these two groups, as compared to the general population, necessitates the development of culturally appropriate and accessible TB control programs.

Homeless Populations

Although TB in the homeless population is widely acknowledged, there is a paucity of research dealing with the health perceptions of homeless persons. Two studies have addressed this issue.

A. In a study on the control of TB in a homeless shelter, Mayo *et al*[23] found that many of the homeless had a "present time orientation," that led them to "shrug off" the threat of future health consequences—much to the exasperation of the attending nurses. Other factors that complicated the provision of health care to the homeless included social stigmatisation; substance abuse; poor social and problem-solving skills; mental illness; chronic conditions such as hypertension, diabetes and HIV infection; and poor access to services and the necessities of life. The authors also report that some individuals, whose peer group actively drank, found it difficult to refrain from consuming alcohol while on TB drug therapy. In addition, seeking employment was foremost in the minds of many homeless, and so took precedence over continued drug therapy. Mayo *et al* recommend that health care providers appraise the values of homeless peoples so that more acceptable health delivery models can be developed.

B. In a study on TB health education in homeless shelters, Kitazawa[24] found the participants' perception of personal susceptibility to TB appeared to be circumscribed by their limited knowledge of TB as a disease. The subjects' perceptions of the severity of the disease were reported to be limited as well. The author reports that most of the perceived barriers to initiating or continuing TB treatment was linked to a general apprehension of the health care system. Other concerns stemmed from a lack of knowledge of the disease and were sometimes related to knowledge of TB in the pre-antibiotic, sanatoria era.

Aboriginal Populations

Very few studies have looked at how socio-cultural characteristics affect the successful control of TB in Aboriginal populations.

A. A notable exception is the extensive study by Jenkins,[25] wherein the author surveyed 190 Aboriginal individuals from 31 bands in BC using an orally presented questionnaire. The study found that most of the participants believed that TB was a disease of the past, and no longer a health concern. Two-thirds of those surveyed did not know the aetiology of TB, and a lack of knowledge was most prevalent amongst under-30 year olds. In addition, most of the participants were unaware of the new methods of treating TB, and still feared being hospitalised and removed from their communities. This fear is consistent with the historical record, which confirms the pattern of removal from home villages.[26] It is plausible that this legacy of forced separation still influences the willingness of Aboriginal people to acknowledge and seek treatment for the disease.

   According to Jenkins, the lack of awareness of improvements in TB chemotherapy contributed to poor clinic attendance and failure to complete TB treatments. He suggests that this lack of knowledge is partly the result of cultural and language differences between community members and health professionals. This observation is supported by the fact that many of the participants had negative feelings towards health services and non-Aboriginal health providers. Similar results were found by Low *et al* in the Skid Row area of Vancouver, where the authors report Aboriginal people tended not to use available medical services, despite an awareness of their existence.[27]

B. The effect of the patient-caregiver relationship is further illustrated by a study on adherence behaviour amongst the Cree of Lake Mistassini, Quebec. From 1981 to 1985 adherence to preventative TB treatment averaged around 78 percent, but abruptly declined to less than 20 percent in 1986. According to Rideout and Menzies,[28] the only identifiable change that occurred in 1986 was that the responsibility for the preventative TB program was shifted from Native community health workers to non-native workers. The change in adherence behaviour reflects the importance of cultural factors on adherence. As the authors observe "the absence of shared concepts between practitioners and patients may impede even willing compliance, due to lack of understanding from initial encounter." (Pg. 35)

Research on Other Populations

A. Rubbel and Garro,[29] who reviewed the anthropologic research on culture and TB, reported that many Hispanics attribute TB to folk illnesses such as "wasting sickness" or to grippe or bronchitis, for which over-the-counter medications were taken. After hospitalisation for TB, many Hispanic patients risk being rejected and ostracised by their families.

B. Menegoni,[18] who studied how cultural perceptions of illness influenced the Tzeltal Indians' utilisation of health services, concluded that individuals' perceptions of illness and the quality of medical services influence their response to TB programs.

C. Teklu[30] found that social and cultural events sometimes made it difficult for TB patients in Ethiopia to take medications. Vecchiato,[17] in his study on ethnomedical systems in Ethiopia, found that the symtomatological concepts for TB coincided with biomedicine, but the aetiological model postulated causes unrelated to tubercle bacilli.

D. Metcalf *et al* [31] found non-working women in Cape Town, who were otherwise well informed about TB, thought that cold, wet weather was a major cause of the disease. Social ostracisation was also a concern.

E. Mata,[32] who conducted surveys and focus groups with healthy adults and patients in Honduras, found there was a strong stigma associated with the disease. Patients believed they were a threat to others and that their disease was caused by aberrant behaviours such as exposing themselves to "night air." Patients reported rejection by others, and some said they would prefer death to the social isolation that came with TB.

F. Barnhoorn and Adriaanse[19] found that receiving TB treatment was embarrassing for patients in Wardha, India. They conclude that social rejection substantially contributed to patients' suffering and that compliance behaviour was associated with social support from family and/or others. The authors also indicate that the attitude of practitioners towards their patients affected adherence behaviour.

2.1 Theoretical Framework

Ethnomedical Knowledge, Health Culture, and TB

In pointing to the repeated failures of disease-control measures based solely on biomedical parameters, medical anthropologists have emphasised the importance of understanding patterns of medical knowledge articulated within the frameworks of culturally embedded ethnomedical systems.[33]

Anthropological research has identified some of the characteristics displayed by systems of ethnomedical knowledge. First, ethnomedical systems are not homogeneous, but rather are characterised by intra-cultural variation in illness interpretation and management.[34] Medical knowledge does not consist of a normative body of medical axioms that is universally followed by all members of a community. Individual idiosyncrasies, social expectations, economic constraints, and ecological determinants shape the nosological contextualisation of an illness. Second, medical knowledge is not shared equally among all members of a community. A distinction should be recognised, for example, between medical professionals and lay people. In most contexts, medical professionals are the keepers of a repository of medical knowledge that far exceeds that of lay people. Third, systems of medical knowledge are not immutable. Indeed, they are characterised by the same dynamics of continuity and change as any other cultural subsystem. Patterns of ethnomedical knowledge are modified by the constant incorporation of new health-related ideas into medical thought and practise.

Systems of ethnomedical knowledge form an integral part of the health culture of health-seekers and shape their illness meaning, behaviours and therapeutic choices. According to Rubel and Garro, **health culture** refers to "the information and understanding that people have learned from family, friends, and neighbours as to the nature of a health problem, its cause and its implications." (Pg. 627)[29] The notion of health culture emphasises the existence of complex patterns of ethnomedical knowledge and illness management, which influence therapeutic decision-making and adherence to prescribed regimens.

In the case of tuberculosis control, it has become increasingly clear that non-medical factors must be included in case-management strategies. Thus, it is fundamentally important to identify not only the socio-cultural correlates of TB, but also how a patient's health culture influences the onset, course and outcome of the disease.

This study takes the position that health behaviour must be understood within the total context of a person's life. Concern with contextualisation is predicated on the assumption that "social actions and events can be adequately understood only in relation to the social contexts in which they are embedded." (Pg. 20)[35] In the case of homeless individuals, it is hypothesised that

health behaviour regarding TB will be affected by the interaction of elements from both the macro-level (socio-cultural context) and the micro-level (individual context). In other words, an individual's health behaviour is structured by normative beliefs and by socio-cultural factors that facilitate or impede certain behaviours. For the purposes of this paper, socio-economic and political factors will be included in the macro-context, in order to avoid over-emphasising cultural factors at the expense of socio-economic factors that may account for health-related behaviour. As Farmer has observed, "strenuous insistence on the causal role of culture (or personality) runs the risk of conflating cultural (or psychological) difference with structural violence." (Pg 353)[36] To do so conceals both "the social causes of sickness and the social embeddedness of the experience of sickness."(Pg. 168)[37]

The Health Belief Model

The starting point of this study is the Health Belief Model (HBM), which has been used by various scholars to explain and predict health-related action. The HBM proposes that health-related behaviours depend upon an individual's perception of four factors:[38]

1. The level of personal susceptibility to the illness.
2. The degree of severity of the illness.
3. The potential benefits of the health action in preventing or limiting the susceptibility or the severity.
4. The barriers to carrying out the health action.

These assumptions are compatible with the literature that deals with explanatory models. According to Arthur Kleinman, explanatory models serve as an individual's representation of specific illnesses.[39] These models give personal and social meaning to the experience of illness and are derived from a person's beliefs about health and illness. The sources of a person's health beliefs include ideas from the professional health sector, the popular sector, and the traditional sector. The beliefs are dynamic and are continuously modified through interaction with people from each sector. They are sustained within a wider social discourse that shapes not just how individuals think about health, but also how they feel they ought to think.[40] People constantly construct and re-affirm their own health status in the course of everyday life. Health and illness are metaphors with which an individual communicates, and the body is both the medium, and the message of this social discourse.[41]

While the relevance of the HBM to tuberculosis care is apparent, it is important to realise that validation of the HBM has been conducted almost exclusively in North America, and its applicability in other cultural contexts has yet to be established.[29] It is worth noting that the HBM draws on a calculus of lay beliefs conceptualised by health professionals. In effect, it is blind to the

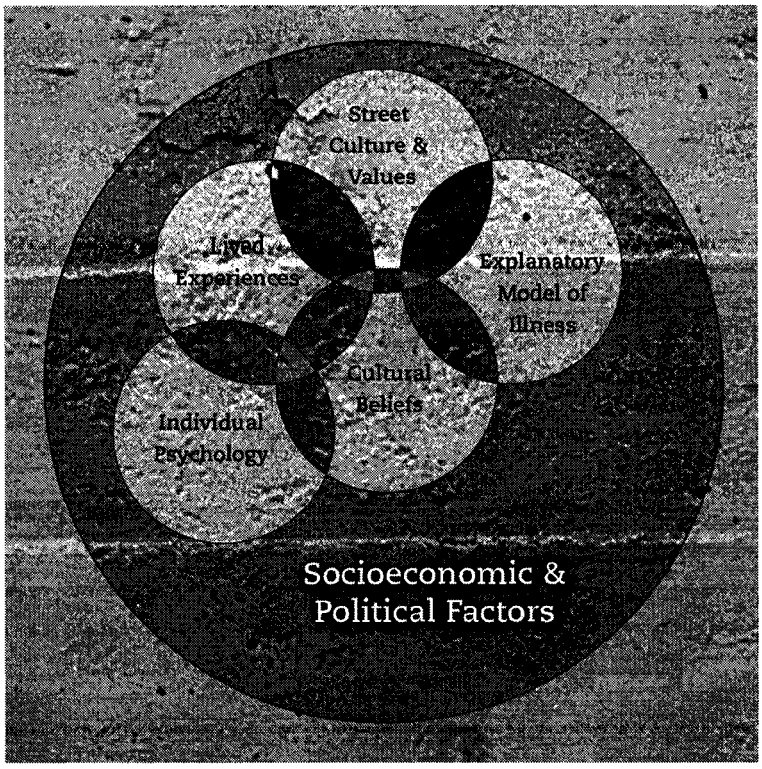


Figure 1: Factors Affecting Health Behaviour of Homeless Individuals.

gulf between lay and professional concepts. It places the emphasis on the individual's rationality having a scientific basis, and in doing so ignores socio-economic impediments to health behaviour such as poverty, and unemployment.[42]

In the case of our target population (homeless individuals), it is hypothesised that health behaviour regarding TB will be affected by a number of overlapping sets of elements, which are presented on the left. As Figure 1 illustrates, health behaviour results from the interaction of elements from both the macro level (ethnocultural context) and the micro level (individual context). In order to conceptualise the complex interaction of these elements, this study will combine two social-cultural models—Kleinman's model of socio-cultural behaviour and the Triandis' social-psychological model of interpersonal behaviour.[c]

Kleinman's Model: Behaviour and the Cultural Context

Kleinman conceptualises individual health behaviours as existing in and influenced by the cultural context of the individual.[43] Three overlapping domains are relevant to understanding the experience of disease and illness in any culture. As briefly mentioned in the previous section, these are:

1. The professional sector, which includes medical practitioners, health educators and researchers.
2. The popular health care sector, which includes community-based care, family-based care, & self-care.
3. The folk health care sector, which comprises indigenous and traditional healers.

An individual accesses the sectors according to how an illness is interpreted by both the individual and the community (or communities) to whom he or she belongs. This study is particularly interested in how individuals mediate and ameliorate existing or potential health problems by moving between these sectors.

To understand health behaviours as they relate to their cultural context,

Kleinman has identified five precepts. These are as follows: (1) the psychosocial experience of illness, (2) the guidelines for health care seeking behaviour, (3) the management of illness, (4) healing activities, and (5) the management of therapeutic outcomes from cure to death. An **explanatory model** of health care can be constructed by identifying the content of each of these precepts and the way in which they interact with one another within a given sector, and by comparing the interaction between sectors in relation to the messages and attitudes about TB treatment.

Although these precepts were designed for clinical applications, the model is relevant to understanding the process of adherence to TB treatments. The Kleinman model has been used as a conceptual foundation for several cross-cultural health care studies, including Anderson's [44] research on cross-cultural management of children's long-term illnesses, and Manson Singer and Bates' design of primary care for disadvantaged patients in the urban core.[45]

Triandis Model: Understanding Personal Behaviour

Triandis stresses the psychosocial process of translating community and other external influences into individual behaviour.[46] The model is based on research that identifies factors associated with the performance of social behaviours in different cultures and has been successfully used in studies on oral contraceptive use, the desire to have children, and tests for detecting cervical cancer.[13] Triandis views behaviour as resulting from three factors:

1. The strengths of the habit to behave in a certain way.
2. The intention to perform a particular behaviour.
3. The presence of conditions that facilitate or hinder the particular behaviour.

Triandis describes intention as influenced by four factors: (1) cognition, (2) affect, (3) social determinants, and (4) personal normative beliefs. According to the model, the varying ethnocultural norms with respect to age, gender and social position influence individual behaviour by reinforcing certain behaviours, setting the conditions in which behaviours occur and by influencing cognitions, affects, and personal norms, which in turn create the intention to behave in a particular way.

Relationship of the Two Models to the Research

From the perspective of Kleinman, effective programs to reduce non-adherence to TB treatment need to understand the socio-cultural environment in which adherence or non-adherence behaviours occur.

From the perspective of Triandis, the socio-cultural environment produces the social conditions that facilitate or impede certain behaviours, the norms that are interpreted by the individual, and the context for the reinforcement of

certain behaviours. Behaviour is the result of certain intrapersonal processes, which result from interpersonal and person-environment interactions. For TB treatment programs to be effective they must address both the personal and cultural factors defining behaviour. Figure 2 illustrates the integration of the Kleinman and Triandis models.

The combination of these two models respects the complexity of individual behaviour, and the heterogeneity that exists even within cultural groups. It also recognises the fact that individuals often have more than one social identity, and that these identities are sometimes in competition with one another.[47]

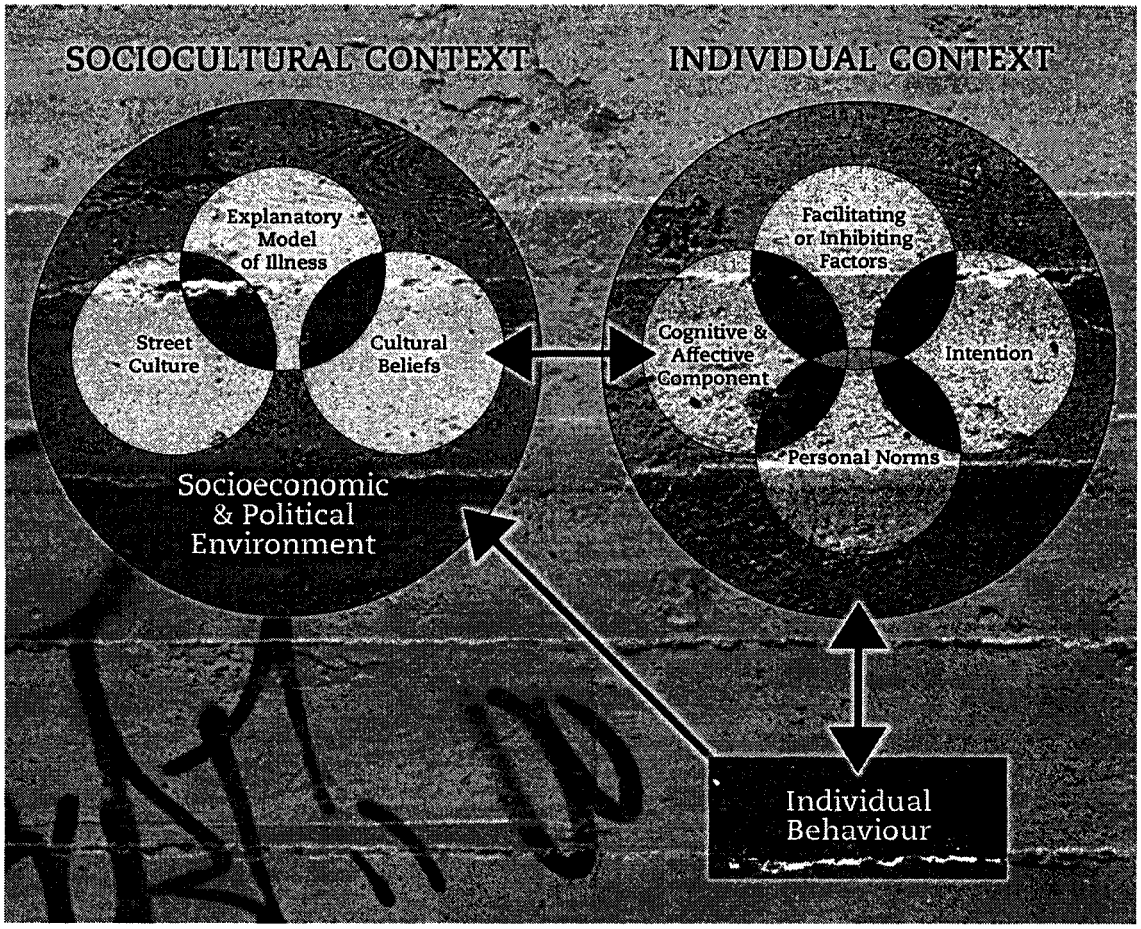


Figure 2: Integration of the Kleinman and the Triandis Models

3.0 Hypotheses, Objectives & Setting

A. Hypotheses

i. Non-medical factors—cultural, economic and political—strongly influence TB treatment behaviour in high-risk populations such as homeless people;

ii. Some norms, values and experiences are common amongst the homeless in Edmonton's inner city and these 'ways of knowing' are rooted in the reality of life on the streets.

iii. Health behaviour can best be understood from the perspective of the patient—as the individual mediates normative, cultural and cognitive/ affective factors with elements from the socio-economic environment that facilitate or inhibit certain behaviours.

B. Objectives

i. To identify the socio-cultural factors influencing the adherence behaviour of homeless individuals in Edmonton's inner city.

ii. To develop a model of adherence behaviour in this population that:

- Identifies the cultural barriers of existing TB research and programming models, and;
- Reflects the complexity of health behaviour and presents a set of indicators to measure the appropriateness and accessibility of TB prevention and treatment programs aimed at inner city populations.

C. Research Setting

The setting for this research was Edmonton's inner city, and the social agencies located in the area—namely, the Forte Health Clinic,[D] the Bissell Centre, the Boyle St. Co-op, the Single Men's Hostel, and the George Spady Centre.

The Bissell Centre, an agency that provides a range of services to the inner city population, was the primary setting for the participant observation component of the research. The Bissell Centre served as the ideal research setting because of its proximity to several inner city establishments, including the Forte Health Clinic, and several inner city hotels, bars and flophouses. In addition, the Bissell Centre operates a drop-in centre that serves as a gathering place for about 150 street people daily. Individual interviews were arranged at the convenience of the participants and occurred in a variety of locations in the inner city.

The Bissell Centre was considered "ethnographically clean," since the centre was not involved in programs that inner city people might interpret as intrusive or punitive. The majority of the services provided were directed towards meeting the emergency needs of clients and advocating on their behalf.

4.0 Methodology

According to Kuhn, *paradigm* refers to "the entire constellation of beliefs, values, [and] techniques...shared by the members of a given community." (Pg. 175)[48] As used by researchers, the term implies a worldview and comprises a set of assumptions about the nature of reality. The real power of a paradigm is that it shapes, in fundamental ways, what issues we choose to explore and the manner in which we choose to do so. In the case of this research, an **interpretative paradigm** will be used. Stemming from the ontological position of relativism, the interpretative paradigm regards reality as consisting of multiple, sometimes conflicting, mental constructions of everyday life experiences that are context and situation dependent.[49] This position holds that facts exist only within a frame of reference, and that there is no such thing as 'pure experience.' Theoretical presuppositions are always involved.[50]

Methodologically, an interaction between the researcher and the participant is necessary to elucidate the meaning of these experiences, and this creates a construction that is specific to the researcher-participant interaction.[E] The researcher participates in the social world, and reflects on the products of that involvement. Rather than attempting to eliminate the effects of participa-

tion, the researcher tries to explain them.[51] The combination of the insider and outsider perspectives produces insights that are deeper than those provided by either perspective alone.[52] By using a process of comparison and contrast, the researcher seeks input from the participants to create a representation of reality by consensus that is more sophisticated than previous understandings.

Methods

A qualitative, ethnographic design was used to answer the research question. Since it is the researcher's contention that knowledge is obtained through an understanding of meanings of behaviour in relation to the perceptions and interpretations of those engaging in the behaviour, the researcher will use a method, which examines how the study population constructs reality in its own terms. A central tenet of ethnography is that people's behaviour can only be understood in context; that is, the elements of human behaviour cannot be separated from their relevant contexts of meaning and purpose.[51] According to Spradley, "people make constant use of complex meaning systems to organise their behaviour, to understand themselves and others, and to make sense out of the world in which they live." (Pg. 5)[53] These systems of meaning constitute their culture. Focusing on the participant's point of view is known as the **emic** approach. To gain knowledge of cultural meanings, the researcher explores the language of the participants, describes their perceptions of reality, and identifies their conceptual frameworks.[54] An **ecological** approach[55] that emphasises sets of causal elements—including environmental features, material/economic constraints and political considerations, in addition to the ideational systems—guided data collection.

Sampling Strategy

A *representative case* sampling strategy, a variant of the purposive sampling strategy often used with "intensive" research designs was used to select participants for the study.[56] In this method, cases are not chosen at random but rather selected because they typify the phenomenon under investigation. Through selecting cases with maximal theoretical relevance, the representative case method seeks to learn about a general class of individuals by studying "typical" members. For the purposes of this study, four classes of representative cases within our study population (homeless individuals) were selected:

1. Those who have accepted prophylaxis or treatment;
2. Those who have been offered prophylaxis but did not complete treatment;
3. Those who have been treated for TB and have recovered;
4. Those who have no direct experience with TB but have a history of homelessness.

In addition to these criteria, research participants were limited to those without obvious psychiatric problems and without noticeable effects of substance abuse at the time of recruitment. Verbal consent was obtained from participants during the observation phase of this research; written consent was obtained prior to formal ethnographic interviewing.

Representative cases were identified through clinic records[F] and consultation with the Public Health nurse working out of the Forte Health Clinic and through interactions between the researcher and street people at the Bissell Centre.[G] Based at the Forte Health Clinic, the public health nurse works on the streets and in the inner city agencies supervising TB treatment, assessing clients referred for TB investigation, finding persons who have been in contact with new, infectious TB cases. The nurse also encourages staff and physicians of inner city agencies to be vigilant in identifying people with symptoms of active TB and to refer them for assessment. A physician assists with clinical services at the Forte office one morning per week.

In this study, the sample size was determined not by the number of participants but by the completeness of the data or *redundancy.* According to Nelson,[57] "redundancy is evidenced when no new information is heard about the study phenomenon." (Pg. 61) In this study redundancy was achieved with a sample of 16 participants, eight (8) of whom were recruited by way of the public health nurse. The principal investigator identified the remaining eight (8) participants. There were no refusals. A breakdown of the demographics of the research participants is presented on the following page. This data is presented in tabular form on page 19, as well.

Demographics of Research Participants

- Thirteen (13) were male; three (3) of the participants were female; Fourteen (14) of the individuals were *unattached*, meaning that they were not members of an economic family. A person living alone is always considered unattached regardless of marital status.

- The ages of the participants ranged from 32 to 55 years. The mean and median age was 44 years.

- Nine (9) of the participants were Aboriginal (either full-blooded or of mixed ancestry (Metis)); Six (6) were of European ancestry and one (1) was African American.

- Nine (9) of the participants were identified as being TB positive and were treated with prophylaxis; Four (4) received treatment for active pulmonary TB. The remaining three (3) individuals were chosen as comparison cases. These individuals had no direct experience with TB, but had extensive personal experience with homelessness and street culture.

- Two (2) of the participants did not complete their prophylactic treatment.

- All of the participants (16) had histories of addictive and high-risk behaviour including alcohol and drug abuse and all of the participants had some experience with street life. In addition, all of the participants had experienced some degree of homelessness during their lifetime. At the time of the interviews, two (2) individuals were absolutely homeless; six (6) were sheltered and two (2) were relatively homeless. The remaining six (6) individuals had stable housing. For the sake of this study, homelessness was defined in the following:

a. **Absolute homeless**: Individuals who have no housing alternatives. This was represented by individuals who self-reported that they had no permanent place to reside, and therefore ended up sleeping "on the street," under bridges or in abandoned buildings.

b. **Sheltered homeless**: Individuals who are living in emergency accommodations and expected to be "on the street" at the end of their stay.

c. **Relative homeless**: Individuals who are residing in sub-standard rooming houses or inner city hotels, where their accommodation is tenuous and prone to the whims of the landlords who own the buildings. The term "relative homelessness" describes the condition of those who have a physical shelter, but one that does not meet basic standards of health and safety; these include protection from the elements, access to safe water and sanitation, security of tenure, personal safety and affordability.[58]

- Six (6) of the participants relied on temp agencies for employment—three (3) of these participants were identified through a contact investigation involving Casual Labour Services (CLS)[H]; Six (6) participants were on social assistance at the time of the interview; and the remaining four (4) had no formal income.

Table 1: Demographics of Research Participants

Alias	Sex	Age[1]	Ethnicity[2]	TB[3] Status	Adherent	Currently Street Involved	Current Smoker	History Alcohol Abuse	History Drug Abuse	IDU[4]	Hep C+	Social Assistance	Employed	Housing[5] Status
Beth	F	55	M					✔	✔	✔	✔	✔		Stable
Iris	F	41	N	L	✘	✔		✔	✔	✔	✔	✔		Stable
Janice	F	32	N	L	✔	✔	✔	✔	✔	✔	✔			Sheltered
Barry	M	35	N	A	✔	✔	✔	✔					Temp	Sheltered
Brent	M	51	A	A	✔	✔	✔	✔	✔				Temp	Sheltered
Burt	M	51	C	A	✔		✔	✔				✔		At-risk
Dave	M	53	M	L	✔	✔	✔	✔	✔	✔	✔			Sheltered
Donald	M	35	M			✔	✔	✔	✔	✔				Homeless
Earl	M	44	C	L	✔			✔	✔				Temp (CLS)	Sheltered
Ernie	M	33	M			✔	✔	✔	✔	✔				Homeless
Gary	M	50	C	L	✔			✔	✔	✔		✔		Stable
Joe	M	41	C	L	✘	✔	✔	✔					Temp	Sheltered
Luke	M	39	N	L	✔	✔	✔	✔	✔	✔	✔	✔		Stable
Paul	M	52	N	A	✔	✔	✔	✔	✔	✔		✔		At-risk
Roger	M	44	C	L	✔		✔	✔	✔	✔	✔		Temp (CLS)	Stable
Ted	M	54	C	L	✔		✔	✔	✔				Temp (CLS)	Stable

Notes:

[1] The ages ranged from 32 to 55 years; The mean and median age was 44 years

[2] A=African American; C=Caucasian; M=Metis; N=Native

[3] A=Active TB; L=Latent TB

[4] IDU refers to injection drug use

[5] At-risk=Relative homelessness; Homeless=Absolute homelessness. [See page 18 for definitions]

Data Collection

Several methods of data collection were combined including participant observation, ethnographic interviews, key informant interviews, and documentary analysis. The multi-method approach was employed to allow for comparison, and verification of results.[1]

One common approach for verifying qualitative findings is **triangulation**—a process which involves "the comparison of data relating to the same phenomenon, but from different phases of the fieldwork, different points in the temporal cycle occurring in the setting...or the accounts of different participants involved in the setting." (Pg. 198)[51]

Participant Observation

Participant observation was the primary form of data collection and it is the foundation upon which the in-depth interviews were based. The reasoning behind this is twofold. First, it allowed me to gain exposure to the inner city environment. Since the topic of interest, health behaviour, is embedded within a specific social and economic context, an understanding of how these contextual factors shape the lives of homeless people is essential. Witnessing the socio-behavioural interactions of the target group was particularly important, and required that I become a permanent fixture at the Bissell Centre.

Second, participant observation facilitated the development of rapport with the target population. This is an important consideration in all ethnographic research, but it acquired a greater importance with a population that is justifiably wary of outsiders. Cohen and Sokolovsky observed that the norms of the inner city admit "an easy surface conviviality, but do not readily permit probing of another's history," (Pg. 32) and that any real penetration into the lives of homeless men would require a good deal of quiet participation in daily activities.[59] Access to marginalised populations such as street-people, required befriending 'gatekeepers' in the community who served as the initial contacts and important sources of information for the researcher.

In this study, participant observation occurred over a period of about eighteen months while I was employed at the Bissell Centre. During this period, I had the opportunity to witness the devastating interplay of addictions, anomie and violence that characterises street-life. I spoke to men and women struggling in the throes of addiction; I frequented the inner city hotels and saw first-hand the deplorable conditions people are forced to live in; I visited crime scenes and spoke to victims of violence. At times, I assumed the role of peacemaker and stopped bloody fights. Most of the time, I simply sat and listened to the powerful narratives that, despite the apparent chaos, were ever-present.

While the Bissell Centre was the primary site for participant observation, I also shadowed the TB nurse bi-weekly for about three months. During this period, I witnessed patient consultations, followed the nurse on house calls and sometimes helped administer DOT. In addition, I was present when the initial clinical consultations occurred with four of the participants and was

able to observe their reactions to being diagnosed with TB. In one instance, I accompanied an active case as he was masked and driven by ambulance to the TB isolation unit (5C3) at the University Hospital.

Ethnographic interviewing

Ethnographic interviewing was based on the experiences and observations acquired during participant observation. Interviews involved both directive and non-directive questions.[51] In the ethnographic method there is a constant interplay between data collection, comparison, and analysis leading to "rich points" and ultimately to general patterns that characterise an emerging understanding of group life. In this sense, ethnography is both deductive and inductive,[J] in that, new theoretical propositions are generated to account for observations that are not explained by old propositions.[60] The process of inquiry is an iterative and evolving one. In recognition of this, I conducted a free-flowing, open-ended style of interviewing that was responsive to the information and the cues provided by participants.[61] Interviews largely consisted of friendly conversations in which the researcher slowly introduced questions of a descriptive, structural, and contrast nature.[61] This time-consuming, open-ended interview format allowed for the gathering of spontaneous and detailed responses that would have been missed by using more efficient closed-ended questions. Although the interviews were free-flowing, they were structured to explore six major areas:

1. General Background / Demographics / Housing Status
2. Street Experience / Street Culture
3. Personal History
4. Personal Health & Individual Agency (Attitudes / Behaviours / Medical Conditions)
5. Formal Institutions (Medical / Social / Legal)
6. TB Knowledge & Attitudes / Treatment Experience

The approach to interviewing was important for reasons other than the methodological, as well. A frequent and painful part of the lives of many homeless men and women is being treated as non-persons. An interview style that is too formalised and structured is likely to convey a sense of unequal power, with the interviewer explicitly scrutinising and implicitly judging the behaviour of the participant. It was essential that the interview represented an opportunity for the participants to talk about themselves and their lives to someone who is both knowledgeable and empathetic.

In this study, ethnographic interviewing occurred over a six-month period from November of 2000 to April 2001—a period of time that corresponds with the identification of 7 active cases of TB in the inner city. This was buttressed by follow-ups that occurred for about seven-months afterwards, as I met informally with several of the participants who were regular clients of the Bissell Centre.

Key Informant Interviews

Key informant interviews were conducted with service providers in the community including health care providers at the Forte Clinic and the TB Clinic, and social workers at agencies such as the Bissell Centre, the Boyle St. Co-op, the Single Men's Hostel, and the George Spady Centre.

The informant interviews were much more structured than the ethnographic ones, and were designed to elicit information about the health delivery system, the perceptions of service providers of their homeless clients, and other topics related to the research.

Documentary Analysis

Health care documents were analysed to determine rates of adherence and non-adherence to TB treatment in the target population, number of active cases in the target population, and so forth. In addition, an extensive analysis of demographic and socio-economic data on housing and homelessness was conducted to elucidate the socio-cultural context.

Data Recording

The nature of ethnographic inquiry means that analysis begins as soon as observation does. In acknowledgement of this, field notes were recorded as soon as the research began. Field notes included: (A) condensed accounts of observations including key phrases, single words, and uncorrected sentences, and (B) expanded accounts which will include details recorded as soon as possible after each observation or interview.

In addition to field notes, I kept a journal in order to document experiences, ideas, problems in methodology, and any practical points of concern. Each journal entry was dated. Making an introspective record of fieldwork enabled me to explain personal biases and feelings, and to understand the influence of these factors on the research process.[48]

Tape recordings of interviews were initiated once sufficient rapport had been earned.[K] All taped interviews were transcribed verbatim. Detailed notes on the response styles of participants and other relevant elements of the interview context supplemented the transcripts.

In addition, *photography* was used to supplement and enrich the field notes and tape recordings. Used both as a visual record and 0diary, photography provided a visual context in which to immerse research findings.[L]

Data Analysis

The data gathered from the ethnographic and key informant interviews were analysed using the following schema adapted from the work of Willms *et al* on socio-cultural factors affecting HIV.[62]

1. Completed interview transcripts were read with the purpose of identifying actions, experiences, beliefs, or vernacular expressions that reflect an understanding of TB and its treatment.

2. Emergent themes were identified in the transcribed text (by highlighting or underlining), and the corresponding codes for these themes were written in the margins of the text.

3. Based on the identification of emergent issues and themes, a coding scheme was developed which provided the framework for describing the socio-cultural factors affecting the target population.

4. The emergent themes and issues identified in the interviews were then compared for similarities and discrepancies to the detailed observations made during participant observation.

5. Data from the ethnographic and key informant interviews were compared with data collected during participant observation and document analysis to identify general patterns and to embed the analysis in the socio-cultural context.

Trustworthiness of Research Findings

Several researchers have written about the issues of reliability and validity as they relate to qualitative inquiry.[63, 64] A model for evaluating rigor in qualitative research is the assessment of trustworthiness. Criteria for establishing the trustworthiness of interpretative research include the requirements for credibility, applicability, dependability, and confirmability.

According to Sandelowski, the *credibility* of qualitative research is enhanced when the investigator describes and interprets their own behaviour and experiences as researchers in relation to the behaviour and experiences of participants. Although it is desirable to have a congenial atmosphere for the interview process, the researcher must be cautious not "to lose the ability to interpret the findings." [64] In order to maintain this interpretative distance, a journal was kept, as stated previously.

The criterion of *applicability* is used to establish the degree to which the audience views the findings as meaningful and applicable, and the degree to which the findings "fit" the data from which they were derived.

Representativeness usually refers to the "typicality or atypicality of observed events, behaviours or responses in the lives of the informants." (Pg. 32)[64] The use of purposive sampling in this study facilitated obtaining data that is representative. Validation from the participants themselves was obtained by using summary-type questions in later interviews and by allowing community members to review draft results.

The 'audit' strategy is the major method for establishing *dependability* and suggests that another researcher could arrive at comparable conclusions given the same data and research context.[65] The following practises were used to promote *confirmability* from the outset:

1. Consultation with thesis advisor during initial data analysis;
2. Review of the emerging analysis and comparison with the raw data;
3. Precise documentation of the procedures followed during data collection and analysis, and;
4. Maintenance of detailed field notes and research journal entries.

Confirmability is achieved when the criteria of dependability, credibility and applicability are established.

5.0 Research Findings

The Call of the Drag

Standing in the living room
looking out the window
Trying to figure out how
I can break the call of the drag
I've tried so many times to leave
But I just can't do it.
I know it is a difficult life
But so is livin' straight
When I was on the drag
I had nothing.
Today I have everything
So why can't I just leave
and not go back?

Betty Nordin
(Pg. 28)[275 TT]

To remain consistent with the theoretical framework described earlier, the research results are organised to reflect the interaction of elements from the macro-level (socio-cultural context) and the micro-level (individual context). In the current usage of social theory, it is common to distinguish between micro-level explanations of agency (that is agents' purposes, beliefs and rationality), and macro-level explanations of the *structures* within which these actions take place (such as social institutions and societal norms.)

In order to do so, I first present an overview of Edmonton's inner city and some of the norms and values of *street culture.* The analysis is based on more than six-years of personal experience working in the inner city in a variety of capacities. This has been buttressed by an eighteen-month period of formal participant observation and ethnographic interviewing, as well as by the numerous discussions I have had with colleagues and homeless

people regarding life on the streets. Due to the limited focus of this project, the analysis is far from exhaustive. Despite this limitation, it is essential that a rudimentary foundation be established since many of the themes that originated in the interviews are reflective of community-held values and normative practises. Skid row culture has been the focus of countless academic books, dissertations and reports dating back to the early 1960s. The same can be said for the plethora of literature on homelessness that has appeared since the 1980s. To illustrate, Rossi, in an exhaustive review of these studies, noted that his "working bibliography on the homeless exceeds sixty single-spaced pages of entries, of which three-quarters are from 1980 or later." (Pg. 65)[67] Wherever possible, the study observations have been grounded within the relevant literature. While not every participant in the sample was street-involved at the time of the interview, they were all residents of the inner city and interfaced with street culture and the institutions that serve this population. In addition, all of the participants had experienced homelessness in their lifetimes. At the time of the interviews, ten (10) of the sixteen (16) participants identified themselves as being "currently street-involved."

Following this analysis, the findings relating to the individual context are presented. The micro-context is divided into two parts. The first deals with general themes as they relate to individual norms, lived-experiences and notions of personal health. The second part deals with themes as they pertain to tuberculosis specifically. Areas discussed include: knowledge of TB, experience with DOT, attitude towards health care providers and so forth.

5.1 Socio-cultural Context

The Inner city

The inner city is a harsh environment, full of paradoxes and cold realities. It is a place that is shaped by the powerful interplay of economic and social marginalisation. It is Edmonton's equivalent of the **ghetto**—an area in which geography and economics are combined "to define, to isolate, and to contain a particular population group held to be inferior by the dominant powers in society." (Pg. 179)[68] The September 2000 [69] homeless count in Edmonton identified 927 individuals as being homeless.[M] Forty percent (368) were Aboriginal and 76 percent (282) of the Aboriginal individuals were observed to be absolutely homeless—that is, living on the street. Aboriginals are over-represented in the homeless population compared to the general population. They make up 40 percent of the street population but only represent about 4 percent of the total population of the city.[N] This corresponds with national data that indicates Aboriginal people in cities are more than twice as likely to live in poverty as non-Aboriginal people. On average, 55.6 percent of urban Aboriginals were living in poverty in 1995, compared to 24 percent of non-Aboriginal people. [118] [0] In this study, nine (9) of the sixteen (16) participants were Aboriginals (either

full-blooded or of mixed ancestry (Metis)). At the time of the interviews, two (2) individuals were absolutely homeless; six (6) were sheltered and two (2) were relatively homeless. The remaining six (6) individuals had stable housing. Of the 16 participants, fourteen (14) were single and unattached.

The inner city is often romanticised as a city within a city, as a place where everybody knows one another and where all are accepted despite their differences. In comparison to mainstream society, street culture is often described by its members as being "closer knit" and comprised of people who are "more real." The notion of "real" refers to people being stripped of the pretences and facades of mainstream society. People in the street community are deemed to be less judgmental and less critical of individual failings. Life is seen as being reduced to its lowest terms:

> Ahhh, I think it was just the freedom of it. You don't got to answer to nobody. You got no responsibilities. You got no family, you know. You can sleep outside and nobody's going to say nothing. You can eat out of a garbage can, you know. You can panhandle, you know. You can do whatever you want...as long as you don't steal, you don't kill someone or do anything illegal...you're OK. I never followed those rules, except for the killing person.

> The street is a form of freedom. If you look at street people...basically street people want nothing to do with nobody. Nothing. Like me, if you came up to me and you started asking me questions my first instinct would be...I give you a phoney name and all the information you need just to get you off my back or else I would just tell you to fuck off and leave me alone...like most street people would.

While some participants painted an idealised portrait of the inner city, the bulk of the narratives revealed a darker reality. Life on the street was typified as *basic survival*—a concept that captures all of the desperation and brutality typically associated with life at its most basic. While social assistance is a source of income for many people on the streets, its insufficiency drives the street populace to seek ways of supplementing it. Some individuals refuse to deal with social assistance and therefore rely solely on other sources of income. As Janice, a 32-year-old prostitute, says:

> I was a freelancer. My next high...if it interfered with my high forget it, I'm not interested. You know...Go sit in welfare for 2 hours you know how much money I can make in 2 hours, you know how much drugs I can do in 2 hours...I'd rather be on the corner than get money from Social Services, you know.

For some, this entails working for temporary labour agencies on a day-by-day, weekly, or seasonal basis. Others employ informal economic practises to make a living on the street, examples of which include: panhandling, bottle-picking, prostitution, pimping, hustling, drug dealing and stealing. Individuals supplement the deficiencies in their income by relying on shelters, soup kitchens and food banks to meet their basic subsistence needs (food, clothing and shelter).

Economic Practises

The participants interviewed in this study relied on a range of formal and informal economic practises. At times, individuals moved between the formal and informal economies in order to survive—for example, doing temp work one day and bottle-picking or prostituting the next. In terms of formal economic practises, six (6) of the participants relied on temp agencies for employment; six (6) were on social assistance; and the remaining four (4) had no formal income.

Day Labour & Temp Agencies

The most salient feature of street life is poverty. Although homeless individuals can often obtain free food and temporary shelter, other amenities such as cigarettes and beer must be purchased or procured in other ways. A daily challenge for street people is to acquire quick cash.[35]

Many street people deal with this predicament by seeking casual, day labour jobs. Because this employment is secured on a day-by-day basis, it is as Snow and Anderson say, work "without a tomorrow." (Pg. 122)[35] Typically, businesses contract with labour pools to provide cheap unskilled labour on a temporary basis for "spot jobs," such as construction work, unloading vans or moving furniture. Day labour is characterised by its "irregular hours, changing locales, and pay that is usually lower than regular work." (Pg. 123)[35] As a former employee of a casual labour office says: "A lot of businesses will rip these people off. They never get paid their worth."

Despite these obvious limitations, day labour offers several advantages for street people over regular employment.[35] One advantage is that labourers are paid cash on the same day they work—an obvious incentive for individuals with immediate needs and a lack of economic resources. Another benefit is that most day labour jobs provide transportation to and from the worksite—although the cost of this service is usually deducted from the worker's pay. In addition, day labour jobs seldom require that applicants have a recent work history, employer references or a clean appearance.[35]

Although day labour serves the immediate needs of street people the sporadic nature of such employment makes it nearly impossible for them *to work themselves out of poverty.* The result is a vicious cycle where individuals become dependent on shelters, soup kitchens and day labour agencies to meet their basic needs—with the resources in each component of this cycle being insufficient to allow individuals to break free of poverty. As one participant explains:

> Nobody's actually given up on work. They are always willing to work but they settle for temporary. They won't go out and find a regular job and they'll float from agency to agency. And again all they do is get the dispatcher pissed off at them and they don't get put out one day and they say "Screw you" and then they go to the next agency and...It's a vicious circle, because a year later they're back where they started.

[What would get them out of that way of life?]
Well, they'd have to change their mind first. That's always the hardest part, because a lot of times you start young and I fell into the same trap in Toronto. You start young, you're working for a temporary place, you're living in the shelter or very cheap housing and what happens is you get paid every day, $50 in your pocket; you don't put it towards anything. You don't put it towards your rent or groceries because you're already getting that from the shelter, so you got 50 bucks you go out to the bar and drink it or you go and buy pot or you go and gamble it or whatever. You get up the next morning and you're broke. Go to work, get off work you got 50 bucks in your pocket. You know...it's a vicious circle and you don't get ahead at all and you sort of get into a routine like that and you can get stuck in that routine and it can have disastrous effects on you eventually. One year of that and then to actually go out and find a job, you can't wait 2 weeks for the first paycheque. So you quit the job and go back to the temporary place or you call in sick and go work the temporary place so you get a little bit of money in your pocket, right, so you can go party on Friday night. You do that a couple of weeks and you get fired from your regular job and you don't have a paycheque to speak of, you know.

Day labour is also deleterious to efforts of the homeless to "pull themselves up by their bootstraps" because workers are often exploited by employers. Workers are part of a triangular relationship—client, temp agency, and worker—that creates significant disadvantages for them since they have little leverage in the labour market and usually lack information on such things as the temp firm's mark-up.[P] The average industry mark-up is 30-50 percent of wages for every hour worked.[70] This translates into workers being paid $9 per hour for labour worth around $12 to $15 per hour. Participants described temp agencies as "making money off the poor," as Earl (a 44 year-old participant) states:

Well, you know as far it goes there is the CLS crowd and I made a decision that I don't like their politics so I'm not going to work for them. I'll give you a quick story, because I did some shutdown work for them last year...well, there was this guy by the name of Ben and here he is and he's half-pissed and they have this little cage at CLS where you sort of grovel for your money and meanwhile he had worked two-and-a-half days that week so here he is and he was only entitled to seventy bucks but it was Christmas and the guy's worked for them for nine years...now I guess we all have choices...but anyway here he is at the front of the cage looking for another $30 from Don, the guy who inherited the business from his dad and somehow he's got power over a bunch of lackeys that make their money off the sweat of their backs...so at any rate, he just wants another thirty bucks for Christmas...the guy's worked there for nine years and meanwhile Don is telling him to fuck off and making him feel really small. And the most pathetic thing is how Ben kept on grovelling and he never did get the thirty bucks. And after that I said I'm never working for these guys again.

I think they [temp agencies] serve their purpose but that's about it. Unfortunately, what they do is they just perpetuate the cycle of poverty and they really don't serve any other need than basically help the entrepreneur that's running it get richer. They take advantage of the downtrodden. I mean it's no coincidence that A-Active is right across from the hostel. I mean it's pretty hard to have any respect for these people at all. It's need and greed. You get enough for maybe half a crack at the end of the day or maybe a couple of pitchers of beer and maybe you can get yourself into the mat program down at the Sally Anne.

For many workers, employment by a temp agency does not mean going to work. It means simply being available to the temp agency, which conducts all discussion about the job with the client, including wages, assignments, and schedules. Individuals are typically instructed to come to the temp agency at an appointed hour early in the morning. Because a person's chances of working are determined by the availability of spot jobs, punctuality does not guarantee work. Some are chosen; others are not. "Often deductions from the day labourer's paycheque for taxes, the agency's fees, and transportation to the job site provided by the agency are as much as one-third to one-half of what a worker earns." (Pg. 42)[71] Gary, a 50 year-old man who has done casual labour in the past, communicates his disdain for temp agencies:

> Put it this way, they should be outlawed. The only ones that are getting rich or making any money are the temp places. Another thing...now how many of these people...like there's a cookie factory that has been using a temp place for years. They don't put nobody on the payroll that way they don't have to pay them a decent wage. You've got no benefits. You've got nothing. And then they nickel-and-dime you on everything. Sure they drive to the worksite but it's three bucks one way. Like on the bigger jobs where you're making 9/hr, so that's six bucks a day. If they're paying me nine they're getting anywhere from fifteen to twenty. Put it this way, [to the employer we are just] warm bodies. I know some people that by the time they get their paycheques they've got half their wages. One day, they're broke again so if they get an advance...if they don't have money for cigarettes and they smoke...there is your tobacco. There're lucky if they got half their paycheque.

In today's labour market, agencies compete with each other for clients—less so for workers. The temp industry is highly competitive, and there are many incentives to cut prices charged for temp services. Yet little evidence suggests that temp agencies reduce their margins as they reduce their charges. Instead, lower prices are passed on to temp workers as lower wages, placing downward pressure on wages for all workers.[70]

In this study, the majority of the temp workers (4 out of 6) were employed as general labourers with the exception of two (2) individuals who specialised in the clean-up of hazardous chemicals. The latter two individuals were paid substantially more than the typical temp workers (averaging around $15/ hour) due to the skilled nature of their work, and were more established economically compared to the other participants. Despite this, all the workers felt that they were exploited by the temp agencies.

TEMPTED

Been straight for a long time now.
Need money to pay the bills.
Maybe a couple of hours
on the corner.
Worked before, why not now?
Got to look for a job.
Got to go to school.
Need money to buy clothes.
Maybe a couple of hours
on the corner.
Worked before, why not now?
Sure tempted to go back
to the old way of livin'
but its not worth going
back to all that pain
of yesterday.

Betty Nordin
(Pg. 22)[275]

The Informal Economy: Shadow work

Participants identified engaging in a variety of informal economic practises, which in the case of this sample included: prostitution, bottle-picking, panhandling, drug trafficking, stealing and "hustling." The term "hustling" refers to a range of activities that involve "ripping people off." This includes such activities as muggings and "scamming money off people." As one participant describes:

> I used to be a boxer, so I used to knock a guy out and take his money and get a room. Not people on the street. People that I had never seen before. Just somebody that was flashing their money around. That's how I used to make my money. I'd knock somebody out and take their money. Then I'd get a room and get something to eat and drink. Just stay in the room. Sometimes, I would go home for a day or two and then come back.

The informal economy is often referred to as **shadow work.**[35] While it is not *work* in the traditional sense, it is work to the extent that personal

energy is directed towards procuring money or material goods for personal use or exchange. Unlike the formal economy, this exchange of labour for money is not regulated nor is the activity officially sanctioned. Instead, "they are compensatory subsistence strategies that are...pursued in the shadow of more conventional work" because individuals are excluded from the workforce or because other forms of income (such as wage labour or social assistance) are insufficient for survival. (Pg. 146)[35] Shadow work involves the opportunistic use of whatever resources are available to meet immediate needs. As such, it is characterised by a high degree of innovation and improvisation. As Wiseman observed in her study of skid row alcoholics in the 1960s:[72]

> When the skid row man thinks of getting money, he...must show ingenuity in creating something out of nothing. Thus, he thinks in terms of objects, relationships, or short-term tasks that can be converted into enough cash to take care of current needs—liquor, food, shelter, incidentals.

Concept of Time

According to Rowe, many street people are masters of **contingency**—adjusting to external forces and events whose general direction they cannot change.[73] Thus, street people find themselves "mixing and matching scant resources at the dictates of chance." (Pg. 15) The skillful use of timing on the streets takes precedence over the structured and goal-directed orientation typical of mainstream society. In the calculus of a street person's day, opportunities are constantly weighed according to immediate needs—for example, a chance meeting with an acquaintance can lead to a night's shelter or a missed appointment with an intake worker for temporary accommodation. Key temporal events include conversations, serendipitous encounters, immediate survival strategies and ways of coping with boredom. While this sense of time is essential for survival on the margins, it is poorly suited to social agencies that rely on schedules and timetables.[73]

The present-time orientation (contingency) is an adaptive response to the vagaries of homelessness—with all of the inherent instability and unpredictability this entails. Living on the edge of both economic and psychological subsistence, street people expend all of their resources on maintaining themselves from moment to moment. As Daly says: "In an opaque, uncertain, turbulent, fatalistic world it is difficult to distinguish between preparing for the future and living for the present." (Pg. 11)[74] Gratification of hunger and addictions, and the desire for simple creature comforts cannot long be deferred. Neither can support for one's flagging self-esteem, even if that support occurs within potentially destructive relationships. Hence, the almost paradoxical actions many exhibit—the spending of welfare cheques in a blur of partying, the renting of hotel rooms and so forth. Street people spend what they have today because they have no guarantees for tomorrow. As one drop-in worker says, "It's chicken today and feathers tomorrow."

In some ways, the term "present-time orientation" is a misnomer. It would be more accurately described as a "troubled future orientation." It is not that street people only experience time in the present. It is rather that their experiences of marginality have engendered in them diminished expectations for the future. As Beth, a prostitute and street person says:

> I think that is one of the reasons people are so afraid to do something...to make a change for themselves. Because once you've had something good and you lose it, it's the most horrible, horrible feeling to end up with nothing...after you've had everything.

The issue is one of an articulation between the past and the present, as Elliot Liebow describes saliently in his comparison of black "street corner" men in the 1960s to their middleclass counterparts.[75] People in the mainstream envision a positive relationship between the immediate present and the future. They believe that their present-day efforts will "yield a tomorrow that is as *good as* or *better* than today." (Pg. 170 emphasis added)[35] This sense of entitlement is not shared by the marginalised—their futures do not inspire the investment of their meagre physical or psychological resources. As George Orwell says: "the great redeeming feature of poverty" is that "it annihilates the future." (Pg. 20)[76] Beth captures the same sentiment:

> I see emptiness, it's just a shell...you know, people have given up. They've come to the drop-in centre and this is all that they've got. They wake up in the morning and that's all they have to do—to go to the drop-in centre. There is nothing else for them to do and that must be pretty frustrating. Pretty unhappy...and no wonder every once in a while you'll have a blow-up downstairs.

While contingency carries with it the sense of living "on the pulse of the moment," constant contingency can be as monotonous as it is unpredictable. (Pg. 16)[73] In their classic ethnography on elderly men in the Bowery, Cohen and Sokolovsky note that life for homeless men is largely cyclical with their daily existence moulded by the agencies and institutions on which they depend for daily meals, monthly checks, and accommodation.[57] Similar patterns are present in Edmonton as well. Joe, a 41-year-old alcoholic, describes a typical day at a local men's hostel:

> They dictate the three times a day that you eat, so plan your day around that. You know you get up in the morning...you have to get up in the morning, you have to get up at six, breakfast at seven, so you know you're up at seven for breakfast and in that time you have to shower and what not, get ready. After breakfast, you have to be out of the place, so you find something to do for the day. Either you go out for temporary work and you're back for supper. If you don't I go to the library, 11:30 I leave the library and come back for lunch, have lunch. If in the afternoon I want to go for a walk, it's a nice day...go for a walk, but I have to remember I have to be back at 5 o'clock for supper, because they don't have late suppers. You know, you have to work on their schedule.

[How do you think that affects people?]
A lot of people are not happy about that, because they'll come out of jail for example. They did 6 months in Fort Saskatchewan or whatever and...when they get out of jail they're finally free of the institution and they end up in the hostel and they're still institutionalised. Sure they get freedom, they can go out the door and get away from it a couple of hours in the morning, a couple of hours in the afternoon. You know...but they have to be back for meals or they starve. They have to be there at bed call. If you're not there you don't get your bed, which means you're out on the street all night and the next day you have to start all over again. So you're still institutionalised and they don't like that, because when they come out of jail they expect to get back to a normal lifestyle.

Idleness is a characteristic of street life. One thing many homeless people have an abundance of is unscheduled time.[35] Bereft of its productive value, time becomes something they have to *kill* from moment to moment.[73] Time, instead of being a tool, becomes a burden. Every day, however unpredictable, becomes like any other. As Eighner says, "Every life has trivial occurrences, pointless episodes, and unresolved mysteries, but a homeless life has these and virtually nothing else." (Pg. XI)[77] Street people spend much of their time waiting—for agencies to open, in line-ups at soup kitchens, in the packed lobbies of welfare offices.[73] Their lives are proverbially *on hold.* As one participant says:

You're always waiting. Like today I can't stand line-ups...you're waiting for the sandwich... you're waiting, you're waiting, you're waiting. Waiting for what? And when you get to the front, it's all gone. There is nothing left for you.

If one's ability to control time is seen as a measure of power then the painful drudgery of homelessness is a reflection of a lack of power and integration into modern society.[73] As Freund *et al.* say: "Time is socially organised and the ability to schedule time and to manage it is socially distributed. Those with more power have more control over time." (Pg. 91)[78] For homeless people, the constant waiting is a reinforcement of their own irrelevance and powerlessness. A perpetual state of boredom led several of the participants to seek ways of obliterating their idle time. Addictions were the primary weapons in this assault, as the following two excerpts illustrate:

[I drink] Whenever I can. There's nothing else to do. I don't want to sit in my room and just look around all day, so I come outside. I'm supposed to be on my oxygen but I come walking around. I leave it at home because it's to heavy to carry around all the time.

Paul (52 -year-old, relatively homeless, Native man)

The thing about it is, what'll kill you is the boredom. Because I get bored really easily. And that's what the addiction and shit like that, you're just...so now, a lot of the times, I'm sitting around wondering what to do.

Earl (44-year-old, sheltered, White man)

The use of drugs and alcohol is a defining characteristic of street life. This avenue for escaping the oppressive realities of the inner city, while stigmatised by the larger community, is "consonant with the subculture

of street life itself." (Pg. 208)[35] In this study, all of the participants had histories of addictive behaviour. Due to the centrality of substance abuse in the participants' lives, formal and informal economic practises were directed in varying degrees towards feeding the insatiable appetite of their addictions. For homeless people, engaging in informal and often illegal activities exposes them to the risk of peer violence as well as the threat of police apprehension. Even the most benign of activities such as bottle-picking or panhandling exposes individuals to potential risks such as police harassment. Police closely scrutinize the homeless as they wait to enforce vagrancy, panhandling, and public intoxication by-laws. Instances of police brutality are also not unheard of—with a number of participants recounting times where cops had assaulted them.

Street Culture

The essence of street culture "resides not so much in a distinctive set of cherished values as in a shared fate" and the adaptations and rituals the homeless have resorted to in response to this fate.(Pg. 109)[35] These responses are not haphazard. "They are structured by a set of organisational, political and moral constraints."(Pg. 109) As Snow and Anderson articulate:[35]

> Since the seeds from which subcultures germinate are structurally embedded, the behavioural (what people do), artifactual (what they make or use to do it with), and the cognitive (the meanings people give to things) elements coalesce to give a subculture its distinctiveness and can be construed in part as adaptations to structural exigencies and opportunities. (Pg. 39)

A system of **reciprocity** exists on the street, as an adaptive response to the survival needs of individuals. Sharing is a valued action in the street community, and is often expressed in the karmic code of "what comes around, goes around." This ranges from the lending of cigarettes and alcohol to the provision of food and shelter. This translates into individuals being *lenders* in one situation and *debtors* in another. An example of this occurs in the context of drinking where alcohol is shared today on the premise that the favour will be returned tomorrow. The formation of bottlegangs, for example, allows for the communal sharing of alcohol.[79] The notion of reciprocity even extends to situations that are more exploitive in nature, as one participant explains:

> It's a mutual understanding that if I scam off you today then tomorrow you can scam off me...and if we scam together and make this money together and fuckin' split it up...then that's fine too. And that is how it basically is everyday. It's a form of survival. Basically, you have to learn to use every means possible to survive.

In addition to the sharing of commodities, reciprocity is also demonstrated by the sharing of information. Within the street community, there exists a complex system of knowledge and normative practises that constitutes the "street

culture." This culture encompasses values and beliefs but also includes practical information related to survival. As John, a 39-year-old Native street person says:

> Street life is basic survival and where you learn that basic survival is from other street people. They tell you who not to trust and who to trust...which places to eat and which places to go. Basically care about each other. They do. If a man falls down on the street, any man, and a street person is walking along, they'll be the first one to help that person. But if you see the regular Joes...they'll just keep going. I think that the basic difference between street people and the regular Joes is that street people take care of their own.

Word of mouth is the primary mode of disseminating information amongst members of the street community. An informal network of relationships connects individuals in the various gathering places such as the downtown bars, drop-in centres, parking lots, empty fields and alleyways. As Iris says:

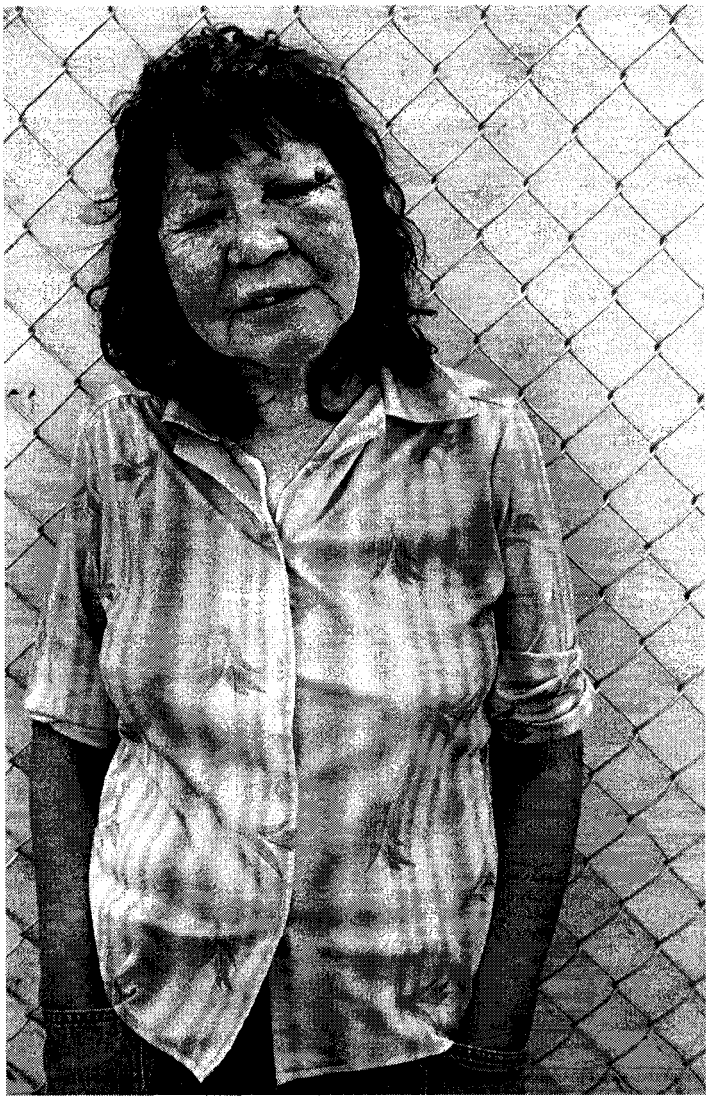
> Ah...with my street family...the highlight of my day was the New Eddy, the Alberta Hotel, the Cecil...I mean that's where you can find them at anytime or a Bingo Hall, as they got older and had to quit drinking. The street...I guess for some people it provides extra money but then at the same time it takes. But for some people it's there way...I look for people and they're constantly looking for me and that's the street—that's the street way. There's a lot of people that are just too solid to say where your address is but they will pass on messages. The bars are your access route for finding people if it's important or getting messages.

The effectiveness of the grapevine was evident throughout the research process. Individuals were uniquely aware of the changing life circumstances of their peers, and of their whereabouts. It is through the grapevine that social cohesion is maintained and cultural values are propagated. It is this loose network of relationships that allows the informal economy of the streets to exist.

The Context of Violence

Although some participants identified sharing and mutual concern as redeeming aspects of street life, others believed that the streets were getting harsher. Participants felt that the social environment was becoming increasingly more violent and uncaring. As Donald, a 35-year-old homeless man who had at one point been stabbed over alcohol, describes:

> I grew up with all of these people down here, but lately no...lately with the killings and everything that has been going on, stabbings and killing and even *me*, being stabbed over a bottle of beer...and no respect because it is younger people doing it to an older person that doesn't even harm nobody. Like this guy the other day that got killed...Willie...killed over here. I think it was over beer, too!. And he was the type of person who wouldn't even hurt a fly. He was quiet and by himself all the time. But what I heard was that he bought three Colt 45's and walked across the street and that's what happened. And that's why I know my sister is, out in Westlock, my older sister, eh...she worries about me a lot. She worries about me constantly because she hears all the time that people get killed down here and she worries that it is going to be me.



Bad Time Betty

In the past I would hear,
"Bad time Betty in on the streets.
She is causing havoc
and commotion all over the place.
When she's bad,
she's really bad.
Dumping people in garbage bins,
Stealing from the stores,
Givin' the johns a bad time.
She is drunk and mean."

Today
Bad time Betty
is good time Betty.
Walking with her head held high.
Goin' to school,
done her probation time.
No more being the street drunk,
livin' in half-way houses.
Today she is havin'
a good time off the streets.

Betty Nordin
(Pg. 7)[275]

While it is beyond the scope of this research to confirm the veracity of this anecdotal evidence, the inner city is undoubtedly a violent place. Studies in other urban centres have borne out this reality. In Toronto, for example, a survey found that 40 percent of homeless individuals had been physically assaulted and 21 percent of homeless women had been raped in the previous year.[80] A study conducted in the same city found that homeless men are about 9 times more likely to be homicide victims than their counterparts in the general population.[81] In Edmonton, seven (7) of the twenty-two (22) homicides in the year 2001 occurred in the inner city. Three of these murders occurred in the Lodge Hotel—a notorious skid row flophouse.[82]

Due to the confluence of addictions, anomie and violence, skid row can be described as a "socially toxic environment." [83] As one inner city resident commented, "If your life seems hopeless, how much is it worth? When you don't have much to lose...you're either the aggressor or the recipient of aggression." [Q] Ironically, in seeking refuge on the streets from violence and abuse, many of the participants found themselves in an environment that was ripe with the same destructive elements they had sought to escape, as Iris says:

> It seems we spend so much of our lives running away from it [violence] that we run right into it. We're fighting so hard not to have it in our life that it is always in our life. It seems like you are fighting yourself. I used to be a really peaceful person up until the age of twelve. I was very much into music. I had it planned I was going to be a veterinarian. And then all of a sudden everything blew up. I ran away and that's what I have been doing running away.

As indicated previously, the homeless suffer from higher rates of victimisation than the general population. Participants portrayed violence as an unavoidable part of life on the streets as well as a necessary component for survival. Many described themselves as being hardened to this reality. As one individual says, "After this life on the drag you just get so cold you just don't feel anything except anger." While emotional disengagement and avoidance of threatening incidents such as muggings and assaults are adaptational responses to a dangerous environment, these strategies often fail to buffer individuals from the emotional and psychological impacts of either witnessing or being victims of violence.

On June 21st 2001 Mark Rutherford Meggeson, 36, was beaten to death in his room at the Lodge Hotel on Jasper Avenue near 96th Street. Police said it appeared that two men entered a third-floor suite where Meggeson and his friend, Brian Palm, 40, were confronted. An autopsy revealed that Meggeson died from blunt force injuries. Palm died two weeks later in hospital.[82] In the following selection a fellow resident of the Hotel describes his reaction to the murders:[84]

> It had a profound effect on everyone there, you know, even on myself. Didn't sleep well and then it really hit home how delicate we are as human beings, the physical body. It's rugged in some ways, but then...just like that, you die. I mean, Mark, he was dead right off the bat. Brian you could talk to. He walked out of the building. Then he dies. It's a shock.
>
> I don't know what might have happened if I had been in the building. I might have died. I'm not willing to see someone being beaten to death in the hallway. That's my home. It's a shitty-ass home, but it's my home.
>
> I survive because I'm not dead. I went and I got drunk. I went out and drank my face off one day and vented. It was my way of getting rid of the pressure of dealing with death. I've dealt with death before, but still for me, it doesn't make it any easier. Like I may be desensitised to more things in life, but when the taking of a life is pointless, without any heroism, no purpose to it whatsoever, it affects me.
>
> Still the fact is, it's them not me. Better them than me. It could happen at anytime. I knew that before. It's either live with it or die with it. The choice is pretty simple. I'm pretty tenacious as an individual, but what can I do? Can I kill myself? For me that's not an option. And at the same time I feel safer than the average person. I don't hang around with aggressive assholes. I choose my companions very, very carefully. I don't let aggressive assholes into my home. If someone tried I would stop them...violently. Either that or be mowed over. I'm not a tough guy. I'm not a mean guy, but it's my home. I'm going to defend myself.
>
> I have some trepidation, but lightning has already struck. I'm still here, but I want to move. It's sad enough. On that floor, we're putting flowers in front of the door. One of the guys is drinking more than usual. My neighbour is in shock. He's moving to Saskatchewan. It's death, it's our neighbours, it's our home. I was pretty shaky. I still haven't gotten over it. I mean, I walk past the door and it comes up. I wasn't there for the violence. I was only there for the aftermath. It looked like an abattoir.

One of the dominant values of street life is the notion of being "solid" which entails not interfering in the affairs of others and remaining silent about behavioural transgressions such as illegal activities. At its most primal, the notion of being "solid" can be reduced to: "Don't fuck with me and I won't fuck with you!" It is a tacit understanding that keeps antagonists apart and thereby reduces potential conflicts.[35] The code of silence and non-interference is described in the following excerpts:

> Oh, here is the big one—there's no challenge there. Like you can walk around there and if you have your wits around yourself and you can consolidate some people (and you don't have to consolidate many). If you're only going to be in three or four environments in that situation then you have no problem at all. As long as you're solid and by solid I mean you turn a blind eye to everything. And that's important in the inner city.

> That's an old jailhouse attitude being solid. A lot people say you got to be solid. The street people are expecting you to be a certain way all of the time. To be rough, and act tough. Some of these street people that's how they act. It's a form of acceptance. Solid to me is that you have to have some muscle behind you and you have to keep your mouth shut.

A graphic illustration of this street code was provided during the research process when I met with a rape victim who was unwilling to identify her attackers. The event is captured in the following excerpt from my diary:

> I spoke to woman today who is an amputee, in a wheel chair. Over the weekend, she was savagely beaten and raped. According to her she was leaving one of the inner city bars with some money in her purse and 3 bottles of Big Bear in a plastic bag. Three men took her into the back alley. Her face is bruised around her right eye, her torso is blackened as well her stump. She refuses to identify the three men who committed the crime for fear of being labelled a "rat" and incurring retaliation. In tears, she tells me she has been on the drag for 14 years and nothing like this has ever happened to her. She spent four days in the Royal Alex after the police found her in the alleyway. The code of silence prevents her from involving the police any further. It is rumoured that her boyfriend had beaten someone to death with a two-by-four while defending her in a past assault. She is worried that he will seek similar retribution following this incident. (April 11/01)

Ironically, the strategy of "turning a blind eye" helps people survive the challenges of street life, while simultaneously reinforcing their disenfranchisement. "Acceptance and resignation become the norm, and control is left to those in authority." (Pg. 97)[85]

Social order is maintained by the values of sharing, acceptance and non-interference as well as by a system of "street justice"—of which retaliation is the primary operant. Individual grievances are settled by the use of intimidation or physical force.

> It's protection. You have to muscle. You have to step on people's toes to get some place. You have to. It is the same as the business world. In the business world you have to step on people's toes. You have to be violent in a different way. Not physical violence but you have to be aggressive in the business world to get ahead and gain respect from your peers. It's the same when you're a street person. You have to beat the hell out of someone or stab someone or act like you're fuckin' solid when deep inside you're a hurtin' son-of-a-bitch and you're lost. A lot of these people that muscle people and are aggressive when you pull them aside and talk to them there's a totally different story behind all that shit and caboodle.

Entrenchment in Street Life

Violence and intimidation are so pervasive in street culture that some participants found it difficult to adjust to mainstream society and its social norms—a clear example of which is provided by the case of John, a 39 year-old Native man and alcoholic. He was deeply entrenched in street life, having spent most of his adult life either in jail or on the street. When I met John, he was desperate to change his life, as he says:

> This last time, I was really sick and I just got tired of being sick. You know physically sick...hung-over in the morning...shaking and feeling like you're going to die. You need another drink. I got tired of that shit! I got tired of it. I ran out of fuel at the end.

With the support of workers at a local social agency, John received treatment for his alcoholism and has been sober for over a year. Throughout this period, John made incremental steps in bettering his life. He completed a job-preparation course aimed at getting Native individuals into the workforce. At a local drop-in centre, he managed to get the occasional relief shift. In addition, he obtained social assistance and an apartment of his own—a marked improvement over the alleyways and parkades he slept in before. Despite his personal progress, John struggled to bring order to a previously chaotic life. As he says:

> To really give up that life is hard. I had to relearn everything. I had to relearn how to sleep in a real bed. I had to relearn how to use table manners. Just basically how to live. Every day is a challenge for me.

He moved numerous times during the year from one apartment to another. Even with the job-preparation course, he was unable to secure employment—being minimally educated and absent from the workforce for over twenty years. Eventually, his relationship with co-workers at the drop-in centre began to strain. He found it difficult to live up to the expectations of his newfound community. Initially, he had received accolades and public recognition for having dealt with his addictions. Eventually, however, the constant stream of praise began to ebb as people expected him to "move on with his life." As time wore on, John increasingly reverted to his street ways, relying on intimidation and aggression as a way of dealing with interpersonal conflicts. According to John, "the street was still in his blood." In response to a growing sense of malaise and alienation, John quit his position at the drop-in centre. Shortly thereafter, he got into a fistfight with another client at the centre, which culminated in him threatening one of his former co-workers.

The difficulty some street people have in adjusting to the norms and values of mainstream society can be likened to **culture shock**—the feelings of discomfort, helplessness and disorientation experienced by an outsider attempting to effectively adapt to a different cultural context.[86] This is understandable given that street life often entails dwelling "on the margins of language, com-

Budget

Budget for rent
Budget for power
Budget for phone
Budget for cable
Budget for groceries
Budget. Budget. Budget.

Didn't have to budget
livin' in a
garbage
bin.

Betty Nordin
(Pg. 10)[275]

Changes

Got to change my ways
or I'm going to die
on the streets.
Getting too old living like this.
Getting up in some back ally,
on a river bank or a flea bag hotel,
just doesn't cut the mustard
for me anymore.
Scrounging for food, standing
in soup line, going through
garbage bins.
There has got to be a
better way of living.
Getting up in the morning
to see my parole officer or
I'll be in trouble again.
Never had to live with a clock before.
Now I'm always late.
Eating in the morning sure
feels good.
Especially when the food comes from
my own cupboards.
Now I've got clean clothes and
sheets to sleep on.

Man life is good.

Betty Nordin
(Pg. 5)[275]

munication and sociability." (Pg. 122)[87] This theme was repeated throughout the research. In one instance, Don—a 35-year-old homeless man who was accustomed to sleeping outside or on the floor mats at the Spady Centre—revealed his difficulty in adjusting to mainstream society. He had a sister who lived in an outlying community who invited him to stay at her place. She had prepared a guest bedroom for him, replete with all the comforts of home. Despite these amenities, this individual was more comfortable sleeping on the floor than in a bed. Another participant, a 32-year-old prostitute described her experiences in the following:

> I tried to lead the straight normal life but I didn't connect, didn't connect with anyone. They all seemed prissy to me, like you big baby or something so (laughs)...And I can understand I had a lot of anger issues...Um that I would just lash out at people, you know...I was pretty free in what I would say like "I think you're an asshole!" I'd just come out and say it, and they would sort of ahhh (gasp) and these are Christian people. I would just like Oh-Oh, what did I say, what did I do? I didn't know how to live a straight normal life. And so of course it became overwhelming with all the anger and suppressing it, I was right back to the street in an instant.

The Social Embeddedness of Addictions

Addictions are intertwined in all aspects of street life. Street values such as *reciprocity* are demonstrated and reinforced by the activities necessary to procure alcohol and drugs and by the subsequent sharing of these substances. "Using" is a social activity, which solidifies relationships between individuals, "hence the group divisions of Alkies, Druggies, and Sniffers." (Pg. 15)[164] The bottlegang, for example, is one way in which individuals organise socially and bond ritually.[79] "As one fluid body of affiliation, the bottlegang group is a spontaneous and tenuous structure. The formation of the group permits the men to pool their resources and thereby drink communally as well as cheaply." (Pg. 182)[79]

Addictions not only bring people together but they also contribute to the violence that tears people apart. Addictions are often maligned by individuals while at the same time being encouraged by the complex social interactions that occur in drop-ins, in hotel bars and on the street. This is apparent in the personal narratives of alcoholics and addicts who admit to the terrible ravages of their addictions and yet find themselves in an environment that reinforces this activity. Joe, a 41 year-old homeless man describes why he always gravitates to the inner city:

> Um, two reasons...the first one me being an alcoholic I can find more people I can associate with in the inner cities and also I find that it's a little bit harsher down there but it is sort of a friendlier atmosphere once you get to know people. You tend to stick together as a group better. You know, there are a lot of people who can watch your back.
>
> Mostly, [I stay in] hotel rooms. I rent the hotel room by the month. I find it a lot easier...you don't have to move bedding around and it saves a lot of inconveniences like that...some are better than others. Some of them I've had to move out right away because of the noise and the general tenants in there. Some places are not too bad, you end up with other alcoholics as neighbours. You can go over and share beers and whatever...so it's pretty good that way. It's a lot better than staying in the hostel.

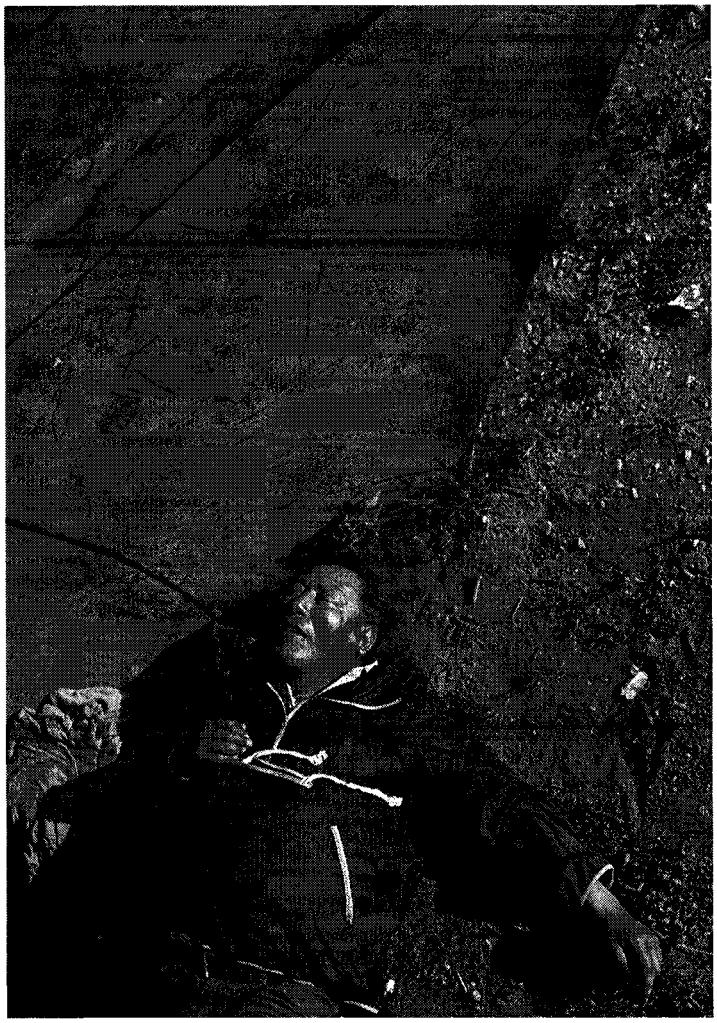
Addictions play such a dominant role in social relationships that individuals actually report encountering social disapproval for trying to change their lifestyles:

> I've come down here before when I was clean, with good clothes and looking healthy. People don't like it. They say, "Do you think you're better than us?" The only way they accept you is if you are dirty, drunk and drugged out. They want to drag you down and these are your so-called bros. They only like you when you're as low as they are.

Street people are acutely aware of differences in social position, to the extent that even a change in lifestyle can be perceived as a change in status. This has been observed in other studies, as well. In his ethnography of Winnipeg's skid row, Hauch notes the following:[88]

> Some men will attempt a clean break from the street despite all the resultant pressures to the contrary. Still living on Skid Row, perhaps being able to afford a hotel or cheap rooming house by the month in the area, a new "straight" may be less than amicably reminded by old friends of "street obligations." Censuring takes the form of ridicule, often of his presumed lost freedoms, neat appearance, and imagined obsequiousness with employers. (Pg. 42)

The social embeddedness of substance abuse is a major barrier to treating addictions. Dealing with addictions entails confronting the socio-environmental factors that reinforce the addictive behaviour. Social acceptance positively reinforces addictive behaviour while at the same time the fear of encountering social disapproval and ridicule deters individuals from seeking addiction treatment (negative reinforcement). Addictions are so enmeshed within the socio-cultural environment that even the sensory qualities of place, time and



The Bottle

They sit behind railway ties, garbage
bins, behind the buildings
And among the trees and shrubs.
You hear the laughter, words of anger,
sometimes singing
As they pass the bottle around.
The bottle is their friend.
It won't let them down.
People have let them down
so many times.
Broken promises, I will do it,
see me later.
The list goes on.
The bottle only lets them down
when its empty.
They all know when that happens,
there is another bottle.
And another gathering behind
railway ties, garbage bins,
Behind buildings
And among the trees and shrubs.

Betty Nordin
(Pg. 17)[276]

language can trigger addictive cravings. Janice, a 32-year-old recovering drug addict, provided a poignant example. My interview with her occurred in an inner city restaurant that was close to where she had formerly worked as a prostitute. Despite my offer to go elsewhere, she was eager to test her reactions to this familiar territory. During lunch, Janice was visibly agitated and hypersensitive to the environmental cues around her. This was the first time she had been permitted to venture outside of the protective confines of the treatment centre. After our interview, I drove Janice to a medical appointment that she claimed would only take "half-an-hour"— a term that was emotionally loaded, as she says: "Geez, I can't even say that! It's a trigger: 'half-an-hour' means a half-gram of cocaine; an 'hour' is a full gram."

In the world of addictions even language can evoke ideations and desires for substance use. Breaking the cycle is so difficult that some individuals are driven to escape the inner city in order to do so. One participant, a 35-year old alcoholic and solvent-user, turned himself into police in a frantic attempt to deal with his addictions. After a four-month period of incarceration and enforced sobriety, he returned to the inner city. Even with the support of staff at

a local inner city agency, he relapsed as soon as he was released from custody.

The concern over social position is a direct reflection of their lack of status in society. Typical statements of being "down and out" and having "slipped through the cracks" are references to social status, as well as reflections of social isolation. The homeless are subject to the processes of marginalisation in their quest for safety, security and recognition. Many of the informal economic practises street people employ such as panhandling, bottle-picking and prostitution expose them to public scrutiny and judgement. These very acts of survival reinforce the common stereotypes that plague them. In order to cope with disaffiliation and social isolation, homeless people seek material assistance and emotional support from other homeless people and networks. The public gathering of street people in fields, alleyways and parking lots only furthers their reputation as vagrants. While these ties may help individuals cope with isolation, they also contribute to the entrenchment of the homeless condition. The "quick and easy conviviality and an ethos supporting the sharing of modest resources are counterbalanced by chronic distrust of peers and fragility and impermanence of social bonds." (Pg. 194)[35] The street only offers the façade of community. "It belongs to everybody and nobody, and puts everyone on the same footing. It cancels out the past and makes the future uncertain: only the present moment counts." (Pg. 136)[89] As one participant says:

> The street is a way for people not to be pressured into caring. Everybody has different values but solidarity is supposed to be number one, because you find out very quickly who the rats are. The street doesn't have as great expectations as the rest of your life did. You can hide in the street. You can hide personally but then you can't hide because the street keeps moving.

Social Agencies and Social Services

For street people, life consists of a series of indignities that they are forced to endure and in doing so they are constantly reminded their own irrelevance.[74] The daily insults and the accompanying experiences of impotence and frustration are an assault on their selfhood. If one's home is "the outer envelope of personhood," then being homeless, either in the absolute or sheltered sense, is a deprivation of the self. (Pg. 29)[73] Interactions with the larger community—whether they occur as encounters with social workers and medical personnel or with the public while panhandling—are fraught with the potential for judgement. Under these circumstances, any perceived setback or slight (however small) can be interpreted as a major defeat.[73] For the large proportion of homeless individuals in Edmonton who are Aboriginal, the effects of racism compound the injustices of poverty. As the following two selections illustrate:

> These people down here [referring to social and health workers]...they poke you with needles, they take your paperwork but they let you sleep on the street. It's because we're Native. Yeah, go sleep at the Herb [makes a sweeping motion with his hands.]

> It's the general public's opinion of Native people through media and all that other stuff. The only time that they look at us is when they see us as drunks or as people living on the streets. The media has a big part to play with it and they hide a lot of things. If a street person dies on the streets, they don't care. It's just another dead street person. Like that guy with the Alzheimer's, you know, like he went missing and he was all over the media, you know...and then they find some [homeless] guy out by the liquor store [frozen to death] and that wasn't even mentioned in the paper. You know, stuff like that.

Social Assistance

Chief among these is the judgement received by those applying for social assistance. Many of the participants expressed anger at a system that appears to foster degradation and control. The experience is typically described as one of "jumping through hoops." Those who successfully brave the process find themselves confronted by the paradoxes of a welfare system that, on the one hand, provides a living allowance that is insufficient for survival; and on the other hand, penalises individuals for supplementing this amount with their own efforts. The allowance for a single employable in Alberta is $408/month but recipients are only permitted to top this up by $115 a month (combined net income) plus 25 percent of any amount over 115 dollars.[90] For a single person working full-time at minimum wage (i.e., more than 30 hours/week) the policy means a total earnings exemption of $303 a month. Since earnings in excess of the exemption are automatically deducted from the monthly allowance, an individual working 32 hours a week at minimum wage would be ineligible for SFI—the individual's total deductions being greater than his SFI allowance.[R] A further lunacy is that applicants require a place of residence before they're eligible for funding.[S] The result is that those with the most urgent needs (i.e. the homeless) are unable to receive assistance, while those receiving welfare are trapped by a system that discourages personal initiative.

Information from the Edmonton Task Force on Homelessness indicates that SFI rates are inadequate to meet basic expenses—either there is not enough money to pay for accommodation, or money needed for basics such as food, is used to pay for housing.[91] In other words, many recipients of social assistance spend more than their shelter allowance on rent and are obliged to subsidise their welfare cheques by cutting into their food allowance. This observation is buttressed by statistics provided by the Edmonton Food Bank which indicate that 65 percent of their clients are either receiving or waiting for SFI benefits with 80 percent of the recipients reporting that their income does not last through the month.[92] In addition, SFI recipients reportedly rely on the Food Bank 30 percent more over the course of the year than people who depend on other sources of income such as employment. This suggests that SFI clients are mired in a greater "long-term financial bind than other food bank recipients." In addition, 46 percent of the Food Bank population are reported to be unattached singles with 79 percent of this group being male. This indicates the difficulty single unattached males have in escaping poverty—a reality that corresponds with the testimony of the participants in this study.

Gary, a 50-year-old welfare recipient referred to welfare as *farewell*, alluding to the insufficiency of the SFI benefits. Gary's case illustrates the frustrations faced by individuals living in poverty. Previous to going on social assistance, Gary worked as a manual labourer: laying concrete and doing carpentry work. He only obtained a minimum education but his lack of schooling never posed a problem in his earlier life because jobs were readily available. In 1980, he went back to school for a carpentry ticket but never completed the program because at the time he was earning nearly as much money as ticketed employees. According to Gary, he always "worked hard and played hard." Throughout much of his working life, Gary struggled with addictions—oscillating between alcohol and drug use—but he managed to keep the problem in check. But as he grew older his fortunes began to change. Gary fell victim to the changing economy, his increasing age and his lack of education. As he says:

> Somebody said that life begins at forty. That's supposed to be your "easy street." But when I hit forty that's when I started to go the other way. When I moved back to Edmonton the boom hadn't started yet [and] I thought everything would be all right. Like when you work construction, one day you've got a hundred bucks in your pocket and then when things are slower, like in the winter, and you don't have money salted away then you only have a dollar. I should have had more education. I know I have to get some upgrading.

He found it progressively more difficult to get construction jobs because employers told him he was too old for manual work. According to Gary, he was "fit as a horse" until the summer of 1997 when he developed a range of ailments that he attributes to his years of back-breaking labour, namely arthritis and a debilitating curvature in his lower spine. It was at this point that he moved to the inner city in pursuit of cheap housing. Being unemployed weighed heavily on Gary—he had always taken pride in his work. Unable to pay for an apartment, Gary was forced to stay in an emergency shelter. Eventually he resorted to alcohol and drug use as a way of coping, but this time without the restraint he had exercised earlier in his life. As Gary says:

> The pot and the booze I was using every day. I was on a death-wish. The worse was when I came back from the hotel and I had smoked up. It was a Monday holiday so I was in there from one o'clock to nine o'clock at night. I was staying at the Urban Manor—the first-time about a year and the second time about 15 months. Now, I have my own place again. I was mad at myself and I didn't know why? I didn't care. I just said, "What the fuck is going on?" And I just let her rip.

Gary sensed that he was loosing control over the situation and sought treatment for his addictive behaviour. In addition, he managed to obtain medical welfare and a place of his own—an improvement over the stress-inducing environment of a communal shelter. Unfortunately, the social assistance he received was inadequate to meet his basic subsistence needs. He received $487 dollars a month—$315 of which went directly towards the rental of a small one-bedroom apartment. This left him with $172 for food, clothing and incidentals. Due to the insufficiency of his income, Gary was forced to rely on soup

kitchens and food banks to cover the shortfall—an experience that further reinforced his feelings of inadequacy and dependence. In the following selection, he describes how he survives on his meagre earnings:

> I'm not the only one who does it. You try to pick up some work on the side, especially during the summer. That way you don't have to go to the Seed and all the suppers and get involved in all the crowds. This year in October I had an extra expense so I started hanging around the Mustard Seed: Thursday, Friday, Saturday, Sunday. I started coming to the Bissell on Sundays. I've never been to the Mission before—I went there. Some people helped me out at Christmas with food so I didn't have to use the Food Bank. The thing is even without "using"...like I don't smoke. Basically, I just pay my bills: my rent, my cable...buy groceries. And I stretch out what I got. Usually by the middle of the month I'm broke. That's when you start hanging out where the free meals are. And the thing is there is nothing wrong with going there, but after a while you just get into the habit and then after while...like I don't know how other people react but it is an aggravation, like standing in line and people jumping in front of you. Just little things and after a while you say to hell with it and you don't bother going if you don't have to. You'll cut it down [going to soup kitchens] until it's the last straw.

According to Gary, being on social assistance is a demoralizing experience, fraught with stigmatisation and feelings of personal incompetence. The experience carries with it the seeds of a self-fulfilling prophecy, as stigmatised individuals participate in a "conspiracy of understanding" [93] about their identities that makes it difficult for them to escape the constraints of whatever labels are attached to them.[73] Hence, the *poor person* is bound by the stigma of *poverty* and all of the prevailing notions that ascribe this condition to a defect of character or moral fibre. Their life circumstance—being poor or homeless—is evidence of their incompetence.[73] This is often referred to as **role encapsulation.**[94] The mainstream encourages individuals to make such attributions, and these attributions have the function of deflecting blame away from the system. Merton states that the central message conveyed by the hegemony is that "success or failure are wholly the results of personal qualities; that he who fails has only himself to blame."(Pg. 222)[196] As a result, "aggression provoked by failure should therefore be directed inward and not outward, against oneself and not against a social structure which provides free and equal access to opportunity." (Pg. 191)[196] This is demonstrated in the following excerpt where a participant accounts for his destitution and alcoholism in a manner that is consistent with the flawed character hypothesis:

> Because I've had every opportunity in the world. I have been wholeheartedly exposed to enough things that have been put in front of me, why I'm where I'm at is just total failure...total failure or denial of wanting to do anything to the extent. So I can't romanticise who I really am. It's probably just laziness now or whatever. But within the core of self-belief, I keep something alive.

The classic sociological concept of stigmatisation describes the social processes that create and reproduce definitions of *outsider* and *other.* These processes ultimately lead to the *labelling* and *stereotyping* of specific groups and individuals as undesirable or deviant. "The labelling act devalues the individual, effectively

separating them from mainstream, normal and valued society members." (Pg. 54)[95] In the following excerpts, Gary describes the experience and his fears of being trapped by the stereotype of the welfare-user:

> It's demeaning. As soon as they [employers] find out you're on welfare, well, then you don't exist. You're invisible. That's the perception: "Well, we don't want nothing to do with you" ...employers...well, try to rent a place on the Southside if you're on social assistance. Like...whatever...it seemed like I had to work to put in that extra effort just to show people like I can do things. Always second questioning.

Institutionalism

The disempowering effects of dependency were also apparent in the narratives of those participants who relied on shelters for accommodation. Emergency shelters are not substitutes for permanent housing but rather are politically and economically expedient responses to complicated socio-economic problems.[85] At best, they are stopgap measures to provide beds to growing numbers of homeless people. At worst, they amplify the marginalisation of homelessness by acting as dumping grounds for problem populations. In their day-to-day management and control practises, shelters are organisational barriers to individuals escaping homelessness.[85] Examples of these practises include: the housing of a large number of residents in dormitories (where there is no privacy); short-term limitations on the length of stay, which promotes transience; night use only, which forces residents to leave early in the morning and (in the absence of work) find ways of "killing time" until the shelters re-open in the evening.[74 T] The management of individual behaviour is favoured over structural reform, thereby reinforcing the inequalities inherent in capitalism.[U] As one resident of the Herb Jamieson Centre (the single men's hostel) says:

> I went to the worker at the Herb [Single Men's Hostel]. She said she received my cheque and as soon as I get a rent confirmation I will get it. I asked her if I could look at it. The amount on the cheque was $747. I asked her what's going on. I'm on AISH I should be getting $850. She said: "We treat everyone the same regardless of whether you're on AISH or not." But what about these people 15 blocks over, they've got a house. They've got a place to stay. It's society—they don't care about us people.

Gounis views the shelter as an institutionalised response to the increasing numbers of homeless persons—a response that is *disempowering* due to its regimented and controlling nature.[96] As he says:

> Shelterisation describes the complete immersion of a shelter resident into the routines of shelter life. It involves the gradual acceptance of the views of oneself and the institutional appropriation of one's short- and long-term objectives. (Pg. 688)

The causes of **shelterisation** are located in the structural formations of institutional culture, in the degrading regimentation of life and in the ways residents cope with their "state of captivity." Like prisons, shelters disempower residents by segregating them from valued members of society and creating dependency.

The result is institutionalism: "a syndrome characterised by a lack of initiative, apathy, withdrawal, submissiveness to authority, and excessive dependence on the institution." (Pg. 26)[74] For many individuals, the shelter experience is part of a "downward spiral", which negatively impacts their "personal appearance, morale and physical and mental well-being." (Pg. 158)[74] One participant who had stayed in the medical wing of the Herb Jamieson Centre for over two years describes the experience as "feeling like being in jail."

> Well, the building is designed like a jail...you've got the dorms...you've got the staff coming in at night checking on you with their flashlights. All of that stuff you go through in jail, eh. You have to get a tray and line up for your meals. Somebody has told me that I might need counselling after being in there for so long.

Large shelters, reserved for single adult men, are impersonal and bureaucratic and "tend to induce feelings of shame, inadequacy and hostility." (Pg. 157)[74] The regimented and controlling nature of shelters, as well as the theft, violence and invasions of privacy that occur in such communal settings contribute to the helplessness many shelter residents experience, as the following excerpts illustrate:

> *[What's it like in the hostel?]*
> In the hostel? Before I got into the medical side I got my backpack stolen twice with a change of clothes and all of my shaving gear and what not...twice that was done and all my important papers were in the backpack. The first time they took my wallet, my pager and everything I own...my wristwatch.

> *[What bothers you about the hostels?]*
> The fights and the thieves—they sort of go hand-in-hand. You know one guy steals someone's work boots, rumour gets around, the guy who owns the work boots goes and beats the shit out of him. You know that's a common thing. And then there's the drugs. There's a lot of drug usage over there. Although, they'll [the management] deny it.

> At the Herb, everything is controlled. I can understand the point of everybody being straight [sober] in there. But it's like...when you can take a shower, all the little things. You've got to do this to get a towel. You got to be there at a certain time for this and if you're not there then you don't get it. Your baggage is locked up and there's a certain time you can get your baggage out. You're not allowed in the building during the day. But I think the worst thing is that they are supposed to be Christian. I'm religious but I don't just out of the blue...I don't know you...and then all of the sudden pop the question: "Do you believe in God?" They try to convert you. And if you put anything under your bed nine out of ten times it's not going to be there. [Theft] Somebody is going to scoop it up. They got their books and there's no grey area. It's just black and white. No give and take. Like I'm not saying you've got to bend the rules for one guy but if you need something for whatever reason...

Faced with these realities, it is easy to understand why many homeless individuals have a deep-seated apprehension and resentment towards authority figures. For those individuals who had been involved in the child welfare system—leaping from one agency, social worker or foster home to the next—the seeds of their aversion were planted early in their lives. As Janice, a 32-year-old street prostitute observes:

> Just when you start getting used to one home you're moved right into another. I believe that's where a lot of people that have grown up in the system start losing their identity, their own identity. Cuz you are too busy trying to focus in on the family, trying to fit in and stuff.

In the course of being shuffled from one institutional setting to the next, individuals lose their sense of autonomy as their private lives are documented, itemised and controlled to a degree inconceivable to most people in the mainstream. There is an almost endless stream of intake interviews, case conferences and assessments. Every move within the system is accompanied by the recapitulation of their woes and the re-examination of each detail of dysfunction in the person and his family. As adults, this process continues as shelter workers, addictions counsellors, social workers and police scrutinize the lives of street people. As one participant says:

> If you're dressed like a street person and you walked into an establishment they would not serve you. It does not matter if you've got a million dollars in the bank or anything. If you're dressed the way I am now and you go into a place, you know, a Wal-Mart or into Safeway or any other place: Bang! The security would be right there following you.

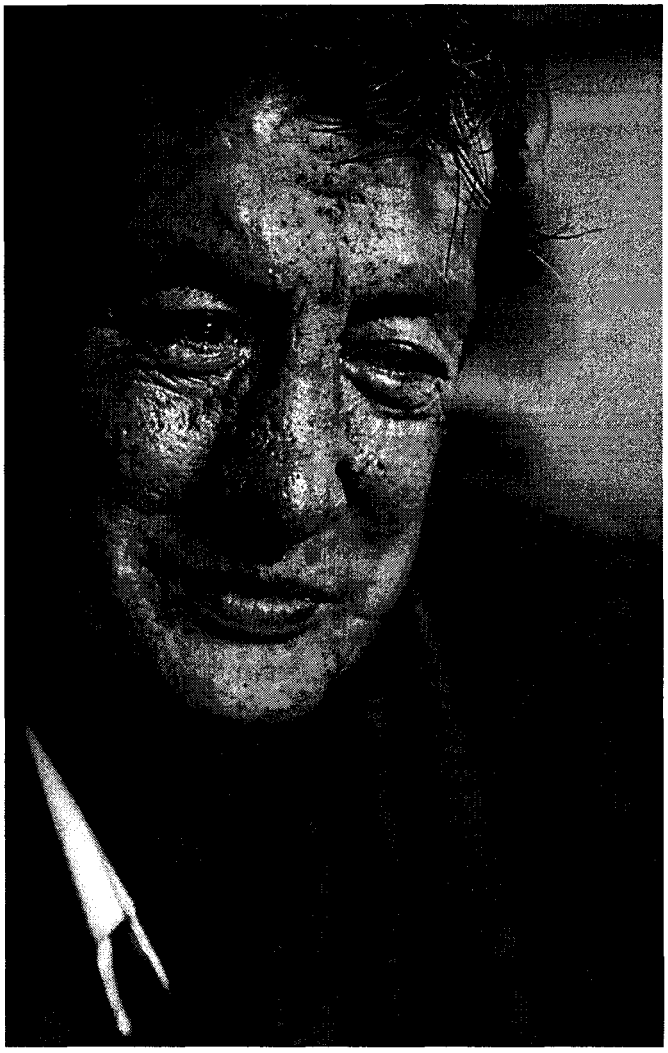
The Medicalisation of the Poor

In six years of working in the inner city, it has become apparent to me that the bulk of the agency responses to homelessness focus on the detection, diagnosis and treatment of understood shortcomings or deviancy among individual homeless people. Despite the wealth of literature linking homelessness to structured inequalities, few actual practises address this relationship. The approaches tend to be reactive rather than instrumental. They focus on repairing "damaged people" rather than on reforming a "damaging system."

This oversight is evident even in the anthropological literature, which for the most part, emphasises the description of traits or behaviours among elusive populations such as the homeless. In addition, much of the ethnographic work on homelessness has focused on the daily survival strategies of the disenfranchised. (See for example: Hauch[88]) These accounts are potentially detrimental because they focus on the marginalised population at the expense of looking at the socio-political world which has created the dynamics of poverty and isolation in the first place.

The result has been the **medicalisation** of the poor, with the disenfranchised being categorised in terms of whatever dysfunction or deviancy they happen to embody.[97] Mental illness, addictions and family dysfunction are itemised and chronicled in order to produce a composite of the problem. As Gowan notes:[97]

> This individualisation of the causes of homelessness restricts legitimate research to examinations of the individual characteristics that prevent the homeless from fitting in, and studies of the best ways to help them move back into society. The nature of the society they are expected to fit into *to*, is rarely the subject of debate. (Pg. 138)



The Bar

The bar is nearly empty.
There's only three, four people here.
I sit down and have a drink,
And as I sit my memory lapses to
the good ol' days
Or so I thought.

In the middle of the afternoon
the place is busting to the seams.
At one end of the bar in a
a darkened corner, business is roaring
for the working girls.
Everyone is happy.
Even the druggies and potheads are
flying high.

The drag as we knew it was not
the drag it is today.
We looked out for each other.
Today, people look out for themselves.
There is so much anger and pain
on the streets today.
Pardon me, what did you say?

As I looked around the bar,
it's still the same;
Only different faces, different people
with the same anger, despair and pain
Of the streets of yesterday and today

Betty Nordin
(Pg. 5)[276]

The disease model sets up a false opposition between 'proximal' causes such as depression or substance abuse and structural conditions beyond the individual's control—for example, the shrinking market for manual labourers and the loss of affordable housing.[97] This line obscures the complex relationship between the personal and the structural. The picture as a whole becomes distorted as the medical gaze shifts away from the community and its place within the larger society and towards the individual. While alcoholism or substance abuse is often ascribed as a reason for individuals becoming homeless, this explanation is overly reductionistic. Substance abuse aggravates other problems. "It is as a precondition for vulnerability." (Pg. 36)[98] Drinking-associated problems increase an individual's "vulnerability" by reducing the protection afforded by social networks and by increasing the deleterious impacts of disaffiliation—which, in turn, can spur mental health problems.[99] For men like Gary, there is rarely a simple linear relationship between depression, drinking, unemployment, and homelessness. As illustrated in the earlier case study, Gary's life was dramatically altered by a combination of factors: his increasing

age and physical disabilities and a lack of skills to compete in a rapidly changing labour market. His destitution was not the result of some kind of individual pathology. It did not arise from some failure of moral character such as sloth. His problems with depression and addictions developed in the context of having been told unequivocally that he had no place in society. Gary worked hard until there was no more work for him. As Anderson says in his seminal work on hobo culture:[100]

> All of the problems of the homeless man go back in one way or another to the conditions of his work. The irregularity of his employment is reflected in the irregularity of all phases of his existence. To deal with him even as an individual, society must also deal with the economic forces which have formed his behaviour, with the seasonal and cyclical fluctuations in industry. This means that the problem of the homeless man is not local but national. (Pg. 121)

Neoliberalism and Poverty

Since the 1980s the poverty rate has grown in the United States, Britain and Canada—a trend that corresponds to the shift away from Keynesian economic models towards a new fabric of relations between the state and civil society. This new fabric consists of neoliberalism in the form of deregulation, fiscal austerity, and the corporatisation and privatisation of the public sector.[101] As McCay and Acheson observe:[102]

> The second half of the twentieth century may someday be recalled as the time that we became painfully aware of the social and ecological costs of industrialisation...We cannot rely on the normal market forces nor on people's best intentions to save their environments and themselves...In the 1960's and 1970's...the only thinkable solution to commons dilemmas was government intervention. [Now]...the same problems and the same theory trigger discussion of another solution: privatisation. (Pg. 1)

During the 1980s such political leaders as Ronald Reagan (USA), Margaret Thatcher (Britain) and Brian Mulroney (Canada) embraced economic growth.[74] Spurred by the ideas of economic theorists such as Friedrich von Hayek and Milton Friedman, the "tax-and-spend" model of Maynard Keynes was abandoned in favour of "market fundamentalism." Whereas previous responses to a range of social and economic problems involved increased government intervention, the shift in public policy since the 1980s has favoured the marketplace as the primary determinant of economic and social agenda—the theory being that market-centred strategies would re-energize economic growth and social improvements would follow, trickling down to lower income groups. Macro-economic policy has been dominated by the themes of price stability and deficit elimination. Program spending as a share of GDP was drastically cut in the mid-1990s and continued to fall in the late 1990s even though surpluses emerged, reflecting the growing perception of welfare spending as a cost rather than as an investment in human development.[101]

As a consequence, Canada is increasingly heading towards the American model of growing inequality, lowered tax bases, and decreased services. In Alberta, citizens have been re-defined as individual consumers of newly competitive public services, and citizen rights have been re-defined as consumer rights—an example of which is provided by the recent Report of the Premier's Advisory Council on Health, which states explicitly that "it is time to put 'customers' first."(Pg. 6)[103] The public sector itself has undergone considerable downsizing as the government has pursued the privatisation agenda. And even more alarmingly, there has been a clear shift in social welfare away from universality to "a modest safety net."

Through the imposition of commercial values, neoliberalism has brought increasing poverty and growth in income differences. This has been hastened by the attempted destruction of the collective institutions capable of counteracting the neoliberal effects, primarily those of the state as Clarke argues:[104]

> The neo-liberal strategy has been consistently hostile to the public realm. It has challenged conceptions of the public interest, striving to replace them by the rule of private interests, aggregated by markets (and forms of corporate collusion and combination). It has insisted that the 'monopoly providers' of public services be replaced by efficient suppliers, disciplined by the competitive realities of the market (or, in some of its neo-conservative combinations, by philanthropy). It has disintegrated conceptions of the public as a collective identity, attempting to substitute individualised and economised identities as taxpayers and consumers. (Pg. 3)

The changes that have occurred in the public realm are reflective of the shocking reality that Canadians are harbouring tougher attitudes toward the less fortunate. We now tolerate a level of poverty that leaves many without adequate shelter—a reality that has been exacerbated by a critical shortage of affordable housing in most Canadian cities.

Lack of Affordable Housing

Significant social trends involving public policies, private-sector restructuring and individual actions have contributed to this situation. One of these trends has been the unanticipated preference of many households since the mid-1970s to reside in the urban core, rather than in the sprawl of the suburbs.[105] This migration to the inner city has lowered housing density in these areas due to the replacement of traditional multi-family housing with single-family housing. In the past 25 years, Canada has suffered a combined net loss of accommodation for over 250,000 people in the central core areas of four major cities. While the vast expanse of suburbia continues to provide almost unlimited space for residential housing, the gentrification of the inner cities has reduced the amount of housing available in the areas where the poor have traditionally lived—in the areas where housing used to be affordable. As Rossi said in 1989:[106]

> One must remember that homelessness is a housing problem: homelessness on the scale seen today is in large part an outcome of the shortage of inexpensive housing for the poor, a shortage that began in the 1970s and has accelerated in the 1980s (Pg. 31)

Because they are frequently underemployed or on social assistance, the homeless are hampered in the competition for fewer affordable housing units. With plummeting vacancy rates, there is little incentive for landlords to provide accommodation for low-income individuals or families since they have many potential tenants from which to choose.[105] In addition, welfare recipients are further handicapped by negative stereotypes that typecast them as "undesirables." Survey data suggest that one-third of small-scale landlords and two-thirds of corporate landlords with rental housing affordable to persons receiving social assistance will not rent available units to persons receiving such payments.[107] This is the simple and brutal economics of low-vacancy rates. A long-term needs assessment conducted by the Edmonton Joint Planning Committee on Housing in 2000 estimated that there is a demand for an additional 4950 units of low-income housing.[108] Over 1,800 low-rent units were lost, mostly in Edmonton's central core, as various federal program-funding arrangements expired, allowing conversion of rental housing to condominium ownership.[109] In 1995, almost 21,000 households in Edmonton were spending more than half of their monthly income on rent—a total of 18.5 percent of the renter households.[110] In addition, the rental vacancy rate in Edmonton has dropped from a high of more than 10 percent in 1995 to a critically low rate of 0.9 percent in October of 2001.[111] Accompanying the catastrophic drop in vacancy rates, the average weighted monthly rent in Edmonton rose from $489 in October 2000 to $537 in October 2001—an 8.7 percent increase.[111]

The growing crisis in affordable housing has occurred in the midst of a neoliberal transformation of the state, wherein many senior levels of government have devolved their responsibility for low-income housing to local governments. In 1986, the federal government introduced its New Housing Directions, which made two changes related to public housing policy. Social housing was directed to households in "core need" (a shift away from mixed-income housing projects), and the delivery of social housing was delegated to provincial and territorial governments.[58] This was followed by the tabling of a constitutional proposal in 1992 that called for the end of federal government's involvement in a number of areas of provincial jurisdiction including urban affairs and housing. In the February 1992 budget, the federal government terminated its co-operative housing program—a program that had built nearly 60,000 homes for low- and moderate income Canadians.[58] About a year later, the federal government froze expenditures for social housing in its April 1993 budget and restricted future financial support in this area to 1993 levels. This was followed by a 1995 budget that proposed a 6 percent decrease in Canada Mortgage and Housing Corporation (CHMC) spending by the fiscal year 1997-1998—a $128 million decline in a program that directs 90 percent of its

support to social housing programs.[58]

On November 20th 1998, the Big City Mayors' Caucus of the Federation of Canadian Municipalities (FCM) adopted a declaration calling homelessness a national disaster. On December 4th of the same year, Canada was strongly admonished by the United Nations for inaction on homelessness and other poverty issues. According to the UN Committee on Economic, Social and Cultural Rights, Canada failed to implement policies recommended by the UN in 1993 and, in doing so, had "exacerbated poverty and homelessness among vulnerable groups during a time of strong economic growth and increasing affluence." [112]

The criticism levied by the UN was followed in 1999 by a report released by the Mayor's Homelessness Action Task Force in Toronto that concluded that the federal government's negligence had contributed to the growing shortage of affordable housing in Canada.[113] Although the shortage of affordable housing is not solely responsible for an increase in homelessness, the general consensus in the reports issued by other municipalities is that homelessness is significantly linked to a lack of low-income housing.[114, 115]

In December 1999, the federal government announced that it would invest $753 million over three years in a National Homelessness Initiative. The federal government's approach to homelessness is based on partnerships with the provinces and territories, municipal governments, and non-profit and private-sector organisations. The cornerstone of the Government of Canada's strategy is the new *Supporting Communities Partnership Initiative* (SCPI), which consists of $305 million allocated over three years to cities with a significant homelessness problem.[116] These funds are provided for the planning and implementation of strategies to reduce and prevent homelessness. Because the cities of Vancouver, Calgary, Edmonton, Winnipeg, Hamilton, Toronto, Ottawa, Montreal, Quebec City and Halifax have the most acute problems they will receive 80 percent of the funding. The remaining 20 percent of SCPI funds are directed at smaller communities that are able to demonstrate a homelessness problem. The federal government has allocated an additional $59 million over three years, to address homelessness among youth. This component is delivered in collaboration with the Youth Employment Initiatives of Human Resources Development Canada (HRDC). An additional $59 million is being targeted toward the needs of Aboriginal people through the Urban Aboriginal Strategy (UAS). Another $43 million will be directed towards the Shelter Enhancement Initiative under the CMHC to repair and improve existing shelters for women and children who are victims of family violence. Moreover, $268 million will be allocated to the Residential Rehabilitation Assistance Program (RRAP). This supplementary funding will support the renovation and repair of low-income housing.[v] The balance of around $10 million has been set aside for the construction of residential accommodation for homeless people on surplus federal property.

In November 2001, the federal government announced the Affordable

Housing Initiative promising $680 million over five (5) years contingent upon each province signing a bilateral agreement with the federal government to match the funds.[W] Under the proposal, the federal government will recognize as matching contributions those commitments made by Provincial and Territorial governments and third parties for eligible programs, retroactive to January 1, 2001. As of April 2002, only British Columbia,[X] Quebec,[Y] the Northwest Territories[Z] and Nunavut[AA] have signed agreements.

While the federal commitment to homelessness is promising, it is too early to tell whether these initiatives are anything more than stopgaps in a growing crisis. For homeless individuals in Alberta, the federal re-investment in human capital pales in comparison to the deficit cutting that has occurred at the provincial level. In Alberta, provincial spending on affordable housing was slashed by 67 percent. In 1993/94 the provincial government spent $287 million on housing versus only $93 million in 1999/2000.[117] These funding reductions are consistent with the Alberta government's privatisation agenda, as outlined clearly in a policy paper released in August 2000, which states that "the Province should not be directly involved in building or public ownership of new housing" (Pg. 3) and that affordable housing should be "developed, owned, and operated by private developers and private non-profit organizations." (Pg. 15)[118] This is despite the fact that the same document claims that:

> Based on 1996 Statistics Canada information, 58,000 low-income Alberta households live in rental housing which is unaffordable (greater than 30% of the gross monthly income), in need of significant repairs, or overcrowded...The average household income for this group was $13 500 with 45.1% of their income going towards rent. The situation has likely deteriorated further in the last four years, resulting in an increased need for affordable rental housing. (Pg 2)

In addition to these spending cuts, the Alberta Government also reduced benefits under the Supports for Independence (SFI) program by nearly twenty (20) percent in 1993—making life even more difficult for low-income Albertans. Despite repeated pleas from advocacy groups regarding the insufficiency of the SFI rates, there has been no real cost-based adjustment of the rates since 1993. Meanwhile, the effect of inflation as reduced the purchasing power of these rates by a further eighteen (18) percent.[119] This has occurred despite the wealth of literature that indicates that income support is a key factor in addressing homelessness. During the early 1990's, after welfare payments were reduced in Calgary, 55 percent of the recipients were reported to be facing eviction.[120] A similar pattern was reported in Toronto where following a 21.6 per cent reduction in social assistance rates, there was 25 percent increase in the number of households evicted from their rental properties.[121]

In June 2001, Clint Dunford, Minister of Alberta Human Resources and Employment (AHRE) established an MLA committee to review the programs and supports provided by his department to low-income Albertans. The results of this review were promised by the fall of 2001, but as of April 2002 the Al-

berta Government has provided no follow-up.

In a presentation to the MLA low-income review committee, the Alberta College of Social Workers (ACSW) argued that the government's disregard for low-income programs has clearly conveyed to the poor that they "are not part of the Alberta family." (Pg. 4)[119] According to the ACSW, the sense of exclusion has been reinforced by punitive policies such the application of the "least eligibility" principle and the division of recipients into "deserving" and "undeserving" poor. The ACSW also claimed that the problems extended beyond public policy to include allegations from low-income Albertans of the "demeaning and less than professional manner in which Alberta's public service treats them." (Pg. 4)[119] This included instances where individuals and the agencies that served them claimed that they were fearful of incurring governmental retribution (by having their personal benefits cut off or their agency funding arbitrarily reduced or taken away) for speaking unfavourably about the services provided by Alberta Human Resources and Employment (AHRE).

Hardening Attitudes Towards Welfare Recipients

The phenomena of homelessness and poverty are not new, and neither are the responses they generate.[74] Typical reactions are to stigmatise poor people and to distinguish between those that are "deserving" or "undeserving" of societal support. The stereotype of "the welfare bum" remains potent. The problem of homelessness, however, has more to do with a reluctance to commit public funds than with the shortcomings of homeless individuals. The actions (and inactions) of governments at the federal, provincial and municipal levels, have contributed to the problem.[74]

"Homelessness may be seen as a manifestation of a loss of shared common ground or abandonment of the notion of the public realm in a civil society." (Pg. 14)[74] In Alberta, the erosion of civil society has occurred under mantle of self-reliance and independence. As the introduction to the discussion guide released by the Alberta Government on the Low-Income Program Review states:[89]

> Albertans value independence. We prefer to make it on our own, without government support. If we need help we want a hand up, not a handout. But some Albertans don't have enough income for what many of us consider "the basics"—food, shelter, health care, and the needs of their children. (Pg. 1)

Over the past 20 years, the notion of self-reliance has gained rhetorical force as one of the dominant values in social and political discourse in Canada.[105] This has been accompanied by a shift from a welfare state to a welfare society. "The welfare state is characterised by a sense of collective responsibility for social welfare, and by highly developed universal social services." (Pg.4) In Canada, this has translated into a strong centralization of fiscal and decision-making

for social programs, and the development of a mechanism for overriding the constitutional division of powers that entrusted the provinces with the primary responsibility for social programs.[122]

Historically, the social programs that formed the foundation of the Canadian welfare state—family allowances, Unemployment Insurance, Old Age Security, the Canada/Quebec Pension Plan, the Canada Assistance Plan, the Hospital Insurance and Diagnostic Services Act and the subsequent Medical Care Act—evolved in the relative prosperity of the post-war reconstruction era. This period was marked by three major influences: (A) the ravages of the Depression and the conviction to avoid similar hardships in the future; (B) the dramatic economic growth that was fuelled by the technological and industrial advances following World War Two; and (C) the influence of Keynesian economics over the government and the public sector.[123] As a result, the federal government emerged as the primary funder of social services and became the cornerstone of the "social safety net." Accordingly, the welfare system reflected the interventionist beliefs of the time—namely that the government had a legitimate and necessary role to play in altering the unequal distribution of goods and services in the marketplace.[123]

In contrast, "the welfare society is based upon ideals of individual responsibility." (Pg.5)[122] As such, the responsibility for providing social care is placed on individuals, families and local communities. In the welfare society, the government assumes a more restricted role by focusing primarily on "core services, on strategic planning for the service delivery system, and on maintaining the standards for service delivery." (Pg. 5)[122] Universal comprehensive services are abandoned in favour of rationalised programs which are only accessible to those with demonstrable needs. Not surprisingly, the decentralization of both decision-making and the provision of social services is featured prominently. Under the new paradigm, there is a growing opposition to state-sponsored universal social services because these services are thought to "foster dependency and bureaucratic inefficiency." (Pg. 5) Whereas, the sustained economic growth of the post-war era contributed to people's faith in governments to act as instruments of collective choice and social progress, the economic difficulties of the last twenty years have eroded that confidence. In the 1990s, legitimate public concern over unsustainable government deficits set the stage for an unprecedented retrenchment in the role of governments in the social and economic lives of Canadians.[124]

Evidence of this retreat is provided by the 1995 Federal Budget that outlined a new role for the federal government in delivering social programs. The most obvious change was a reduction in the budgets of departments responsible for social programs with the Human Resources Development budget being cut by 34.8 percent over a three-year period.[122] But the restructuring involved more than just the restriction of the resources available for social programs; it involved the redefinition of the role of the federal government vis-à-vis social

services.[125] This was shown by the termination of the Canada Assistance Plan (CAP), which historically structured the cost-sharing of social services funding between the federal and provincial governments. In its place, the Canada Health and Social Transfer (CHST) was introduced in 1996 as a block funding arrangement for federal transfer payments to the provinces for such social programs as health care, post-secondary education, and welfare. Under the CHST each province was given the legislative power to allocate this funding, as they saw fit—as long as they didn't impose residency requirements and as long as they complied with the regulations of the Canada Health Act. This level of freedom sharply contrasts with the high degree of federal control that characterised the previous funding arrangements.[122]

The 1990s were a difficult time for the Canadian welfare state. In the early part of the decade, the federal government and most provincial governments were facing significant budget deficits, and were under pressure to reduce spending. The recession that began in 1990 complicated the situation as unemployment increased and more people turned to Unemployment Insurance and welfare for assistance. In response to a chronically high unemployment rate that had fuelled long-term increases in both UI expenditures and the numbers of recipients, the federal government replaced UI with a system that emphasised employability, job training and individual responsibility. The new income support program was appropriately named Employment Insurance (EI), reflecting the philosophical shift from "passive" dependence to "active" employment.[126] The objectives of the reforms were to reduce the number of EI recipients by tightening eligibility requirements, by moving recipients off EI as quickly as possible, and by encouraging greater workforce participation through skills training and upgrading.[127]

The federal reaction to the escalating costs of social programs was paralleled by the actions taken by the province of Alberta to gain control of its deficit.[122] In 1993, the province elected the Conservative government of Ralph Klein with a mandate to reduce the provincial deficit—which was estimated at the time to be about $3.8 billion per year. The provincial response to this dilemma was to initiate a series of aggressive spending cuts which were predictably aimed at the province's social programs. The result was the complete transformation of social services within the province as the budget of Alberta Family and Social Services (AFSS) was reduced by 21.4 percent (from $1,722 million in 1992/93 to 1,353 million in 1994/95). The greatest changes occurred in the area of welfare (SFI) and particularly for those classified as "single and employable." Funding for these programs was chopped by more than 45 percent. As was the case with UI reform, a number of general themes were evident: (1) increased emphasis on "means" testing; (2) funding cutbacks; and (3) the creation of an "active" rather than a "passive" program.[129]

Supports for Independence (SFI)

> Oh, it sucks out here. I don't even fuckin' bother with them. You spend two weeks for four hundred dollars...Looking for a job and going through all these programs and shit. Then they help for a month and you're back to square one.
>
> *Participant describing SFI*

> If you could visualize our situation: we find people where they're at, and then we try to move them forward. If we find them in social services, people needing temporary assistance on our part, we provide that assistance, but then we want to move them into training and into some sort of career development plan. Again, the philosophy of this government is the fact that our assistance program, the *welfare* program in Alberta, is one of a temporary nature. We believe very strongly that Albertans feel pride in themselves and in their families, and of course they want to be independent. So it is our task and it's our mandate to then move them toward independence. If we find them in social services need, we move them into training. If we find that they need training, then we'll provide that training and then move them into the workplace. When we find them in the workplace, we want to make sure that we have a safe and an equitable situation in that workplace.
>
> *Clint Dunford, Minister of Human Resources and Employment*[BB]

SFI was conceived as a program of last resort that actively promotes self-reliance by emphasising "the temporary nature of assistance; self-sufficiency and family responsibility; and the creation of training and employment opportunities for recipients."(Pg. 14)[129] It is based on a three-part philosophy: (1) people want to work; (2) any job is a good job; and (3) people on welfare should not be better off than other Albertans—the so-called "least eligibility" principle.[128] According to Alberta Human Resources and Employment (AHRE) welfare is "available only if you have no other way of providing for yourself and your family." It is meant "to assist people who can work for a short time while they prepare for a job." To this end, individuals must use other sources of income (including family and friends) and they must do everything possible to get a job before asking for welfare.[122]

Participation is expected for those categorised as "able to work" and temporary assistance is provided with the main focus being on independence via employment or training. "If a recipient demonstrates little or no effort to become independent, the worker reviews the impact this lack of effort has on a participant's eligibility."[128] Because of the centrality of "independence" within the adminstration of SFI, recipients can be denied benefits if the expectation of self-sufficiency has not been met. The assumption is that participants want to become autonomous. One way of gauging this desire is through an attitudinal evaluation. For example, if a participant's appears to have a negative attitude (such as in cases of violence or substance abuse), a referral may be made (to an anger management workshop or an addictions program) to overcome these barriers to independence. A participant can be removed from the program on the basis of this evaluation.[128]

Prior to the intake interview, individuals are required to provide informa-

tion regarding income, assets and basic needs. Because the welfare system is designed "to discourage people from applying for social assistance," applicants are forced to divulge this personal information in a public setting, namely to a secretary who sits in a packed waiting room.[CC] Once this data is obtained, individuals are instructed that they must attend a two-week job search program if they wish to continue with the application process. This employment program is intended to divert people away from welfare into the workforce or as the government literature says, to keep "you independent of Social Assistance and able to provide for your own needs." In Edmonton, there are two private agencies that have been contracted to provide these services. Applicants are expected to remain in "daily contact with the agency and meet all laid out expectations" if they are to be considered for SFI. Individuals may only apply for welfare if one of the following two conditions is met:

a) When the applicant brings in a written job confirmation on company letterhead or on a provided form. The job must start within 2 weeks and commission sales or temporary jobs are not acceptable.

b) When the applicant has completed the two-week Job Search Program and has brought in an employment history form stamped by the agency.

Typically, only about 50 percent of the individuals continue with the application process after the referral to the two-week program. Those who have successfully completed this requirement are instructed to attend a mandatory one-hour informational session where they are informed of the expectations and requirements of the SFI program. About 33 percent of the remaining applicants fail to show up for this session, effectively disqualifying them for SFI. Those who attend the informational session are given appointments to see an intake worker, at which time they are informed of their eligibility for social assistance. According to an SFI informant, an applicant's eligibility can be determined at the first stage of this elaborate process but the intervening steps are intended to deter potential applicants. As the informant says, "How many different ways can we tell them not to come back?"

According to Section 16(2) of the Social Development Act, a person applying for a social assistance or a current recipient of SFI can be denied support if the individual has:

a) Refused to seek or to accept reasonable employment for reasonable wages (i.e., minimum wage),
b) Terminated employment which he might reasonably have held (i.e., quit or been fired from work),
c) Refused or neglected to collect income to which he is entitled or to realise on his assets, or both,
d) Refused or neglected to avail himself of the advantages he may have received under any other law (i.e., EI, WCB or any other source of funding such a savings bond in trust.)
e) Refused or neglected to avail himself of appropriate training or rehabilitative measures,
f) Refused to provide complete information or has provided false information required to determine his eligibility for a social allowance.
g) Left Alberta.

Under the current SFI policies, applicants are expected to have exhausted all of their current assets (including RRSPs, savings, stocks, bonds and securities) before they are even considered for SFI. A single employable is only allowed to have a maximum of $50 worth of assets when applying for social assistance.

During the intake interview, the expectation of the recipient moving toward self-sufficiency is made clear. "An employability assessment is done for all participants to develop a profile of the person and to determine his or her readiness to get and keep employment." Participants are categorised in terms of their relationship to the labour market with those with the greatest barriers to employment receiving the most financial support. SFI has four basic categories:[128]

1) *Supplement to earnings.* Recipients in this category are working full-time or part-time but are unable to meet their basic needs. Recipients are expected to look for ways to increase their earnings by increasing their hours of work, seeking higher pay or obtaining different work. They are expected to keep their current job while trying to achieve these ends.

2) *Employment and training support.* Recipients are unemployed and are expected to look for employment or engage in training activities. People who refuse to participate in these activities may be disqualified from further benefits.

3) *Transitional support.* Recipients in this stage are temporarily unable to work because of circumstances such as illness or health issues. They are not expected to seek employment while in this category but will be placed in another category when their circumstances change.

4) *Assured support.* These recipients have been assessed as not being able to work continuously in the normal labour force. Most of these cases have mitigating factors such as age, medical impairment, deficits in terms of formal education, social skills and work history or other social factors such as family situation, extensive criminal record, drug/alcohol dependency. While any one factor may not in itself create a barrier to employment, a combination of these factors may form the basis for assured support.

The assessment identifies the areas that must be addressed to facilitate the person's move towards self-reliance. It examines the individual's life circumstances, as well as their strengths, weaknesses, interests, and abilities. The four main factors for assessment are vocation, health, life management and accessibility—with each having sub-factors that are rated in terms of strengths or obstacles. Once all the factors have been rated and the significant strengths and obstacles are summarised, a preliminary employment plan is developed. This plan establishes "the recipient's commitment to employment or training, focuses the attention of both the recipient and department on increasing the recipient's independence and informs the recipient of the consequences of not following through on the plan."[128] The recipient participates in the plan by specifying the activities he or she will undertake to become independent and by establishing the timeframes necessary to complete each step. "All recipients placed in employment, employment preparation programs or training are

followed up to ensure that there is stability in the placement." The goal is to hasten SFI clients towards self-sufficiency by moving them from lower-level categories (greater dependence) to higher-level ones (greater independence). Towards this end, recipients complete a monthly reporting card on which they can indicate their needs or concerns to their support worker.[128]

As a consequence of the reforms to social assistance, the welfare case load in Alberta dropped from 94,087 in March 1993 to 40,625 in October 1996 —a 57 percent reduction.[129] According to one SFI worker, the department measures success "by the amount of file closures." However, the informant states that internal AHRE documents show that the welfare caseload in Alberta has returned to pre-1993 levels. This has occurred despite the tightening of the eligibility requirements for SFI. A survey of 816 food bank recipients (of whom 65 percent were receiving SFI) indicated that individuals with demonstrable financial needs were denied SFI benefits.[130] One-in-five SFI-involved respondents were cut off SFI at some point in the past three years. Fifteen (15) percent of the respondents had their applications denied with 1 in 2 denials having nothing to do with their level of financial need but rather with non-financial reasons such as past employment or age. Of the individuals who were denied SFI benefits but appealed the decision, 43 percent had their decision overturned. This turnover rate suggests that the reported grievances may have some validity and that eligibility is determined somewhat haphazardly.

The arbitrary nature of the decisions regarding eligibility is illustrated by the case of Donald—a 35 year-old Native man. According to the SFI informant, Donald was initially classified as being eligible for *assured income* (i.e., not being able to work continuously in the normal labour force). The assessment was based on a number of mitigating factors that included addictions, a lack of education, an extensive criminal record, the absence of work experience and health concerns. Donald had spent most of his life on the streets and had been an addict since he was twelve years of age, as he says:

> Oh, I was doing heroin, coke, speed, T's & R's...whatever I could get to poke into me. I was cranking Halcyon pills, valium. And I was that for thirteen years. I started when I was very young.

Although Donald had successfully overcome his dependency on illicit drugs, he was a chronic solvent abuser and alcoholic and spent most of his time either drunk or "sniffed-up" on lacquer thinner. While being a junkie, Donald had acquired a substantial criminal record. Since he was sixteen years old, he had been imprisoned "forty-six to fifty-two times" as a consequence of a $1200-a-day drug habit and the "break and entries" he committed to support his addiction. In addition to the health deficits he had incurred due to his substance abuse, he also suffered from the after-effects of a serious car accident and a near-fatal stabbing he had endured. Donald claimed that he felt physically like a "56 year-old man," because as he says, "I've had both of my legs broken. I've had my arm broken...I'm missing my kidney and my spleen...my gall bladder taken out and my intestine." Based on this information, an SFI intake worker

appropriately assessed Donald to be unemployable. However, he was promptly re-classified by a higher-level bureaucrat (the Financial Benefits Worker) as only needing *training and employment support.* Apparently, the re-evaluation was based largely on his youthfulness and the presumption that he could work.

The Deserving and the Undeserving Poor

In Alberta, the various provincial income support programs reflect a range of values and judgements about merit. Albertans are generally seen as being "independent" while those receiving income support are viewed as "dependent." These values correspond with societal notions of who is considered deserving or undeserving of community support. The "deserving" poor are those individuals deemed incapable of supporting themselves through paid work and thus worthy of public support. As for the "undeserving" poor, they include able-bodied men and their dependants, who are expected to support themselves through paid work and therefore are not worthy of public assistance. The antics of Premier Ralph Klein provide a graphic example of this value judgement. In December 2001, Klein made an unscheduled appearance at the Herb Jamieson Centre (Single Men's Hostel) during which time he is reported to have sworn at several homeless men, telling them to "get jobs" and punctuating his performance by throwing money at them.[131] The notion of the undeserving poor pervades even the upper echelons of the Alberta Government.

In the case of the SFI program, this distinction is enforced by castigatory policies designed to separate the self-reliant from the reliant. The most notable of these is the least eligibility principle—the belief that no one should receive a social benefit that exceeds the wages of the lowest paid worker. The application of this principle for SFI benefits is inherently punitive because of its relationship to Alberta's minimum wage. As noted by the Alberta College of Social Workers, the latter is so meagre that no one can be expected to carve out a meaningful existence on it.[119]

At $5.90 per hour, Alberta has one of the lowest legislated minimum wage levels in Canada. A Canada West Foundation study *Welfare Reform in Alberta: A Survey of Former Recipients,* found that as a result of changes to SFI, many welfare recipients moved from SFI poverty to labour market poverty (minimum wage and part-time employment). About 7 in 10 (68.2%) of the respondents reported not having had enough money to meet their food and shelter needs at least once since leaving the program. This is understandable given that "many welfare recipients live and function on the edge of the labour market." [132]

Employment has generally been considered an antidote for poverty but at minimum wage (and even higher salaries), employment alone does not guarantee an escape from impoverishment. In 1996, there were 16,500 unattached Edmontonians who were employed full-time who still had incomes below the LICO [DD] and could not meet their basic needs.[133] At Alberta's current minimum wage of $5.90/hour, a single person would need to work more than 64 hours per week just to reach the LICO. In a 1999 survey, 19 percent of the

families who relied on the Edmonton Food Bank reported wages as their source of income. Twenty-eight (28) per cent of families who turned to the Food Bank were homeless sometime during the past five years. Other families were at risk of being homeless with seventy-five (75) percent reporting they had been late with the rent, and 42 percent reporting they had missed rent payments during the past two years.[134]

Economic Trends

The burgeoning ranks of the working poor and the homeless are indicative of the rise of a social underclass in Canada. At the root of this changing class structure are economic trends, which have resulted in a dramatic shift in income distribution. In the latter part of the 20th century, Canada experienced profound economic changes as a result of globalisation, technological improvements and international trade patterns.[135, 136] Although this restructuring has benefitted many Canadians, it has created economic uncertainties for many others. High levels of unemployment and labour market polarisation have complicated the matter. In Canada, there is an increasing concentration of jobs at the extremes of the country's range of earnings. In previous decades, the country had few jobs at the extremes and many in the middle; in today's economy, the opposite is the case. Because of the polarisation of job earnings, Canada is losing its middle class, and there is a corresponding widening gap between the rich and poor. Since the mid-1970s the structure of the labour market has changed. Manufacturing and clerical jobs, which are often middle-wage jobs, have dropped as a percentage of the market. At the same time, jobs have grown rapidly in the service sector. Between 1988 and 1998 the services sector was the leading job generator in Alberta with the creation of some 74,500 jobs.[137] These occupations tend to be polarised between low-paying jobs in restaurants or sales, for example, and well-paying professional jobs. Average incomes in real terms (adjusted for inflation) have remained fairly stable over the last twenty years but average real incomes rose for the higher earning groups and dropped for those with lower earnings. The *Growing Gap* report indicates that in 1973 the richest 10 percent of families in Canada made 21 times more than the poorest 10 percent of families. By 1996, the richest 10 percent of families made 314 times more than the poorest 10 percent of families.[138]

A clear indicator of these changes is the increase in the average frequency and length of unemployment in Canada. The proportion of the unemployed who were without work for more than half a year rose from 14.1 percent in 1976 to 23.1 percent in 1998.[135] In addition, a growing percentage of working-age individuals do not even participate in the labour force. Labour force participation rates dropped to 65.3 percent in 1994, reflecting reduced job prospects—especially for those lacking specialised skills or higher educations. Structural economic shifts displaced workers and at least one-quarter of them

have had long-term problems finding new jobs: the average duration of unemployment grew from less than sixteen weeks in 1981 to twenty-one weeks in 1991.[139]

Further evidence of this restructuring is illustrated by the growth of non-standard employment in Canada. "Between 1989 and 1994, the rates for part-time employment, temporary employment, self-employment, and multiple jobholding all rose." (Pg. 55) [118] These trends are important for a number of reasons. First, the increases in part-time and temporary employment are reflective of declining hours of employment for many in the labour force. Secondly, the rise in self-employment and multiple jobholding is indicative of lower wages. Non-standard employment is typified by "less job security, lower pay and fewer fringe benefits." (Pg. 55)[118]

In the past, unemployment insurance and social assistance programs buffered the impact of labour market changes. Cutbacks in these programs in the early 1990s have clearly made low-income people more vulnerable to labour market changes. This has been complicated by the fact that minimum wages and other measures of low-end earnings have declined in real-dollar terms. The groups most affected have been those least well established in the labour force, such as those with the least education—about 56 percent of Edmonton's poor have less than a high school education.[EE] In a competitive job market, those with less human capital (skills, education and work experience) usually earn less than others. In general, the occupational structure in Canada has become dichotomised with growth "in high-skill, high-wage jobs at one end of the spectrum and low-skill, low-wage jobs at the other." (Pg. 55)[118] While this pattern may suggest that there are more employment opportunities available for under-skilled or under-experienced Canadians, it also indicates that the jobs available to them are increasingly only those that pay poorly.[135]

This changing pattern of job opportunities is distinct from the issue of poor economic growth. Enhanced economic growth will not alter this trend toward a polarised wage distribution. Economic growth may lead to higher employment rates and more profit for the rich, but will not curtail the structural trend, which is keeping many people in low-paying jobs.[135] Social and economic indicators are closely linked. Significant changes in job patterns affect income, unemployment rates, the number of people receiving welfare benefits and the incidence of homelessness.

Homelessness is much more than a housing issue. The phenomenon is rooted in the political economy of the state and the nature of the decisions regarding resource distribution. In Canada, there is a close connection between global economic changes, poverty, unemployment, welfare policy, housing and homelessness.[91] These economic and social policy trends inevitably have implications for poverty in terms of incidence, depth and persistence. The confluence of these factors is summarised by Timmer *et al* in their cogent analysis of the historical and economic roots of homelessness:[71]

> The current and expanding crisis of urban homelessness results from the convergence of two contradictory and proximate forces: the rapidly dwindling supply of low-income housing and the increased economic marginality among the poor and the near poor, caused by the changing economy, changes in family structure, and shifts in government policies. These proximate causes of urban homelessness, it must be remembered, are in turn embedded in and derived from the structure of a historically changing corporate capitalist economy and society. (Pg. 17)

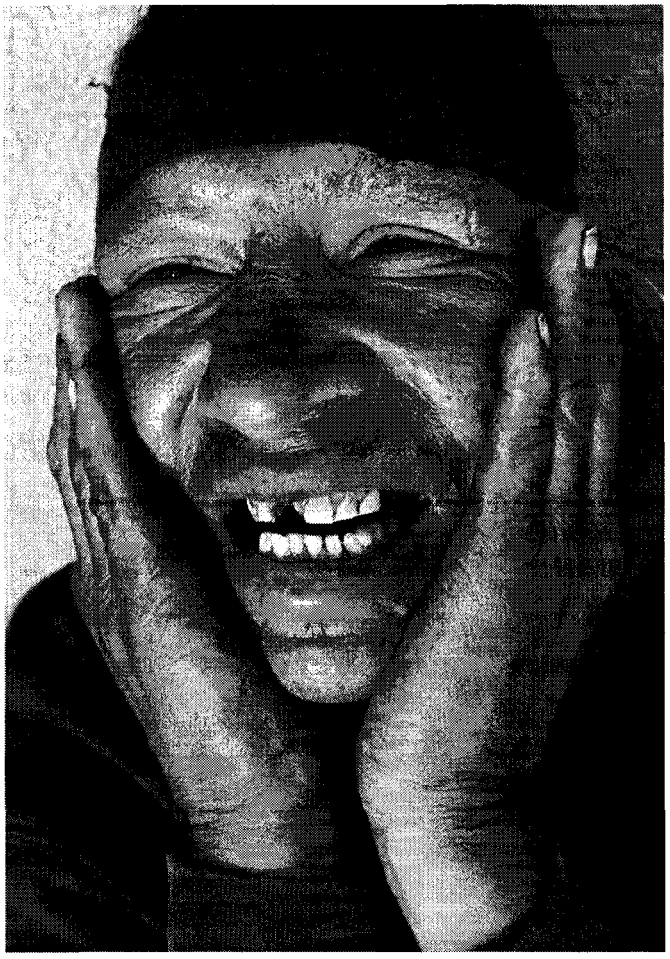
Urban Aboriginal People

While socio-economic factors threaten the tenuous existence of the urban poor in general, the Aboriginal segment of this population is especially vulnerable. As previously indicated, demographic data indicates Aboriginal people are over-represented in the homeless population in Edmonton—a finding that corresponds with trends in other cities. The September 2000 homeless count in Edmonton identified that Aboriginal people were disproportionately represented in the homeless population. While Aboriginal people only represent about 4 percent of the total population of the city, they comprise about 40 percent of the homeless population. This corresponds with national data that indicates Aboriginal people in cities are more than twice as likely to live in poverty as non-Aboriginal people. On average, 55.6 per cent of urban Aboriginals were living in poverty in 1995, compared to 24 percent of non-Aboriginal people.[135] In Edmonton 61.6 percent of the individuals with incomes below the LICO were of Aboriginal descent.[140]

Edmonton has the second highest number of Aboriginal people of major Canadian cities, after Winnipeg. Although Aboriginals comprise only a small percentage of Edmonton's population, their numbers are rapidly increasing. Canada-wide, between 1991 and 1996, the Aboriginal population increased by 24.6 percent, compared to growth of the general population of 5.2 percent. In Edmonton, the Aboriginal sub-population is significantly younger than the overall population.[140]

The concentration of Native people in Edmonton is part of a larger migration of Aboriginal people from reserves and rural settings towards urban centres. Based on 1996 census data, 49.5 percent of the Aboriginal population is urbanised with only 29 percent living on reserves and 21.5 percent living in rural non-reserve settings.[141] The urbanisation of Aboriginal people is especially apparent in western Canada where sixty-five (65) percent of Canada's urban Aboriginal people are concentrated. In Alberta, for example, over 68 percent of Aboriginal people live in towns and cities.[142]

Many Aboriginal people face acute challenges in several areas of urban life.[141] In comparison to the general population, the Aboriginal populations of Western Canada's six largest cities (Calgary, Edmonton, Regina, Saskatoon, Vancouver, and Winnipeg) tend to have lower educational levels, lower labour force participation rates, higher unemployment rates, and lower income levels[142]—as the Royal Commission on Aboriginal Peoples reports:[144]



Seeing Things Diferently

It's such a beautiful day
I thought I would
walk through the drag.
Haven't been there
since I left some time ago.
Same old building,
same people walking around.
Went and walked in the
park close by.
As I'm sitting on the park bench
I see that there are still
cans and bottles lying around.
I can also see rigs
lying here and there.
It is then that I noticed
the drag hasn't changed,
I've changed.
I see things differently.
And I think how lucky
I am today.

Betty Nordin
(Pg. 21)[275]

Aboriginal people face discrimination in hiring and employment. They earn about one-third less in wages. They are less likely to hold down full-time, year-round jobs. They are much more likely to be employed in manual trades such as construction than in white collar jobs as professionals, administrators, managers or clerks. (Pg 39)

In addition, urban Aboriginal people are more likely to live in single parent families, have poorer health status, and have higher rates of homelessness—a situation that is exacerbated by a housing market that is often prejudicial towards Native people. For example, Beavis *et al* found that prospective Aboriginal tenants often received different housing listings than their non-Aboriginal counterparts. In addition, they were frequently referred to poorer neighbourhoods, given limited time and opportunity to inspect rental properties, and were told that suites were not available when in fact they were.[FF] As Mary Ann Beavis and colleagues claim:[145]

Aboriginals and the Aboriginal homeless are easy targets of discrimination in the housing market. There is a common perception that Aboriginals on the streets are all drunks. Perceptions can discourage landlords from renting to needy Aboriginal tenants. Discrimination may be a bigger problem between Aboriginals looking for housing and landlords of certain ethnic origins (Pg. A9).

The urban data are consistent with the socio-economic picture of the Aboriginal population as a whole, which indicates that Native people live in straitened conditions as compared to non-Aboriginals. For example, Canada's Aboriginal population scores substantially below the general population on the Human Development Index and has a status closer to that of developing countries.[146] [GG] Aboriginal people have an average life expectancy that is five or more years less than the general population, and their mortality rates are higher.[147] Epidemiologically, the Aboriginal population rates poorly on almost every conceivable indicator of health—a burden that is "inextricably linked to native peoples' history of oppression." (Pg. 1577)[148] The Royal Commission on Aboriginal Peoples (RCAP), for example, concluded that the underlying causes of many of the disparate conditions faced by Aboriginal people could be traced back to government policies, including the ongoing effects of the government-imposed residential schools policy "which expounded an unquestioned belief in the moral and intellectual superiority of white culture, and vilification of all aspects of native life." (Pg. 1)[149] Aboriginal nations are dealing with the intergenerational fallout of this enforced assimilation—which include high rates of suicide, substance abuse, family breakdown, domestic violence, and criminalisation.[150] According to RCAP, the "legacy of our colonial history bears heavily upon Aboriginal people in the form of culture stress. It also distorts the perceptions of non-Aboriginal people, sustaining false assumptions and a readiness to relegate Aboriginal people to the margins of Canadian society." (Pg. 586)[151]

In spite of the size of the urban Aboriginal population, public policy discussions have focused almost exclusively on the rural reserve-based population. Given that Aboriginal households living off-reserve experience a higher incidence of poverty and poor housing conditions than the population in general, the rural to urban migration adds to the demand for social housing and housing assistance. In addition, the social and economic marginalisation of the urban Aboriginals increases the possibility that the Aboriginal population will become ghettoised, as Alan Cairns warns:[152] [HH]

> We face our version of the American big city pattern where an Afro-American bourgeoisie coexists with a submerged inner core Afro-American ghetto class. The Canadian reality will be, although the numbers are both proportionately and absolutely smaller, an Aboriginal middle class fed by post-secondary school graduates and the marginalised and the downtrodden of the city's inner core. For the latter, urban existence will be a life of marginalisation, immiseration, youth gangs and other social ills capable of generating a downward cycle of despair if governments disengage themselves. (Pg. 33)

The trend of Aboriginal Peoples leaving reserves also invokes the federal-provincial dynamic. While the federal government has exclusive jurisdiction and program-funding responsibility over Aboriginal Peoples on reserve, this jurisdiction ends when the individual leaves the reserve. The provinces are therefore implicated in funding any programs normally provided in non-Aboriginal

communities, including social assistance, education, and health care. The result has been a policy vacuum as it pertains to urban Aboriginals.[142]

Historically, Canadian governments have been reluctant to draft policies specific to urban Aboriginal people. Much of this hesitancy is rooted in conflicting views about governmental responsibilities for urban Aboriginal people. The issue of responsibility affects matters of jurisdiction, access to services and programs, and financing.[153] Under Section 91(24) of the *Constitution Act, 1867* legislative authority over "Indians, and Lands reserved for the Indians" is conferred to the federal parliament. This has given the federal government exclusive jurisdiction over treaties and reserves, and wide authority over the lives of Aboriginal Peoples. However, the federal government has chosen to limit its responsibility to those defined as *status* Indians by the *Indian Act.* To be eligible to receive benefits under the *Indian Act,* individuals must be recorded in the Indian Register, which is maintained by the Department of Indian Affairs and Northern Development (DIAND).[11] With the exception of some education and health benefits, federal services are not available to status Indians once they leave their reserves. Métis and all others who are not Indians as defined by the Indian Act receive no services under federal legislation. Accordingly, "the federal government's position has been that the provinces bear primary but not exclusive responsibility" for non-status Aboriginal people, including urban Aboriginal people.(Pg. 9)[141]

The provinces, in turn, have traditionally argued that they have no special responsibility for Aboriginal people. Aside from some programs aimed at all Aboriginal Peoples, provincial governments have treated status and non-status Indians as part of the general provincial population for the funding and provision of services.[141] Although urban Aboriginal people are theoretically served by the same policies that apply to the general population, several gaps are apparent—as the Royal Commission identifies:[154]

> First, urban Aboriginal people do not receive the same level of services and benefits that First Nations people living on-reserve or Inuit living in their communities obtain from the federal government.... Second, urban Aboriginal people often have difficulty gaining access to provincial programs available to other residents.... Third, ... they would like access to culturally appropriate programs that would meet their needs more effectively. (Pg. 538)

The resulting uncertainty over responsibility has created problems for all Aboriginal Peoples, especially for those living off-reserve. Jurisdictional disputes have led to the inadequate provision of services and funding. As well, federal-provincial differences have interfered with Aboriginal Peoples' efforts to assume responsibility for the provision of their own programs and services. As noted by the Royal Commission on Aboriginal Peoples (RCAP), Aboriginal control of health and social services is essential to ensure that health programs are culturally appropriate. In the last twenty years, a gradual process has been underway to transfer the delivery of health services from the federal to Aboriginal control. However, defining which Aboriginal Peoples qualify for federally funded health services is complex.[155]

This constitutes a dilemma when it comes to programming for urban Aboriginal people. Some commentators such as RCAP have argued convincingly that urban Aboriginals are being neglected by the current policies which "have evolved ad hoc" and are for the most part inadequate. (Pg. 544)[154] At the same time, others such as Calvin Hanselman have pointed out that a complex maze of programs currently exists at the federal, provincial and municipal levels—some of which may apply to urban Aboriginals.[141] However, because no one level of government has assumed primary responsibility for urban Aboriginal people, "gaps have developed in the policy landscape." (Pg. 21)[141] Although the Royal Commission included recommendations to close these breaches, little substantive action has occurred.[141] Given the dire conditions facing many urban Aboriginal people, a resolution of these issues is essential.

From the Macro- to the Micro-setting

While the previous sections may appear to be diversions from the intended purpose of this study, it is essential that an understanding of the macro-context be fleshed out prior to any examination of the individual context of behaviour. The necessity of this is apparent when we consider that our notions of *health* and *well-being* are references, at some level, to our sense of place, individual agency and degree of social inclusion. As Labonte says, "Peoples' experiences of health are more about their experiences of capacity and connectedness than about their experiences of disease or disability." (Pg. 16)[156] "How we feel about ourselves depends very much on both the extent to which various social interactions validate or affirm our sense of self and our social position." (Pg. 100)[78] From this perspective, it is clear that homeless individuals suffer from a constellation of disadvantages of which material deprivation is only a part. On one level, poverty is a "qualitative threshold that excludes people from the competitive individualistic and consumerist behaviour typical of industrial societies." (Pg. 371)[157] Poverty not only entails physical dimensions such as malnourishment but also psychological ones such as despair, powerlessness and alienation. Dressler coined the term "cultural consonance in lifestyle" to refer to the degree to which individuals succeed in attaining the lifestyle considered customary for their community.[158] Using an ethnographic technique called "cultural consensus analysis," Dressler has demonstrated that many communities have a single shared cultural model of the acceptable standard of living. For example, in a rural U.S. African American community this standard is defined by a set of lifestyle items which includes ownership of a house and car, access to TV and newspapers, and socially specific items such as holding a leadership position in the local church. Individuals strive to adopt material styles of life that are considered customary for their community. Interestingly, this "customary" standard of living is not characterised by "conspicuous consumption," but rather by what

Thorstein Veblen termed a "conventional standard of decency."(Pg. 102)[159] The more closely individuals approximate in their own lives the shared expectations of local cultural models, the better their health status. In studies conducted in the United States and Brazil, Dressler has established that the degree of departure from cultural consonance is a strong predictor of systolic blood pressure (SBP), even after adjusting for other covariates such as age, sex, obesity, diet, and conventional indicators of socioeconomic status.[160] Given the social and economic constraints placed on impoverished individuals in Alberta, it is almost impossible for them to achieve the cultural ideals of "rugged individualism" and "self-sufficiency." The changing labour market, the lack of affordable housing and the openly hostile political climate towards poor people are the insults added to the injury of poverty.

"One of the central tenets of sociology is that social stratification creates inequalities in the distribution of desirable resources and rewards in society." (Pg.81)[161] In keeping with this expectation, considerable evidence suggests that there is a positive association between health status and socio-economic status (SES) across the entire social spectrum.[174] Research on health inequalities identifies socio-economic factors as the principal determinants of human health.[162, 163] As a consequence, a *population health* framework has emerged that emphasises the profound influence of social structures on health and well-being.[161, 162, 163, 168] "Because social structures shape individual values and behaviour, SES differentials in health statuses are due in part to the conditions that derive from an individual's differential structural position." (Pg. 81)[161] These psychosocial factors are not individual characteristics as much as they are "patterned responses of social groups to the realities and constraints of the external environment." (Pg. 82)[161] People's socio-economic circumstances, the meanings they attach to these circumstances and the feelings they have about themselves relative to their lived-experiences are key to health inequalities.

On the surface, the environment of street people may appear rife with chaos, but it has an order of its own. To detached observers their behaviours may appear contradictory—for instance, attempting to satisfy basic survival needs while engaging in self-destructive activities. Yet these apparently paradoxical actions connect in a coherent way.[74] The distribution of behaviour is not random in the population. Most behaviours are influenced by social forces and often cluster with one another in predictable patterns. Thus, many people who consume alcohol also use tobacco, and those who drink heavily tend to have poor dietary practices. Individuals with low SES, and low levels of education are more likely to engage in a variety of risk-related activities and less likely to engage in health-promoting ones.[165, 166] In addition, shared norms around activities, such as drinking and smoking, are powerful sources of social influence with direct consequences for the behaviour of group members.[167] This clustering of behaviour led Link and Phelan to speak of situations that place individuals "at risk of risks."(Pg. 80)[163]

Understanding why "poor people behave poorly" requires that we acknowledge the impact of the social world on individual behaviour. (Pg. 809)[168] Cultural

norms and mechanisms of social control operate to facilitate or impede particular behaviours. Social structures create opportunities for some members of society while restricting opportunities for others. The differential access to rewards and resources is an important source of psychological and physical stress—for which specific behaviours (such as drinking or smoking) may be effective short-term coping strategies.[169]

The theory of **relative deprivation** contends that individuals compare themselves to others when determining their subjective well-being. This is based on the premise that an individual's desires and aspirations are fostered in a social context or as Sherif says: "The major sources of an individual's weighty attitudes are the values or norms of the groups to which he relates himself, that is, of his reference groups." (Pg. 286)[170] These reference groups could be contemporaneous (How am I doing now with respect to my peers?) or historical (How am I doing now with respect to myself or someone else in my position a decade ago?). If past-present comparisons are unfavourable, as in the cases of downward social mobility, loss of employment, or financial setbacks people may feel relatively deprived by their own previous standards. In addition, the severity of anomic tensions is likely to increase to the degree that others to whom one relates directly or indirectly have done better.[171] Psychologists have found that assessment of relative position is an important predictor of satisfaction and mental health outcomes.[172]

A heightened sense of relative deprivation can increase psychological stress, which may result in two possible outcomes. The first is a "problem-focused" response to alter one's relative position in order to alleviate the negative feelings of relative deprivation. In this respect, relative deprivation motivates competition among individuals to improve their economic standing by upgrading their skills or by seeking better jobs. In fact, the dynamic nature of capitalism encourages individuals to adapt to changing economic opportunities, as Lea and Young say:[173]

> A major source of one's making comparisons—or indeed the feeling that one should in the first place "naturally" compete and compare oneself with others—is capitalism itself. We are taught that life is a racetrack; that merit will find its own reward. This is the central way our system legitimates itself and motivates people to compete. (Pg. 95)

The second possibility is that individuals attempt to manage the stress, hostility, and low self-esteem caused by relative deprivation by employing "emotional coping strategies." Wilkinson explains that "among the many ways people respond to stress, unhappiness and unmet needs, one is to increase their consumption of various comforting foods...including alcohol and of course tobacco." (Pg. 185-186)[174] Jessor *et al* tested specific hypotheses relating factors in the social environment to deviant behaviour. They found support for the theory that an unequal or discriminatory opportunity structure—which makes socially legitimate means of satisfaction inaccessible—pressures people to adopt deviant means of satisfaction such as heavy alcohol use.[175]

These two outcomes correspond theoretically to the **Transactional Model of Stress** developed by Lazarus (1966), which provides a conceptual framework for understanding the complex area of adaptation to socioenvironmental pressures.[176] Two processes are central to this theory: appraisal and coping. The concept of **appraisal** refers to the evaluation of the situation in terms of: *What is at stake?* and *What can be done about it?* According to Lazarus, stress occurs when the individual feels a discrepancy between the demands of the situation and his capability to respond to it.

The concept of **coping** refers to the process of managing external and/or internal demands that tax or exceed the resources of the person.[176, 177] There are two types of coping: (A) efforts that are directed at the situation or 'problem focused coping' and (B) efforts that are directed at managing the emotional response or 'emotion focused coping.' In other words, adaptation to stress involves either influencing the existing reality or accommodating to it. Because the Transactional Model considers the interplay of situational and personal factors in the development of stress, it allows for the consideration of sociocultural factors in the adaptation to stress. The notion that the subjective evaluation of a stressor, rather than its objective characteristics determines the outcome of a specific interaction is of particular importance. As Helman has pointed out "cultural factors play a complex role in the response to stress." This role can be considered either protective or pathogenic. (Pg. 255)[178]

Successful adaptation to stress demands that individuals deal with their existing reality in a problem-focused way, while at the same managing the emotional by-products of stress such as hostility, anxiety and depression. Several factors mediate the process of adaptation, such as socio-economic, cultural, and personal factors. The most significant is **social support,** because it subsumes the other factors. Ever since Durkheim's classic analysis of suicide, [179] social support has been implicated in the aetiology of stress.[JJ] Currently, there are two distinct theories of social support. The first is the **direct effect hypothesis** that argues that social support enhances well-being regardless of the level of stress experienced. The second theory, the **buffering hypothesis,** claims that support exerts its effects in the presence of stress by shielding people against the damaging effects of stress.[180] Freund and McGuire, for example, claim that social support "reduces strain by preventing the loss of self-esteem and by aiding a sense of mastery that overwhelming stressors can erode." (Pg. 114)[78] Mastery refers to the degree to which a person views life as being under his control as opposed to being fatalistically determined. The concept describes an intrapsychic resource that "influences, and is influenced by, one's perceptions about past and current experiences in controlling and managing life's challenges." (Pg. 192)[181]

While the notion of social support appeals to common sense, recent research indicates social support operates much more ambiguously than was previously thought. One study indicates that *perceived* support might be more important than *received* support in coping with stressful events.[182] In another study, Eurelings-Bontekoe *et al* claim that both the qualitative and quantitative

elements of social support operate to mediate stress. According to the authors "at high levels of psychological distress the number of contacts one has appears to be equally relevant to health as the experienced quality of the relationships, which becomes most important under low levels of distress." (Pg. 1087)[183]

According to the **relative deprivation hypothesis**, an individual's health is also a function of the incomes of others in his reference group. Low relative income may cause stress and depression, conditions that may raise the probability of contracting a disease or increase the tendency to engage in risky behaviour. Wilkinson suggests that relative deprivation influences health primarily through psychosocial stress that affects those with low relative incomes. Individuals who perceive themselves as being relatively deprived may experience negative emotions, such as depression or anxiety. This psychological distress, in turn, can affect health both directly (by way of heart disease, high blood pressure, and suicide) and indirectly (through increased smoking, poor eating habits, and substance abuse).[184] Much of the evidence for the relative deprivation hypothesis comes from studies that link income inequality to population health. Where income differences map onto differences in social status they are closely linked to health. Income inequality can be seen as a proxy for deprivation, in that as the gap between the rich and the poor grows, so does the overall deprivation in society. According to an editorial in the *British Medical Journal* "What matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society."(Pg. 985)[185]

There is biological evidence to support the notion that relative status plays a role in both psychological and physical health. Sapolsky's work with wild baboons provides a model of the biochemical pathways through which the enforcement of rank by dominant over subordinate animals can lead to disease.[186] Inferior animals are repeatedly stressed by insults or aggression by superior animals. The attacks stimulate the "fight or flight response," which is protective in the short-run but is hazardous to health when permanently activated.[187] [KK] Studies indicate that socially inferior monkeys have lower levels of serotonin, higher basal cortisol concentrations, and greater vulnerability to viral infections than dominant animals.[188, 189, 190, 191] Low serotonin levels and high basal cortisol concentrations are associated with numerous negative health outcomes including affective disorders, anorexia nervosa, sleep disorders, and Alzheimer's disease. The relationship between social status and health persists even when the social hierarchy of the primate troop is manipulated scientifically. While human social hierarchies are more complicated and more difficult to study than those of baboons, social scientists draw parallels between research on primates and the potential relationship between relative income and health in humans.[184, 190, 192]

Further evidence of the harmful effects of relative deprivation is provided by the famous Whitehall study that tracked the mortality outcomes of members of the British Civil Service.[193] The results of a 25 year follow-up of the original

study revealed that civil servants in the lowest employment grade were four (4) times more likely to die than those in the highest administrative grade.[194] Just as striking as the difference between the highest-ranking and lowest-ranking employees is the gradient. Position in the hierarchy shows a strong correlation with mortality risk. This social gradient was seen not only for total mortality, but for all the major causes of death, including coronary heart disease and stroke. Although these results are not adjusted for income or education levels, even the lowest-ranking civil servants were employed and had access to nationalised health care. One conclusion that is often drawn from the Whitehall Study is that the dynamics of relative deprivation contributed to the mortality difference between the highest and lowest civil service grades.

According to Merton, a disjunction exists in North American society between the culturally assigned goals and aspirations and the means to achieve these ends. Merton argues that people are socialised to want certain things out of life ("desired ends") such as health, prosperity, and personal happiness.[195] The cultural system places a high relative emphasis on monetary success. "The goal of monetary success is entrenched in American culture" to the extent that individuals "are bombarded on every side by precepts which affirm the right or, often, the duty of retaining the goal even in the face of repeated frustration." (Pg. 190-191)[196] As Evangelisti says:[197]

> Capitalism goes into people's imagination, dreams, and most intimate visions of the world. The growth of communication has permitted it to go there, imposing lifestyles, creating needs that did not exist before, deliberately increasing people's thirst for approval. (Pg. 13)

However, because of structured social inequalities and discrimination people have differential access to the means for achieving success, and large segments of the population are almost completely blocked from attaining these ends. In particular, Merton notes that every social system provides certain opportunities for success and that access to these opportunities is strongly influenced by one's position in the social structure. In this respect, while North American culture places a high social value on success in all its forms, opportunities for legitimate success are effectively closed to all but a few. The vast majority of people will never achieve prosperity by working. As Lea and Young argue: "The values of an equal or meritocratic society which capitalism inculcates into people are constantly at loggerheads with the actual material inequalities in the world." (Pg. 95)[173] The discord between the cultural and social components of the social structure generates tension and frustration. This in turn is likely to lead individuals to withdraw "allegiance from one or another part of the prevailing social standards"—a situation that Merton described as **anomie**. (Pg. 218)[198] LL

In order for society to maintain a normative function there must be a balance between aspirations and the means to fulfil such aspirations.[195.] According to Merton balance will occur as long as the individuals feel that they are achieving the culturally desired goal by conforming to the "institutionally

accepted mode of doing so." (Pg. 674)[195] It is also important that the culturally desired goals be achievable by legitimate means for all social classes—examples of legitimate means include work and education. If goals are not equally achievable through an accepted mode, then illegitimate means might be used to achieve the same goal or as Merton says:[196]

> It is when a system of cultural values extols, virtually above all else, certain common success-goals for the population at large while the social structure rigorously restricts or completely closes access to approved modes of reaching these goals for a considerable part of the same population, that deviant behaviour ensues on a large scale. (Pg. 200)

To supplement his theory, Merton proposed five possible individual reactions to the disparity between goals and means. The first of these categories—*conformity*—involves acceptance of both the prevailing cultural goals and approved means of achieving them. In stable societies, Merton says, this is the most common adaptation. A second possible reaction is *innovation.* In this case, the individual accepts cultural goals but takes alternative approaches to attain them. This is the type of individual who would turn to deviance or illegitimate means in order to reach the sought-after goal. The third possible reaction—*ritualism*—combines the abandonment of cultural goals with a deep attachment to the socially approved means of attaining them. In effect, individuals scale down their aspirations to a realistic level; at the same time, they continue to abide religiously by the "rules." The fourth reaction is *retreatism,* or what has since become known as "dropping out." It entails the rejection of both cultural goals and approved means of attaining them; "people who adapt (or maladapt) in this fashion are, strictly speaking, in the society but not of it." (Pg. 195-210) [196] Examples include such individuals as drug addicts, and alcoholics. According to Merton, Charlie Chaplin's *The Tramp* is a precise characterisation of the retreatist—an individual who is "always the butt of a crazy and bewildering world in which he has no place and from which he constantly runs away into a contented do nothingness." (Pg. 251)[199] The retreatist is the least common of all the adaptations and is the most resented by society for rejecting both society's goals and the means of achieving them. The fifth and final possible reaction is *rebellion,* which "presupposes alienation from reigning goals and standards" and aims to bring about "a social structure in which the cultural standards of success would be sharply modified and provision would be made for a closer correspondence between merit, effort, and reward." (Pg. 195-210)[196] Merton reserves rebellion for those individuals who, due to frustration, opt for a new social order to replace the old.[195]

The participants in this study experienced, for the most part, a multiplicity of overlapping stressors and life-long cumulative experiences of social and economic marginalisation. In the face of these structural constraints many of the participants engaged in behaviours and exhibited fatalistic attitudes to life that corresponded to Merton's notion of retreatism. This is evidenced by the overwhelming theme of powerlessness that pervaded many of the narratives and by the strategies many of the participants used to cope with these feelings such as alcohol and drug use.

The concept of **powerlessness** has been examined by social scientists since the 1950's,[143] and has variously been referred to as alienation,[200] learned helplessness,[201] and internalised oppression.[202] Maier, Seligman and Solomon first introduced the *learned-helplessness hypothesis* in 1969. It assumes that during exposure to uncontrollable shocks, animals learn that the shocks occur independently of their behaviour—i.e., that there is nothing that they can do to prevent electrocution. The expectation of uncontrollability undermines their subsequent learning by making it difficult for them to learn a positive-reinforcer contingency, and by reducing their motivation to try to control future reinforcers. The response is one of 'giving up and giving in.' [203]

"As an overarching construct powerlessness has both subjective and objective dimensions."(Pg.198)[143] In his early work, Seeman defined powerlessness as the expectancy or belief that an individual cannot determine the occurrence of outcomes.[193] This mirrors Rotter's *external locus of control* which is the expectation that outcomes are determined by forces outside of one's control such as luck or fate.[204] The sociological concept of alienation adds a social dimension to the subjective experience of helplessness.[143] The notion of alienation has many meanings in the literature; it denotes an oppressed state in which individuals are lonely, purposeless, and powerless. Marx claimed this estrangement was created by the socially structured separation of humans from their work. Alienation reached its highest intensity in capitalist societies where the bulk of the population depended for subsistence on working under the direction of others. In the capitalist workplace, individuals were separated from ownership, control and direction of their work and were unable to achieve personal creative expression. The competitive nature of the workplace also alienated workers from each other.

Similarly, John Gaventa examines situations where people lack objective power in the socio-economic system.[143] In one case study, Gaventa examines the resistance of Appalacian miners to a reform movement within the United Mine Workers of America. He explores the political response of the downtrodden as a function of power relationships and illustrates how power works to develop and maintain the quiescence of the powerless.[205] As people perceive their failure to achieve societal promises, (such as the promise of "equal opportunity") they become damaged psychologically—internalising their impotence as their own fault, rather than as the result of systemic discrimination.[143] Gaventa provides a revealing analysis of the lack of rebellion amongst miners and uses the study to illustrate how power serves to protect the powerholder, even to the extent of shaping the perceptions of the oppressed about a given conflict.

On an individual level, people with an internal locus of control are more likely to engage in health promoting behaviours than those with more fatalistic orientations to life.[143] Control is defined as the intentional manipulation of a situation in order to achieve desired outcomes and has also been conceptualised as a "sense of coherence." According to Antonovsky, a sense of coherence (SOC) is a global orientation that expresses:[206]

> The extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges worthy of investment and engagement. (Pg. 19)

People with a high SOC believe that their lives are comprehensible, meaningful and manageable with the resources available to them.[206] Cultural factors and an individual's position in a social structure can affect this sense of coherence, although Antonovsky does not thoroughly examine the ways in which environmental conditions disempower people nor how these conditions are built into the social organisation of everyday life.

In an attempt to overcome these shortcomings, Syme has introduced the broader concept of "control over destiny" which links the social psychological studies of control with research on socio-economic inequities.[207] Control is expanded to include how individuals interact with social systems. As Wallerstein observes:[143]

> People with enough resources in their lives, such as decision-making power, finances or system access can adequately cope with the psychological and actual demands in their lives. (Pg. 200)

These resources include the social and physical dimensions of the environment. People who are marginalised have limited access to socio-economic resources and face greater structural barriers. The constant struggle of daily life exceeds their physical and psychological reserves. As stressors accumulate, their ability to cope physically and mentally becomes overtaxed—leading to an increased likelihood of disease, injury or psychological distress.[208]

A life of poverty is characterised by higher levels of stress and negative life events outside a person's control.[209, 210] Poverty severely restricts individual choice by making a person more susceptible to external pressures and by weakening an individuals' ability to cope with new problems and difficulties. Mirowsky and Ross have reviewed the literature that suggests that a sense of control is shaped by the conditions of everyday life and have concluded that individuals with low SES are exposed disproportionately to experiences that lead to a sense of powerlessness.[211] Not surprisingly indicators of SES such as income, education and occupational status are associated positively with a sense of control. Individuals with lower economic and educational standing exhibit higher fatalism and lower sense of mastery.[201] As Mirowsky and Ross argue:

> People in lower socioeconomic positions have a triple burden: They have more problems to deal with; their personal histories are likely to have left them with a deep sense of powerlessness; and that sense of powerlessness discourages them from marshalling whatever energy and resources they do have in order to solve their problems. The result for many is a multiplication of despair. (Pg. 30)

5.2 Individual Context

Abuse

Eight (8) of the participants reported experiencing physical and/or emotional abuse in their lifetimes. The abuse occurred in childhood and in some instances was mirrored by abusive relationships later in life. As Beth, a fifty-five year old former prostitute recounts:

> Well, the marriage was very abusive. You've heard of Stampede Wrestling? Well, this was Stampede Wrestling—either he was in the hospital or I was in the hospital. It was a very abusive, very controlling marriage. Like both of my children are the results of rape by my husband.
>
> *[What made you decide to marry him in the first place?]*
> It was to get out of the situation from the home life I was living with my parents.
>
> *[What was like that?]*
> I always had my father coming to see me at night...sexual touching and he was forever kissing me. Not in the way a father should kiss a daughter. It was very sexual in the way he would kiss me. And then he would laugh because I wouldn't like it. And also I was raped when I was sixteen by a neighbourhood boy and then I had two of my cousins that were using me sexually and my one brother who was using me sexually. So when this gentleman asked me to marry him, I thought I was going to get away from all of that and settle into something new. Well, he was also...well I'm fifty-four and today he's sixty-five. So there's a large age gap and after I got married to him I found out that all he wanted was a woman to do his cooking and to do whatever he wanted to do sexually.
>
> *[How long into the relationship with your husband did you see that things weren't what they appeared to be?]*
>
> Three days after we were married. He says, "I'm your husband. I will do what I want, when I want and how I want"...and I got a beating three days after we were married. And I thought I made a mistake but my pride wouldn't let me leave that marriage. I was going to try to make it work, because I didn't want to go back to my parents. I didn't want them to say, "See, you can't even make a marriage work, you're so stupid." Because I was always being told how stupid I was, so I wasn't going to go back and tell them what was happening in the marriage.
>
> *[At what point did you leave this man?]*
> The last beating when I got beaten...I'd made my mind up that enough is enough. And I knew...I probably thought if I stayed with him, I might not survive. I probably wouldn't live.

Abuse experiences had a major impact on how the participants looked at their lives. Participants reported having diminished self-esteem and trust in people because of the abuse. In addition, abuse experiences engendered anger and depression in the participants as John, a 39-year-old alcoholic, says: "I was physically abused. That happened to everybody in the family, though. It was just part of living. They said they had to toughen you up. But I don't think abuse toughens you up. I think it just makes you angry." The following selections capture the psychological impact of abuse:

I think there's a lot of hurt. I think there's a lot of things that have happened in their past lives such as physical and sexual abuse...mental abuse...all kinds of abuses, and I think family life has something to do with it, you know. When you're growing up, they say you're not going to amount to fuck all, so that's the way your thinking is all of your life.

John (39-year-old, formerly homeless, Native man)

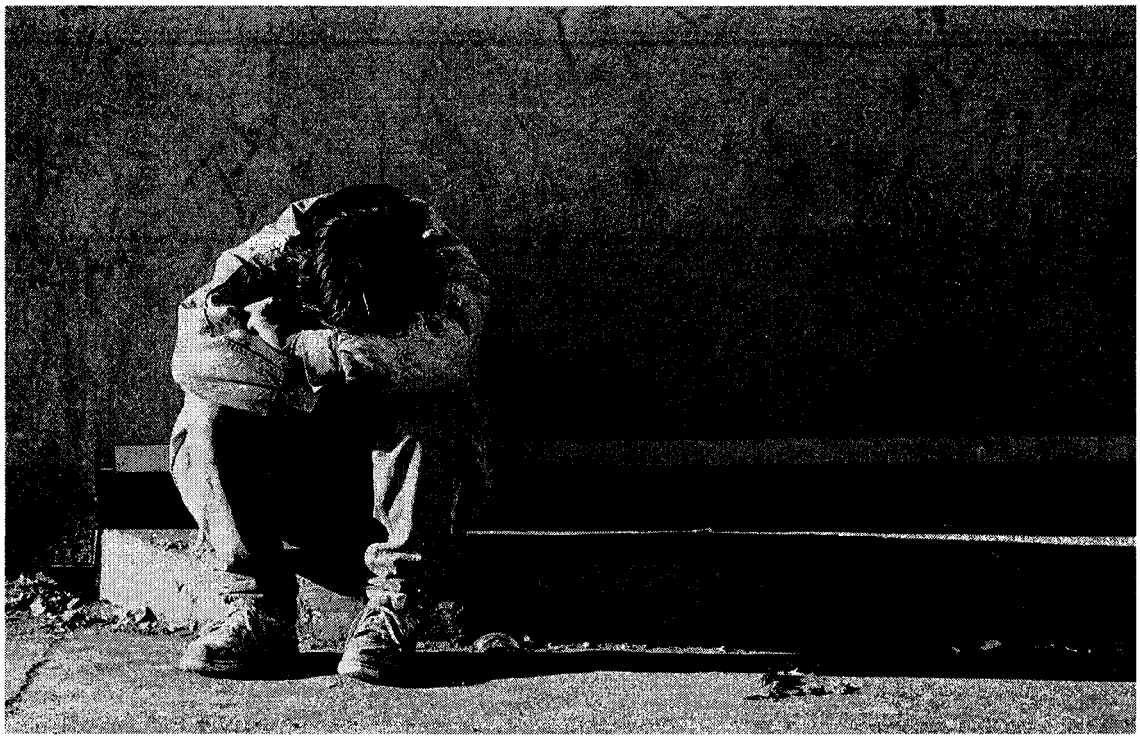
I didn't start caring until I was about nineteen or twenty. Because I totally gave up on everybody. I hated everybody. There was nobody that I trusted. There was so much abuse over the years that I gave up on everybody and I didn't give a damn about anybody. I hated myself and I hated everybody. I didn't trust anybody. I didn't even trust myself.

Donald (35-year-old, homeless, Metis man)

Pain. Always. This is the first time in my life that I've been happy. Everything from the younger years...I was physically abused. That is just it. You just carry that around. Because you're too young...nobody explains it to you when you're young. My mother tried to kill me. That's all there is to it. She dropped me on my head. She threw me out of a car window while the car was moving and shit like that. [I've been depressed] Probably, since I started realising that...every time I ended up in the hospital, which was a lot between the ages of two and six...and finally her losing custody, and me going into foster care. And they say that your best learning years are between the ages of two and four and that's when I got my worst beatings. And then I have really nice aunties that tell me that I flew like a rag doll. I was on her lap in the front seat and flew like a rag doll and they all saw me...and I just flew about fifteen feet and landed PLUNK on my head...and that's when they found out I had a hard head. I do have a hard head. I've been piped, two-by-foured, punched and my nose broken. I've got a hard head but you can take a million beatings but if you don't understand why you're getting some of them, it just depresses. I should have been gone a long time ago. But I need a purpose and I'm not even sure that I have done it yet.

Iris (41-year-old, stably housed, Native woman)

Abuse in the lives of homeless persons is a major factor for understanding critical pathways from childhood and adulthood into homelessness.[212, 213, 214, 215, 216] Research on humans and animals indicates that early experiences, especially social experiences between primary caregivers and infants, are powerful determinants of social, behavioural, and physiological development.[159] In a study of 230 homeless individuals in Ottawa-Carleton, 42 percent of the males and 76 percent of the females reported to having been physically abused in childhood.[217] In specific, abuse can be viewed as a marginalizing experience. Abused people and those with substance abuse problems are alienated or dehumanised by the extreme experiences.[218] The diverse after-effects of childhood abuse include substance misuse, post-traumatic stress disorder, depression, shame, self-harm, eating disorders, increased hospitalisation and dissociative disorders.[219, 220, 221, 222, 223] Relationally, there are also difficulties with trust, intimacy, sexuality, and a tendency to have re-traumatising adult relationships. In addition, physical abuse has been associated with later aggressiveness,[224] and depression;[225] and emotional abuse has been linked with damaged self-esteem.[205] Exposure to violence and victimisation is among the strongest predictors of the use of violence.[226]



Addictions

All of the participants had histories of substance abuse—consequently addictions played a major role in their lives. Twelve (12) of the sixteen (16) participants identified themselves as alcoholics, five (5) of whom were in recovery, and the remaining participants admitted to having experienced problems involving the use of alcohol. Two (2) participants identified themselves as drug addicts and eleven (11) participants admitted to having drug problems in the past. Ten (10) participants were formerly injection drug-users. Seven (7) of the participants admitted to having used Talwin and Ritalin,[MM] eight (8) used cocaine; one (1) individual was a solvent-user. Other illicit drugs that were used by participants included: heroin, LSD, speed and marijuana. Twelve (12) of the sixteen participants were chronic tobacco smokers at the time of the interview.

The high rate of substance abuse in this sample is consistent with the literature, which indicates high prevalence rates for substance abuse in the homeless population, especially among single men.[NN] Alcohol use disorders are especially common among homeless men, with lifetime prevalence rates of about 60 percent.[227] Among homeless individuals, problems with alcohol are 6 to 7 times more prevalent than in the population at large.[227] In addition, the conjoint use of alcohol and tobacco in this sample is reflective of other studies that show that about 80 percent of alcohol-dependent men and women regularly use tobacco products.[228, 229, 230, 231] Less information is available on the prevalence of drug abuse in the homeless population, although data from

the United States indicate that the median prevalence of drug use disorders is 30 percent.[227, 232] In Canada, marijuana and cocaine (especially crack) are the illicit drugs most often used by homeless people.[227, 233, 234, 235]

The theme of addictions was pervasive in all of the narratives. Addictions served as a major organising principle in the lives of the participants—influencing their social relationships and the cycle of their daily lives. Drugs and alcohol affect everything in an addict's life, creating new problems and deepening those that led to the substance abuse in the first place. Several sub-themes fell under the rubric of addictions.

Substance Abuse as a Way of Coping

Ten (10) of the participants reported that they drank or used illicit drugs as a way of dealing with negative emotions; nine (9) of whom claimed to have experienced episodes of depression in their lifetimes.[oo] This was particularly the case with those individuals who identified themselves as being victims of abuse. One participant, a 31-year-old alcoholic and drug addict, reported using Talwin and Ritalin as a way of "self-medicating" her depression—a condition she believed was brought on by the systematic abuse she experienced as a child. Beth, a 54-year-old formerly homeless woman, repeats this notion:

> It [sexual abuse] started when I was seven years old and that was with my father and after that it was with my two cousins. I started drinking when I was twelve years old. That was the only way I could deal with things. Binge drinking. Even through the years until towards the end. Then I was drinking constantly.
>
> *[Did you drink when you were with your husband?]*
> Oh, yeah. Oh, yeah. There was him and his brother and myself. I drank quite excessively because that was the only way I knew how to deal with the pain...to deal with living with him. It covers everything. It hides all your feelings. It hides all your fears.
>
> The drugs started about a month after I came on the streets...when I was in the Cecil, I was introduced to *speed*. And the drugs did for me what the alcohol was no longer doing for me. Alcohol, you know, used to bring me that high and I was able to relax and everything...but I had been drinking too long so I wasn't getting that high...and then when I got into the speed and the MDAN, marijuana and Dexedrine's and all of those speed pills, it just got me up to that twelve years old again...being twelve years old. Because that's when I got my first high...that's when I started drinking.
>
> *[So was that a quick process? Were you a regular user after that first month?]*
> No, no, my therapist was still the alcohol. The last two or three years before I got off the streets that's when I got into the really heavy drug scene. It was more the drugs than it was the alcohol. The alcohol no longer...like I couldn't get drunk anymore on alcohol, like I could throw back five or six shooters and still be like this...anybody else after five or six shooters they would be under the table...because my tolerance level was so high.

In addition, participants identified using drugs and alcohol as way of dealing with losses—such as broken relationships or the deaths of loved ones. Barry, a 35-year-old alcoholic explains why he started drinking heavily when he was 28 years of age:

> I was raised up by grandparents...I lost...I used that as an excuse, eh. But then I look back today, eh and no it's no excuse for myself. Things weren't going good for me, eh. I broke up with my ex-old lady. I was living common-law, eh. Other than that, I know my grandmother passed away. I used that. Anyways, there's a lot that goes through a person's mind that can bring them down. A good person could be well-off...I've seen it...I've seen people that come out of rich families just get pushed down the hill. Even if you piss-off a person and call him down...you know...you're this and that and it depends how he takes it. He can turn around and say "Ah, fuck you!" or go to the bar and start boozing with his friends, eh. You see him the next day and "I've got a hangover." Cure your hangover by starting again. Booze is bad, eh. It's potent power. It's a lot of Natives in the ground, eh...suicide...drugs or whatever.

Substance use was also seen as a way of coping with boredom. This was especially the case with individuals who were unemployed or unable to work due to disabilities. As Iris, a forty-one year-old women with chronic arthritis reports:

> I started drinking in 1984 and then in 1985 I was hitting it pretty hard smoking a lot of pot, and I think...I don't know I'd say it was boredom. You need some kind of high. You're so spiritually low that you think...you know and all that you do is get lower. You think this is taking you higher, so you're high and then you're low and then you take some more and then you're higher and you take more and more and then finally your in that rut of being a junkie.

The issue of addictions is a complicated one. While participants touted substance use as a way of coping with negative emotions, addictions also led to distortions of the individual time experience. Participants engaged in *drinking* or *using* in order to manipulate their experience of time. They drank or used *to forget*—to erase the past and mask the present. In addition, substance use was one of the primary ways of dealing with anomie and boredom—*to kill time.*

Substance abuse, especially alcohol, has been hypothesised to buffer and to serve as a coping mechanism against stress.[236] It is commonly accepted that people drink alcohol in order to cope with the effects of stress.[237] Stressful life events such as being a victim of crime, getting a divorce or breaking up, worsening financial position, are positively correlated to heavy drinking among men.[238, 239] For men, chronic stressors such as being single, separated or divorced, and being unemployed are positively related to the heavy use of alcohol.[232] This predicament is aptly described by Gary as he reveals the pitfalls of being unemployed and on welfare:

> Yeah, put it this way, somewhere along the lines one of my biggest fears is that I will fall between the cracks...and ahhh. Because you're going to be in a rut, like "Why should I get up today?" Instead, of getting up...I guess it's for anybody who's out of work...My [addictions] counsellor says "Gary you've got to stay focused. Once you're focused you know what's going on and as soon as you hit a brick wall you knock your head. And after there's no use knocking anymore you're just off and you're mind's off on other things and that's when you start using again and saying, "To hell with everything!"

For participants, heavy drinking led directly to cognitive impairments since alcohol affects semantic, episodic and perceptual memory.[240] An example is provided by the following account where a Native individual describes how he almost froze to death following a night of heavy drinking:

> I walked for two hours last night only to end up where I began. [Perceptual impairment] My head was frozen but somewhere I had a little bit of my brain left that said I didn't want to die. I found the train tracks...I fell and hurt my elbow. I thought they were gonna find me the next day: "A fuckin' guy frozen on the railroad tracks."

More concretely, daily drinkers developed an increasingly restricted perception of time, extending their consumption until they were drinking around the clock. This pattern was only interrupted by sleeping hours, which did not conform to conventional day-night routines because of alcohol-related reduced sleep latency.

The structuring of the *present* was related to not only addictive behaviour but also individual perspectives of the *future*. Participants exhibited a "troubled future orientation" that was intimately linked with the cyclical nature of their lives and was reinforced by the cognitive impairments caused by substance abuse. Under the onslaught of addictions and anomie, there is no future. There is only the oblivion of the present. As Joe—a 41-year-old alcoholic says:

> Oh, there comes a point in your life where you have to wake up to reality. Right? And that's one of the realities of life. Because it can do one of two things. You can either admit and get on with your life and go forward or you're stuck in that little circle going around and around and around and not going anywhere and not facing up to the truth. It doesn't give you anything to look forward to. You get to the point where you don't even set a goal for tomorrow, except to find another beer.

The Cyclical Nature of Life

Participants reported a cyclical pattern to their lives. This applied not only to their daily lives but also to larger patterns of build-up and breakdown. In the case of addicts and alcoholics, the cycle of their daily lives was dictated by the necessity of feeding their addictions. Participants organised their lives around obtaining their next dose of drugs and "making a living," that is, obtaining resources for drugs through such illegal means as theft, drug trafficking, and prostitution or legally through temp work. In the desperate pursuit for the next "fix" or the next bottle, time is distorted and every day becomes like any other. The following excerpts illustrate this:

> It was a hell—a living hell. You know...I remember one time waking up on a Sunday morning and going to see a doctor for T's [referring to Talwin] and I remember thinking to myself: "If I ever straighten up and got a job and worked this hard at the job as I work to get my dope, I could be a very rich woman. Because I would get up Sunday morning and before 11 o'clock I'd have seen five doctors. Like I knew which doctor's to go to for the T's. So I'd get my T's get into a service station with the two people I was hanging around with and crank up in my arms...get back into down to the Calgary Hotel...sell the rest of my T's

> and go and get coke or heroin. And then when I ran out of money I would go to the Woolco and shoplift some cigarettes, sell them, go get some more T's, go and get some more heroin, go and get some more coke and go and get some more booze. It was just a fog the last year. It was just a nightmare. Just a constant cycle, just go go go. I never thought about it [life]. I never thought about. I just lived from day to day, especially towards the end of my living on the streets. I didn't even know if I was going to make it off of the streets. I didn't even know if I was going to survive, especially that last year. It's like a fog.
>
> *Beth (55-year-old, formerly homeless, Metis woman)*

> There is no time. It's mostly just kind of a continuous thing to do. Your day continues into the next day, so you don't even worry about it. You know that the next day you're going to be drunk anyways. It just becomes the same thing...like you do the same thing every day. Like I'll go out and panhandle to make enough for another bottle and then go drink that bottle and go make enough for another one. You just keep going like that. It is a vicious circle. The only time that I ever thought about time was in the morning, you know, before the liquor store opened up. That's the only time I thought about time and the other thing was which liquor store can I hit before I go back to the George Spady...but in between that I always tried to make up for lost time so I can go there and panhandle.
>
> *John (39-year-old, formerly homeless, Native man)*

The distortion of time was exacerbated by the cognitive impairments caused by the drugs and alcohol. In the worst cases, participants referred to blackouts and bouts of amnesia. For example, one individual described how he had begun drinking in Edmonton, passed out and woke up in Calgary without knowing how he got there. Participants reported that time became distorted to the extent that entire days, weeks and even years became muddled, as Joe says:

> I don't think even science can figure out what causes an alcoholic to drink. It just happens. I do know that if I do start drinking I can go for months without being sober. [Drinking] The whole day. You get up in the morning and you go looking for a drink, you drink right through the day until you pass out. You get up the next morning and go looking for a drink. For months it can go on and ahh...it takes a lot to talk yourself out of doing that. You pretty well have to end up flat broke with no more sources for alcohol to think about sobering up.

The cyclical nature of life was also reflected in larger patterns of boom and bust. Ten (10) of the participants reported receiving some form of addiction treatment in the past—ranging from short-term detoxification to long-term treatment. Other reprieves from substance abuse included incarceration in prison. For some participants, this treatment opened a window of sobriety and stability. Unfortunately, most participants reported that this period of sobriety was short-lived and was followed by a relapse to drinking and a subsequent loss of stability. As Janice says, "I made attempts before to straighten-up but always had reservations to go and use...you know...and each time I did that it just got worse and worse and worse." One individual referred to this as "coming full-circle." As Joe recounts:

When I came back [to Edmonton from Toronto, a year-and-a-half ago] I got a job right away and I worked a couple of months and I started drinking again...and hit bottom again...so I checked into the Salvation Army rehab centre and stayed there for the minimum 3 months...for their rehab program...and then they have it extended for another 9 months that you can live there under their roof as long as you stay sober. So, I stayed a total of 9 months...completely clean. I was 3 months in the program and 6 months in the extended. I ended up working full-time and living there...But then I got tired of living there, so I moved to an apartment on the Southside... A basement suite...and from there I got sort of isolated because all of my friends were living on the Northside and nobody wanted to travel to the Southside to visit, so in order for me to meet people I started drinking again and from there I got into a regular habit of drinking, missing work, finally got laid off or fired, and then no rent. I ended here at the shelter and I'd come full-circle. So then from there I was in the shelter I did my 3 or 4 weeks there and then they moved me to the Spady, and now Judy got me back in the shelter again. But...ah...nothing surprises me. I've been full-circle several times now—different cities, always the same thing.

[How do you keep optimistic or do you just live with the circle?]
I know it's a circle, it's always going to be there and it'll always happen.

[What part of the circle are you at now?]
I'm at the top of the circle about to venture out again (laughs)

Participants described being trapped in patterns of life that were difficult to change. This notion of "being stuck" spurred feelings of frustration in many of the participants. This was apparent even in those individuals who worked for temporary labour agencies. For participants, the advantages of temp work included the possibility of "quick cash" and the flexibility of working when they wanted to—factors which were amenable to the transient and unstable lives led by many. One participant described this process as "working to drink." As Joe describes:

[How do you run your life?]
Two ways: I go through periods like that where everything has to be planned, where I have a steady job. I know I have to get to bed at 9 o'clock, 10 o'clock, get up at 6, get to work, do the 9 to 5 thing, you know. Take it easy, maybe have one or two beers after work, come home, have supper, relax, go to bed and get up the next day. There's that way and then there's the other way where if I'm drinking and I'm really, you know, out on a bender, I'll go out...I'll do half-a-day's job or something, you know...till I get 20 or 30 bucks in my pocket, go out drinking. If it lasts two or three days fine, if not then go back to work the next day.

[How do you budget for food as part of your life?]
I don't.

[So where do you usually eat then?]
Ah, soup kitchens, hostels. Canada is a good country. It's virtually impossible to starve to death in this country. It is. In Toronto, like I said there was lots of work there, I'd go 6 months without a day off. Even Sundays I'd end up working, like I said guys would pull up in a truck and say "let's go to work." You know...so a holiday in Toronto you'd take say a week, 2 weeks off work you got money in the bank to drink with, take a couple of weeks off work and you go to the liquor store. They have one that opens at 7:00 o'clock in the morning there, which wasn't too far from where I was staying. Again, in the inner

city...But you go there Saturday morning you pick up a bottle or whatever and then you do the soup kitchen stroll, you have a list, like here, of all the soup kitchens but there they have more daily ones...but they' re spread out all over the city, so you start with the local ones for breakfast and its about a 2 hour walk to the next one, and at 11 o'clock they're serving lunch. So you have your breakfast so stroll over there and you have your drink on the way and you stroll over to the next one and have your lunch, and then you stroll back around to where you started because next door they have supper.

[So you have the whole stroll mapped out in your head?]
Oh yeah, there's no pressure, no time limit, you know. You have to be there from, lunch is from 11 to 1 PM so if you show up at quarter to one you can still get in. You show up at 11 o'clock and you'll stand in line but you'll get in as one of the first ones. It's the same lunch no matter whether you're first or not. So you know, Vancouver is the same way. They have couple of soup lines. You know, two o'clock one place they only feed 96 people but its good for a bowl of soup and a sandwich or in my case I was living about 2 blocks from there, had my own apartment with a fridge. I got margarine, peanut butter, some lunchmeats, maybe cheese or whatever. I go down to the soup kitchen for 2 o'clock. I'd go down to this particular soup kitchen and they hand out bread, and buns and donuts and whatever, so you bring a little shopping bag with you, grab a couple of loves of bread, donuts or whatever, go back home, throw them in the freezer so now you can eat for another couple of days...

The advantages of temporary work, however, were offset by the exploitation these individuals experienced in the workplace. Contingent workers are often consigned to the bottom of the economic ladder, where they experience frequent job changes, have little economic security and no hope of economic advancement.

Powerlessness

A sense of helplessness was apparent in many of the narratives, especially in the interviews conducted with alcoholics. Interestingly, the degree of powerlessness communicated by participants seemed to correspond to the degree of material and psychological deprivation they were experiencing. Those individuals who were living under the worse circumstances exhibited the bleakest outlooks on life. Participants described being impotent to their addictions as the following excerpts illustrate:

It was...was feeling sorry for myself. That was the big thing. I had to deal with that. Feeling sorry, "Oh, this happened to me and that happened to me. I deserve to drink. I can do this and I can do that because I deserve it. I'm definitely an alcoholic but I'm not...like my mom passed away from cirrhosis and my dad's a vegetable in hospital directly related to drinking...Well, I should have [quit drinking] by now, with all of the family I've lost and everything...even I lost my mom over drinking so I should have known by then. But I keep doing it I don't know why. It's like God gifted me with two brains—one to keep me going, and one to destroy me. It's like a suicide mission that's what it is like. You stop caring about everything, and once you stop caring about yourself everything starts going downhill.

Donald (35-year-old homeless, Metis man)

> A good picture I seen one day...I was sitting in this doctor's office and I looked at this book and there were these little tiny people in this bottle, you know...and I thought "Yeah, that's where I was stuck. Right there! Look at how small that bottle is compared to me." It's what was inside that bottle that had me trapped. A little bottle like that controlled my life! I let it control my life for thirty years! Like how stupid can I get? How stupid can I get to let that liquid inside that thing control my life...and this is what I want you to do today to feed me. This is what I want you to do to make me survive, to keep me going. That's what alcohol wants to do to keep you going, because alcohol is a very STRONG drug, a very strong drug. For all that alcohol to control your life for thirty years, don't you think that's a little bit insane, you know. That's insanity. That's perfect insanity to chase around that bottle. Like I have to question commercials when they say that this substance makes you feel great. Yeah, it does! But what else does it take. Alcohol takes away your spirit. It takes away your clothes. It sure as hell removes pain, but it sure as hell takes away your life and it takes away your decisions. To really look back at all those things, is to think how did my life come this far?
>
> *John (39-year-old, formerly homeless, Native man)*

Interestingly, all of the participants (16) identified their substance use as problematic (either past or present usage) and they were cognisant of their addictive patterns. Yet, even with this awareness, the majority of them were incapable of changing their patterns of usage. This occurred despite the fact that the bulk of the participants (14 of 16) had received some form of addiction treatment in the past. In fact, many of the narratives reflected the collective argot of the 12-step programs used by most of the participants. This illustrates the pernicious nature of addictions and provides insights into the frustration expressed by the participants. One participant expresses his disillusionment:

> OK, the thing I regret...I knew all this eventually would happen...the alcohol would take its toll...it wasn't like I woke up one day and realised I was an alcoholic...no, no...I knew this would eventually happen. I knew what to do about it or how to try to do something about it. But I just let it slide. I figured, "Oh well, I'll stay sober for a little bit." And it just didn't work that way.

Alienation

Many of the participants described feeling marginalised from society. Participants were keenly aware of their social position and notions of being "looked down upon" or "being forgotten" by the larger community were common. As one individual says, there are "cracks in society...nobody cares, nobody gives a damn, so why should we give a shit? Why do we have to dress up for you?" For some individuals, this alienation was related to experiences of racism, as the following excerpt shows:

> It is hard to love. Especially when you've grown up with hate. Being a full-breed Native, I was put down by the homes, you know, growing up. And then when I got placed into a Native home, I was put down because I was too White. I was an apple. I was like an Oreo cookie; you know (laughs) brown on the outside and white inside. It's really hard for me. It still is difficult in some ways to know where I fit in.
>
> *Janice (32-year-old, sheltered, Metis woman)*

These feelings of alienation were often expressed in the form of anger towards society and were used as justifications for self-destructive behaviour. John, a formerly homeless Native man, explains:

> *[What are street peoples attitudes towards mainstream society?]*
> I think that the reason a lot of them are stuck is because of their anger towards society. Because they think that...I really thought society owed me a favour. But society didn't owe me nothing. I owed myself that freedom.
>
> *[Why would someone think society owes him or her something?]*
> Because they blame society for being there. Because I did. I blamed society. I blamed the White man. I blamed the alcohol. I blamed everything. But really...it really comes down to one person and that one person is me. The White man didn't come up to me and say, "Here, I'm going to pour this drink down your throat. The White man didn't say "Here's a needle, I'm going to stick it in your arm." The White man didn't say "Here, I'm going to throw you on the street with nothing." I made that choice to be out there. It's an individual's choice.

In some cases, the marginalisation was attributed to interactions with the larger community and with service providers who were thought to be judgmental and manipulative. Participants were acutely aware of **power-over** relationships and were apprehensive and resentful of authority figures. For some participants, this resentment extended to the agencies and services they relied upon for basic survival. Earl, a 44-year-old homeless man, describes his feelings:

> I think that part of the frustration is that you think you're a captive and it's almost like they know they've got control, although they haven't really earned it. But then again some people almost thrive on it.

In other instances, the feelings of marginalisation were accompanied by feelings of shame and personal failure. A common theme in the narratives was the notion of "a loss of status." Several participants made references to past lives where they had been economically stable and socially established. This is consistent with other studies. For example, a 1997 study [241] conducted in Calgary found that the three most common life events that preceded homelessness were job loss, the ending of a relationship, and eviction.[PP] The following excerpts are variants on this theme:

> Again, I was with my ex-girlfriend and we were right across from the convention centre, making the call for cocaine (Laughs). It used to be the W.W. Arcade but now it's the Hardware Grill. I come in there and I just asked to use the phone and I didn't realise how far down I got. Basically, the impression that I got from them was "Sorry, we don't want bums in here." That was sort of a transformation for me because I realised that there was a time when I was the person sitting there at the nice table with the linen, and I was "Look at that freak." (Laughs) I was standing there and I was thinking, "What is that person thinking that is speaking to me." So it's how people treat you; it's how they perceive you (sighs)... and when part of it is true then I guess it hurts because the truth hurts.
>
> *Earl (44-year-old, sheltered, White man)*

I didn't really start using lots until I was twenty-two. I used to drive cabs in the Yukon. I drove cab for three-and-a-half years. I had my own taxis, my own truck, my own $65,000 trailer. I worked hard, sixteen-hours a day, driving a cab and I used to run heavy equipment. I quit drinking for two-years so that I could pay off everything. I had three other taxis going for me and other guys working for me. Everything was going great and then she started drinking again. In the winter-time I would run cabs and in the summer-time I would work on the highways running heavy equipment. We quit for two years and everything was going good. We had a nice fucking place and it was OK for her to drink but not OK for me to drink. Then Christmas rolled around and I said, "Fine, fuck it," and I started drinking again and then a couple of months later I got an impaired and we lasted for about two or three months after that and we broke up. I had a little boy with her. I lost my little boy. And by the time, I was twenty-six I moved to Vancouver. So I had my own trailer and she started drinking. She come home one night and she blanked out and she stabbed me. When I left the Yukon, I had $5500. I hopped on the plane from Whitehorse to Vancouver. I used to use cocaine but I never used to fix it. I used to snort it and smoke it but not fix it. But when I got to Vancouver, I lost all of my feelings for myself because I was missing him and I just started using the needle.

Ernie (33-year-old, homeless, Metis man)

[Describing his destitution and alcoholism] It's something I don't like to be. It's a fact of life. It means like...in my heart and my mind I still have hope for myself. I still can talk and I still have a little bit of intelligence left—a hell of a lot. It's just I've wasted it all and now I'm a little too old to start over again. I'd love to do it all over again.

Burt (51 year-old, relatively homeless, White male)

For some participants, the experiences of powerlessness and marginalisation engendered a deep despondency and an estrangement from the Self, as one participant says: "Why should I care? Because nobody cares about what I care about!" The anomie is apparent in the following excerpts:

I lost my apartment; I lost my belongings; I lost everything. I didn't care anymore. I lost all my clothes and everything. I didn't keep myself up. I didn't look after myself. I lost my pride. I lost my self-esteem. I gave up on life. I didn't want to go on anymore. I didn't even eat properly. Garbage bins, cardboard boxes, riverbanks.

Beth (55-year-old, formerly homeless, Metis woman)

Like this is not right, to wake up in the morning and all you got to look forward to is nothing. That's no way of living. To wake up in the morning and say there is nothing for me so all I might as well drink. I might was well go do this or go and do this drug or rip this off.

John (39-year-old, formerly homeless, Native man)

All of us especially in our younger years were totally rebellious especially on the streets. We have something to prove and yet we have nothing to prove. I truly believe now that I was on a suicide path when I drank that moonshine that killed some friends...and why didn't it kill me. But you see I thought I was living life on the edge—but a more clinical term was a suicide path. But I saw it as living life on the edge, that thing about proving to other people how tough I was.

Iris (41-year-old, stably housed, Native woman)

One participant confessed that his biggest fear was to fall into a rut, where he would be so overwhelmed by despair that he would stop caring about his life:

> Like how many times do you do something before you say, "Well, I did everything"...jumping through hoops...and then say, "Fuck everything!" You know...just say, "What's the use?"

Violence and Death

Death was a pervasive theme in the narratives. For street-involved individuals, death was portrayed as constant companion to life on the streets. Participants recounted stories that bore testament to the brutalities of survival in the inner city. As one individual quipped, "Death is around every corner." Joe captures this sentiment:

> That's another thing about the inner city, you tend to experience more about life and death and you have a better understanding of what is going on. What some consequences are, you know...and how to survive those consequences. Because some people...if you import someone say my age from Lessard—way out in the West End, a nice ritzy area—into the inner city they will get sick to their stomach within a week just from some of the bullshit that goes on here. You know, the constant fights, the little gang wars, which you see in front of the liquor store quite often.

The portrayals fell into a number of identifiable sub-themes. One such theme dealt with the loss of friends and companions due to drug overdoses. Earl, a 44-year-old cocaine-user describes the death of a friend:

> Ahh...I am scared. Yeah, I'm scared. I'm actually scared. I'll give you an example, a couple of days ago a buddy of mine...and I've never done the needle or anything but it's the crack cocaine that I got into...Because I just can't see myself going to the level of doing...because I respect myself too much. Although, I've come close a couple of times and that's kind of scary. But...ahh...a buddy of mine a couple of nights ago...I don't know if it's the crack cocaine but I've got to find his room-mate, because I think he just went to Jamaica...he had somebody die in his arms—OD'd and died in his arms a couple of nights ago. And this was a buddy of mine and he was into the cocaine. Umm...and in the last year, my ex-two roommates died of drug overdoses. So I mean...also I was living out in Abbottsfield and we knew this guy who used to come around and things got pretty bad...umm...he ended up getting murdered out in Sherwood Park because of cocaine and we also know the guy that murdered him. So I'm just saying that as far as being scared about it, the reality is that this shit will kill you!

Another theme involved violent death. Six (6) of the participants reported having lost loved ones or friends in homicides:

> One of my brothers was [dealing drugs] and he probably made some bad moves or whatever. I don't know the whole story but I know it was over that kind of stuff. They found my oldest brother and he was beat to death. Beat to death with crowbars. You couldn't even recognise him. The only way my sister could recognise him was the tattoo that he had. It was the only way. It was a closed coffin.
>
> *Donald (35-year-old, homeless, Metis man)*

When I was a working girl this one guy took me outside the city...the limits of the city and I had a feeling of fear that you wouldn't believe ...that I wasn't going to get back into the city. I had that feeling that I'm going to be dumped in this brush pile and nobody's going to see me until I'm a pile of bones. That was the one time and then there was another time there in Riverdale. The guy took me down there by the riverbank and he tied me to a tree and he did all kinds of things to me. And I thought I was not going to come out of there. That was two times that I had bad dates and it really scared me. And when Julie, my roommate was killed. I was never so scared in my life. A guy had picked her up and did some terrible things to her. He beat her so that she was beyond recognition and pushed a branch up her vagina. The only way that I could recognise her was by the ring that she was wearing...that I got for her as a birthday present.

Beth (55-year-old, stably housed Native woman)

OK, I'll tell you the real reason I came back to Edmonton was because two of my friends were on the unsolved murder list. Two very good friends. My best friend was murdered on 129 Ave and 65 Street. The freak-out part of it is when I came back to Edmonton in '91 for some reason something told me to go and get an apartment in Belvedere. I grab this apartment. It took me two months to find her mom and I finally did and I said "Can you please get her to phone me." And she said "You don't know? We've been looking for you since August of 1990. She was beaten to death." And she was very much of a homebody, excellent mother, excellent children, and excellent husband with an excellent job. She was caretaking. She is just a little woman...just 4'11 but just pure gold to me. And somebody went in and beat her to death and stole $3000 of rent and all her diamonds. They almost cut her fingers off to get her rings off.

Iris (41-year-old, stably housed, Native woman)

Eight (8) of the participants revealed situations in which they had either been the victims or perpetrators of violence. The reported experiences of victimization included beatings, stabbings and rape. This harsh reality is captured in the following:

I had breaks in my face. I had broken arms, you know...my hands have all been broken from punching people from hitting walls, hitting guys (laughs). I didn't hit a lot of women but I hit a lot of guys (laughs). I put a few [guys in the hospital]...you know...when I look back at my past I'm not proud of the life I have lived. Today, I can't believe the angry person that I was. I can't believe that I was that angry—that vicious of a person.

Beth (55-year-old, stably housed Native woman)

I do have a hard head. I've been piped, two-by-foured, punched and my nose broken. I've got a hard head but you can take a million beatings but if you don't understand why you're getting some of them, it just depresses. I should have been gone a long time ago. But I need a purpose and I'm not even sure that I have done it yet.

Iris (41-year-old, stably housed, Native woman)

Last time, I was beaten good...held down by four people and kicked in the face. Of course, they didn't get the dope. I shot up before I went to the hospital. Same thing happened when I was stabbed. I almost bled to death, but I shot up before help arrived.

Janice (31-year-old, sheltered, Native woman)

The reported experiences of violence have important implications for both physical and psychological health. The literature indicates that exposure to recurring and unpredictable violence is associated with decreased levels of perceived control and depression.[242] In addition, chronic exposure to violence may be cumulative—leading to anger, despair, and emotional numbing.[243] Furthermore, Cohen *et al* found that community stressors such as levels of violent crime are associated with anomie among community residents.[244]

Addictions & Personal Health

Addictions were central to health decision-making to the extent that participants were not concerned about their health during periods of heavy alcohol or drug use, as the following excerpts illustrate:

> I didn't care about my health when I was drinking. I didn't care about anything when I was drinking. Alcohol played a big part in my life because I started drinking at a young age. I started drinking when I was nine, so I didn't have time to think about my health. I drank for thirty years, you know, actually twenty-nine years I drank...
>
> *John (39-year-old, formerly homeless, Native man)*

> *[How high is health ranked in the lives of your friends in your street family?]*
> It's not. For the most, I believe number one is getting high on something, whether it is beer or drugs. And I think health wise, because that's when the sharing of needles [happens]... even with the needle exchange program. How long has that been in effect? Ten years? People still...they think if they bleach it once they won't get Hep. I was the same way, because it was my personal rut, so how do I speak for others...as to say I felt low enough, dangerous enough. I lived on the edge and I may have used a dirty needle. I remember sharing, not even thinking about it because there was nothing else in the house and we had to get it into us. And it doesn't hit you until somebody else gets it. Then it hits you personally. Actually, it didn't hit me until he [referring to her partner] got it. It was something that somebody else had, until you're scared enough and they do an HIV test on you and you're waiting for the results. Then it all comes into focus about razors, toothbrushes, and needles, sleeping with someone. But it's too late.
>
> *Iris (41-year-old, stably housed, Native woman)*

> A lot of people when they come off the streets like myself...I wasn't aware that I had Hep C and if I hadn't come off the street I probably still wouldn't have found a doctor, because that was the last thing for me to worry about.

> *[So what are the primary concerns of street people?]*
> To get a place to stay for the night...to have money so you can get your drug of choice and the last one is to get your drugs or your alcohol. That's the extent of the things that you are working for that day. It's those three things. If you go to the doctor and the doctor says you have pneumonia, big deal. What's the big deal? You don't worry about it. You don't even think about it. You just go and get another bottle and keep on going. That's why some people die on the streets because they don't take into consideration the seriousness of their health problems.

[When your were living on the streets did you think about health at all?]
No, no. When I came off the street, I didn't realise...like I was living in a half-way house called Exodus House and started to cough and blood shot out of my mouth...and I was huge in front, huge...my liver had swollen up so bad...so they drove me to the hospital and they had to do a surgery on me...like they took a quarter of my liver out...and they told me if I hadn't come off the street when I had that I would never have made it. So I never thought about my health. The only time I sought out medical help was when I went to a doctor to get T's. [I thought] Ahqq...I'm invincible. Nobody can kill me. I'm not going to die. That was my attitude.

Beth (55-year-old, formerly homeless, Metis woman)

Concerns over personal health were constrained by addictions—with health concerns being relegated to the periods of sobriety in-between binges. Eight (8) participants identified a boom-and-bust cycle in their lives wherein periods of heavy alcohol use were separated by brief spells of relative sobriety. An AADAC addictions counsellor who had worked at the George Spady Centre described these interludes as "sobriety binges." Six (6) participants reported that what had initially started as binge drinking eventually evolved into chronic drinking. Participants reported "going on binges" that would last from several days to several months. Episodes of binge drinking were interrupted by periods of "drying out" and "getting healthy." This theme is reflected in the following selections:

I would go on a binge and my binges would usually last a month to two or three months. [I would be] stoned and right out of it and not knowing what I am doing the whole day—all of the time. And then I would come off my binges and I would straighten up, get cleaned up, cleared out and everything else. But then I found that through the years my binges were no longer getting to be binges anymore – they were just one long drunk.

Beth (55-year-old, formerly homeless, Metis woman)

I try to look after myself. When I drink, I'm a binger, eh. So when I stop I try to eat right and get healthy.

Brent (51-year-old, stably housed, African American man)

[What do you think about your own health?]
Well, shabby. I've lost a lot of iron [from drinking] and I have to build it back up. I drink but only drink maybe 2 or 3 days ...[then] I'll sober up a couple of weeks. But I always eat. You gotta eat. It helps you with DT's and sclerosis. This one guy in an AA program told me.

Barry (35-year-old, sheltered homeless, Native man)

Several participants referred to *health* in terms of recovering from the health degradations caused by substance abuse. In some cases, this included returning to basic activities that were neglected during periods of heavy consumption, such as eating. A former employee of Urban Manor captures this sentiment when she repeats the common refrain: "Why waste a two-hundred dollar drunk on a ten-cent sandwich?" Iris, a forty-one-year-old Native woman defined being *healthy* in the following:

Eating for anyone that's got to be the priority because too many people drink or do drugs and forget about eating. It used to bother me that I was always saying: "I have to diet, I have to diet." And, no, eating has got to be a priority. It has to be. Vitamins...there's got to be a better...you see there's nobody that covers vitamins, nobody. It should be a considered a priority but you should have your choice. Because there are some people who can't eat, they have no appetite. But I'm always forcing people. I always have to practically chase them around with my bannock and stuff. And that is it eating and I have had members of my family die from sclerosis like my real mom... Mind you, most of the time if you ask for ten bucks for food you can never get it, but if you tell somebody you need ten bucks for beer...(makes snapping sound). And everybody says that...every street person I know. "Don't tell anybody you're hungry, just tell them you're thirsty."

John, a recovering alcoholic and formerly homeless man, defined health as:

Getting up in the morning and praying and just being alive. Just breathing and seeing what the Creator made in the morning. That's part of health. Basically, it has to do with being alive. [When I was on the streets] I didn't feel alive. I felt like I had to survive. It was mostly survival. It wasn't being alive. It was being able to survive every day and then to get up in the morning and know what I did the next day...that's part of healthy living, you know...actually remembering where I went that night. You know...how I got there...to actually do that's healthy living there too, you know.

Several participants referred to their health in terms of the long-term impacts of their addictions, which in the case of this sample included six (6) individuals with Hepatitis C, two individuals (2) with neurological problems caused by chronic drinking and three (3) with respiratory problems aggravated by excessive smoking. Other health concerns included injuries sustained during drunken episodes or as a result of violence. The following excerpts show the range of health issues:

I froze my hands on a severe drunk one time. I hit my head on a sidewalk...I'm lucky to be alive actually. There was another big one because I had to play devil's advocate to survive on that one...I did look at the sky and it was dark and there were black windows and I knew I was not getting into this building and I actually did say something that I don't know where it came from but I said "God, I need one more chance in this one!" [This happened] twelve-years ago and my hands blackened completely and there was some possibility that I would lose them too—but you don't know that for six or seven weeks. I had some fourth degree...I had some taken off here [shows amputated fingers]. You would figure I would learn something from that experience but as soon as I had the operation, two days later I was so drunk I didn't know who I was.

Oh, it has to be wicked. It has to be wicked. I've damaged my kidneys and liver to a bad extent for sure. But the liver is regenerative to some extent, but once your kidneys go...

Ted (54 year-old, stably housed, White male)

Right now...like just about all the neurons are shot in my brain, eh. That's why I've lost my motor movements...my legs, walking, my sense of balance. I had to go to physio for a whole year just to get to the shape I'm in now. Ahh...I'm in chronic pain. I hurt from my feet to my neck. It's from my neurons being fucked up, eh. It's mostly the alcohol. I went through all those specialists at the U of A, the Royal Alex and they reckon I could die at any time but if I quit doing drugs and drinking I might live ten years, eh.

[Do you want to live ten years?]
No. Not in this condition. It hurts too much. I'm really in a lot of pain every day.

Dave (53 year-old, sheltered homeless, Metis male)

I'm an alcoholic and coming off the booze I get grand mal seizures and Dilatin doesn't work... Oh, God...the first seizure I had was 1974...after thirty years of drinking I can be sober for three days and go on a grand mal seizure... I have chronic bronchitis (says he smokes 50 cigarettes a day)

Burt (51 year-old, relatively homeless, White male)

Personally, I don't know...I think my health has deteriorated so much that...I'm not in good health anymore. I smoke a pack and a half of cigarettes a day and I'm constantly coughing.

Joe (44 year-old, sheltered homeless, White male)

For three (3) of the participants, concerns about their health only became paramount after severe degradations to their health had already occurred. Participants reported reassessing the importance of their health due to a growing awareness that their "health was leaving them." In the case of these individuals, this acknowledgement came late in their alcoholic careers.

The lack of concern about personal health was consistent with a *fatalistic* attitude to life and a *present-time* orientation to decision-making. This fatalistic attitude is apparent when Joe, a 41-year-old alcoholic, describes his attitude towards personal health:

You see up until I contracted TB, it never bothered me. Sure, I knew somewhere in a little square corner of my mind that there's always the possibility that I could get Hepatitis or TB or a thousand other diseases that are mostly common in the inner cities. But its never bothered me because if it happens it happens. Shit happens and there's nothing you can do about it.

Alcohol is directly related to serious health problems. Besides the obvious cognitive and emotional effects of addictions, several health problems are aggravated by chronic alcohol abuse or drug dependency. The most common causes of death among alcoholics are suicide, murder, accidents and illnesses such as hepatitis, cirrhosis, subdural haematoma, pneumonia and alcohol-related heart disease.[245] In addition, impaired immunity has also been associated with chronic alcoholics.[246] This is further complicated by the common behavioural attributes of heavy drinkers. In general, they smoke more and commonly eat less. In addition, they typically lead irregular lives—staying up all hours, never exercising, sleeping it off on sidewalks and outdoor benches.

Attitudes towards Health Professionals

Participants expressed a range of opinions regarding health professionals—attitudes that were consistent with their lived-experiences and their attitudes towards personal health. Five (5) individuals were indifferent to health professionals, stating that they either had no opinions about medical staff or they rarely sought medical attention. Roger, a 44-year-old manual labourer who prides himself on his physicality, explains:

> *[How often do you see a doctor?]*
> I don't. I let my Alberta Healthcare lapse so far that I'm in for about twelve to fourteen hundred and that's about a year ago. I've got to get a hold of them for one of these payment plans in case I have to do follow-up on this other one [referring to Hep C positive status].
>
> *[Where do you usually go for doctors?]*
> I've never been sick. The worse I ever got was a cold, eh, which is why this is so shocking to me [referring to TB positive and Hep C positive status]. Like what's this going to do to my body? I'm built like a brick shithouse too, eh. I've always taken pride in my health and that.

Three (3) participants reported being distrustful of medical professionals, especially physicians. For some individuals, this distrust was linked to the prescribing practises of doctors, as Joe describes:

> But if you're working on the revolving door syndrome then you start making mistakes. A guy comes in and says "Well, I need some Halcyon." You know, "Oh, no problem." (gestures prescription writing) "Next, next" Writing prescriptions left and right. And there's quite a few of those doctors around too. They have no idea what the case history is; they have no idea what you're doing with the drugs, they just write the prescription. "Make sure you have that filled at the pharmacy next door." Because they own the pharmacy too! (laughs) You know so they get you for the $68 for the office visit for healthcare or whatever it is. Two minutes, $68 and then they get you for the over-priced drugs next door at their drugstore. Ten dollars for the prescription and $35 for the filling fee (laughs). So they're making money hand-over-fist.

Ted, another participant repeats this scepticism:

> Because we've put doctors in the Western sense on a pedestal and their approach pharmaceutically is nonsense in one way to the extent that they just replace mechanics and the numbers they have to serve just belie the whole program itself because they're treating something that they don't even know.

John, a 39 year-old and formerly homeless Aboriginal man mistrusted health professionals because he perceived them to be prejudiced towards Natives and street people. At the time of the interview, John was recovering from a broken hand that he had acquired in a domestic dispute. His hand was badly swollen and he was in considerable discomfort, yet he refused to seek medical attention. Several months earlier, he had developed an ear infection that he was also reluctant to have treated—despite the repeated urgings of the staff at a local inner city agency. In John's case, he didn't trust physicians because "they asked

too many questions." In addition, he believed that physicians were reluctant to provide him with painkillers because they assumed he would illicitly distribute them, as he says, "Oh, here comes another Native guy. Like what kind of medication does he want for free?"

> I still never go and see doctors. I still don't judge their opinions. Just because I'm sober doesn't mean that I can trust everybody, especially doctors. Because I think as a minority we get far less treatment than the people that aren't a minority. Poorer treatment from the doctors and nurses...a lot of ignorance because they think...you go and see a doctor and you have a legitimate beef and they think all you want to go in there for is for pills so you can sell them on the street. Like if I go to a doctor now to get my finger checked out, they'll give Tylenol 3's but they'll be very reluctant to give them to me, because they'll think this guy just came in and he wants to take these Tylenol 3's and sell them on the street. And I don't want to do that. I just need them for pain and that's a legitimate pain because I do have a broken hand, eh.

According to John, this prejudice was more pronounced amongst inner city doctors and, therefore, on the rare occasions that he sought medical attention, he did so elsewhere:

> Some doctors...they've been through the game...you know what I mean? So they're a little bit reluctant to help you, especially if they know you live on the street. You know when you don't have a fixed address that's when it's very hard.
>
> Mostly on Jasper Ave. They're easy. Jasper Ave. doctors are the easiest to get pills off of. Actually, there's one in Millwoods and there's one on the Southside. There are some doctors in the city that won't give you pills for anything and there are some doctors that will treat you with the same respect as they treat other minorities, like whites.

Ironically, John admitted to having previously sold prescription drugs such as Valium and Tylenol 3 (T3's) on the street—an experience that likely influenced his negative opinion of doctors. While it is beyond the scope of this study to confirm the extent to which prescription drugs are illicitly distributed on the street, the practice is quite common. In the course of this fieldwork, I was approached several times by individuals wanting to sell me T3's. This occurred within the confines of several inner city bars—settings where both illicit and licit drugs are frequently exchanged. At the time of the study, the going rate for T3's was about 50 cents per pill in the inner city and about one dollar per pill downtown. In addition, six (6) other participants admitted to having "used" prescription drugs such as Valium, Tylenol and Talwin and Ritalin.

While some individuals were openly sceptical of the medical profession, others regarded doctors in a positive manner. Four (4) participants expressed favourable assessments of physicians, regarding them as "caring and trustworthy." Burt, a 51 year-old chronic alcoholic with a seizure disorder that required him to see his physician regularly, describes his doctor:

> He's not one of those doctors that when you walk in he's got his pen in his hand, inking dripping off and his script pad right there: "What do you need today?" "I need some T's and R's." He's very cautious about what he gives. Like he wants to see me stop drinking but not turn from drinking into heavy drugs and all of these pills and shit. That's the kind of doctor I like.

Interestingly, Burt's positive assessment of his doctor was based on the same criteria that formed the foundation of John's distrust of physicians—namely the willingness of doctors to prescribe medications. As in John's case, Burt preferred to see doctors outside the inner city—an opinion that was shared by other participants. In total, two (2) individuals preferred the doctors on Jasper Avenue; two (2) individuals primarily sought medical attention on Edmonton's Southside; and one (1) went to the Misericordia Hospital. Of the remaining individuals, seven (7) said they primarily attended the Forte Health Clinic. One (1) individual lived in Calgary and saw physicians there. Three (3) individuals claimed they rarely visited medical facilities and therefore had no preference. Eleven (11) of the participants revealed that they had received treatment at some point at the Royal Alexander Hospital. Given the shifting contingencies in the lives of participants and their fluctuating concerns about personal health, a clear pattern of their utilisation of health services could not be determined. Some individuals reported seeing their doctors frequently; others claimed to seldom seek medical attention. In addition, several participants made contradictory statements regarding how often they saw health care providers.

For Iris, a 41 year-old Native woman, her regular doctor was a source of emotional as well as medical support, as she says: "She is my social worker. She is my doctor and she's my sounding board and I really don't have any dealings with anyone else because I can't take the time to keep explaining things to people."

As can be expected, a number of individuals had mixed feelings regarding health services—recounting both positive and negative clinical encounters. Four (4) participants described scenarios where medical staff treated them poorly, although they did not generalise these experiences to all health settings. Alarmingly, three (3) of these individuals revealed that these negative encounters occurred in the emergency room of an inner city hospital. One individual referred to the facility as a "butcher shop" and described the staff as being callous because "they see all drunks in there, the druggies and the people who got stabbed." Another participant who contracted TB while living with an infected case, made a similar observation regarding the manner in which she was informed about her partner's health status. As Iris reveals:

> The nurse at the ICU...She didn't even prepare me. She just stood and said "He's got HIV pneumonia." Not could you sit down, I have something...if you care about this man. Blah, blah, blah. Nothing. Out of her mouth she said he has HIV pneumonia, he's got TB, he's got Hepatitis B and C and Chicken Pox. And I stood there and I looked at her and I felt my legs just turned to rubber. I thought I was going to faint; I thought I was going to puke; I didn't know if I was going to scream or cry. And she just stood there and said "Wash your hands if you want to go and see him." It was so cold. And then I said "That's impossible. I just had a physical on October 1st. I had an HIV test and I'm fine." And she looked at me and said "Then you're lucky I guess."

5.3 Focus on Tuberculosis

In this study, nine (9) of the participants were diagnosed as having latent TB and were treated with prophylaxis—of these individuals, seven (7) were on a two-month (60 doses) short-course treatment regimen of Rifampin (RMP) and Pyrazinamide (PZA). Four (4) participants received treatment for active pulmonary TB. Two (2) of the individuals who received prophylaxis did not complete the full course of treatment.

Eight (8) of the participants were recruited for the study with the help of the public health nurse and they were interviewed during the course of their treatment. The principal investigator was present for the initial clinical consultation with four (4) of these individuals. The remaining five (5) individuals were identified by way of the local grapevine—one (1) individual was receiving treatment at the time of the interview and the other four had previously completed treatment.

Of the four (4) participants who had been treated for active TB, three (3) were interviewed while receiving treatment at University Hospital. One of these individuals was from Calgary—the remaining participants resided in Edmonton.

Tuberculosis: Transmission, Pathogenesis & Testing

Tuberculosis is a respiratory disease, transmitted by inhaling "droplet nuclei" from the respiratory tract of a person suffering from active infection. It is normally contracted only by those in close contact with an infectious case. The primary stage of infection occurs when *tubercle bacilli* enter the body and attach themselves to the host tissue (typically the lungs). At the site of implantation, the bacteria replicate for several weeks until their numbers become sufficiently large (estimated to be 10^3 - 10^4 bacilli) to trigger the body's immune response. This response is called a "cell-mediated reaction" because the host cells respond by encapsulating the mycobacteria. In most individuals the primary infection is contained by the body's immune system, and the lesion (called a tubercle) becomes calcified. At this **latent** stage of infection, the tubercle is commonly sealed off and the bacteria become dormant. "Tubercle bacilli are able to survive for years in the small granulomas or solid caseous material of lymphohematogenously seeded foci." (Pg. 39)[5]

Individuals who are infected with **latent** tuberculosis are asymptomatic and non-infectious. However, they may develop active TB at some point in the future. About 10 percent of those with latent infections develop tuberculosis—5 percent within 2 years of infection and 5 percent after 2 years. With prophylactic treatment, this percentage is significantly reduced.[5]

In many individuals the infection is permanently arrested even without treatment. In others, the disease may break out again and become active years

later, usually when the body's immune system is compromised. Untreated, the infection can progress until large areas of the lung and other organs are destroyed. It is for this reason that immuno-suppressed individuals, such as those with HCV, HIV and/or a history of alcohol abuse, are routinely recommended for prophylactic treatment in Edmonton's inner city.

The major tool to diagnose tuberculosis infection is the **Mantoux** tuberculin skin test. This test consists of the intradermal injection of a small amount of purified protein derivative (PPD) into a patient's forearm. If a previous TB infection has occurred, there are sensitised lymphocytes that react to a repeat encounter with antigens from the TB bacilli. In a person who has been previously exposed to TB, a delayed cell-mediated reaction will occur within 48 to 72 hours. This will cause localised swelling and manifest as a red **induration** of the skin at the injection site. This induration is interpreted clinically in terms of: (1) the size of the reaction (the transverse diameter of the swelling in millimetres); (2) the predictive value of the test based on possible causes of false-negative and false-positive reactions; and (3) the risk of development of active tuberculosis.[5]

In most of Canada, ten millimetres (10 mm) is the standard cut-point to determine the presence of tuberculosis infection—meaning that reactions of over 10 millimetres are considered positive indicators of TB. However, this standard applies mostly to non-immunocompromised individuals. In the presence of immune suppression (as in the case of individuals with HIV) indurations as small as five millimetres (5 mm) are significant.[5]

Although, a positive tuberculin skin test indicates that an individual has been infected with TB, further testing is required to verify the existence of tuberculosis. These further tests include a chest x-ray and a bacteriologic examination (the collection of a sputum sample for laboratory testing). By itself, a positive skin test does not indicate the presence of active disease.

When active TB disease is present, the tubercule bacillus can be cultured from the sputum and may be seen with an acid-fast stain. Chest X-rays of individuals with current or previous active disease demonstrate characteristic changes. Nodules, calcifications, cavities and hilar enlargement (enlarged mediastinal lymph nodes) commonly are seen in the upper lobes. A positive skin test indicates the need for yearly chest X-rays to screen for active disease.

Initial Diagnosis

Five (5) of the participants (out of the 13 participants who had been exposed to TB) reported that their initial diagnosis of TB occurred after they had sought medical help for pre-existing respiratory problems—a finding which is consistent with literature that shows a high prevalence of upper respiratory infections in the homeless population.[247] Four (4) of the participants had been previously hospitalised for pneumonia. As Barry, a 35-year-old Native man who was treated for infectious TB, states:

> Two weeks before I went to the hospital I had a chest x-ray and the way the x-ray went I had white stuff down here. I don't think my doctor was specialised in TB, he said it was pneumonia, eh. So I was drinking and that. Usually, when I'm drinking I don't go to the point where I am going to blackout. I know what I'm doing, eh. I'll cut down and walk around. I don't know. I woke up in a bus stop and I ended up in the hospital. I even told them I think I have pneumonia, eh. They did one of the sputum samples. I thought I had pneumonia and it turned out I had TB. I didn't know. I thought I had pneumonia.

Another participant with active TB reported that he had been diagnosed for TB after seeking treatment for chronic bronchitis—a recurring problem aggravated by his excessive smoking.

Of the participants, two (2) individuals were screened and diagnosed with TB prior to entering substance abuse programs. One (1) individual was screened and identified while in prison. Four (4) of the participants were identified in contact investigation that was conducted in response to a case of infectious pulmonary TB at a local temp agency. The remaining six (6) individuals were identified following visits with medical professionals.

Knowledge of TB

The majority of the participants who had been exposed to TB (8 out of 13) had a limited knowledge of the disease, although all of them understood TB within a biomedical framework. While participants were aware of the contagious nature of TB, they expressed misunderstandings regarding its mode of transmission. This finding is consistent with other studies that have dealt with TB knowledge in homeless populations, most notably the works of Kitizawa[24] and Kelly.[248] This trend was apparent even among individuals who had been treated for active tuberculosis. In addition, participants reported having little knowledge of TB prior to exposure. Notable exceptions were provided by three (3) Native informants who understood TB within the context of the European colonization of North America. Tuberculosis was seen as a "white man's disease" that killed Natives in the "old days." Three (3) of the participants had prior knowledge of tuberculosis through having relatives who had been treated for TB and therefore understood the disease to be curable. This knowledge, however, did not translate to an understanding of how TB is spread.

Despite consultations with Public Health Officials, misconceptions about TB persisted to the extent that four (4) of the informants reported not understanding the aetiology or transmission of TB until it was explained to them during the research interview. A common misperception was that the sharing of drinks or cigarettes could spread TB, as one participant with infectious TB states:

[How do you think you got TB?]
I don't know. I got a feeling. When I was in Calgary the cops brought me to this drop-in centre where homeless people sleep...and a lot of people cough in there. There are about a hundred people in there and...you share your drinks with somebody. That's the only thing I can think of. I don't think I got it from back home. I think it's from Calgary. I was there for about a month. I was on a binge. I don't know how...but you know you got to test everybody...like there's got to be a carrier in order for me to have it...Yeah, that's another thing that I have been thinking. Like I hung out with a lot of people, eh...in Calgary. I drink with them and they drink with me, eh. Good friends, eh...street friends. It scared me to have TB, eh...and I realised when I want to drink I'm gonna buy a Colt-45 and share it with my friends. I'll drink with them but I'll tell them to grab a cup.

Barry (35 year-old, sheltered homeless, Native male)

Some individuals also believed that TB infection could be the result of exposure to the outdoors, as one participant who had been hospitalised for pulmonary TB states:

> I think it's from drinking outside all of the time, especially in the wintertime. Sitting on the cold cement and my kidneys got infected from the cold wind coming up your back. Not really dressed right for the weather

The lack of understanding regarding the transmission of TB was also apparent in the confusion participants expressed about the distinction between being TB positive and being infectious with TB. Four (4) TB positive participants reported being concerned about transmitting TB to friends or family, despite prior consultations with the public health nurse and the TB physician. It is likely that the sense of urgency in which TB cases are identified and contacted by Public Health officials contributed to the misunderstanding. The confusion is illustrated clearly when one participant states: "This is a communicable disease, but I can't spread it?" and then goes on to express concerns about infecting his wife:

> Could I pass it to my wife? If we have kids will it come out? That's something I still don't know. If I have the bug inside me and she got pregnant right now, could I pass the bug on to her and on to our kids?

In addition to these misunderstandings, three (3) of the participants reported being apprehensive about the safety and the potential toxicity of the prophylactic treatment. The following selections illustrate a range of concerns:

> There is a sense of being vulnerable to being a guinea pig. I don't want to belittle the program but I would think now that we're in the 21st century that they would now, because it is very harsh on your liver and it's one of the organs that you don't want to mess with.

> Well, there is one nagging thing in the back of my mind. There's a little voice that is suggesting that perhaps there are some long-term ramifications of taking this medication that they're not telling me about or that they're not even aware of. I hear that it can be hard on your liver if your enzymes are up (which mine aren't). I just wonder if there is something that they're not telling me. But that's just me...What does that toxicity do in the long-term? And here's another thought that entered my mind that they're not going to tell

you because they want you to be compliant. They're not going to tell you that guess what ahh...now you're not a threat to the public health but guess what happened. That is just the one nagging thought to me.

I'm totally confused. I really am...I don't know why I'm taking these pills...I'm fine, I'm healthy and I'm taking all these pills. And it's scary. I mean is there going to be after-effects to this stuff...It's scary. They've done so much research on antibiotics and their saying its more negative and everything and the side-effects. And I'm saying, "How new are these pills?" I really...you guys have given me pamphlets but nobody's given me pamphlets on the pills. I need a compendium.

One participant who was exposed to TB by a co-worker while returning from a job site in Fort McMurray reported being concerned by the lack of information given to him and took it upon himself to become a source of information to other individuals who had been in contact with the active case. As Ted, a fifty-four-old alcoholic who works for a local temp agency states:

There are probably maybe 25 people involved in this program [referring to TB treatment] that I know of and I probably know 80% of them personally, because I work for CLS. The stigma has been...nobody knows the implications of this program. There is no guarantee on this program, maybe to the extent that 4 or 5% chance that we can remove the cellular knowledge of TB in your body but you'll always test positive...to myself thinking oh I can beat this game, what I'll do until I found out because there wasn't enough information and I didn't do enough homework, I thought that I would do this program for half the time prior, then I'm going to go to a private doctor...be tested, find out I'm OK and that's the end of this game. But in my preservation of health, it was foolish not to do it...to at this point almost being aware that this program isn't doing anything for me, because my body has already done it...to knowing that in the '50's they exposed nurses to TB, and watched them and tested them every year and I personally knew two people who had 50 years of exposure here to no problem...to people that eventually were ill enough that were exposing us to this were just sick people anyway at this point...TB was just the acknowledgement or announcement that that's how sick I am, you know tragically...but they weren't of other health levels before this thing happened.

But anyone that I've known that is in this program, I've said "Please call, because I have a ton of information that isn't readily available to you, in the sense that maybe you haven't thought about it this way. I mean don't be nervous about any of this...some of them are really concerned about their wives and their children. Absolutely don't give this a second thought. Get rid of that fear right now because it's not even there. You know" To...to... this program to make it a little more palatable or sellable why don't they give you 10 pages of this stuff. Like what is tuberculosis. I mean that pamphlet should be there. Not a pamphlet, I mean it could be much more detailed than that...then I don't have to sit there for half-an-hour...if this program is this far along, how this has not been established I don't know. I mean that's incompetent.

A limited prior knowledge about TB was also evident in the initial reactions of participants to being diagnosed as TB positive. Four (4) of the participants reported being frightened upon first hearing of their TB positive status. The fear is evident in the responses of the following two participants:

> Because I didn't know what the reaction was, I thought I was positive and I was like "Oh no, this can't be happening to me". Uh, you know, "My life's over!" Like I felt devastated partly because people don't understand. All they hear about is like tuberculosis from the Middle Ages almost and a scourge that wiped thousands of people out. A lot of people think it's incurable and uh, and that type of a thing, eh? But then when I found out I was positive again, which Kathy [TB nurse] thought, but I still had some of these misconceptions...But uh, but I felt pretty pissed off cuz here I am trying to go to Fort McMurray to try and do something to try and... and then ironically enough CLS shafts me and I only get 5 shifts, practically make nothing and on top of it I end up with the TB germ. I felt like I say really uh... like born under a bad sign or cheated or something like that.
>
> *Earl (44 year-old, sheltered homeless, White male)*

> I thought I was going to die. I really did. I've seen the pain and the suffering that my mother goes through. And it's scared the living daylights out of me. I have twin girls and a year-old baby. And for me it was really scary. Nobody told me there were different kinds of TB. I thought there was only one kind and that it takes your life. I hear about the TB that was passed around in the old days and how it took so many Natives' lives...How TB took tribes and that. It was some sort of epidemic like small pox. It was really scary. My husband was really leery about me being around the kids and of course I was too. Cuz I didn't want them to get it.
>
> *Janice (32 year-old, sheltered homeless, Native female)*

For those participants employed at CLS—a branch of an Edmonton temp agency that specialises in industrial clean-ups—their fears were amplified by the panic that ensued when it was discovered that they (and a van full of co-workers) had been exposed to TB while returning from a job site in Fort McMurray. Because CLS was concerned about being typecast as having an infected workforce, the agency attempted to muzzle discussions about the outbreak, as Ted describes:

> *[What has the reaction been from CLS?]*
> Pandemonium...to complete denial from the staff...to ignorance...to not even these people going in to be tested...and they have a staff of twelve or fifteen people...pardon me I don't get this...to phoning to ask about the severity of William [Active case] and having no response...to understanding now that you can't use the word TB because you're involving casual labour...you could destroy their business...but within that they are very difficult people too, very insensitive people—total users [CLS management]

The findings suggest that a limited and fragmented understanding of the aetiology and transmission of TB contributes to a climate of fear and confusion, which in turn provides a fertile agar for stigmatisation. Indeed, social stigma appeared as a dominant theme in the interviews.

While these misunderstandings were related to a lack of public awareness about TB, insufficient clinical supervision and consultation with patients also played a part. At the time of the interviews, the public health nurse was overwhelmed by a sudden outbreak of TB—seven (7) new cases were identified from December 2000 to March 2001 and 408 individuals were screened for TB.[7] A rapidly growing caseload combined with the increased demands of a contact investigation limited the nurse's ability to follow-up with patients.

This was exacerbated by the fact that she was uncomfortable in her capacity as a TB nurse. As she says, "I feel like I don't know what's OK in my role and what's not OK." Part of her discomfort was related to the difficulties she had "selling" preventative treatment to individuals with more pressing life issues, as she relates:

> So far I've had to come up with a sales pitch for every client I've seen. You know and... I feel that's not really what I want to get into. I don't really want to be a salesman. I don't want to have to sell prophylaxis to people...or bribe them or any of that kind of stuff.
>
> If a person's basic needs aren't met how can you expect someone to look after their health needs...How can I say, "Take the medication on a full stomach," if the patient doesn't know where his next meal is coming from. At the Herb, the social worker was on site and she was familiar with what the medical staff dealt with. I feel like a complete hypocrite offering prophylactic treatment to these people when they deal with so much else. The TB program is focused on the health of the community rather than on the health of the individual. But we shouldn't be ignoring the patients' personal lives in the process.

Participant observation and discussions with the nurse revealed that she felt that she "was loosing control of the situation." This was a sentiment shared by a number of participants, as Ted comments:

> I didn't see much of Kathy [TB nurse] actually...I don't want to be too harsh on her but it seemed that she was carrying a big burden in terms of running that thing, and I found completely that she was not being candid at all about the information that I'd like to hear.

Eventually, the nurse was provided with additional staff support. In response to the unusually high number of cases the inner city staff quickly grew to a team of seven: five public health nurses, a non-nurse outreach worker, and a clerical support person. This help, however, did not arrive until the participants were well into their treatments—a fact which may partially account for their limited and fragmented understanding of tuberculosis.

Stigma

The fear reported by participants was reinforced by the social stigma they encountered when they informed people of their TB positive status. Eight (8) of the informants reported experiencing stigma due to having been diagnosed with TB, as Ted states:

> The stigma that was attached to this was like brutal and fast. The first 7 or 8 people that I said "I tested positive here from what I know so far," was brutal. One girl was actually an LPN. Well, she flipped screaming over the phone, because she's from another part of the city and now I'm being branded as being not only being a carrier but now I'm active... Now within that because a friend of mine...Jim comes to see me, he drinks a beer...she's now taking this unbelievable quantum leap like we're all going to die now...to my best friend saying now don't come back now until you've finished the treatment and I consider it highly respectful. This Native girl I know that was her first instinct...and I said I'll find out lots about this for sure...I'll put it on hold until I find out more about it.

I have a friend—my bridge partner, in fact—his wife when I phoned them to tell them I was on a TB program for 60 days, she said "Well, I would appreciate it if (because she has a son) you wouldn't come around for 2 months." I said to her that's not what I'm hearing about this at all. In effect, it's just an exposure which means that I will have this bacteria in my system for a long time and this program guarantees 99% or whatever, that I'm not going to have anything left that would cause any detriment in the future...So because I was not doing anything, I was willing to do this. So she said "Well, OK find out what you can about this first."

The label of *carrier* and the fear of public avoidance led participants to be secretive about their TB status—a finding that has been supported in other literature on the subject.[18, 24, 29, 31, 32] Participants reported that after communicating their concerns about TB to their peers, they were met with fear and rejection. The conspiracy of silence is apparent in the following excerpts:

I guess it's a sort of a...I guess it's a human need or something to share something. But I uh, told a couple of my, you know, friends and you know, the reaction was "Gee, I'd a...hope, hopefully you haven't given it to me." Part of it is misconception and even after you indicate to them that you know, it's not contagious that you have the germ. You know I just really got tired of having to work so hard to try and convince somebody um, that, um, that I wasn't contagious. And I guess part of it too, it's just...um...if they knew me at all they would know that if I was contagious I wouldn't put them at risk like that. It's almost like saying the message that, that I don't care or that I'm irresponsible that I could be as callous as to be contagious and be around anybody. But that's just, I think, our own survival mechanism where we won't, you know uh, I think I would have reacted the same way cuz I mean, you know, "Gee, TB. Get away from me." It's just a lack of knowledge. And there is a big lack of knowledge partly because uh, you don't hear much about TB anymore.

Earl (44 year-old, sheltered homeless, White male)

Now the other point I want to get across, because I have TB—and I know it's dormant—if somebody asks me what I'm taking the pills for—because they often want to know why I'm in the medical dorm. They'll ask: "What are you in for?" And I'll say "Well I'm taking pills for a lung condition." That's all I'll mention, because I made the mistake of telling one friend that I had TB. He understands that it's dormant but he let it slip to one of his friends and one of his friends instantly covered their mouth like this (gestures: hand over mouth) before he talked to me, right. Instant fear sets in at those two little words: TB. I think it scares everybody. But like I say...but you see with me I know its dormant I know its safe to somebody, but as soon as they find out I have TB immediately they back away from me and they cover their face...you know...they don't want to breathe the same air as me. I imagine it's the same with people with Hep C or AIDS. I know people with AIDS...People don't talk to them. They're afraid to shake hands. Like when people ask me about my lung condition...if they're very straightforward and they seriously want to know what my lung condition is I will tell them. But in the meantime, I just have a lung condition. If I really don't think they should know or they're not that important to me I'll say its asthma and bronchitis, which I do have. I'm not lying to them. I'm just not telling them the whole truth. Because I've already experienced what happens when I tell people I have TB, even though it's dormant. They tend to hide from me or stand way back when they talk to me. So...to have an intelligent conversation with somebody you don't want to be yelling across the room.

Joe (41 year-old, sheltered homeless, White male)

The stigma is consistent with a lack of public knowledge concerning the contagiousness and curability of TB. In some cases, this has led to an over-reaction on the part of service providers. One participant, a 52 year-old Native man who had been successfully treated for active TB, reported being apprehended by police who were led to believe he was still infectious. As Paul says:

> And I came down here and the next thing I know, they phoned the cops and said "Hey, that's guy down here spreading TB," and they phoned the cops. The cops come along and they had rubber gloves and masks and everything. They surrounded me with about seven cars and they put me in the paddy wagon. They were pretty good to me in front of the public, but as soon as they got me out of sight in the paddy wagon, they flipped me over and handcuffed me in the back and they kneed me in the back and they said "You shouldn't be out here spreading TB." And they made me wear a mask. They forced a mask on me. They took me to the hospital and they released me from there. They had to bring me back home, because I had nothing. My doctor came there and told them there's nothing wrong with this guy.

This occurred in full-view of Edmonton's local media and led to the public stigmatisation of Paul as a TB carrier. An article that appeared in Our Voice Magazine describes the media circus that surrounded Paul's apprehension on July 9, 1996:[249]

> The cameras were trained on this quiet man like he was some kind of sick animal. As I stood and watched all of these TV and newspaper people in action, it sickened me. They were stomping all over this man's dignity. What interest did they possibly have in a sick man who lived in the inner city? How is that newsworthy? They were so intent on videotaping the police apprehend this man they displayed no real concern for the man himself. Their only concern was to structure the reality of the situation so it would be worth putting on their news programs or their newspapers. "Rabid TB carrier nabbed by police!"

On the following day, the story of Paul's arrest was splashed across the front pages of Edmonton's two most prominent newspapers—the Journal and the Sun. The June 10th article in the Edmonton Journal recounted the event under the headline: "Police nab inner city man, force him to take TB test." [250] It was preceded by an illustration on the front-page that documented the incident under the heading: "Police prepared for bacterial hazards." The unwanted publicity led to the social isolation of Paul, who claims that people avoided him for over a year afterwards.

While Paul's case is a dramatic illustration of the stigma that surrounds tuberculosis, participants also recounted subtler forms of prejudice. Roger, a 44-year-old man who was exposed to TB while working for a temp agency, describes the judgement he received from a Social Services employee:

> Shit...the guy from Social Services...I went over there and got the quick welfare cheque, because I had the medical. The guy over there says it serves me right for catching it [TB] because I was working out of a place like that! I just looked at him, "You asshole. Here I am making a living. What do you mean working in a place like that?" Like it is a walk-in workplace but we have two divisions in it. One is to work on these little six-dollar, seven-dollar an hour jobs, right. I don't make a lot more than that...I make up to fifteen dollars an hour, but we have another separate division for all of us experienced guys. I've been nine years on the same job and this guys telling me that it serves me right for working there. Screw you!

Attitudes Towards DOT

The majority of the TB positive participants communicated strong reservations about being on directly observed therapy (DOT). This ranged from mild irritation in some cases to outright frustration in others. Of the nine (9) participants who received prophylactic treatment, eight (8) individuals received DOT under the supervision of a public health nurse working out of the Forte Clinic. One (1) participant received DOT while in prison.

Directly observed therapy was administered in a number of ways. Clients could receive their daily dose of prophylaxis directly at the clinic, through arrangements with local pharmacies or by having the public nurse deliver the medication to them. Four (4) of the participants received their DOT from the clinic. Typically, these individuals reported to the front desk of the clinic where upon they were given prophylaxis "over the counter" by the reception staff. Outside of the operating hours of the clinic (such as on weekends), arrangements were made with local pharmacies or with social agencies such as the Herb Jamieson Centre (Single Men's Hostel) to administer DOT.

The public health nurse delivered prophylaxis to the remaining four (4) participants. Of these participants, one (1) received DOT at her residence; two (2) received treatment while residing at the Single Men's Hostel and one (1) while attending an addictions program at the Salvation Army.

DOT as an Instrument of Social Control

For participants, the experience of being diagnosed and treated for TB (active or latent) was interpreted through the contextual lens of their lives. Accordingly, an analysis of the narratives revealed a number of themes that reflected the socio-economic, physical and psychological realities of the participants. One participant—Earl, 44-year-old man—saw contracting TB as a malicious act of God. At the time of the interview, Earl had recently become homeless after losing his job, his family and his house as a result of a devastating gambling addiction. In an effort to get his life back together, Earl was working at a local temp agency while living at the Single Men's Hostel. It was at the work site that he contracted TB, as he says:

[What are your feelings about having to be on these meds every single day?]
Ahh, there's some anger because I feel it wasn't my fault that I got it. But I also understand that it was beyond my control. But I also feel fortunate that they were able to track me down and find me.

[Anger in what way?]
Partly, and I think it maybe something mixed in with the CLS and the fact that...the irony of trying...the fact that I was trying to get ahead and got knocked down. Because if I wasn't trying to get ahead I wouldn't have got it. It's like double indemnity with all of the other things that happened. It's kind of like: "What else can happen to me?" You know everybody wants to hear a little good news today but everyday it's more bad news. Umm, so in a way I felt maybe a little bit cheated but once I started to rationalise it I realised it was just something that happened—almost like an act of God. It had nothing to do with me or who I am. It just happened because I was the wrong person at the wrong place at the wrong time.

For Gary—a participant whose case was discussed in the previous section dealing with the socio-cultural context—his prophylactic treatment for TB occurred during a time when he was dealing with a variety of personal, health and employment issues, not the least of which was dealing with the bureaucracy of the SFI program. As Gary says:

[What was it like being on DOT?]
Well, I'll tell you I made a comment to the nurses upstairs. They were saying "You've only got ten days left or whatever" and I said, "Yeah, coming here is like being in jail." You've got no freedom. You've got no privacy. And besides taking the TB meds, I had to get a monogram done on my hip and seeing my regular doctor and seeing the chiropractor and the acupuncturist and trying to get some re-training. And I just put that on hold because I had to wait for everything to straighten out. I talked to Margaret [mental health worker] about it. I talked to my counsellor at AADAC and when he saw me he put the word in my ear, "Have you thought about re-doing the program [day treatment for alcohol and drugs] to get re-focused." Just to get re-focused because everything that I started off doing was getting pushed back and I was jumping through hoops. I had so many things going on in my life. The TB treatment just added on more stress and even my regular doctor said, "I think you should get into an anger management program." And September rolled around and my wheels were just spinning and I was going no place.

Gary's frustration was reinforced by the lack of control he had in all areas of his life. Being monitored while taking daily doses of prophylaxis was seen in the same light as having to line-up for food and having to negotiate the punitive complexities of the welfare system with its myriad of social workers, employment counsellors and so forth. For Gary, the experience of DOT was fraught with the same loss of independence and demoralisation that characterised his slide into poverty. Since becoming stranded economically and socially, he had become sensitised to being treated as a "second-class citizen." Accordingly, he says:

I even asked her [TB nurse], "Is this thing only for the inner city? Are there different rules?" And she couldn't divulge nothing, eh. And then her eyes lit up, "And how come you know this?" Like I shouldn't have brought up that I knew people who had the same thing I did. And anyways, I just mentioned...and "How do you know that?" Trying to get an answer if there is a different set of rules if you live in the inner city. I'm going out on a limb here...I think if I had TB in Riverbend [a wealthier part of town] I would be treated differently. Like everything would be hush-hush. Like your immediate family would know and maybe your employer, just to be on the safe side...and maybe while you're taking the pills you would get a leave-of-absence from work. Go see your local druggist and go take your pills there.

[Did they ever give you the option of getting your medication from a pharmacy?]
No...but they said, "Well, we could go to your place to give you the pills." And I said, "Like what time are you going to be there? Am I going to have to sit around all day? If I go out and you come what do I do then?" I'll have to go to the clinic.

Other participants shared the view that a different set of rules applied to inner city people. Iris—a 41-year-old Native woman—thought that street people were placed on DOT because service providers distrusted them. As she says:

"Why do they have to watch you swallow it?" [Researcher explains DOT to participant] You know being a street person, I had to know that because I was getting paranoid...because I thought and some of us think that you don't trust us in taking the medication. So I'm glad you explained it. That has to be explained to people because that's why they don't want to go in and be TB-tested and everything because they don't want to be monitored for this 70 days or whatever. Like I said, it's like an invasion of privacy.

[Did you think it had to do with your social economic status? Because you're a street person?]
I read to many Gestapo books; I thought we were in a police state. I thought what the heck! It's just some people are sceptical like that—street people are. They don't like to be monitored at any time, so I was thinking "Why can't they just give me the medication?" I don't want to infect somebody else.

For two (2) participants this perception was strengthened by negative interactions they had with support staff at the Forte Clinic and other helping agencies. Several participants described scenarios where they felt judged by front line staff or where they were treated in ways that violated their confidentiality. In the following selections, Earl describes the belittling experience of receiving DOT in the packed reception area of the Forte Health Clinic.

Well, I have some resentment with sort of the apathy of some of the staff over at Forte or their lack of sensitivity in so much as some of them don't realise that I don't want the whole world to know it. And sometimes they'll just give you the meds over the counter there. Basically, they're sending you a message that you don't count. Typecasting you. It's like somehow they're putting a value judgement on you. That it's your fault that you got it somehow because you weren't practising due diligence and sort of lumping you in the same basket as some of the people that put themselves at risk. It's like somebody getting AIDS almost. It's almost like there's a hidden, unwritten thing that you deserve...that this is your own fault. You deserved it. You deserved to get this and they really don't know anything about you. And I find there's a high level of disregard there at the Forte Clinic. They want to lump everybody into the same category... Basically, the staff at the front desk there and I feel that a lot of those people should be replaced because no matter how patient

> or tolerant you are, you can wait there for sometimes fifteen minutes, and some of those staff shouldn't even be there. There should be front-line people there. It's just like they're senile or completely out to lunch. They're horrible there and I guess of it is the fact that they have been anaesthetised to some of the people who come in there and maybe give them a hard time. They start treating everyone the same.
>
> It's like whether they do it intentionally or not, they try to make people feel small when you're at the front desk there. The way I look at it is and I don't know what their infrastructure is, the people or the person that is in charge are they observing what the front-line people are doing? If it's a question of funding, then you'd think because this is one of the front-line places for medical services in the inner city that would be the one place where instead of them being harried and completely over-worked, you would think they would have enough people at least. What is so difficult about this? Why can't people be treated with dignity and respect and why does it have to be that everyone always has to feel that they are under the gun. For what?

This encounter was a micro-political situation that confirmed Earl's diminished social position. Prior to the precipitous downward drift that brought him to the inner city, Earl had been a successful businessman. The respect and the presumption of competence that had accompanied his prior status were now conspicuously absent. Interestingly, Earl was aware of the public health implications of TB and understood the necessity of enforced compliance:

> I realise that it is a public health issue and I realise that the compliance thing isn't necessarily about me but it is about their way in the future to probably cover their asses for example if I did get full-blown contagious TB down the road and if they didn't force me to be complaint there could be some wider issues. So I don't have a problem with that.

Earl was more concerned about the general tenor of these clinical encounters than about being monitored while taking medication. Unfortunately, the insult of these interactions was repeated for him when he went to the Herb Jamieson Centre to get his weekend dose of prophylaxis:

> I go to the hostel on the weekend to take them [prophylaxis] and there's one comment there...I didn't even want to tell the guys at the hostel behind the counter...*"What are you trying to say they don't trust you enough to take them on your own."* Almost like making another value judgement on me that I've been a bad boy and I haven't been...First of all they don't know what the meds were but making that value judgement...but that's how people are. That's what they said once, yeah. I felt like saying "Well, I'm taking my TB meds," but another thing that I object to is the fact that you can see right on the envelope "TB meds." Like, I guess you know now don't you. And it's almost like the mass hysteria thing, because people don't understand.

Another participant described a similar encounter at the Forte Health Clinic. Once again, the lack of concern over privacy and the insensitivity of the reception staff at the Health Clinic predominate:

> In June, I started on my meds for TB. I was going upstairs, like I was going directly to them [TB nurses]...but they weren't around. Then I would have to go get it over-the-counter downstairs. I said, "I'm here for my pills." So the things are in shelf so they pour you the water and you're standing right by the shelf. So anyways I talked to one of the nurses and she apparently talked to somebody on the staff and they're supposed to take me into a

> room off to the side. And this went for a while and everything was fairly good. But halfway through my meds...there were signs that said, "If you want to go upstairs check with the front desk." So I walked in on a Friday afternoon and I saw the sign so I told the girl at the front desk to call upstairs and tell them that I'm coming up. And she says, "Oh, you want to see the TB nurse!" It's three o'clock in the afternoon and the place is jammed pack. Everybody just looked. I just blew a gasket and I said to her, "Where's the sensitivity?" I said, "You just call upstairs because I'm going up right now!" And she couldn't have called upstairs because I took the elevator up and by the time I got in the office and the first person I saw I just tore a strip off of...like I was...I don't usually swear at women...put it this way it is easy to find out who's taking the pills. But you don't want to broadcast it, like people don't come into the Bissell and say, "Yeah, man, I got to go to the clinic everyday because I have to pop TB pills."

Given the stigma attached to TB, the reported violations of privacy are significant. It should be noted, however, that participants drew a strong distinction between the encounters they had with reception versus clinical staff. Participants had favourable opinions of the TB treatment they received from the nurses and physicians at the clinic. The public health nurse and the TB physician were perceived as being compassionate and tolerant in comparison to the negative characterisations of the reception staff. As one participant remarked: "Like I said, Kathy [public health nurse] is really a good caring person. Otherwise, she wouldn't even be working there."

Although this study did not examine the institutional environment of the clinic in any great detail, the Forte Health Clinic is a busy place. Usually, the waiting area is packed with patients who exhibit the range of physical and mental health concerns common to the inner city. Some are sober; others are in varying states of impairment. As one participant comments:

> It takes too long to get in there, because the last time I was in there it took two hours to see a doctor, because there are a lot of street people that go there. Street people just sleep there. Plus too many people are sniffing [solvents] outside or trying to panhandle money off of you.

Clients report to the front desk and are processed by reception staff in a curt fashion. Typically, they are told to "sit down and wait." The environment is charged with the tension that occurs when excessive needs are combined with a scarcity of resources—a situation that is all too common to the inner city.

DOT as an Economic Impediment

For the three (3) participants employed at CLS, treatment was an economic barrier since they frequently worked out-of-town. For these individuals, the decision to begin or continue treatment was influenced by simple economics, as Ted— a participant who remained in close contact with his infected co-workers—explains:

> They are getting really annoyed now in the sense that they can't go to work. And their dependency is that...well...90% of the work is out of town if you want to make any money... Because of the duration there, it is really prohibitive. Umm...because it is easy to say that it

> is a 60-day program but it's not. Typically, it would be three months. That's a long time for anyone to be available without any compensation...What I'm finding within the fellows that are not taking the program, is tremendously a matter of economics and economics only. If they could somehow get subsidised to the extent that they could past the general human resources level...just $400 or $500 to exist. A lot of these guys are family men and I know three of them whose wives are working just to help the situation out.
>
> There is one fellow yesterday who started and I get forget his name. I worked with him before but I don't know him that well. He's there now. He's 35...38. He's now trying to get compensation for this, saying "I've literally been forced not to work."
>
> Especially within, some of these people aren't even asking any questions I'm sure at CLS... They're coming in and starting their medications and then finding out like 30-45 days later that it is really prohibitive now because they can't do everything they want to. I think that some of the people at CLS have been steam-rolled into taking it. I don't know if that's the right word to steam-roll but the general concurrence is that you're seeing a senior who has a much more informed opinion says "Please do this." [Referring to TB physician]

The economic limitations created by DOT and the lack of control participants felt in the face of this contingency are apparent in the following selection:

> Just being in the position of not being in control of what I'm doing, like right now I could be up in Whitecourt. Steeple Jack phoned me and they have a job for me up there. I could be up there right now but I have to be on this medical care everyday. So it's kinda putting a hold on what I need to do.

In an attempt to gain control over their situation, several of the infected workers tried to negotiate the terms of their treatment. According to Ted, the attempts were unsuccessful:

> At least four or five interrupted their medication enough to say that "Would it be OK to come back in five days?" and she said "No, you can't interrupt your treatment for that interval of time." Well, at this point you can't take the program because you've disqualified yourself...they tried to make arrangements like "Please, can you understand that I will have this documented? Please give me a five-day supply and I'll take it and give it to some reputable authority." And they can't do that because it is...

DOT as an Inconvenience

As can be expected given the regimented nature of DOT, five (5) of the nine (9) participants receiving prophylactic treatment considered DOT to be inconvenient and time-consuming. In contrast, the four (4) participants who had been isolated for active TB had a greater appreciation for the necessity of treatment and did not identify inconvenience as a significant barrier.

For those participants with asymptomatic tuberculosis, visiting the clinic for daily doses of Rifampin (RMP) and Pyrazinamide (PZA) was considered a major encumbrance—especially since this frequently involved waiting in a busy reception area.

> Well, because I'm fifty-five basically I'm saying like "pardon me," you know. Inevitably, if they had another way of dispensing this service, I would have a whole different approach to it...But within the idea of going there, and I've been there for like 35 minutes and I know they're LPN's [referring to reception staff] and they have a busy schedule but you get no eye contact and you might as not even be there...you just get treated as a number. That's what you are. Inevitably, they try to do the best they can with what they're doing, but I'd rather go there, get my pills and I'm done. So, inevitably, if there was a way to dispense this, even by machines or something (with coding or something), I'd be really happy. And I don't see that as prohibitive as hell or not. It's a waste of time, a lot of it, eh.

DOT as a Temporal Event

Participants' attitudes towards DOT were linked to their life circumstances at the time of treatment as well as to pre-existing notions of personal health and personhood. Adherence was related to a combination of physical, environmental and psychological factors. The decision to continue treatment was impacted by the realities of everyday life, as individuals mediated normative, cultural and cognitive/affective factors with elements from the socio-economic context. As the TB nurse observes:

> The most important factor contributing to compliancy is what's most important for the patient at that time...what their priorities are: where they're going to live, eat; where the money's coming from. For example, in Janice's case, her personal health is now her number one focus. There are other cases, where women wanted to stop treatment because they wanted to get pregnant.

For the three (3) participants who worked at CLS, prophylactic treatment was seen as necessary to avoid future health problems, although all three men were concerned about the economic ramifications of DOT. The decision to continue DOT, however, was influenced by the nuances of each person's life.

The case of Ted, a 54-year-old alcoholic, provides an example. Ted, along with several other individuals, was identified as TB positive following a contact investigation involving a local temp agency. At the time of his diagnosis in mid-January, Ted was receiving EI because he had frozen his hands twelve years earlier on "a severe drunk" and was unable to work during the wintertime. According to Ted, he had "a window and a lot of availability" so it "seemed foolish" not to seek prophylactic treatment for TB, although he was concerned about the cumbersomeness of DOT and whether it would interfere with his drinking—as he says during his initial meeting with the TB physician:

> My only hesitation is a matter of convenience. Like I'm still capable of binge drinking...like I drink on the weekend and this weekend is the Super Bowl...when I worked at CLS I drank as much as I could get my hands on. I have to live with this...What's the easiest way? You know what I'm trying to do is make it as easy as possible. There's no way I could do 30 doses with supervision and then get a prescription for the remaining 30 pills?

Following this clinical consultation, Ted was conflicted over whether he should go on DOT. He eventually opted for short-course treatment, despite this uncertainty, because he trusted the TB physician. As Ted comments:

> I don't have enough factors here to guarantee that I should be involved in this and I don't like the lack of communication I'm getting either. I had 15 minutes with Dr. Jones, who I have the utmost trust in, because I think he's a good person...um...and has enough personal involvement that he feels he's doing the right thing at this time, which is good. That's probably the biggest reason why I went on this program. It's just the nature and character of this man.

At the time of the research interview with Ted, it was mid-March and he was halfway through his treatment. His frustrations with DOT, however, had not dissipated. In fact, they had intensified because of looming economic pressures, as he says:

> To the extent that I may not even go up north now. I may go to Shell, eh. I could have lost my...in terms...I probably could have gotten a scaffolder's job—either survey or a scaffolder's. The crux of this now is...I don't mind this being in March, but now heading into April this is getting a little bit too costly now.

In addition, Ted's alcoholism was interfering with DOT to the extent that he even considered aborting his treatment (although he eventually did complete the full course of prophylaxis):

> Because I've abused this program because of my alcohol or whatever to the extent that I almost said that I'm out of this program. There is no point even going because I'm not going 65 days here without a drink. Not for this program, not from what I know now! I'm what's the word...very inconsistent because I'm a beer-drinker and that leads to rye on Saturdays—Friday's beer and Saturday's rye—within that context of that level (because I'm not working) I was hesitant or at least awkward about going on a 60-day program because I felt we were doing some sort of antibiotic treatment during this program...

As the previous case study illustrates, diagnosis and treatment are temporal events within the context of an individual's life. As such, health behaviours are immersed within larger processes of stasis or change. For some participants, treatment was a chance to become healthy, whereas for others it was simply a requirement to remain so. Treatment acquired symbolic relevance for some participants, since it represented an opportunity to break free of addictive and abusive patterns; for others, it was part of an ongoing process of healing and self-discovery.

For Janice—a 32-year-old street prostitute and addict—her diagnosis and treatment for latent tuberculosis occurred at a time when she was receiving treatment for addictions after years of heavy substance abuse. As she says:

> I have grown up in a traumatic life...lots of different kinds of abuses... um... alcohol and drugs came to me at a young age. I was born with severe Foetal Alcohol Syndrome...I started drinking at the age of 3 and started using solvents at the age of 5. And that just progressed through my life. I was on Talwin and Ritalin since approximately the age of 12...I was self-medicating. I found it the most powerful drug for me. Due to my childhood and stuff I was used to living in depression and Talwin and Ritalin just did that for me.

Janice's childhood was incredibly unstable. At the age of seven she was apprehended by Child Welfare after her mother reportedly threw her down some stairs. From that point onwards, she was shuffled from one foster home and institution to the next—a pattern that was frequently punctuated by her running away from her placements:

> I believe I started experiencing institutionalisation since I was a young child, since 8 years old. Growing up with all different kinds of kids—it's just like jail. Going through detention centres, group homes, and institutional settings has been my way of life. If I was not in an institution resting then I was on the streets.

By the age of twelve, Janice was living on the street and working as a prostitute. It was during this period that she was first exposed to T's and R's—the addiction she would eventually seek treatment for. Her life of addictions and prostitution continued until she entered treatment in the fall of 2000.

Two years earlier, she had married a former john with whom she had two children. At the time, she was so entrenched in street-life that she returned to the streets within the first week of her marriage, as she says, "I knew no other way of life." This precipitated a vicious cycle where she would run away only to have her husband come after her. She would return to him periodically and then leave unexpectedly:

> Well, he tried to use force and stuff at first. He tried chasing me, but I got really angry at him, and I said "Why do you always come chase? Why do you always show up at my friend's place? Why do you show up here?" And he said because he loves me, and he didn't want to see me hurt myself, of course. So he just stopped chasing me and waited until I decided to make an appearance at home. Sometimes, I'd go from Monday to Friday and come home on the weekend or sometimes I'd go out the weekend and stay home during the week 'cause I only had to put up with him at suppertime, you know. After supper, he's sleeping (laughs), so...Um, and then I'd take off for months at a time and not phone or nothing.

At times, the situation was abusive:

> I know what buttons to push, and when I want an excuse to run, I'll push his buttons until he physically hits me...just so I can run back to my home on the street. It's sad that I put that man through that, you know. But we're dealing with those issues today. I never had love. I was never shown love and it was really difficult for me to do that. Anytime someone tried to show feeling or anything that was good for me, I was gone. You know..."See yah!" It was really difficult to deal with that.

When I interviewed Janice she was in the third month of her addictions program and her language was peppered with the argot of the 12-step program she was attending. According to Janice, addictions had taken "everything away"—her self-respect, her health, and even her cleanliness. In addition, her life on the streets had robbed her of her two children. Both were in foster homes and she was prohibited from seeing them without direct supervision. After years of not caring about herself, she was now highly focused on her personal health and well-being. In her words:

> I couldn't go on the way I was going. I was tired of the street life. I wanted something. I wanted a life! I wanted to raise my children the way I've never been raised and to be a wife...not a whore-wife...you know (laughs). So, I started to see how much it was hurting my children, how much it was hurting my husband and including myself.

It is under these circumstances that Janice received prophylactic treatment for TB. As such directly observed therapy was part of an ongoing process of healing and personal growth. Janice eventually completed DOT and her addictions treatment—an accomplishment that was facilitated by the structured environment in which she was treated.

In a follow-up meeting I had with Janice about six weeks after our initial interview, she revealed that she was seeking to legally separate from her husband. Janice felt that her husband was impeding her recovery from addictions, preferring that she remain dependent on him. She was, in her own words, "Not the same women he married." She was worried about her level of dependency in her marriage as well as in past relationships. When she was on the streets she relied on others for her basic needs—paying acquaintances, for example, to do her laundry and handle her bills. She was so dependent, in fact, that she didn't even inject herself. She always had someone else do it for her. She was concerned whether she could survive on her own and to this end applied to enter a halfway house to address her dependency issues. In addition, she was pursuing legal channels to regain her custody/visitation rights with her children.

Unfortunately, about five months after this meeting, Janice was reportedly back on the streets—working (prostituting) and using. According to the TB nurse who had remained in contact with her up until her relapse, Janice's failure to get her children back may have contributed to her setback.

As Janice's case illustrates, adherence is a dynamic behaviour that is embedded in a complex web of psychological and social factors. Street people are highly susceptible to shifting contingencies in their lives—a volatility that is reinforced by socio-economic and psychological vulnerabilities. It is conceivable that Janice's willingness to adhere to TB treatments was impacted by the conditions of her life at the time of treatment—had she received prophylaxis before she entered the addictions program it is unlikely that she would have been complaint. Similarly, if preventative treatment had been administered after her relapse, her adherence would have been improbable.

Burt, a 51 year-old alcoholic, who was diagnosed as having sputum smear positive pulmonary tuberculosis, provides a further example. Burt was residing in a run-down flophouse, inhabited largely by chronic drinkers, when he was identified as infectious. With my assistance, he was apprehended and masked by the TB nurse. At the time Burt was visibly intoxicated and dishevelled, as the nurse commented: "If this guy were cleaner I would have masked and taken him myself [to the hospital], but I'm worried about all the things I could catch." Despite her reluctance, he was driven to the Forte Health Clinic where he was informed of his TB status and told he would be admitted to the isolation unit at the University Hospital for TB treatment. Arrangements were made to

have him transported by ambulance. While he waited, I had the opportunity to observe his initial reactions. As can be expected, he was confused and frightened about having TB, as he said, "I don't want to die." Furthermore, he was "scared shitless" about being admitted to the hospital because he experienced grand mal seizures when he "came off the booze." He had been drinking heavily since he was 24 years old and had experienced his first seizure at around the same age. As a consequence, he took daily doses of Dilatin (phenytoin). The medication controlled his seizures while he was drinking but as Burt says, "After thirty years of drinking I can be sober for three days and go on a grand mal." For Burt, his life had been reduced to drinking everyday although he no longer enjoyed doing so, as he says:

> It's getting to the point where I don't enjoy it as much as I hate coming off wicked hangovers. Because when I come off a hangover, Christ I hurt...Seizures hit my whole body and everything and my whole head. Headaches.

According to Burt, his life was filled with loneliness and despair. As he explains:

> "When I walk down the street I don't look at how a person is dressed or what kind of clothing they're wearing or whether they're scruffy or stink. It doesn't matter, they're just ordinary human beings going through the same pain and torture."

At the time of the research interview, Burt had been in quarantine for about five weeks during which time he was able to reflect on his lifestyle. According to him, treatment for TB "was a good learning experience." It had allowed him to re-evaluate his life:

> Oh basically, because I deserve a better life for myself. I am sick and tired of living day-to-day with nothing to smoke and basically nothing to eat. Waking up with wicked hangovers. Getting nowhere fast. For me, my drinking is a slow form of suicide. Because, I basically sometimes I think back when I was twenty-five or something when I could drink and my body...yeah, I would get hangovers and that, but I would recover—bounce back. It doesn't do that anymore. No, suicide in that I know once I start drinking...It's self-induced. It's not like TB. I have choice to drink or not to drink and when I drink it's gradually going to take me down.

For Burt, his treatment for TB represented a break in the pattern of his life—a pattern that had previously been dictated by the ravages of alcoholism. Treatment offered an opportunity to overcome some of the health deficits caused by thirty years of substance abuse. As such, it was a key temporal event that carried with it the potential for reflection and personal change. As in the case of Janice, his respite was fleeting. After completing his treatment, he returned to his previous ways. While in hospital, Burt's symptoms of alcohol withdrawal were controlled by a protocol of Librium (chlordiazepoxide). Upon his release from the hospital, Burt returned to his former residence. He was prescribed weekly doses of Librium. But because he was no longer in a supervised clinical

setting, his prescription was reduced to only four days worth of the medication—a situation that left him vulnerable to withdrawals on the remaining days of the week. In the absence of treatment for his alcoholism, Burt relapsed into drinking. He was, as one nurse says: "Drinking to live." According to the nurse, he was incredibly isolated. He rarely left his apartment for fear of being victimised. A fellow tenant supplied him with his daily ration of Colt 45 for a small fee. He was in a constant state of malnourishment, because not even hunger could compel him to visit a food bank or a soup kitchen. Out of desperation, he periodically phoned the nurse to bring him something to eat.

Focus on Non-adherence

Two (2) of the participants in this study were non-adherent to their prophylactic treatment. In both cases, non-medical factors played a role in their decision to discontinue treatment. For Iris, a 41 year-old Native woman, economic as well as emotional factors contributed to her non-adherence. Iris was initially diagnosed as being TB positive following a contact investigation involving the man she lived with—an active case of pulmonary tuberculosis who was co-infected with HIV and Hepatitis B and C. According to Iris, she did not know her partner was infected with any of these diseases until after his hospitalisation. To make matters worse, when she was informed of her own TB positive status, she also discovered that she had Hepatitis C. Iris describes her reaction:

> Scary, because I really didn't understand anything about it. [Hep C] I didn't really know anyone who had it. And its not something anybody talks about even if they have it. I do. I have to be open with people because I have so many people coming and out...showers, bathroom, sleeping on the couch. I have enough health problems and I don't need anymore and you're just full of regret because you can't pinpoint the time of contact. You just can't...not when you're a street person.

Although, she wasn't sure how she had contracted Hep C, she suspected she had become infected after sharing a dirty needle with her partner. According to Iris, tuberculosis and Hepatitis C were the most recent additions to a long list of ailments (such as chronic migraines, depression and arthritis) that had kept her from working. "Every job I had that I ever liked always failed because of medical reasons." As a consequence, Iris was on SFI—a situation that left her scrounging for money every month. In fact, she anticipated that electricity in her apartment was going to be shut-off by the utility company because she was late in her payments. She claimed that when she first moved into her apartment her monthly power bill was about 13 dollars, but that it had risen to about 60 dollars per month since then. As a result, she said that she couldn't always afford to eat. Her general practitioner at the Forte suggested that she apply for AISH funding (Assured Support for the Severely Handicapped) due to her depression. Unfortunately, she was unable to keep in touch with the mental health workers as she says:

> It's just a Catch-22 situation because Dr. Herman wants me to deal with the mental health. Mental health wants to be able to have call-backs and I don't have a phone. The phone company wants $171 plus a $200 deposit. It will never happen. I just can't see it. Unless I win the lottery.

When I interviewed Iris she was under considerable economic and emotional stress. Her TB treatment was occurring at a time when she was reeling from a series of negative life events—not the least of which included discovering that her common-law husband was dying from a terminal illness. According to Iris, she was conflicted between being concerned for her partner's well-being on one hand, and her feelings of betrayal on the other:

> It's made me look at everyone like they were a walking infection and yet I snapped out of it. But there's still going to be that fear...there'll always be that fear of not-so-much infidelity as fear of intimacy. What am I going to get next?

According to Iris, she had not been able to muster up the strength to visit her partner since his initial hospitalisation. She claimed that she had been drinking as "a release thing" since then—a strategy she had used earlier in her life to cope with negative life events. To further complicate things, she was also highly suspicious of the TB treatment she was receiving. She did not understand the distinction between latent and active tuberculosis and she did not know why her TB treatment was directly observed. "Why do they have to watch you swallow it?" In the following excerpt Iris communicates the jumble of concerns she was experiencing:

> It's very aggravating. I'm not doing very well. I'm stressed out again...I've got bills piling up and my cat's sick. She's my number one reason for living...and I don't think these pills are doing me any good. It's my body and I don't think I should be taking anything that's not doing me any good. I'm going to go see Doctor Herman [GP] and take all my paranoia to her.

Shortly thereafter, the TB nurse reported that Iris had been "non-compliant" in her treatment. In a follow-up interview with Iris, she revealed that she had "lost track of time" because of mounting economic pressures and because she was "having difficulty getting out of bed." Iris describes her final encounter with the TB nurse:

> Last time I saw Kathy I told her I didn't want her coming around anymore. I didn't want to hurt her [TB nurse] feelings. She said to me, "But Iris you've been around people with diseases!" I told her that I had been around diseased people my whole life and I'm still here.

In the case of Iris, it is apparent that non-medical factors contributed to her decision to stop her treatment.

Joe, a 41 year-old alcoholic who was also non-adherent to DOT, provides a similar example and, in doing so, illustrates how changing life circumstances can affect adherence behaviour. When I met Joe, he was completing the last two months of a nine-month treatment protocol of INH (Isoniazid) to which

he had previously been non-adherent. According to Joe, he had been transient for most of his adult life, following work from one city to another. In the course of his travels, he had lived on skid rows in Edmonton, Toronto and Vancouver—preferring inner cities because of the cheap cost of housing and the increased likelihood of meeting fellow alcoholics. Joe claims that his life had come "full-circle" several times. In other words, he had achieved some stability in his life, only to have his drinking disrupt whatever equilibrium he had managed to attain. At the time of the interview, Joe claimed he had only been in Edmonton for about a year-and-a-half since returning from Toronto. After his arrival in Edmonton, he managed to secure a job that he worked at for a couple of months before he hit rock bottom again due to his drinking. In an attempt to regain control of his life, Joe entered an addictions program run by the Salvation Army. It was while he was receiving this treatment that he was diagnosed as having non-infectious tuberculosis. According to Joe, his DOT did not begin until his third month in rehab, because of a backlog of paperwork at the Salvation Army. Joe completed seven months of INH treatment while residing at the treatment centre. Eventually, however, he grew tired of living at the facility and decided to rent a basement suite on the Southside. Unfortunately, his relocation left him isolated from his friends who lived on the other side of the city. In order to deal with his isolation, he started going to a local bar to meet people—a strategy that eventually led to his relapse to drinking. The results were as predictable as they were tragic. He lost his job and his apartment and was forced to rely on emergency shelters for accommodation. Without a place of residence, he was ineligible for social assistance.

When I interviewed Joe, he was living at the Herb Jamieson Centre because the TB nurse had made arrangements with the shelter to give him an extended stay in their medical dorm so that he could finish his INH treatment. Prior to this, he had been sleeping on a mat in the Spady Centre because he had exceeded his three-week stay at the Herb. He explains:

> Look at my case in point, I did my three weeks over at the hostel and I moved over to the George Spady for 2 weeks and then I got clearance from the hostel for another 2 months, because of Kathy putting me back in the program but that's the only reason I'm back in the hostel...They have to make room for the next guy. If they housed everyone in there all of the time then it's full. It's full. So you get you're 3 weeks and then you've got to move on, you're welcome to come back but give it a couple of months, you know, we've got to give somebody else 3 weeks of comfort.

Ironically, it was Joe's TB status that allowed him to obtain shelter for two months and it was the stability of this placement that facilitated the completion of his DOT. His adherence was also aided by the enforced sobriety of living at the Hostel. Individuals are not permitted to stay at the Herb Jamieson if they are under the influence of alcohol.[QQ]

As in the previous examples, Joe's willingness to complete his TB treatment was strongly influenced by non-medical factors. In his case, his respite at the emergency shelter was an important consideration. Sadly, his reprieve was

short-lived and Joe was faced by the cruel uncertainties of unemployment and homelessness. Joe captures this sentiment in a follow-up interview:

> Two weeks before my stay was up at the Herb, I felt like "Where do I go from here?" To be quite honest with you, I was a little nervous about speaking to you again because you offered to come over to my place. My room is the last place I feel comfortable in—anywhere but there! Sometimes, I wake up and think, "What has my life come to?" I'm still drinking and living down here in the shittiest part of town. Sometimes, I wonder if there is a God. But in the bigger picture I think there must be a reason I'm down here. I don't know what it is. Maybe I've already served my purpose. I've been struggling the past month because I have too much time on my hands. For the last week I have been lying on my back with nothing to do but watch TV. I must have memorised the entire schedule.

Joe's previously karmic attitude was overshadowed by the cold realities of his existence. In the cycle of his life, he was confronted again by the familiar spectre of anomie, powerlessness and despair. In my initial interviews with Joe, he had been lucid, clean-shaven and optimistic. In subsequent meetings, his condition had deteriorated. He was no longer well groomed and his previous clarity had given away to a glassy-eyed stupor. He had come "full-circle."

6.0 Discussion and Summary

As indicated previously, health behaviour is immersed in a complex matrix of psychological, social and environmental factors. Notions of health and personhood are embedded in rhetorical stances, pragmatic situations and political relationships. They are manifested not only through ideology but also through the practises of everyday life.

The diverse set of social and environmental forces common to street life interact in complex ways. For many homeless individuals, this equates to an existence that is shaped by the agencies and institutions on which they rely for their basic needs. Individuals become rooted in everyday routines, living in a repetitive cycle where their efforts are focused more on a "tangible present" than on a "probabilistic future." For addicts and alcoholics, the cyclical nature of life is reinforced by the necessity of feeding their addictions. The cumulative effects of poverty and the psychological correlates of anomie, despair and dependency erode individual agency. The interactions homeless people have with social agencies typically reinforce their diminished social status. This loss of control is exacerbated by the addictions many individuals have acquired in their attempts to mask their feelings of powerlessness and shame. Life consists of a series of indignities that they are forced to endure. For the large proportion of homeless individuals in Edmonton who are Aboriginal, the effects of racism compound the injustices of poverty.

Faced with these realities, it is easy to understand why many homeless individuals have a deep-seated apprehension and resentment towards authority figures. This reluctance also affects their health-seeking behaviour, with individuals avoiding practitioners and clinical settings that are considered to be judgemental or prejudicial. Viewed from the perspective of the Triandis model, the existence of **power-over** relationships is a factor that severely impedes health-seeking behaviour. This is apparent when one realises that caregiver-patient encounters are "micro-political situations that reflect and support the broader social relationships, including social class and political-economic power." (Pg. 8-9) [251] It is important to acknowledge the asymmetry in knowledge and authority between health practitioners and patients. Many homeless people are acutely aware of this power differential. Institutional settings and the administrative hurdles that have to be overcome in order to receive help reinforce the discomfort. In a study on TB health education in homeless shelters, Kitazawa found that the greatest perceived barrier to initiating or continuing TB treatment was a general apprehension of the health care system.[24] The effects of the patient-caregiver relationship have been well documented in other contexts, as well.

While some participants reported negative clinical encounters, these experiences occurred with peripheral staff rather than with medical personnel. The vast majority of the participants were satisfied with the manner in which the TB staff treated them, characterising the medical staff as compassionate.

Despite this positive assessment, several participants were suspicious of the directly observed therapy. Some individuals believed that they were receiving DOT because they were inner city residents—equating the supervised treatment with their lack of social status and with the belief that the medical staff did not think they were responsible enough to take their medications.

The misunderstandings regarding DOT were consistent with a lack of public awareness about tuberculosis. This has been confirmed by other research on tuberculosis—the most notable of which was conducted by Gibson *et al* in Edmonton.[252] Despite the prevalence of TB in the inner city, the majority of the participants were unsure about the aetiology and transmission of TB. A common misconception was that sharing drinks or cigarettes with an infected individual could spread TB. In addition, a number of individuals reported being frightened about being diagnosed with the disease. Further misunderstandings revolved around the distinction between latent and active tuberculosis. Several of the participants who received prophylactic treatment were concerned about transmitting TB to family or friends despite being asymptomatic and non-infectious.

These apprehensions were reinforced by the stigma participants encountered when they informed people of their TB status. The research findings suggest that a limited and fragmented understanding of TB contributes to a climate of fear and confusion. This is significant because the more knowledgeable patients are about TB the more likely they are to complete treatment.[253] While these misunderstandings were related to a lack of public awareness about TB, insufficient clinical consultation also played a part. At the time of the interviews, the public health nurse was coping with a rapidly growing caseload.

As can be expected given the regimented nature of DOT, the majority of the participants who were receiving prophylactic treatment considered DOT to be inconvenient and time-consuming. For those participants with asymptomatic tuberculosis, visiting the clinic for daily doses of prophylaxis was considered a major encumbrance. This was especially the case for individuals who were employed and for whom DOT was an economic impediment. In contrast, the individuals who had been isolated for active TB had a greater appreciation for the necessity of treatment and did not identify inconvenience as a significant barrier.

While medical professionals may view tuberculosis as a highly treatable disease, the participants in this study had a more troubled view of TB. For them, tuberculosis was an illness that entailed stigma, fear, confusion, inconvenience and a loss of control. This is consistent with Kleinman's explanatory model of sickness, which distinguishes between disease and illness. According to Kleinman, *"disease* refers to the malfunctioning of biological and/or psychological processes, while the term *illness* refers to the psychosocial experience and meaning of perceived disease." (Pg. 72)[254] Accordingly, participants' attitudes towards DOT were associated to their life circumstances at the time of treatment, as well as to pre-existing notions of personal health and personhood. These frames of meaning and assessment were not static, all-defining

structures. They were always time and situation dependent. These subjectivities were not only culturally or historically constituted, they were profoundly pragmatic and political in their makings.

Street people are highly susceptible to shifting contingencies in their lives—a volatility that is reinforced by socio-economic and psychological vulnerabilities. The sense of drifting from one event to the next, of moving from a temporary reprieve to a full-fledged calamity, captures an element of homeless life.[73] Lacking the physical and emotional anchors of a stable and meaningful existence, homeless individuals are driven by the dictates of chance. Survival on the streets is all about improvisation. For many of the participants the seeds of this instability had been planted earlier in their lives. For some, it occurred in abusive upbringings; for others, it developed in the context of addictions. This sense of living on the "cusp of the moment" while being an adaptive response to the uncertainties of life on the street, often conflicts with the practical demands and constraints of helping agencies and their reliance on schedules and appointments.

This fluidity is apparent in the narratives of participants. Their outlooks on life and personal health were in a state of flux over the research period. In fact, some individuals shifted radically from periods of sobriety and optimism on one hand, to ones of absolute despair and chemical impairment, on the other. Adherence behaviour is equally dynamic and susceptible to these currents of change.

The diagnosis and treatment of TB are temporal events within the context of an individual's life. As such, health behaviours are immersed in larger processes of stasis or change. For some participants, treatment was a chance to become healthy; for others it was simply a requirement to remain so. Treatment acquired symbolic relevance for some participants, since it represented an opportunity to break free of addictive and abusive patterns; for others, it was part of an ongoing process of healing and self-discovery. For those individuals who were deeply entrenched in street life, these reprieves were tragically short-lived.

Addictions, especially alcoholism, played a central role in the lives of the participants. The cycle of addictions influenced how they felt about their personal health and consequently their willingness to seek medical help. Participants reported that they were not concerned about their health during periods of heavy alcohol or drug use. For some participants, concerns over personal health were constrained by addictions. As Albertín-Carbó *et al* observe:[255]

> Drug users go through various stages of addictive activity; an addict is not stable and his or her consumption activity fluctuates from abstinence to "being very hooked." At each point on this continuum, users acquire different degrees of attention to self-care. The stage of consumption must be taken into account when making contact; when users are not very hooked, there is a chance that they will show concern for their health as they have more time to become aware of their bodies, identities and social relationships. (Pg. 34)

Several participants identified a boom-and-bust cycle in their lives where episodes of heavy substance use were interrupted by brief periods of "drying out" and "getting healthy." The findings suggest that an individual's willingness to both seek medical help and adhere to prescribed treatments is strongly influenced by the degree to the person is entrenched in addictions and street life. This is consistent with other literature on the subject. For example, in a study on drug users Malotte *et al* [256] found that individuals who reported binge drinking in the 30 days prior to beginning DOT were significantly less likely to complete treatment for latent TB than those who reported no binge drinking.[RR] Given the corrosive effect addictions have on an individual's sense of personal control, it is conceivable that addicts are more inclined to be fatalistic and less inclined to engage in health-promoting behaviour—especially if the health threat is distant and highly probabilistic in nature. This relationship is even more pernicious when it occurs within an overall context of powerlessness and disenfranchisement.

The findings suggest that adherence behaviour in the homeless population is influenced by the degree of stability in other areas of their lives such as housing and income. A life of poverty is characterised by high levels of stress and negative life events outside a person's control. From this perspective, it is clear that non-medical factors such as housing and poverty may be the most important determinants of whether a homeless individual completes DOT. As Dunn and Hayes say: "Housing plays a central role in routinised, everyday life and is fundamentally bound up in one's sense of control over life circumstances" (Pg. 563).[162] Indeed, for a number of participants the availability of safe and predictable shelter during the course of their treatment influenced not only their adherence behaviour but also their mental health status. This study lends empirical support to the notion of competing priorities as an important barrier to completing TB treatment. Accordingly, any attempt to address the health care needs of the homeless must take into account their unmet needs for food, clothing and shelter. This observation has been substantiated in other contexts as well. Gelberg *et al*, for example, conclude that:[257]

> Frequent subsistence difficulty may be contributing to the observed pattern of health behaviour whereby homeless adults do not seek preventive care or care in the early stages of illness, but delay seeking care until their need is acute. This pattern, in turn, may be contributing to the high rate of hospitalisation among homeless adults, which is often for neglected illnesses that could have been prevented or treated in ambulatory care settings if identified earlier in the course of illness. (Pg. 219)

Collectively, the research findings support the theoretical framework that underlay the research (See Figure 2, Page 13). The health behaviours of participants were the products of a complex interaction between individual and structural factors. The decision to engage (or not to engage) in certain behaviours was strongly influenced by personal norms, psychological factors, socio-economic realities and by the culture of the streets. A clear example was provided by the embeddedness of addictions in the social and personal lives of participants.

A large proportion of this study has centred on the structural factors that

contribute to homelessness and the socio-economic factors that limit individuals' opportunities to escape poverty. These factors are real and concrete. They were presented in order to overcome the limitations of other studies on TB that have emphasised individual factors at the expense of socio-cultural context. Issues of power are all-important here. As Pinderhughes argues:[258]

> Power and powerlessness operate systematically, transecting both macrosystem and microsystem processes. The existence or non-existence of power on one level of human functioning (e.g., interactional) is affected by its existence or non-existence on other levels of functioning—for example, intrapsychic, familial, interpersonal, community-ethnic-cultural, and societal. (Pg. 332)

All too often medical research neglects serious discussion of the ways in which people's thoughts, sensations, and knowledge are embedded in pervasive and often pressing economic and political arrangements. In emphasizing the structural, however, there is the danger of portraying the homeless as passive victims. Such a representation is overly simplistic and addresses only one aspect of the individual-structural relationship. It runs the risk of denying any individual agency. Homelessness is a pernicious problem because it represents the interaction of personal vulnerabilities and choices with the vulnerabilities and choices of the larger community. The crux of the problem lies not in whether personal choices can precipitate a downward drift into homelessness and ill health, because clearly they can. Typically, homelessness is the product of a series of miscalculations, poor choices, personal tragedies and misfortune—some of which are within personal control and some of which are not. The real issue lies in whether there are adequate resources available to either halt this downward drift or to reverse it. Clearly, there are not. Once individuals cross a certain socio-economic threshold the issue of choice becomes academic. The day-to-day struggle for survival leaves little psychological or physical resources to escape poverty. One of the victims of poverty is hope. Under these circumstances, it is easy to understand why homeless individuals often adopt a fatalistic and present-day orientation to life.

In the same way as homelessness is a function of a micro-macro interaction, so are health outcomes. This realisation is well articulated by the **social ecological** conceptualisation of health. The social ecological paradigm is rooted in certain core principles. First, ecological analyses characterise environmental settings as having multiple physical, social and cultural dimensions that can influence a variety of health outcomes, including physical health status, emotional well-being and social cohesion. Secondly, the social ecological perspective emphasises that human health is not only influenced by environmental circumstances but also by a variety of personal attributes, including psychological dispositions and behavioural patterns.[259]

The explicit recognition of the interactive effects of personal and environmental factors on well-being poses important, practical implications for the design and implementation of health services. Foremost among these is the

realisation that health can best be promoted through interventions that combine biomedical, behavioural, educational, environmental, and organisational interventions at multiple community levels. The need to involve partners across a wide spectrum of health and human services is apparent when one considers the strong correlation between low socio-economic status (SES) and other socio-medical characteristics, and a heightened vulnerability to a wide range of physical and mental illnesses. Interventions that focus on one level at the expense of others are less likely to be either effective or sustainable. As David Mechanic comments:[260]

> To simply treat manifest symptoms and syndromes without addressing the conditions that contribute to their persistence or reoccurrence is inefficient and perhaps even pointless. (Pg. 1209)

While health is undoubtedly a complex issue—especially when it occurs within the context of poverty, addictions, and social marginalisation—it's multi-faceted nature is often a barrier to public policy. The medical problems of the homeless are numerous and reflect the lives they lead. The myriad of hardships facing homeless people tends to divert attention away from the simple policy solutions that need to be implemented immediately. Examples include the provision and subsidy of affordable housing, the implementation of welfare rates that are tied to a defined measure of an "acceptable standard of living" [55] and the adoption of a coherent framework to address the needs of the urban Aboriginal population. It is tragic that a quarter of a century after the WHO recognised that "the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity," there has been a wholesale abandonment of these principles at the policy level. In Alberta, for example, there has been an unprecedented retrenchment of the government's role in the social and economic lives of citizens. The accompanying shift in social welfare away from universality to "a modest safety net" represents the tacit acceptance of social inequities.

Although, from the biomedical perspective, tuberculosis is caused by *Mycobacterium tuberculosis* infection, the grossly skewed distribution of this disease points clearly to poverty as a major causal factor.[261] Effective treatment of TB should acknowledge this relationship and the way socio-economic marginalisation plays out in the lives of homeless individuals. This research suggests that while adherence behaviour in the homeless population is problematic and challenging, it can be achieved even among those who are substance abusers. Other studies confirm this.[15, 262]

Several factors can encourage adherence. The relationship between the patient and caregiver is of particular importance. DOT is labour intensive and is dependent upon the caregiver's insight into the patient's socio-economic and cultural situation. A sensitive, non-judgemental and flexible approach to dealing with homeless individuals is essential. Such an approach should ac-

knowledge the significant barriers the homeless encounter in their everyday lives. One obstacle that health care practitioners need to be especially aware of is the power disparities homeless people experience when they interact with social, medical and judicial institutions. Typically, these interactions serve to reinforce the diminished social status of homeless individuals by focusing on their deficiencies, personal failures and lack of life skills. Very rarely are the homeless recognised as having expertise in the areas that most affect them—as being "experts in their own lives." Interventions tend to be prescriptive rather than participatory. The flow of information is largely unidirectional with professional caregivers determining the nature of the services directed towards the homeless, as Liebow argues:[263]

> Otherwise well-intentioned workers and administrators are encouraged to tolerate or ignore the needless hardships or the system failures that so often attend the day-to-day operations of our support programs. Beginning with the proposition that "you mustn't make things too easy for them," we end up with an array of support systems staffed by administrators, supervisors, and workers who sometimes forget why they are there, and who put organisational needs ahead of the needs of the people they are supposed to help. (Pg. 142-143)

In this study, several participants described scenarios where they felt "judged"by front line staff or where they were treated in ways that violated their right to confidentiality. Alarmingly, this occurred even within the Forte Health Clinic. For some individuals, the experience of DOT was fraught with the same loss of independence and demoralisation that characterised their slide into poverty. DOT was yet another imposition of control in their lives. Ideally, directly observed therapy should be responsive to this reality and attempt to address the power imbalances that exist even within therapeutic relationships. This can be accomplished by replacing the one-way flow of information from provider to client with a process that encourages negotiation and accommodation between the two parties. As Kelly explains:[241]

> Treatment completion is more likely to be successful if patients' understanding of illness, motivation and willingness to take part in complex, long-term regimens are elicited. Treatment information can be reformatted and adapted to include these understandings and experiences. (Pg. 239)

In addition, it is essential that health practitioners inquire into the socio-economic barriers that homeless patients are encountering. Wherever possible, caregivers should liase with other service providers to meet the basic needs of patients, which may include, for example: arranging temporary accommodation for a patient or getting a patient into an alcohol treatment program. In some instances, this may entail that the health practitioner advocates on behalf of the homeless individual. In addition, the use of incentives should be encouraged. These can range from non-monetary inducements such as clothing vouchers, food coupons and bus tickets, to monetary ones. According to the literature, the use of both monetary and non-monetary incentives is effective

in improving adherence behaviour to TB treatment.[264, 265] Empirical evidence suggests that monetary incentives may be more effective than non-monetary inducements.[258] However, their use poses logistical and ethical problems in clinics that serve many impoverished people.

Another factor associated with increased adherence is the use of short-course treatment for TB. Because of the significant inconvenience posed by DOT, the shorter 60-dose regimen of prophylaxis is highly recommended. In fact, since this regimen was introduced in Edmonton's inner city, the adherence rates to prophylactic treatment have increased considerably. The completion rate for RZ preventative therapy was 56.5 percent at the end of 2001. This compares to a completion rate of 37.7 percent in the previous four years where a nine-month course of Isoniazid (INH) was used as preventative therapy. Because of the potential liver toxicity of this treatment, close monitoring for the side-effects of the medication is essential, especially in patients who misuse alcohol. Given the centrality of alcoholism in the homeless population and the difficulties many individuals have in sustaining long periods of sobriety, encouraging moderation may be more effective than pushing abstinence. Mayo *et al*, for example, found that refraining from alcohol consumption while on TB drug therapy was difficult for homeless individuals whose peer group actively drank.[23] This finding was substantiated in Edmonton's inner city. A heavy-handed approach that over-emphasises the potential of liver damage may cause patients to stop taking prophylaxis rather than cease drinking. This has been suggested by other studies as well.[28] In addition, the issue of addictions needs to be appreciated holistically as being rooted in the complex interaction of personal, social and environmental factors. For example, in the past, *resistance to change* was viewed as a personality trait of alcoholics. Currently, resistance is seen as an interpersonal phenomenon. Defensiveness has been shown to vary in response to therapist behaviour. Therapists who behave in a more confrontational manner elicit greater defensiveness, whereas those who are non-judgemental and use reflective listening are able to reduce client defensiveness.[266]

Yet another potentially effective strategy includes the use of peer health advisors. This has been suggested by other studies on tuberculosis—including the work of Gibson *et al.*[245] Similar approaches have been employed in Edmonton with injection drug-users (IDU's). The Streetworks needle-exchange program, for example, uses community members in its harm reduction initiatives. These advisors, coined "Natural Helpers," are recruited from the inner city and include former IDU's and/or individuals with street experience.[277]

In the case of TB, peer health advisors can be beneficial for several reasons. First, they may be able to establish a strong rapport with homeless patients based on their "street credibility" and shared life experiences. This is important given the social exclusion and marginalisation that so often attends homelessness. A supportive environment can encourage homeless individuals to discuss the issues that affect their lives and, in doing so, ensure that DOT reflects the socio-cultural realities of life on the streets. These understandings can then be incorporated into the treatment.

Given the large proportion of Aboriginal people experiencing homelessness, it would be prudent to recruit Aboriginal individuals. Although cultural differences between caregivers and patients was not identified by participants as a barrier to DOT, inter-cultural differences cannot be ruled out as contributing to poor adherence because of the small sample size used in this study. The literature indicates that shared concepts between caregivers and patients may promote adherence behaviour. Anecdotal evidence, as well as participant observation, has confirmed the advantages of matching the cultural background of client and provider. This is an area that requires further investigation.

Secondly, peer health advisors can serve an important educational function by teaching patients about tuberculosis and other diseases common to the inner city, such as HIV. This is especially important given the high prevalence of blood-borne pathogens (BBP) in the homeless population. In this study, six (6) of the sixteen (16) participants were infected with Hepatitis C. This corresponds with local data. In BBP screening that occurred in Edmonton's inner city in 2001, seventy-nine percent (79%) of the individuals who requested testing were identified as having a blood-borne pathogen. Sixty-five percent (65%) of those tested were Hep C positive.[7] Peer health advisors could play a valuable role in educating individuals about these diseases and how behaviours such as substance abuse impact these medical conditions. This is significant because the majority of the individuals who are recommended preventative treatment for TB in Edmonton's inner city have a history of alcohol abuse and/or testing positive for Hepatitis C.

In the case of tuberculosis, the lack of public awareness and the stigma that surrounds the disease points to the inadequacy of the current educational and treatment approaches. The inability to overcome, by biomedical means, an otherwise preventable disease, highlights the urgent need to develop treatment approaches that are grounded in relevant socio-cultural contexts. One way of making TB services socio-culturally appropriate is to include community members in the design and delivery of the treatment services. Using peer health advisors may be a step towards this goal.

Community participation models stress the importance of participation by the people who are the targets of an intervention so as to increase both the likelihood of addressing true community needs and gaining acceptance by the community.[267] As such, lay participation should be encouraged. However, it should be noted that significant gradations of participation in health care decision-making are possible. According to Rifken *et al*, participation is a social process whereby groups "actively pursue identification of their needs, take decisions and establish mechanisms to meet their needs." (Pg. 933)[268] A marked difference exists between listening to the views of a community on the one hand and shifting full decision-making responsibility to them on the other. A range of levels of participation is theoretically possible. Charles and DeMaio suggest a ladder of increasing participation to describe the different levels of lay involvement in decision-making.[269] On the lower rungs of the ladder are manipulatory and tokenistic forms of participation such as placation and con-

sultation.[270] The top rungs are represented by partnerships, with the highest level of participation being citizen control. According to Charles and DeMaio, much of the current health promotion practise, while espousing the rhetoric of community participation, is operating at the lower levels of this ladder. This is sadly the case in Edmonton's inner city, as well.

It is not sufficient to simply "listen to the voices" of the marginalised and to comprehend the socio-economic roots of their oppression or their downward slide. (Pg. 704)[272] There needs to be the societal commitment to address the systemic causes of the unequal distribution of resources and opportunities—as Anderson argues:[272]

> Achieving health is not just about enabling people to take more responsibility for their health; it is also about naming injustice, and taking action to address social and economic inequity. (Pg.704)

More importantly, there needs to be the explicit recognition that social inequities constitute and compound health care issues. Typically, the intended impacts of policies aimed at reducing poverty and income inequality are economic and social. Health outcomes are not usually the target of poverty reduction. This arbitrary division between health care and socio-economic policy is a substantial barrier to the promotion of health, as Geoffrey Rose concludes:[271]

> "The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart." (Pg. 129)

The adherence behaviour of homeless individuals to TB treatment takes on powerful political and social dimensions when one considers that the health-seeking behaviour of the homeless is grounded within the symbolic and material realities of poverty. The paucity of literature dealing with adherence behaviour as it relates to social inequity is distressing. It calls into question the complicity of the medical profession in furthering the systemic oppression of the already disadvantaged. The insistence on treating the issue of adherence in isolation from the precipitating factors of poverty and powerlessness perpetuates a "blame the victim" mentality—that effectively deflects criticism from the inequalities inherent in the larger socio-political structure, of which medicine is a part.