Health and Homelessness: A Landscape of Living Death

by

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ABSTRACT

This thesis reports the results of a research project designed to investigate the health and health care experiences of street people living in Victoria, British Columbia. Previous geographical research has addressed many facts of the street community but the health of this group has received little attention. However, recent directions in medical geography and the geography of homelessness, including the use of structuration theory, provide the framework for exploring how the street community experiences and perceives health in the landscape. The research is based on data collected through semi-structured interviews in 1995, street journals and elite interviews in 1999, and document surveys. All data were analysed and five major themes were identified. First, Becoming Homeless includes the causes leading to living on the streets. Second, Existing on the Streets incorporates daily activities and the conditions of street life, and how they relate to health. Third, Street Community Facilities and Services refer to the attitudes of the street people towards these facilities in addition to their function and purpose in the street community. Fourth, Street Health examines the health concerns of this group, along with accessing and utilizing health care. Finally, Personal Empowerment and Getting off the Streets considers the measures needed for street people to improve their health and their lives. It was found that the street community's interpretation and experiences of health were shaped by the landscape. This landscape can best be described as a pathological

landscape, in particular, a landscape of living death. Policy recommendations are mentioned, along with suggestions for future research.

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To my mum, Diane Sansom

Chapter 1

Situating the Street Community in Victoria: A Landscape of Living Death

Sidewalks are considered by many as a means to an end, helping us get from one point to another. While doing so, most of us are preoccupied with our personal lives, about work, or some other errand that needs to be completed. Often, our surroundings are ignored, and we forget to actually look at the landscape around us. If we do notice our surroundings, our eyes usually glance toward the dominance of the buildings, or towards the merchandise in the store windows. Often, we dismiss the other elements of the landscape: destitute people begging for spare change; men and women lying on the sidewalk sleeping; people coughing. We forget that we are not just walking on the sidewalk; we could be walking through someone's bedroom. In fact, there are actually two very distinctive landscapes in downtown Victoria: the one used by the "normies, those people that got a place to live" -- as one street person said; and then there is the landscape of the street community.

For many Victorians, the area bounded by Store Street on the west, Burdett Avenue to the south, Princess Avenue to the North, and Vancouver Street on the East simply refers to a section of downtown Victoria. For street people, this is their place, their turf of reality. The streets are not a means to an end, but the end itself. In this part of Victoria, the astute observer sees street people congregating around street community facilities, in search of food and shelter for the night; he or she sees others talking amongst themselves over a cup of coffee. In the wintertime, this cup of coffee becomes a source of heat.

Walking further, we are greeted by outstretched hands. A street person asks for spare change. These two landscapes collapse upon one another, intertwining, as donations are

offered or solicitations are accepted. Often pedestrians ignore the request by ignoring the person. Panhandlers become an extension of the sidewalk itself. People do not walk by, but rather through them. Their human existence is lost on the streets as people scurry along to destinations.

In the downtown area early in the morning, before the normies awake and rush to work, we begin to see the precariousness of streetlife. After sunrise, the shelters empty out and another day of street life begins. Panhandling does happen, but the majority of the day is spent walking to and from various street community facilities to obtain food, to find work, or to find a place to live. Frustration combined with despair and disenchantment is almost palpable on the faces of the street people. This type of existence isolates this community from the normies, but paradoxically places a street individual right in the path of the normie's life. This happens in the downtown area.

This street landscape has been called by one of the street people interviewed, a "living death." Street people shabbily dressed with bandages covering sores or lesions inhabit the downtown. Some pace the streets talking, even yelling to themselves, showing signs and symptoms of schizophrenia. Some street people's arms reveal needle sites. Around the trash bins, there are often street people rummaging through them, looking for scraps of food. Here, surviving on the street takes precedence. Health is sometimes dismissed, often ignored.

Upon closer examination, other facets of this landscape become noticeable. The corner of Johnson and Government Streets is synonymous with prostitution. For some street women, it is a means of securing shelter for the night. For the women who choose to stay at the Streetlink shelter, sleep is a luxury. They are preoccupied with the possibility of being

harassed by men, with threats of assault and rape. Identities are lost on the streets, and become part of a collective term: homelessness. It is the loss of control over one's life. Events such as those described here are common for people living on the streets.

Research has revealed that the health conditions of the street people are usually worse than those who have shelter (Wright, 1990; Lee *et al.*, 1998;). Streetlife is often a contributing factor to poor health, resulting in depression and other street induced emotional problems, since many street people find it too difficult coping with their situation (Ambrosio *et al.*, 1992; Ritchey *et al.*, 1991). The links between this landscape and the street population's health need to be addressed. In other words, how does the street community experience and negotiate meanings of health in their landscape?

The Research Problem

In this study, I use the term street people and its derivatives to discuss the homeless population in Victoria. This reflects the wishes of the participants in my study. When referring to existing research, the term homeless is adopted since it is the most common word used in the literature. Research on health and homelessness has employed a variety of theoretical approaches. Some are concerned with the structural conditions contributing to health status, while other research examines how individual behaviour determines health outcomes. But the determinants of health are multifaceted. Health policies and regulations, along with individual lifestyles and decisions on agency, are both causative factors in health and illness. A theory is required which addresses the agency-structure dichotomy in understanding the street people's experiences and meanings of health in their landscape.

Structuration theory as primarily developed by Giddens is well suited for this study since it involves an examination of how daily activities by various agents or groups, mediated by institutions, interact with socio-economic and political structures to produce a social reality. This thesis employs a structurationist approach for understanding health in the context of the street people's landscape.

Existing research on homelessness employs various methods to study this phenomenon. Studying homeless people can be a difficult endeavour because of their transiency and reluctance to speak with strangers (Ambrosio *et al.*, 1992). It requires a methodology sensitive enough to allow them to talk in their own terms about issues relevant to their life on the streets. Qualitative methods provide the flexibility needed to ask relevant questions about streetlife without compromising the views and experiences of street people. I addressed this issue by talking directly with the street people and by asking them for their concerns and experiences of health while living on the streets. Equally important to the development of my research and interest in this topic are the current trends that mark homeless issues in Canada today.

The Context of Homelessness in Canada

The United Nations declared 1987 as the International Year for Shelter and Homeless (IYSH). Since then, considerable attention has been focused upon this situation by both governments and academics alike. In Canada, a comprehensive study released in 1988 by the Canadian Council of Social Development revealed that in 1986, there were over 100,000 homeless. By 1998, this figure had grown to 200,000 (City of Toronto, 1999). In British

Columbia, there are approximately 15,000 homeless people (*Times Colonist*, March 2, 2000:C8). In cities such as Toronto, Vancouver, and Victoria, the homeless have become a growing concern. Television coverage of the 1998 ice storm in eastern Ontario and Quebec acted as a catalyst for Cathy Crowe (a nurse who works in the homeless community). She formed the Toronto Disaster Relief Committee because she noticed how events classified as natural disasters receive immediate government funding and initiatives, while the tragedy of homelessness had not. This committee, consisting of health and community activists, former homeless people, church leaders and academics, issued a report that declared homelessness "a natural disaster" and urged all levels of government in Canada to make a similar declaration. The report also recommended the creation of short-term rescue measures as well as the addition of one percent to the government budget for social housing. To date, hundreds of organizations have endorsed this initiative, including Toronto City Council (City of Toronto, 1999). In response, the federal government has established a ministry responsible for homelessness and appointed Claudette Bradshaw as the minister. In addition, a homeless summit was organized in the summer of 1999. In December 1999, the federal government promised to spend $753 million on Canadian homeless programs over a three-year period. The money is allocated to expanding and assisting local shelter programs and improving existing social housing.

These events have brought attention once again to the homeless problem, but it has mainly focused attention on the problem in Toronto. Victoria, with its mild winters and relatively warm climate that has made the city the envy of Canada, is a haven for retired people (Tourism Victoria, 1994:3) Recently, it was chosen as the tenth most popular tourist

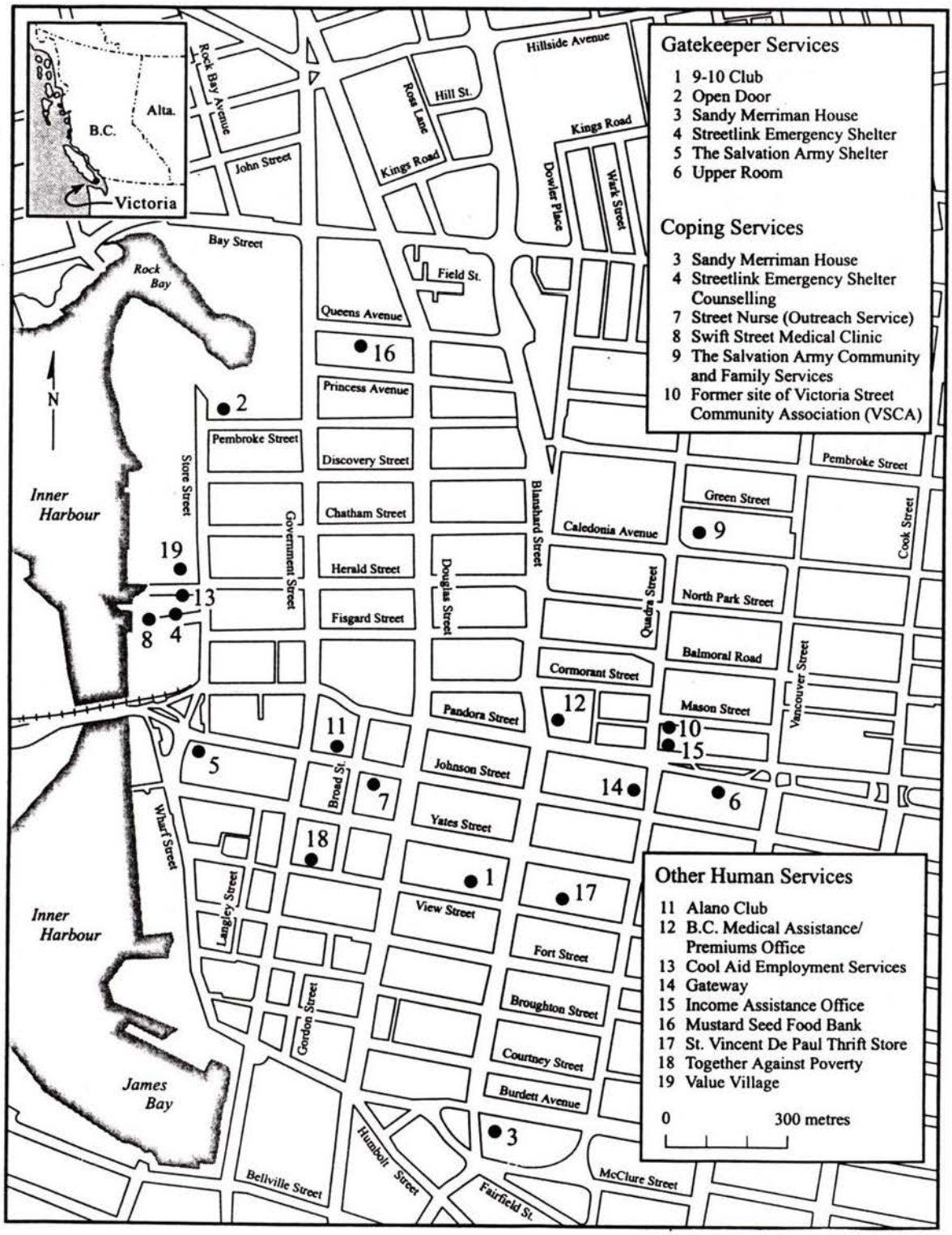
city in the world (*Times Colonist*, September 3, 1999:C1). On a per capita comparison, Victoria has the distinction of having the largest street community in Canada. Estimates of the street community population range between 400 to 500 people, or 2.6 percent of the city's population (Thrasher, 1997; *Times-Colonist*, August 31, 1999; City of Victoria, 1999).

The many street community facilities catering to this population are clustered in the downtown core (Figure 1). These facilities vary from drop-ins, health services, to emergency shelter accommodation. At Streetlink, the largest emergency shelter in Victoria, seventy percent of their clients have either some form of mental illness or drug problems. (Thrasher, 1997). The health concerns of Victoria's street community are handled by Capital Region District (CRD) street nurses known in this community as "Louise" and "Priya", and by the Swift Street Medical Clinic in affiliation with the Streetlink shelter. A study conducted by this agency compared the health status of a sample of the homeless population (n=44) with the health status of a previously homeless population which had recently moved into a supported housing complex (n=33). Nearly 38 percent of the homeless respondents suffered from some form of mental illness, while an additional 39 percent had some form of substance abuse. Only 11 percent did not report any serious health concerns (Norman and Schwandt, 1993:40).

Contemporary Health Policy

The "absence of disease" is the traditional view of health manifested in the biomedical disease model (White, 1981). Contemporary views recognize health as not only involving a biological aspect, but also social, political, cultural, and physical characteristics. The environment itself is viewed in a broader context, which encompasses income, culture,

Figure 1: The Geography of Street Community Facilities and Services in Victoria



standard of living, and behavioural characteristics of the individual's locality (Eyles and Woods, 1983). Various levels of government have adopted this new outlook on health (Kearns, 1993; Kearns, 1994). According to the United Nations World Health Organization (WHO), health is complete "physical, social and emotional well-being" (WHO, 1977; 1984). This all-encompassing vision of health is challenging health care policy and strategy development in both the provincial and federal governments of Canada. This became evident in the early 1970's at the federal level, with the publication of the Lalonde Report, *A New Perspective on the Health of Canadians* (1974). This was one of the first reports to officially recognize that environmental, social, and behavioural factors affect people's health (Taylor, 1990:334). The Black Report, published in the United Kingdom, echoes this more holistic perspective (DHSS, 1982). It reveals that economic factors (employment status and income levels) affect health outcomes as well. Further, in line with this thinking, the federal government's Epp report, *Achieving Health For All: A Framework For Health Promotion* (1986), identifies health as a resource for everyday living.

At the provincial level, the British Columbia's *Closer To Home* study adopts this new vision of health and identifies social and economic environments as critical determinants of health (British Columbia Ministry of Health, 1991:5). Written to examine health care and its costs in British Columbia, this report recognizes the association between poverty and poor health. The life expectancy of the higher income people is four years beyond that of the lowest income groups (British Columbia Ministry of Health, 1991:13). As a result of these findings, the Ministry of Health offered plans to "devote more time, resources, and research efforts to reducing poverty and unemployment, achieving more equitable distribution of wealth,

improving housing, and developing stronger social support networks" (British Columbia Ministry of Health, 1991;13). The provincial government of British Columbia acknowledges the necessity of implementing policies catering to low income people to reduce inequalities of health. A subsequent report by the provincial government with implications for understanding the links between homelessness and health addressed these policy issues. In the *New Directions for a Healthy British Columbia* (1993), priority areas of policy development are identified:

> To deal with obstacles to equitable services and equitable health status, specific health policy frameworks will be developed for aboriginal people, multicultural populations, persons with disabilities, the mentally ill, persons living in poverty, children and youth, women and seniors. (British Columbia Ministry of Health, 1993:13)

While homeless people are not explicitly addressed here, the homeless population is recognized nonetheless, since the homeless comprise people from all of the "priority groups" so identified.

In light of this statement from the Ministry of Health, policy initiatives addressing the health status of the homeless in British Columbia need to be considered. The very nature of homeless life itself, living on the streets, contributes to acute health problems such as tuberculosis, depression, and malnutrition (Lee *et al.*, 1998). There is an inherent spatiality to homelessness and health. Geographical research on homelessness is shifting to an examination of daily life experiences and involves a more holistic perspective (Takahashi, 1996). Knowledge of the connections linking health and the homeless landscape remain limited. Further research is needed to address how the homeless landscape is perceived, and how it influences and shapes the health of the homeless. Moreover, this type of research can

assist in health policy development and can empower both the individual and community groups.

Research Objectives and Thesis Outline

The conceptual basis for this thesis focuses on the convergence of the geography of homelessness and medical geography. The study is situated within a geographical framework since it examines how health is shaped and influenced by the landscape. In order to learn more about the landscape of the homeless, three research objectives were set. The first objective was to describe the personal problems of health and the health care experiences of a sample of Victoria's street population. The second objective was to identify the strategies adopted by the street people in dealing with health and health care issues in the context of their street landscape. The third objective was to interpret the experiences of health problems and health care in the street people's landscape from a structurationist perspective. This examines how individual actions and the wider social processes interact to shape the homeless environment and its health outcomes. The resultant spatial form is a type of unhealthy landscape, containing depression, mental illness, disease and health risk behaviours. This is called a pathological landscape, whereas the landscape of the living death inhabited by the street community is a type of this landscape.

The thesis comprises six chapters. Chapter One describes the landscape of the homeless in Victoria British Columbia, and elaborates on the Canadian context of homeless issues. It also includes a description of recent changes in health policy, and how this has relevance to the thesis. Chapter Two contains a literature review on health and homelessness.

It includes a discussion of the geographical research on homelessness, and details the health problems common in homeless populations. From here, the work is situated within a medical geographical context. Chapter Three examines the theoretical approach of the thesis. It begins with an overview of structuration theory and discusses its important aspects: agency, system, structure, duality of structure, time-space distanciation, and institutional order. The discussion then proceeds to describe geographical studies involving structuration, discussing the advantages and disadvantages of using this theoretical approach. The chapter concludes by reiterating why structuration can be used in examining health in the homeless community studies. Chapter Four fleshes out the research objectives and identifies the methodological issues. Data collection included semi-structured interviews of street people, recorded journals, and discussions with street community facility workers in Victoria. It also included an analysis of articles appearing in the *Red Zone* magazine, the *Times Colonist* newspaper, as well as an analysis of laws and policies affecting street people. This chapter also presents a description of the study area in Victoria, sampling procedures, and methods for transcribing, coding, and organizing the data. In Chapter Five, the data are assessed using a structurationist framework, and the major themes of Becoming Homeless, Existing on the Streets, Street Community Facilities and Services, Street Health, and Personal Empowerment and Getting off the Streets are presented. In order to give a sense of the landscape of living death, theses five themes are illustrated in photos one through nine. Chapter Six summarizes the research findings and discusses policy implications. Methodological considerations as well as some suggestions for subsequent research are also made.

BECOMING HOMELESS

Photo 1: A Derelict building awaiting demolition
This represents a loss of affordable housing for lower-income and street people in Victoria.

EXISTING ON THE STREETS

Photo 2: A Street person panhandling.
A means of earning some extra money for survival on the streets.

EXISTING ON THE STREETS

Photo 3: An emergency shelter bed at Streetlink. One of the 94 emergency bed available for street people in Victoria.

STREET COMMUNITY FACILITIES AND SERVICES

Photo 4: Streetlink Emergency Shelter.

STREET COMMUNITY FACILITIES AND SERVICES

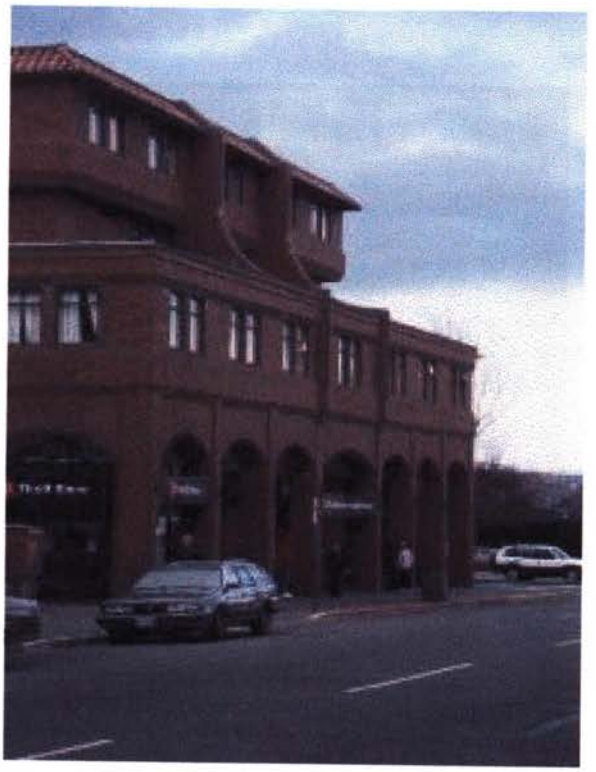


Photo 5: The Salvation Army Emergency Shelter.

STREET HEALTH

Photo 6: A street person sleeping on the sidewalk outside McDonald's on Douglas Street in downtown Victoria.

STREET HEALTH

Photo 7: A location in the downtown where street people 'sleep rough' for the night

PERSONAL EMPOWERMENT AND GETTING OFF THE STREETS

Photo 8: Pandora House Project: A 32 unit supportive housing complex for street people.

PERSONAL EMPOWERMENT AND GETTING OFF THE STREETS

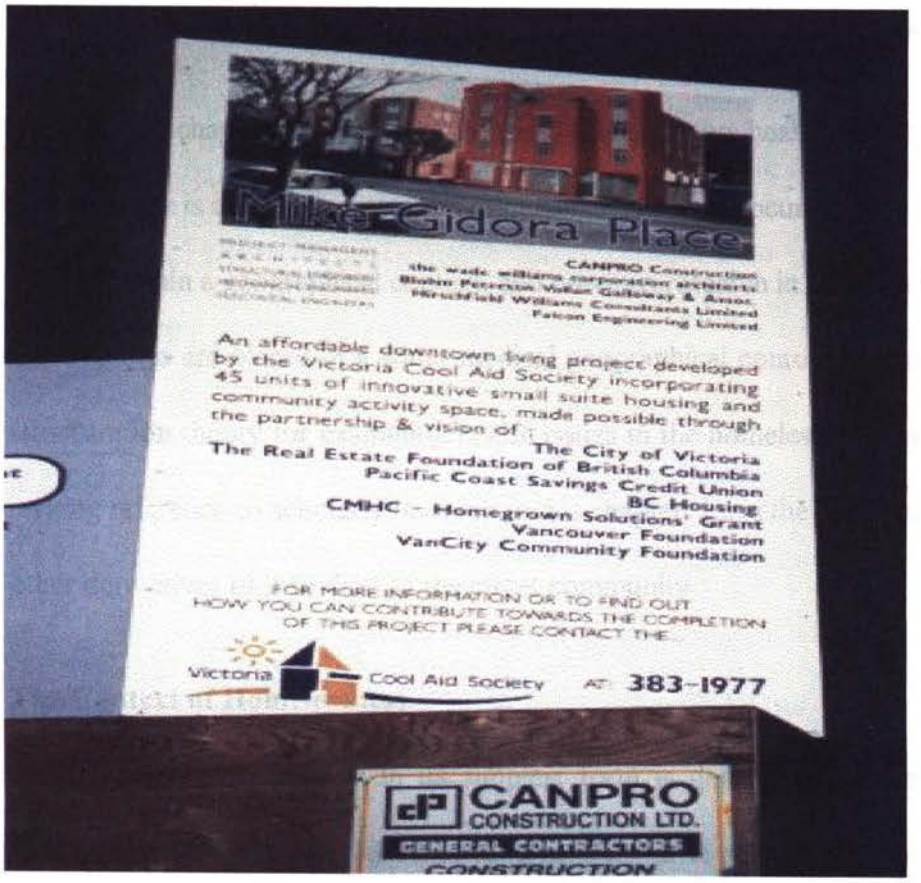


Photo 9: Mike Gidora Place:
A 45 unit social housing complex for street people under construction.

Chapter2

The Literature on Health and Homelessness

This chapter assesses the existing literature on health and homelessness. First, homelessness is defined and some of its characteristics are documented. Homelessness is then situated within a geographical context, and previous research in this area is elaborated. Next, these studies are placed in a wider medical geographical context to show the relevance of structuration theory for examining health issues in the homeless population. Because I am making reference to scholarly research in this chapter, I use the terms homeless people and other derivatives of it to discuss the street community.

The Context of Homelessness

While homelessness in its simplest form is defined as the "absence of a stable residence where one can sleep and receive mail," it is actually a "more complex state of human existence, which is often the final stage in a lifelong series of crises and missed opportunities, the culmination of a gradual disengagement from supportive relationships and institutions" (Dear and Wolch, 1987:175; Dear and Wolch, 1993). The homeless population in Canada is heterogeneous. In 1987, The Canadian Council of Social Development (hereafter referred to as the CCSD) conducted one of the most comprehensive surveys of homelessness. This agency identified refugees, the mentally ill, Native people, seniors, children, women, and families as constituting the homeless population (Dear and Wolch, 1993). Personal events, as well as socio-economic and political structures, contribute to becoming homeless. Street people have usually experienced one or more critical life events: eviction, domestic conflict

(family violence), loss of a job, discharge from an institution, and/or removal of monetary or nonmonetary welfare support (Dear and Takahashi, 1992; Takahashi, 1996). Individual experiences and social processes (economic restructuring, health policy reorganization, and changes in the housing supply) are major causes of this situation. This can lead to the "culture of chronicity," where homeless people become caught in "a vicious circle of deteriorating circumstances," causing their situation to progressively worsen (Wolch and Dear, 1993).

On a structural level, the manifestations of current economic and housing policies also contribute to homelessness in society. Global economic restructuring is causing large-scale deindustrialization. Positions in the service sector, which are generally low-paying, low-skilled and without health benefits, are replacing manufacturing jobs. With this on-going economic upheaval, the welfare state is being drastically altered. In the health sector, for example, deinstitutionalization is designed to replace hospital beds with small-scale community services. However well intentioned, this has also resulted in a significant number of mentally disabled patients being forced to live on the streets (Dear and Takahashi, 1992:192-195). According to the CCSD's 1987 census of homeless people in shelters across Canada, twenty percent of the homeless population in shelters are current or ex-psychiatric patients (Begin, 1993). At the same time, housing supplies for low-income people are diminishing in number and in quality. Gentrification, condominium conversion, and urban revitalization are catering to the middle-income and wealthy. For example, between 1982 and 1986, over 1,700 units in rooming houses in Toronto were lost through demolition or conversion (Begin, 1993). Concomitantly, governments are reducing subsidies for housing and cancelling projects. Canada's 1990 budget reduced the allocation of funds for socially-assisted housing by

$51,000,000 over two years. Then, in 1992, the federal government ended its co-operative housing program and devolved responsibility for social housing to provincial and municipal governments (Daly, 1996: 183). These conditions have forced a new group of people to live in marginal economic and housing circumstances: the proto-homeless (Dear and Takahashi, 1992:193-197; Takahashi 1996; Daly, 1996).

The confluence of the conditions discussed in the preceding paragraph produces a spatial dimension to homelessness manifested through the creation of a "zone of dependency." Dear and Wolch (1987) examined the extent and nature of homelessness with respect to the experiences of the deinstitutionalized mentally ill. Most became concentrated in central core areas of the city, since these areas have a large concentration of street community facilities for the homeless. Here, land values are relatively cheap and public opposition to locating in these areas is usually minimal. The homeless had become "dependent upon this area because all the facilities and services necessary for living can be found in this location" (Dear and Wolch, 1987:14). There is a distinct spatiality to homelessness, and this has attracted the attention of geographers (Takahashi, 1996).

Geographical Research and Homelessness

Geographical research on homelessness emerged from the changing intellectual, social, and political environment of the 1970's. Disillusionment with government policies (e.g., the unpopularity in the United States over the Vietnam war) and concomitantly, an awareness of government's neglect of social injustices (which spawned the civil rights and women's movements), led to the formation of the relevancy or welfare movement (Smith, 1977).

Interest in this movement is directed towards contemporary social issues such as racism, poverty, and access to public services, such as health care (Smith, 1977). In order to be part of the relevancy movement, human geography directed its attention at issues and concerns which people were confronting on a daily basis. These problems or welfare issues were translated into tangible research strategies which examined poverty, the black ghetto, and access to health care (Smith, 1977). Furthermore, Harvey (1973) analysed the spatial context of social justice. This interest ultimately led to the publication of Smith's *Human Geography: A Welfare Approach* (1977), wherein he outlines the spatial context of the welfare theme by addressing the question of "who gets what, where, and how?" (Smith, 1977:7). This led to geographical research of the disadvantaged and marginalized groups. For example, Giggs' ecological analysis of schizophrenia in Nottingham demonstrated how rates of schizophrenia were highly correlated with a series of deleterious life circumstances, such as low social status, high unemployment, and high rates of disaffiliation (Giggs 1973, in Eyles and Woods, 1983:90). These findings indicated that the majority of schizophrenics lived in the city's core, thus suggesting a spatial relationship between health status and the schizophrenic's environment (Giggs, 1973). Giggs pointed to evidence suggesting that the physical condition of housing affects the mental and physical health of its residents. In addition, he emphasized the socioeconomic environment (income, standard of living) as a determinant of health. Subsequent research addressed welfare issues in the context of the poor. Exemplary was Wolch's (1980) study of people living in poverty. She discusses the distinctions between the working poor (labour force individuals living below the poverty line) and the non-working poor (the elderly, mentally disabled, physically challenged, and the chronically unemployed),

who are usually dependent upon government assisted incomes (e.g., pensions, unemployment insurance, and services provided by human service agencies). Wolch used a locational decision model to analyse the relationship between the spatial distribution of human service facilities and the residential location of the service dependent poor. The results suggested interdependency between the human service facility location and the residential location of this population. Marginalized groups (such as the service dependent poor) and the human service agencies (which cater to this group) locate in the same areas of the city because they are mutually interdependent upon each other for survival. This "cycle of interdependency" has lead to the creation of the service dependent ghetto (Wolch, 1980:341). These findings extend an earlier study by Dear (1977) that focused upon the locational factors of human services for a particular population of the service dependent poor: the deinstitutionalized mentally ill (Dear, 1977). A later study by Dear and Wolch (1987), examines the genesis and perpetuation of this service dependent ghetto.

The geography of homelessness addresses several spatial aspects of the homeless condition. One of the earliest geographical studies of homelessness, by Burnett and Moon (1983), examined community opposition to the location of two homeless shelters in different neighbourhoods in Portsmouth, England. Mapping the spatial distribution of opposition in the two areas showed a distance decay phenomenon. As one moved further away from the site of the proposed facilities, the number of opponents decreased. This spatial distribution was associated with land use types, wherein residential areas reported higher levels of opposition than areas of industrial use (Burnett and Moon, 1983).

Further, housing needs and the very nature of housing itself are key issues addressed

by geographers. Single room occupancy hotels (hereafter SRO) provide a cheap source of accommodation, and for many people are the difference between having a place to stay or being homeless. Hoch (1991) describes the loss of SRO's in the city of Chicago and its effects upon the homeless. SRO's have their own unique social networks, playing a vital role in assisting people with improving their lives. This affordable type of housing is being eliminated because of urban renewal and gentrification. The result is that more people are being put out onto the streets. As a result of these measures, many homeless are being forced to depend upon government assistance, for the affordable housing stock is so low in the city (Hoch, 1991).

Other research questions the concept of housing itself and its implications for the homeless. Veness (1992) considered the historical account of the concept of home and homeless in the United States. She argued for the need to evaluate the cultural context of these concepts when considering policies aimed at alleviating homelessness. In another of her studies, Veness (1993) described how homeless people contested normative definitions of home and homelessness by describing what constitutes a "home" to them. She questioned the validity of the normative definitions of home and homelessness after interviewing people characterized as "homeless." She showed how political processes and structures in society socially construct the notion of a home. Addressing the politicized definition of "home" will enhance policy responses to homeless people and assist in empowering them. This politization of the home has also been applied to shelters for the homeless population. Veness (1994) also examined the homeless shelter and the values that the design promotes. Current shelter designs usually reflect the values of the middle-class that can further alienate homeless people

by giving them false hopes about achieving their lifestyle. According to Veness, shelter design should involve the consultation of the homeless themselves in order to create a conception of home more suitable, comfortable, and compassionate for those whom the shelters will serve (Veness, 1994). Bridgman, (1999) explored the shelter design of two supportive housing projects, StreetCity and Strachan House, for homeless people in Toronto Canada. By using in-depth interviews and ethnographic work, Bridgman documents and explores how meanings and understandings associated with streetlife (or the 'street,' as she calls it), were incorporated and implemented into the design and management of both StreetCity and Strachan House. Supportive housing that incorporates design elements of street life has the potential for assisting homeless people in the transition from life on the streets to a domiciled environment (Bridgman, 1999:164).

In a similar vein, Kearns and Smith (1994) suggest geographers should look at how homelessness is defined. Conceptions of homelessness should include more than the actual concrete sense of having no roof or shelter (Kearns and Smith, 1994:420). Instead, they outline three types of homelessness that could serve as the basis of homeless research. First, *literal* homelessness identifies people living on the streets. Most previous studies have dealt only with this type. *Incipient* homelessness refers to people living on the margins of homelessness, in substandard housing or in single room occupancy hotels. Few studies have examined this type of homelessness. *Metaphorical* homelessness entails an abstract sense of the term of homelessness, referring to feelings of not belonging. In other words, the person has shelter, but does not feel at home. It is void of meaning and/or value to the individual (Kearns and Smith, 1994:420-421).

Previous geographical studies addressed the components of housing and shelter, and the values with which they are imbued. Several geographers have examined another element of the spatiality of the homeless: their movement and mobility patterns. Rowe and Wolch (1990) used ethnographic analysis to illustrate that homeless woman 's mobility patterns are associated with women's social networks (Rowe and Wolch, 1990). In Canada, Syrotuik (1990) utilized participant observation and ethnographic analysis to study the homeless in London, Ontario. He explained how the spatial behaviour of the homeless corresponds to the public spaces they frequent. Rahimian *et al.* (1992) conducted face-to-face interviews of homeless men in Los Angeles and developed a conceptual model of homeless migration. An ethnographic study by Wolch and Rowe (1992) and a study of survey data by Wolch *et al.* (1993) demonstrated that mobility patterns of homeless people are intimately linked to the coping strategies of this population. These coping strategies are influenced by characteristics of homeless facilities and their philosophies behind service provision, along with characteristics of the cities in which these facilities are located (Wolch and Rowe, 1992:116). Rollinson (1998) examined the daily life of the homeless in Kansas City in the context of the emergency shelter. Through participant observation and ethnographic research, Rollinson explained how people, after prolonged stays at the Kansas City shelters, began to exhibit changes in appearance and attitude, ones that are "stereotypical of homeless" (dishevelled appearance, sense of hopelessness, etc.). As well, he remarked on how the spatial activity of the homeless declined once they took up residence at these locations. He argued further that shelter life contributes to the homeless condition, since the rules and regulations regarding shelter use confines spatial movement, thereby limiting access to the resources necessary to

escape these circumstances. In addition, living in these places leads to the socialization of the "homeless" condition.

While it is important to focus attention on the homeless themselves, it is equally important to examine the domiciled community and how their perceptions and views affect the spatial form of homelessness. Dear and Gleeson (1991) discuss community attitudes toward the homeless. Content analysis of over 200 newspaper articles from major cities in the United States on the topic of homelessness between 1985 and 1988 show opposition articles outnumbered support by a margin of three to one. Stories expressing opposition to the homeless feature business organizations and local grassroots residents fearful of neighbourhood deterioration, personal safety, and loss of revenue due to the presence of the homeless around their businesses (Dear and Gleeson, 1991:155). Views sympathetic to homeless people suggest and recommend more be allocated towards programs of alleviating homelessness. This sympathetic stance was often expressed by advocacy groups and by homeless associations (Dear and Gleeson, 1991:155).

Opposition to the homeless often creates stigmatization. Takahashi (1996) examined the spatialization of this stigma. In particular, she focused on the stigma associated with homelessness and HIV/AIDS, which she argues is linked to three facets: personal culpability, dangerousness, and non-productivity. Many people in the domiciled population believe that the homeless and people with HIV/AIDS are personally responsible for their own plight. As well, the general population perceive these two groups as deviant and unstable, which further stigmatizes them because they are not active participants in the labour market, meaning they are not contributing to the "good" of society (Takahashi, 1997: 968). In a related study,

Takahashi (1998) showed that public acceptance of homeless shelters is greater than acceptance for AIDS group homes in most neighbourhoods.

Community attitudes and public sentiment toward the homeless have resulted in legislative action in which the homeless are being excluded from public spaces. Mitchell's work (1992, 1995, 1997, 1998a, 1998b) focuses upon the notion of public space and on the anti-homeless ordinances in American cities. The courts in some cities are questioning the legality of begging in the context of the First Amendment. Based upon actual court cases, begging under certain circumstances is not protected by the Constitution of the United States. Many cities have responded by adopting tough anti - begging bylaws to eliminate this practice in their jurisdictions (Mitchell 1997, 1998a, 1998b). Mitchell argues that the real issue is the concept of public and private spaces (Mitchell 1992, 1995). Groups such as the homeless do not have access to private spaces (residences) so they use public space (e.g., sidewalks, alleys, parks etc.) for living. Many are performing their daily activities (e.g., eating and sleeping in parks) in areas considered "inappropriate" to the domiciled population. Smith (1993) discusses the clash between police and homeless people using Tompkins Square Park in New York City as a place to live. For the homeless, the confrontation with police symbolized their struggle to find affordable housing. Politicians and police viewed the clash as a direct violation of civility and moral conduct. For them, a park is not a place to live, legitimizing the removal of homeless people from Tompkins Square Park. (Smith, 1993: 114).

In response to this and other events, politicians and business leaders are fighting to control public space through political means by passing by-laws and other ordinances so as to exclude marginalized and stigmatized people (Mitchell, 1995, 1997). This explains why,

in recent years, there has been a proliferation of anti-panhandling by-laws in the United States (Mitchell 1998a, 1998b). These measures are effectively "criminalizing" the homeless lifestyle of using public space as their "home" (Mitchell, 1997). According to Mitchell, these by-laws are also passed to create "ordered public space" for the social and economic benefit of the community (Mitchell 1998a: 9).

Mair (1986), Wolch and Akita (1989), as well as Law and Wolch (1991), examine the economic issues surrounding homelessness. Mair (1986) situates the current fight against homelessness in American cities as a consequence of economic change in the post-industrial city. Changes in the global economic structure have shifted much of the manufacturing sector to Asia and developing countries. Manufacturing jobs are being lost to these countries because labour costs are cheaper and environmental laws are more relaxed. These jobs are being replaced by service, information, and high-tech positions. Global markets are now driving economies and governments are intervening less than ever before. As a result, cities are competing against one another for new economic ventures. To promote economic development, cities are revitalizing downtown and in the process are demolishing existing facilities for the homeless. All of this is being done by cities in the name of economic gain and prestige (Mair, 1986). Similarly, Wolch and Akita (1989) and Law and Wolch (1991) have examined the economic forces shaping the United States. Cuts in welfare and social housing have exacerbated the homeless problem in the United States (Wolch and Akita, 1989). At a different spatial scale, Law and Wolch (1991) discuss these economic policies and their effects in Los Angeles, suggesting these policies must be considered when conducting homeless research. Taking a more international perspective, Daly (1991, 1996, 1998)

comments on the nature of street life and examined the programs and policy for homelessness in three countries: Canada, the United Kingdom, and the United States. He addressed the differences as well as the similarities in policy and examined local initiatives to deal with homelessness in each country. Daly argued for more government initiatives and the need to enlist the homeless themselves to develop them.

Health, Homelessness and Geography

Dear and Takahashi (1992), Takahashi and Wolch (1994), and Lee *et al.* (1998) explore health issues for the homeless population and their spatial implications. Using information from the United States' Institute of Medicine, Dear and Takahashi (1992) identified three sets of health problems which are unique to the homeless. First, health problems result from homelessness (e.g., hypothermia, skin disorders, trauma). Second, health problems contribute to homelessness (e.g., substance abuse, AIDS, mental disabilities). Third, provision of health care is complicated by homelessness. The following of routine medical advice, such as bed rest, becomes impossible to fulfil (Dear and Takahashi,1992:186-187). In their study, Takahashi and Wolch (1994) compare the health and welfare characteristics of both the homed and homeless welfare applicants in Los Angeles County. While their findings indicate that the health of the homeless sample was slightly better than the health of the homed group, they also found the homeless to be more vulnerable and lacking in appropriate resources to gain access to health and to housing. Lee *et al.'s* (1998) study focuses on the geographical distribution of health and the social agency needs of the homeless. They indicate that there is a "spatial mismatch" between the location of long-term

care facilities and the homeless. This mismatch is rooted in the stigmatization and marginalization of the homeless in society. All three studies stressed the need to address the spatiality of homelessness for health care, housing, and social assistance policies and initiatives.

Homelessness and Health

Although not explicitly stated or examined, connections between space and the health of the homeless have been elaborated in many studies outside of geography. An examination of the literature on health and homelessness revealed several problems endemic to the homeless community. Summarizing this literature to the year 1984, Brickner *et al.* (1985) concluded that:

> The medical disorders of the homeless are of the ills to which the flesh is air, magnified by disordered living conditions, exposure to extremes of heat and cold, lack of protection from the rain and snow, bizarre sleeping accommodations and overcrowding in shelters. These factors are exacerbated by stress, psychiatric disorders, and sociopathic behaviour patterns (Brickner, *et al.*, 1985:3, as quoted in Wright, 1990).

This statement illustrates a spatial context of the health conditions for the homeless population. Lifestyle, like that of a homeless individual, is inherently spatial in nature. People eat, work, and sleep in different spaces. The living conditions and circumstances of the homeless play a role in determining their health status. How different this health status is from those found in the domiciled population has been documented in various studies. For example, the findings of a Canadian study (Ambrosio *et al.*, 1992) indicate higher prevalence rates for many health conditions among the homeless population. When asked about general health conditions, 48 percent of the homeless indicated their health was poor, while the same

response in the general population was 21 percent. The majority of this type of research has been conducted in the United States. Wright (1990) and Jahiel (1992) summarized comprehensive United States studies comparing health conditions of the homeless with those found in the domiciled population. Jahiel (1992) and Wright (1990) both discuss the National Care for the Homeless initiative (NCH) in their summaries, but Jahiel (1992) included the Mckinney Health Care for the Homeless Outpatient data as well. In addition, both studies used the National Ambulatory Medical Care Survey (NAMCS) of domiciled patients visits to walk-in clinics to compare the differences of health status between the homeless and domiciled populations. Upper respiratory infections, traumas, and minor skin ailments were reported three to six times more often by the homeless (Wright, 1990; Jahiel, 1992). Between 20 and 50 percent of this population had chronic disorders, compared with 27 percent for the homed population. Hypertension was between two and five times more common, while gastrointestinal disorders (e.g., ulcers, hernias, diarrhea) was two to three times more likely to occur in the homeless community (Wright, 1990; Jahiel, 1992). Peripheral disorders (venous or arterial deficiencies) were four to five times more severe among homeless people. These high rates of peripheral disorders were the consequence of constantly walking, standing, and sleeping upright: characteristics of street life. This "causes blood and body fluids to pool in the extremities" resulting in " higher venous pressures in order to return the blood through the circulatory system" (Wright, 1990:57). Further evidence shows that homeless people are more likely to suffer from neurological (e.g., migraines,seizures) and thermoregulatory (e.g., heat stroke,exhaustion, hypothermia,frostbite) disorders, as well as infectious and communicable diseases. Exposure to the elements,

crowded shelters, poor nutrition, dehydration, and lack of proper clothing cause these high incidence rates among the homeless (Jahiel, 1992:148). Rates of infectious and communicable disease were five to six more times prevalent within this community (Wright, 1990; Jahiel, 1992). Approximately one-third of homeless people have some form of mental illness (Wright, 1990; Jahiel, 1992; Ritchey *et al.*, 1991; North and Smith, 1993). Forty-one percent were classified as alcoholics, while 13 percent were drug users. (Wright, 1990; Jahiel, 1992). Less comprehensive studies confirm the findings of Wright (1990) and Jahiel (1992). Chronic problems, acute physical disorders, neurological disorders, and dental problems (as a result of poor oral hygiene and lack of dental care) are more significant with homeless people (Ritchey *et al.*, 1991; North and Smith, 1993). Approximately 10 percent of the American homeless population have some type of dental problem (Wright, 1990; Ritchey *et al.*, 1991). In Ambrosio *et al.*'s study (1992) in Toronto, 37 percent had not visited a dentist within the past year. Another study, conducted in Los Angeles, showed the figure for that city to be almost 27 percent (Gelberg *et al.*, 1988). In both studies, more than twice as many people in the general population visited a dentist within the past year (Ambrosio *et al.*, 1992; Gelberg *et al.*, 1988).

Health, Homelessness and Gender

Gender and health issues are other areas of study. According to Wright and Weber (1987), rates of ill health for both men and women are similar. However, for Wright (1990), hypertension and peripheral disorders are more common in men. Differences in health outcomes are attributed to the fact that women perceive health and illness in a different

manner than men. Women are more likely to seek medical advice, while men ignore most health conditions until they begin to interfere with their daily lives (Ritchey *et al.*, 1991). Three times more men than women are alcoholics, but levels of substance abuse are the same for both genders (Wright, 1990; Jahiel, 1992). There is also a higher proportion of women suffering from mental health problems (Wright and Weber, 1987; Ritchey *et al.*,1991). Rates of pregnancy for homeless women are higher than those found in the general population. In part this is due to high rates of sexual abuse (Wright, 1990; Jahiel, 1992). Reports of rape are fifteen times higher in the homeless community (Wright, 1990; Ritchey *et al*,1991; Jahiel, 1992). Approximately 22 percent of the women in the Toronto study had been raped, while 43 percent received unwanted sexual advances (Ambrosio *et al.*, 1992). Moreover, perinatal morbidity and mortality conditions are more common among the homeless population (Jahiel, 1992).

In his overview, Jahiel (1992) makes the following summary of the connections between health and homelessness:

> To improve the health of the homeless people, it is necessary to attack all the factors through which homelessness is an agent of disease: the physical environment of homeless people in the street and in the shelters, nutrition in food services, the stress that homeless life imposes, the harmful habits promoted by the homeless life, and the inaccessible or poor preventative and therapeutic care (Jahiel, 1992:151).

Taking Jahiel's comments seriously means researchers must study the links between homelessness and health, emphasizing the role of the environment in shaping it (Kearns and Joseph, 1993; Kearns, 1994, 1995). This is one of the roles of medical geographers.

Homelessness, Health, and Medical Geography

The interest of medical geographers in health and homelessness stems from an interest in the relationship between humans and their environment. This association between health and the environment has strong historical roots, that can even be traced back to the time of one of the first physicians: Hippocrates (Curtis and Taket, 1996). Since then, many physicians have studied the links between disease, people and the environment (May, 1950). During the mid- 20th century, Jacques May, a French physician, did a comprehensive study of how human behaviour and culture, as well as vegetation, typography, climate, and other physical attributes of the earth, are interconnected and contribute to disease (Mayer, 1996; Jones and Moon, 1987). This interrelationship, known as disease ecology, is still a vital part of medical geography.

Subsequently, many geographers have made contributions by employing various statistical methods and techniques to study the links between disease and the environment. For example, Pyle (1977) discusses disease mapping, disease diffusion, and modelling simulation. Geographers have also focused on the spatial component of health care. For example, Giggs (1979) described the spatial patterns of health care delivery systems to combat diseases. As a result, two main themes have emerged in the study of medical geography: the etiology and diffusion of disease, and health care utilization and provision (Jones and Moon, 1987; Eyles, 1993; Kearns and Gesler, 1998). The first theme, which is concerned with the relationships between environment and disease, is an outgrowth of May's studies, while the second theme focuses on accessibility to, and utilization of, health care

facilities (Eyles, 1993:113). Accessibility and utilization are governed by what people know, by their attitudes about available facilities, and by other variables such as demographic and socioeconomic characteristics (Eyles, 1993). The mediation between disease/ health and the environment - the common link between these two themes - has been examined primarily through approaches emphasizing ecological and spatial analysis (Eyles and Woods, 1983; Mayer, 1996).

Recently, there has been much debate about the nature of medical geography. Kearns (1993) argues for retheorizing the subject, since medical geography in the past has been viewed as atheoretical (Kearns, 1993; Litva and Eyles, 1995). In addition, he stresses the need to take a critical view of space and adopt a more holistic view of health which incorporates the landscape (Kearns, 1993, 1994, 1995; Kearns and Joseph, 1993; Eyles, 1993). While the issue of linking social theory with medical geography had been touched upon before (Eyles and Woods, 1983; Jones and Moon, 1987; Moon, 1990; Mayer, 1992), much of the history of medical geography is positivist and reliant upon the biomedical model of disease and quantitative research strategies. This model explains poor health as a manifestation of symptoms resulting from factors "extrinsic to the normal functioning of the body" (White, 1981:8). Simply put, the role of health practitioners is to examine the symptoms, to find the cause, and to remove the problem (White, 1981:10). While this model usefully explains the mechanisms involved in infectious diseases, it excludes any role for social factors in the etiology of health (Kearns, 1994).

A critical examination of the role of the environment in determining health outcomes means that a distinction between space and landscape must be made. Space, in a geometric

sense, involves distance and location (Kearns and Joseph, 1993). It becomes a "container" or backdrop for human activities (Eyles, 1993:115). In contrast, there are three constitutive elements of any landscape. First, there is a consideration of the human impact upon the physical environment. Second, a landscape is a social construct, a "negotiated reality" that differs from person to person. Third, a landscape is a product of the social processes occupying a particular spatio-temporal context (Kearns and Gesler, 1998). A landscape is the node of human experience where social processes mold and shape people's lives (Kearns and Joseph, 1993:716). It serves as both a medium and an outcome of the "production and reproduction" of health, since social processes, combined with individual actions, recursively create the character and the emotional responses to place (Kearns and Joseph, 1993:715). In other words, landscape is crucial to understanding health experiences, since it is inscribed in the actual processes which shape and determine health outcomes (Eyles, 1993; Kearns and Joseph, 1993: 712 - 715). Contemporaneous with this argument for a retheorization of medical geography, several medical geographers are using qualitative research methods since these methods are "capable of producing place-sensitive and subject-centred analysis of the geographical dimensions of health and health care" (Dyck, 1999:243). Medical geographical research sensitive to these issues leads to the "advancement of a post-medical geography of health" (Kearns and Gesler, 1998:1).

The creation of the relatively new journal, *Health and Place*, the publication of the edited books, *Putting Health into Place: Landscape, Identity and Well-Being* (1998) and *Therapeutic Landscapes: The Dynamic between Place and Wellness* (1999), along with publications in existing journals, reveal that several medical geographers have risen to the call

of taking space and landscape seriously (Jones and Moon, 1993). A few examples from these publications illustrate this response. Humanistic approaches by Gesler (1993, 1998) and Litva and Eyles (1994) show the role of place in shaping people's experiences of health. Gesler (1992,1993,1998) discusses the concept of therapeutic landscapes. These landscapes are associated with treatment and healing (Gesler, 1992: 744). In his research, Gesler examined the supposed healing properties of the Asclepian sanctuary in Epidauros Greece (Gesler, 1993) and the significance of the roman baths in Bath England (Gesler, 1998). In both instances, natural topography, myths, and historical facts contributed to the sense of a healing place (Kearns and Gesler, 1998: 11). Gesler argues that health policy initiatives should consider therapeutic landscapes to assist in the treatment and recuperation of people (Gesler, 1993: 184). In a different study, Litva and Eyles (1994) look at what constitutes "healthy" and "unhealthy" for people living in a small rural town in Ontario. They describe people's constructions of health through their interactions with others and through their own experiences. Being healthy is related to concepts of "being normal," as well as possessing a "moral code" against which people see themselves being judged (Litva and Eyles, 1994: 1089). Illness is often attributed to personal culpability, and is labelled as deviant. These views of health and illness help to situate a person's place in the world (Litva and Eyles, 1994: 1090).

In contrast, Moon and Brown (1998) use a post-structuralist approach to examine health care policy in the United Kingdom. They employ discourse analysis to look at how government uses the language of health policy to create and produce space and place (Moon and Brown, 1998: 270). They show that space and place are pluralistic in nature, since they

are constantly being redefined through axes of power relations (Moon and Brown 1998). This negotiation of space and place has repercussions for directing future policy initiatives and their spatial embodiment.

The examples cited previously show the "emergence of a theorized perspective on place and health" (Moon and Brown, 1998:273). Taking seriously this "post medical geography of health (Kearns, 1993:140) requires "a marriage between recent socio-spatial theory and humanistic views of place" (Kearns and Joseph, 1993: 716). Much of the existing research privileges structure or human agency, but does not incorporate both explanations. Health is shaped not only by structural factors, but also by individual human behaviour (Kearns and Joseph, 1993; Jones and Moon, 1993; Kearns and Gesler, 1998). These studies point to the usefulness of structuration theory, since it does not accord primacy to either human behaviour or structure, but links both through the concept of the duality of structure. This is a recursive relationship between agency and structure, whereby agency reproduces structure which in turn reproduces agency (Giddens, 1984). Moon (1990) uses structuration theory to demonstrate its usefulness by looking at conceptions of space and community in the context of British health policy. Particularly useful, according to Moon, is the concept of locale. This refers to the settings of social interaction, in which the features of locales "are routinely incorporated into how meanings are generated and sustained" (Giddens, 1989:280). Landscape, or as Giddens labels it – locale – is an essential component of structuration theory, and this theory complements Kearns' "post-medical geography of health" since both view landscape as being embedded within societal processes. In fact, Kearns even indirectly advocates the

use of structuration:

> Only a continuing engagement with elements of social theory such as the structure/agency question will provide geographers interested in health with a coherent epistemology that recognizes both the enabling and constraining elements of health experience (Kearns, 1993: 145).

Structuration theory responds to this agency/structure dichotomy and addresses both the individual and structural processes is shaping health (Moon, 1990). This examines how individual behaviour and structural properties act recursively to (re)produce the particular health "locale" or landscape in the street community.

This thesis is a culmination of recent developments in both the geography of homelessness and medical geography. Takahashi (1996: 303) argues for geographers to explore areas of homelessness which have "received limited attention," to move beyond the geographical research summarized in this chapter. Meanwhile, Kearns (1993) and some of his contemporaries lament the lack of both theoretical diversity and the importance of landscape in medical geography. This has increasingly led to the employment of qualitative research methods (Dyck, 1999: 243-244). In addition, there have been calls for a focus on health inequalities and on health beliefs and behaviours of populations such as marginalized groups (Kearns, 1995; Hayes, 1999). This thesis broadens the research in these two areas of geographical research through a qualitative analysis of the street community's perception and experiences of health in their landscape, one that they have termed a "living death."

Chapter 3

Structuration and the Interpretation of the Landscape of Living Death

The previous chapter laid the framework for a theoretical approach to study the relationship between the homeless, their health issues, and the landscape of living death. A post-medical geography of health requires sensitivity to the processes embedded in landscape which shape health issues. Existing research inadequately addresses how individual actions and choices interact with structural processes to produce health outcomes. In order to consider the relationship between individuals and the larger structural forces, structuration theory offers interpretative possibilities. This chapter presents a discussion of Anthony Giddens' theory and its use by geographers, both suggesting how structuration theory can be applied to the argument of this thesis, with particular focus upon the the landscape of living death, a derivation of the pathological landscape.

The Structuration Theory of Anthony Giddens

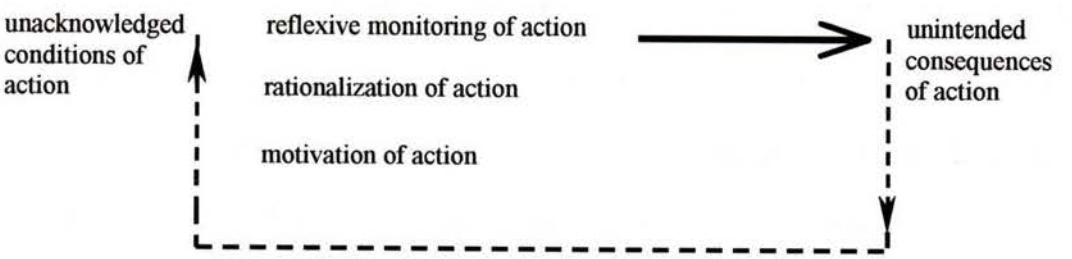
Anthony Giddens' structuration theory (1979,1981,1984,1985,1989) is an attempt to close the gulf between humanist theories which privilege human behaviour as the motive behind societies, and structuralist theories which stress the importance of structures as determining society (Johnston, 1986). In particular, structuration theory focuses upon the interdependency of human action and social structure within a *temporal and spatial context* (Giddens, 1984;Thrift, 1985). Geographers are particularly interested in this theory because of the incorporation of space (Cloke *et al.*, 1991). In his writings,

Giddens identifies seven salient concepts of structuration theory: Agency, Social Systems and Structure, Time - Space Distanciation, Institutional Order, Duality of Structure and Levels of Analysis (Giddens, 1984;Thrift, 1983; 1985; Cohen, 1989; Gregson, 1986).

Agency

Agency involves the process of being able to act. It refers to repetitive actions, practices and behaviours undertaken by human agents (individuals or groups) across time and space (Giddens, 1984; Thrift, 1985:612). Giddens' stratification model of action elaborates upon this concept (Giddens, 1984:5).

Figure 2: Giddens' Stratification Model of Action



Source: (Giddens, 1984: 5)

When undertaking a particular action, agents draw from their body of knowledge. This knowledge includes several elements: practical consciousness assists humans in dealing with day to day situations and is typically taken for granted; reflexive monitoring involves self-examination to see why a person does something and under what circumstances these actions are performed; unconscious motivation includes that which is beyond a person's ability to reflect; and discursive consciousness is knowledge that can

be communicated (Giddens, 1984:6-7). In addition to this knowledge, an individual looks at the motivation behind his or her own actions, as well as their rationalization when deciding upon a course of action. Although the agents use their stocks of knowledge, Giddens recognizes actions may be either unacknowledged, unintended, or both. Since the possibilities for any action taken can vary, there could be many different probable outcomes from any one action (Giddens, 1984; Cloke *et al.*, 1991).

Social Systems and Structure

Agents engage themselves in countless actions each day. These actions form a repetitious and changing pattern of human agency called social systems. These routinized, patterned activities of interaction are situated in time and space (Moos and Dear, 1986:233). In order to (re)produce these social systems, agents must draw upon the rules and resources which characterize structure. They are omnipresent, existing beyond time – space; structures become "grounded in reality" whenever agents draw upon them for their own actions or behaviours in their daily activities (Giddens, 1984; Cloke *et al.*, 1991).

Giddens proceeds to define rules and resources and to discuss the three dimensions of structure. Rules refer to procedures of daily behaviour (re)produced through interaction (Cloke *et al.*, 1991:102). Resources contain the element of power (in the form of authority or property) and sanction interaction through control "over people and over the material world" (Cloke *et al.*, 1991:101). These dimensions or influences of structures are: signification, domination, and legitimation (Thrift, 1983). Signification

refers to meaning, and is created through interactions where representations are transcended into a code of meaning so agents can communicate and understand one another. Domination involves influence and control in interaction, while legitimation refers to the justification of certain practices. It is produced through the use of social norms or a code of conduct during interaction (Giddens, 1984).

Distanciation and Institutional Order

Individual agents utilize structure to (re)produce temporal and spatial behaviour and routines called systems; however, social systems "are more or less distanciated" or extended in time-space, meaning that they permit various levels of interaction between agents, as well as various presences or absences of rules and resources (Thrift, 1985:612). Second, continuously replicated systems are called institutional orders or institutions. These types of systems have become so common in the sense that they are part of society's composition and are embedded in time-space and have different levels of influence (Giddens, 1979). Institutions are an important part of structuration theory, since agents draw upon structures, but interact with and within institutions when producing systems. In other words, institutions are the manifestation of structures and systems used consistently over different areas and over long periods of time. Much like structures, there are also three dimensions to institutions and they closely resemble the dimensions of structure as well (Dear and Moos, 1994:7). These are outlined in table 1 where S refers to signification, D represents domination, and L is legitimation. The first structure in the sequence denotes the mode of analysis, and all three are included in each level

because "structures exist interdependently in institutions" (Dear and Moos, 1994:7).

Table 1 The classification of Institutions

Structural Sequence	Type of Institution
S-D-L	Symbolic orders or modes of discourse
D (authoritative) –S-L	Political
D (allocative)-S-L	Economic
L-D-S	Legal or modes of Sanction

Source: (Moos and Dear, 1994:7)

The first category refers to symbolic institutions such as religion, education or the media. Political institutions exist predominantly in the government sphere and are concerned with authority or domination over people. Economic institutions operate within the economic sphere and are involved with the allocation or domination of material phenomena. The last type refers to legal institutions that involve sanctions on people. The police, the judiciary system and the military are examples of this.

Duality of Structure

Giddens explains the Duality of Structure as the recursive relationship between agency and structure, whereby agency reproduces structure which in turn reproduces agency (Giddens, 1984; Cohen, 1989; Cloke *et al.,* 1991). The dialectic of control shows this in practice. Agents draw upon their knowledge base and call upon appropriate structures (domination, signification or legitimation) to engage in actions or activities. By following this, the agents reproduce the existing system (Dear and Moos, 1994:8). The

issue of power is also important, for some agents have more influence or power (e.g., a politician) than others do. According to Giddens, even "powerless individuals," like the homeless, are able to pool together resources and create areas or "spaces of control" in the context of their daily lives (Giddens, 1982:197-198). This point is important because it does not accord primacy to either agency or structure in explaining power relations (Dear and Moos, 1994:9; Giddens, 1984).

Levels of Analysis

Putting structuration theory into practice means focusing on the relationship between three "levels of explanation" regarding events (Giddens, 1989). People interact in patterned social relations on three levels. The first level is concrete, and considers the daily activities of social life whereby agents interact with and within institutions. On the second level, which is more abstract than the first, events are considered within the context of the interactions between agents and institutions in the formation of social life. Level three is the most abstract of all. This includes not only the interaction between agency and structure, but also the role of structural properties within any interaction (Moos and Dear, 1986; Cohen 1989; Giddens, 1989).

Time and Space in Structurationist Thought

As previously mentioned, spatial and temporal elements play a key role in structuration theory. For Giddens, the passage of time involves three layers. First, the durée is the "immediate nexus of interaction" as carried out in condition to the actions of individuals. This is "the most elemental form of social reproduction" (Giddens,

1981:28). An example of this is a homeless individual deciding to seek health care for an injured leg. Second, the time during the course of one's life is called the dasein. Daily activities at this level lead to the production of institutions. Third, the longue durée refers to the "long-term reproduction of institutions across the generations, the contingency of the transformation/mediation relations embedded in structural principles of system organization" (Giddens, 1981:28). Together, the daily activities of individuals (the durée), the institutions (the dasein), and the structural principles (the longue durée) constitute the structuration of society (Giddens, 1984; Dear and Moos, 1994:10).

Space is equally important as time in the constitution of society (Thrift, 1985). To Giddens, space "is not an empty dimension along which social groupings become structured, but has to be considered in its involvement in the construction of systems of interaction" (Giddens, 1985:368). Regionalisation and locales are the two most important concepts here (Giddens, 1984;Thrift, 1985:613). First, regionalisation is a reference to the "zoning of time-space in relation to routinized social practices" (Giddens, 1985:119). It can occur at many scales and at various times. (Thrift, 1985:614). Second, locales "provide the settings of interaction, the settings of interaction in turn being essential to specifying its contextuality" (Giddens, 1985:271). In other words, space is not a stage or setting for interaction. It is both shaped and constrained by the location of the interaction itself, and has an "involvement in the constitution of system of interaction" (Giddens, 1984:368). The presence and absence of agents and of particular rules and resources of structure in a location (re)produces a specific space. This results in "localized outcomes

of action" (Thrift, 1985:610). The engagement of space in explaining the constitution of society is what has attracted geographers to structuration theory (Cloke *et al.* 1991).

Geography and Structuration

The elaboration of structuration theory and its application to geography focuses upon the role of place in social processes (Gregory, 1981, 1982, 1989; Pred, 1984a, 1984b, 1985; Thrift, 1983, 1985; Gregson, 1986, 1987;Dear and Moos, 1994). Giddens himself notes the connections between time-geography and structuration theory in that both involve an individual drawing upon existing resources in time-space to guide behaviours (Giddens, 1989). Elaborating on Giddens' importance of time-space in structuration theory, Pred illustrates how this theory can be used to describe the "becoming" of a place:

> a process whereby the reproduction of social and cultural forms, the formation of biographies, and the transformation of nature ceaselessly become one another at the same time that time-space specific activities and power relations ceaselessly become one another. (Pred, 1984a: 282)

This "becoming" of a place is dependent upon the dialectical relationship between structure and agency and is contingent upon particular historical and spatial manifestations of social practices (Pred, 1984a). In his work, Pred (1984b) integrates time-geography and structuration theory. He believes the deficiency in structuration theory lies in the "details of exploring daily life" and linking it to the reproductions of institutions (Pred, 1981:9). In effect, time-geography "grounds" or concretizes structuration theory, allowing us to see how the various components of society interact and operate with one another in daily activities across time-space (Pred, 1981,1984b).

Time-geography is particularly useful for illustrating the concepts of structuration theory in a concrete manner and in a spatial and temporal dimension. For example, the study of the mercantile people in Boston during the late eighteenth and nineteenth centuries details how the daily routines and practices of the Boston merchants are intertwined with the (re)production of the properties of the mercantile system (Pred, 1984b).

A different study by Dyck (1989) integrates feminist and structuration theory to illustrate how the constitution of mothering practices involve women drawing upon experiences and meanings contextualized in space for shaping and guiding their actions. Through her use of ethnographic methods, Dyck (1989) describes how these mothers negotiate their meanings of motherhood within their local context while being both enabled and constrained by domestic work and gender differentiated labour. The mother's daily life focuses on both the home and neighbourhood. These locales are "constituted through the recurrent practices of child rearing," and are sites where these actions are (re)produced, "understood and changed" (Dyck, 1989:340).

In a "post-medical geography of health" study, Geores and Gesler (1999) explore the process of the formation of a therapeutic environment for the mentally ill. They do this through an examination of reforms in the mental institutions in the United States, along with the constitutional issue of the right to treatment as raised in the court case of *Wyatt v. Stickney,* concerning the Alabama mental health system. The constitution of the therapeutic environment is a complex one, implicated in a recursive process involving conflict and compromise among various agents (such as patient advocates, patient families, mental health care professionals, etc.,), between "institutional structures" (such

as the legal system, state departments of mental health, state legislatures, etc.) and "between institutions on a structural level" (Geores and Gesler, 1999:109).

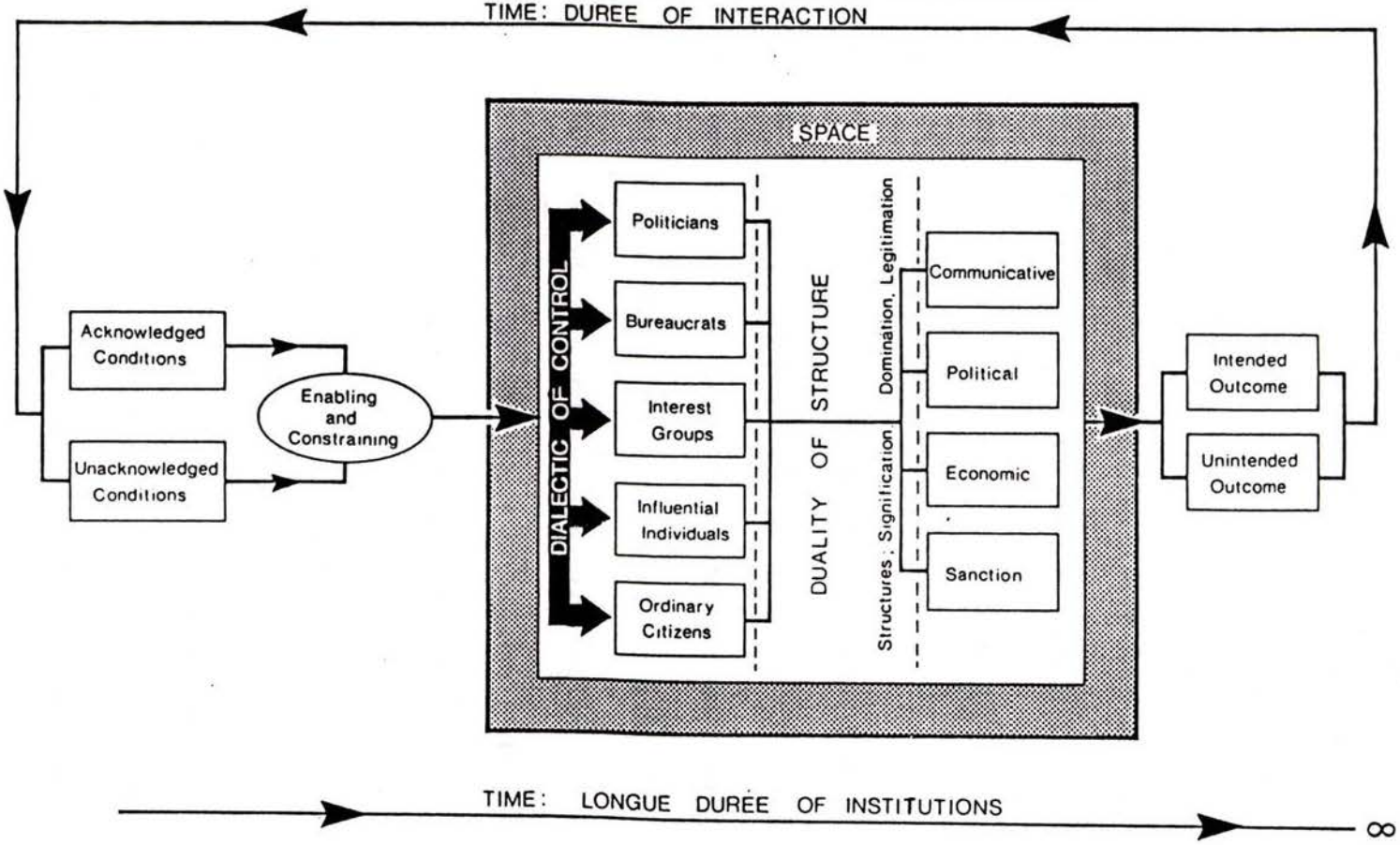
A Model of the Structuration of Urban Space

Unlike the previous examples, Moos and Dear's (1986) analysis of the ghettoization of ex-psychiatric patients in Hamilton, Ontario, is important because it applies structuration theory to the development of a "framework for understanding urban phenomena" (Moss and Dear, 1986:244). This framework can be used in describing and explaining the embeddedness of health in urban space. Moos and Dear (1986) describe how deinstitutionalization and the high cost of housing are among the primary causes of this ghetto. This type of urban phenomenon is (re)produced through specific agents acting to improve the quality of life of the psychiatric patients and by the patients themselves through their negotiation of meaning and decisions in this ghetto environment. Figure 2 shows their model of the structuration of urban space (Dear and Moos, 1994:18). Before an action is taken, there are conditions that are either acknowledged or unacknowledged by each actor, and these preconditions both constrain and enable human agency.

The dialectic of control mediates the agent's interaction through the use of power, of which each agent possesses different levels. For example, the mayor of a city would possess more power in influencing local politics than a homeless individual. Moos and Dear (1986) identify five types of agents in this model. Politicians are elected officials,

FIGURE 3

A MODEL OF THE STRUCTURATION OF URBAN SPACE



Source: (Moos and Dear, 1986a: 245)

and the bureaucrats are civil servants or people working in quasi-governmental organizations. Interest groups are people who unite for a common cause, while influential individuals refer to people who possess a special status or are held in high esteem in the community. Ordinary citizens are the last group. Moreover, an individual's place in society is not fixed or predetermined. People can become different types of agents and can be classified differently according to the situation (Dear and Moos, 1994). These agents interact with the institutions through the duality of structure. This recursive process produces intended and unintended outcomes, or both. Moreover, the outcome of these actions serves as the basis for the next set of actions undertaken by agents (Moos and Dear, 1986). The outcome in this study was the ghettoization of ex-psychiatric patients, but the outcome could also have been concerned with health implications.

This model complements Pred's "becoming" of place and is illustrative of how the landscape is implicated in societal processes. Its importance lies in its applicability to examining health-related outcomes in urban space. In this thesis, Moos and Dear's model (1986) served as a conceptual framework in the development in the landscape of living death in the street community in Victoria (see chapter 5).

Structuration Theory and the Pathological Landscape

Street life becomes spatially manifest in the concentration of services and facilities that cater to this population (Dear and Wolch, 1987; Fallick, 1988). Historically, this district was known as skid row, but has also been labelled as "zones of dependency" (Dear and Wolch, 1987), "marginal space" (Snow and Anderson, 1993), or as "nonplaces" (Lovell, 1997). They have little significance for the domiciled population

since this space consist primarily of warehousing, abandoned buildings, vacant lots, shelters, drop in centres, and soup kitchens (Dear and Wolch, 1987; Snow and Anderson, 1993; Lovell, 1997). In the 1961 urban renewal study for Victoria, attention was drawn to the "three faces" of Victoria: mellowed charm; youthful activity and new construction; and the blighted landscape. This third face was a reference to the skid row district, and of its effects upon the city:

> *This third face is called blight and it is slowly corroding the fair faces of the city and creating both a threat and a challenge.....The Capital Regional Planning Board hopes that this study will prepare the citizens of Victoria for one of the challenges of the future by showing how blight can be recognized and remedied. (City of Victoria, 1961:3)*

In order to meet "the challenges of the future" this report later mentioned that the downtown core needed to be "attractive" (City of Victoria, 1961:8). Urban renewal and heritage preservation policies after the 1960's removed much of skid row's prominence. Today, there are only small pockets of skid row areas in the city. These "pockets" are found scattered within the study area that is bordered by Store, Burdett, Princess, and Vancouver streets. It is in this area that street people spend their existence.

The spatial clustering of social agencies has the effect of "defining the contours of street life" for people who live on the streets (Snow and Anderson, 1993:77), since most of a street person's daily activities revolve around the facilities in this area. Dear and Wolch (1987) who described the urban ghetto of the deinstitutionalized mentally-ill have also called this area a "landscape of despair." Indeed, while this is a landscape of despair, the health component is not explicitly and thoroughly described. Blistered feet, hypothermia, skin infestations, and upper respiratory infections are often common health

issues and are reflective of this lifestyle. Street people are constantly walking, going from one social agency (such as a shelter) to another, and from one drop-in centre to the next. Moreover, when street people do have health problems, they often neglect their suffering because there are more pressing concerns on the streets, such as finding food and shelter. In addition, low-grade depression and stress-related disorders are often a by-product of living on the streets. These conditions produce a "pathology" of street life (Dear and Wolch, 1987:199).

In contrast, there are also therapeutic landscapes. This refers to landscapes "associated with treatment or healing" (Gesler, 1992:735-736). According to Kearns, "the converse of therapeutic landscapes also merits attention" (1997:274). Changes in the economy and the welfare state are altering the spatial expression of cities today. He uses the example of the opening of a casino in Auckland, New Zealand, as "implicitly generating new pathologies and addictions" (Kearns, 1997:274).

There are also other types of changes occurring in cities, such as an increase in the numbers of homeless people (Wolch and Dear 1993; Takahashi, 1996). Street life, with its daily survival tactics, does have repercussions on health. On the streets, malnutrition is a problem and lack of sleep is the norm. Spending the day looking for work, or a place to stay, can be very stressful. Mental illness is a concern of street people too, but it is not always certain if mental illness is a causative factor of the homeless condition or if homelessness results in mental illness. In shelters, safety is another issue, for many people are threatened and/or robbed. So while it is a landscape of despair, it is simultaneously a pathological landscape. This refers to those places where both the social

and physical environment is associated with disease, illness, unhealthy behaviours, and negative feelings. According to one street person mentioned in an interview, the streets can best be described as a landscape of "Living Death." The application of structuration theory to this type of landscape is further elaborated in the next section.

Summary: Structuration Theory and the Landscape

The structuration of the pathological landscape involves street people drawing upon structures (such as the British Columbia Medicare Protection Act) mediated by institutions (such as Swift Street Medical Clinic or The British Columbia Ministry of Health) to (re)produce the system (street life). Health is implicated, both directly and indirectly, with street life in some manner or another. Sleeping outside and going hungry have potential physical health consequences, while panhandling, being treated unjustly by ministry of health workers, and the condition of homelessness itself, all have repercussions for mental health. The confluence of these conditions in the street community produces a type of pathological landscape.

Applying structuration theory in practice can be a difficult endeavour. The concepts are not specific enough to give direction as to *how* to conduct research. For example, Giddens does not elaborate on how a researcher is to address each aspect of the stratification model of human agency. In particular, how does one look at the issue of practical consciousness (that which involves the taken for granted nature of everyday practices)? As well, it is not clear which agents and which structures should be examined in an empirical study (Gregson, 1989:240). Explaining the essence of the duality of structure is also problematic, for it is difficult to capture the recursive character of agency

and structure without reducing them both to elements of opposing dualisms (Thompson, 1989). Wilson (1994) argues that the meaning of recursiveness is hard to reconcile with Giddens' elaboration of structuration. Connections between agency and structure can be shown, but showing how agents actually use structures to shape societal forces is difficult. Moreover, agency and structure do not have "equal weight" in the constitution of society in that some structures, for example, are more susceptible to change than others (Wilson, 1994; Neale, 1997).

Giddens is also criticized for being too deterministic with his labels and categories for actions, rules, resources, and so forth (Cloke *et al.*, 1991). Indeed, the very act of labelling and classification is inherently deterministic because labels do not allow for leeway in an interpretation, and many of the concepts discussed by Giddens (e.g., agency, structure, and system) are very difficult to actually define. In addition, concepts of rules and resources are theory laden, and presuppose an existing framework (Cloke *et al.* 1991: 106). Allocation of rules to agents is not explained, in the sense that how does one know when to use power? This is essential when considering the idea of power and its effect upon rules. Others such as Murgatroyd (1989) indicate that Giddens fails to address issues of gender relations and patriarchy and how they affect the constitution of society.

While there are problems associated with using structuration theory, it does have its merits. First, a structurationist approach recognizes the important contributions of both societal processes and individual actions in shaping society. In other words, it does address the agency/structure dichotomy (Husband, 1994). Further, it assists in understanding and explaining social phenomena. It focuses upon action, process and

consequences (Evans, 1987:123). This is particularly useful in examining local health policy in practice, since structuration offers a framework for analysing the interdependency between agency and structure (Moon, 1995:3). The development of the pathological landscape itself shows the usefulness of the theory in an empirical context. Second, structuration theory enhances the existing agenda of implicating theory within geographical as well as medical geographical research. The engagement of geography with social theory has been an issue with geographers for the past three decades (Peet, 1998), and very recently within the subdiscipline of medical geography (Kearns and Gesler, 1998).

Structuration theory directly implicates space in the constitution of the social world. Applying structuration theory to the (re)production of the pathological landscape involves an examination of "the complexities of action/structure relations" (Giddens,1989:297). Street people are agents, capable of making decisions and studying their options. At the same time, street people are socially constituted and there are limits on the choices available to them. Street people's decisions and actions are both constrained and enabled by existing structures, such as the Canada Health Act and the British Columbia Medical Services Act. In order to look at this agency/structure relationship, the role of institutions must be discussed, since they mediate the interaction between agents and structure. It is important to consider street people's interaction with institutions such as the Streetlink emergency shelter, the Open Door drop-in centre, and the local social assistance office of the British Columbia government. An agent's interaction with these institutions over the course of his or her life (the daesin) produces

a system, which in this instance is street life. Through these institutions, one can "look to discern the structural properties of systems of relationships in which people's activities are engaged" (Giddens, 1989:298). This entails a focus upon the daily (durée) activities of the agents (street people). In other words, it looks at what the street people decide to do on a daily basis (such as deciding to panhandle for an afternoon).

Chapter 4

Methodology and Research Design

This chapter discusses research design and methods in relation to a structurationist framework. First, initial approaches to this study and subsequent changes are outlined. From here, the objectives of this thesis are reiterated and discussed further, particularly the application of structuration theory. The qualitative methods used in my research are described, leading to brief comments on the Victoria study area. To conclude, the major themes that emerged from the data collection, and which guide an interpretation of the landscape of living death in Chapter Five, are outlined.

An Initial Approach to Studying Health and Homelessness

My research of street people was initially influenced by the possibilities of a quantitative approach that would emphasize measurement and analysis "to demonstrate causal relationships under standardized conditions" (Casebeer and Verhoef, 1997:131). The application of quantitative methods to the study of the health conditions in street populations seeks a statistical relationship or significance to the spatial dimension of health status. By using data gathered from standardized questionnaires, these studies offer the potential of revealing the predisposition of health problems in the street community (Ritchey *et al.*, 1991; North and Smith, 1993). This led to the development of a pre-test, focusing on a forty-nine point standardized questionnaire (see Appendix 2). It was comprised of selected questions taken from two existing studies (Ritchey *et al.*, 1991; Ambrosio *et al.*, 1992). The pre-test was conducted in May 1994 at the "9 - 10 Club"

soup kitchen in Victoria. Members of the soup kitchen staff assisted by introducing me to potential participants. In total, forty were approached, with only six agreeing to participate. These people deviated from the questionnaire often and responded in their own words and in their own style. While hearing their stories, I realized that these six people had given an implicit trust to me. I valued this trust and wanted to create an atmosphere whereby street people would feel comfortable discussing their street experiences. While listening to the street people, I was able to gain insights about their experiences on the street, particularly stories of the difficulties they faced maintaining health while constantly moving and being outside. Moreover, these discussions revealed perceptions and meanings of health as experienced by the street people. Based upon these stories, I decided to switch to a qualitative approach, since it would not constrain the participants within a framework of questions and answers. Rather, it would allow street people to answer freely, in their own terms, the research question at hand (Walker, 1985).

Sampling Procedures

Next, the focus of the research was to encourage street people to talk about their health experiences while being on the streets. Because of their transiency, sampling street people is a difficult endeavour. While sampling strategies vary (Burnam and Koegal, 1988; Ritchey *et al.*, 1991; North and Smith, 1993), I decided to use a non-probability sampling procedure for two reasons (Donovan, 1988). First, the premise of this sampling strategy is based upon people willing to participate. The pre-test experiences revealed that many people would refuse to participate in my research. Second, the problem arose

as to where to sample the street population. Streetlink Emergency Centre at 1643 Store Street is one of Victoria's largest shelters. Funded by the Ministry of Health and the Ministry of Social Services, it provides nightly emergency accommodation for 11 women and 44 men, aged 17 years and older. During the daytime, it functions as a counselling centre. The Swift Street Medical Clinic, providing health facilities for street people, shares the same premises with Streetlink. This place was selected because the majority of Victoria's 400 or so street people frequent this shelter over the course of a week. Furthermore, this location offers the opportunity of seeing different dimensions of street life in Victoria (Thrasher, 1997).

This research is concerned with street people who are actually "homeless." For this study, the term homeless is the one Ambrosio *et al.* (1992) adopted in their study of homeless people in Toronto:

> A person is considered homeless if that individual, in the thirty days prior to being approached to participate in this survey, had spent ten or more nights in: (1) a shelter; (2) in an outdoor or public place; (3) at a friend's place because they had no place of their own or no safe place of their own; and (4) any combination of nights spent in any of these circumstances totalling ten or more. (Ambrosio *et al.*, 1992:67)

This definition formed the basis for researching Victoria's street community.

The Research Objectives and Structuration Theory

The research objectives evolved from the pre-test experiences at the "9-10 Club" and from the premises of structuration theory. The objectives focus on the health concerns of the street people and how health is given meaning in the context of street people's landscape. Furthermore, the objectives examine how individual actions and

wider social processes interact to produce the homeless environment and its health outcomes. Structuration theory demonstrates that health is influenced by the recursive relationship between street people's daily activities/practices (agency) and societal processes (structures) manifested in particular locales or environments. In other words, street people draw upon existing structures in society to formulate decisions affecting their health, which shape and is shaped by their landscape.

A key to addressing the concepts of agency and structure is to employ methods that examine the manifestation of both concepts. The investigation of how street people make decisions affecting their health in the landscape requires a methodology which places an emphasis on the experiences of these people and how they perceive and view their daily life. Qualitative methods situate research within an experientially-based inquiry. Specifically, I examine how experiences, decisions and behaviour are constituted in landscapes. These responses are laden with meanings of place, because people's answers to research questions are produced through their actions and the meanings they attach to them within their lived environment (Eyles and Donovan, 1986). While this aspect of the research examines issues of agency, other facets of the research address the role of structure. The semi-structured interviews and the journals show how street people experience and interact with structures through institutions. In addition to this, elite interviewing and analysis of document surveys illuminate the structural properties affecting the health determinants of the street people. This contextualization of place facilitates the use of qualitative methods, since research issues considering "distinctive

local happenings and meanings" make qualitative research the "most appropriate method to use" (Stainback and Stainback, 1988:16).

Reliability and validity are concerns in any type of research. Qualitative research addresses these issues with the concept of triangulation; that is, to use several data collection techniques within one research study to improve "the probability that the findings and interpretations will be found credible" (Lincoln and Guba, 1985:305). I attempted to use triangulation by undertaking the following: semi-structured interviews with a sample of street people; journals kept by the street community; elite interviews with people who work at street community facilities; and analysis of published material relevant to the street community. I now further detail each phase of my research.

The Study Area and Site Profile

With an estimated 1999 population of 330,806 (CRD Regional Planning District, 1999), Greater Victoria is situated on the south-eastern side of Vancouver Island. The capital of British Columbia, Victoria enjoys one of Canada's best climates and is currently the tenth most popular city for tourists in the world (*Times Colonist*, September 3, 1999:C1). While tourism is a significant portion of Victoria's economy, the provincial government is the largest employer in the city. In fact, the top ten employers in the Capital Region District (CRD) are comprised of municipal, provincial or federal government organizations (*Times Colonist,* January 19,1996:C1). This is not the overall picture of Victoria, since it is home to a growing street population. Victoria is a popular destination for street people due to the city's mild winters. This favourable climate prevents many people who sleep on the streets from freezing to death. Estimates of the

number of street people in Victoria range from 400 to 500 people (Thrasher, 1997; *Times Colonist*, August 31, 1999:C1), or 2.6 percent of the city of Victoria's population (City of Victoria, 1999b). In Victoria, the facilities for the street community are found in a seven-block area in the downtown core (see Figure 1).

Semi-Structured Interviews in 1995 and Journals of 1999

The experiences of street people were obtained through semi-structured interviews and through their journals. Semi-structured interviews have a conversational tone that is pursued within a flexible framework of issues or topics (Walker, 1985). The checklist of topics emerged from existing literature (Ambrosio *et al.*, 1992; Ritchey *et al.*, 1991; North and Smith, 1993) and through discussions with the street people during the pre-test phase. Seven topics for discussion comprised the interview format. The first focussed on the consequences of homelessness and revealed socio-economic data (age, sex, income, etc.). The second topic dealt with daily life paths and homeless people's perceptions of the city. Topics three through six addressed health issues, health conditions, and access to health care. The seventh topic dealt with questions focusing upon the homeless person's perceptions and experiences of health within the context of the lived environment. A duplicating strategy, consisting of questions 1 through 5, was employed in case I interviewed the same individual more than once. Duplicate answers in this section would make the data invalid for study purposes, and were subsequently excluded from the analysis (see Appendix 4).

The semi-structured interviews commenced May 24, 1995, and finished on July 19, 1995. I conducted thirty-two interviews, each lasting approximately thirty minutes.

On each Monday and Wednesday of this period I went to the Streetlink shelter on Store Street from 11 a.m. to 2 p.m. In order to receive permission to conduct interviews (see Appendix 3), I agreed to have a liaison person act between the street community and myself. Two mental health workers, whom I shall refer to as Mr. Smith and Mr. Jones, assisted me in this regard. Both were aware of my operational definition of homelessness. Before beginning the interview period, I had offered to volunteer at Streetlink because I thought this might make people more comfortable in my presence. Mr. Jones and Mr. Smith could not find me any jobs to do at the shelter; instead, they concentrated on helping me locate participants. The two Streetlink workers informed potential participants about my presence at the shelter, and suggested that they talk to me if they were interested. Those willing to participate in the interview joined me in a room that provided privacy. Since Streetlink asked me not to tape the interviews, on the grounds that it would make the street people "uneasy", I took extensive notes instead. These note taking guides were from two to seven pages for each interview.

While interviews emulated a conversational manner, I guided the discussion to ensure coverage of all topics during the interviews, thus facilitating comparison of the data for analysis purposes. Giving participants some form of compensation was important to me. I wished to thank them in some manner for sharing their experiences. I turned to Mr. Smith and Mr. Jones for advice. They believed the street people should receive five dollars, so the participants themselves could decide how they would spend the money. From this advice, every participant received five dollars when the interview was completed.

While the data from the 1995 depth interviews were very useful, they were not enough to describe comprehensively the health experiences of the street people. Since I was not allowed to tape the interviews, taking notes instead, I sometimes missed valuable information given to me by the street people because I was too busy writing down everything that I could. Further research was required in order to capture the street person's views and experiences of health. The street life journal evolved from this condition (see Appendix 7). Given to willing participants, the street life journal included a chart to record daily activities for one week (such as places visited, sources of income, etc). It also contained a section for writing comments on six areas of street life (daily activities, money issues, food, health issues, street community facilities, and drop ins and shelters). Each individual had the freedom to express his/her views on these topics or on any others he/she felt important. A worker at the Victoria Street Community Association, (hereafter referred to as VSCA) whom I shall refer to as Mr. Hill, assisted me by approaching individuals who might keep a journal. I made him aware of my operational definition of homelessness, and he initiated contact with people who frequent the VSCA to inform them of the journal exercise. To compensate the individuals for their time, Mr. Hill suggested I reimburse the participants with a payment of ten dollars. From March 11 until March 25, 1999, Mr. Hill informed the people who frequent VSCA about my street life journals. Ten people agreed to participate, and their comments and opinions form part of the data analysis chapter, complementing information gained from the semi-structured interviews.

Elite Interviewing

Elite interviewing refers to a special type of interview with influential or prominent individuals in an organization or community (Marshall and Rossman, 1989:94). These interviews provide useful information concerning an organization's mandate and relationships with other organizations and people. As well, elite interviewing offers insights into policy formation (Marshall and Rossman, 1989). Discussion focused on health issues in the street community and addressed programs and policies at the street community facilities associated with this topic (see Appendix 6). From March 11 to March 24, 1999, I interviewed people from the following social agencies in Victoria: The Open Door, the Upper Room, the Victoria Street Community Association (VSCA), The Sandy Merriman House, Swift Street Medical Clinic, Streetlink Shelter, The Salvation Army shelter, and the Street Nurse Outreach Program. These interviews offered contextual background and motives concerning the street people's daily activities. This information provided an additional perspective on the research, by supplying insights about the health conditions of the street community.

Document Survey

In order to situate the street people's experiences of health in a structural context, the *Times Colonist*, the *Red Zone,* several relevant government policies, reports and acts were examined. In particular, the following publications are relevant to this thesis. The *Red Zone* is an alternative magazine published by the VSCA and is the voice of the street community. In contrast, the *Times Colonist* is the daily local newspaper for Victoria.

Initially, a critical discourse analysis of the newspapers and *Red Zone* was planned for inclusion in the thesis. I read every article on homelessness that appeared in the *Times Colonist* since January 1993 and read every issue of the *Redzone* (20 issues). However, the focus of the newspaper articles and the *Red Zones* suggested that utilization of a few key statements from both sources of media would be more appropriate. Since this thesis is concerned mainly with the health of street people, relevant statements from both the *Times Colonist* and *Red Zone* were used when applicable. Forty-two percent of the newspaper articles were on issues about donations to shelters and the renewal of grants to these shelters and other social agencies, while 36 percent looked at panhandling. Twenty-two percent consisted of a series of articles that examined mental health issues in Victoria. In the *Redzone*, 65 percent gave information about services available to the street community, while the remaining 35 percent of the articles focused upon poetry and personal stories. In addition to these sources, reports and acts were considered. They were: *The Canada Health Act*, the *British Columbia Benefits Act,* the *British Columbia Housing Strategy for Affordable Housing Report* (1996), The *Deinstitutionalization Policy and the Impact on Victoria* (1990), The Victoria By-law on loitering (97-89) and soliciting, (99-84), *Nowhere to Live* (1994), *Nowhere to Live...Next Steps* (1996), the *And Miles to Go* (1997) report and *Taking Responsibility for Homelessness: An Action Plan for Toronto* (1999). These materials assisted in addressing the agency/structure dichotomy, since street people's actions and decisions are both enabled and constrained by structures in society. These publications helped to demonstrate the structures that were in place to affect the lives of street people.

Coding and Major Themes Analysis

Reading and re-reading the 1995 interviews, the streetlife journals, the elite interviews, the *Redzone* and the *Times Colonist* four times each facilitated the sorting and coding process. Coding consists of assigning a word or phrase to summarize or express a theme contained within the lines. Portions of the interview text were coded in the margin using a set of codes and subcodes resulting from the interview topics and the transcripts themselves. A second phase involved major themes analysis (MTA) as an extension of the coding system. MTA refers to issues or concerns discussed at length by the interviewee. After reading through the transcripts many times, major themes were identified. This involved examining the data as the interplay between Major Themes Analysis (MTA) and the theoretical constructs of structuration theory elaborated in Chapter 3 (see Appendix 8 for a listing of the codes and subcodes for the Major Themes Analysis). Working back and forth between the data and the theoretical constructs of structuration, the major themes were developed. These themes help to interpret the experiences that assist in describing the landscape of living death.

Five major themes emerged from the coding process: (1) Becoming Homeless includes the causes leading to living on the streets; (2) Existing on the Streets incorporates daily activities and the conditions of street life, and how they relate to health; (3) Street Community Facilities and Services refers to the attitudes of the street people towards these facilities in addition to their function and purpose in the street community; (4) Street Health examines the health concerns of this group, along with accessing and utilizing health care; and (5) Personal Empowerment and Getting off the

Streets considers the measures needed for street people to improve their health and their lives. These five themes form the basis of Chapter 5.

Chapter 5

Structuration, Landscape and the Street Community

Putting the five major themes -- Becoming Homeless, Existing on the Streets, Street Community Facilities and Services, Street Health, and Personal Empowerment and Getting off the Streets -- into the context of the daily activities of the street community provides a better understanding of how the street people's landscape is shaped by health. A model of the structuration of the landscape of living death is first devised to show how each of the constituent parts of structuration theory are applied to the data analysis. In the second section, the theme of Becoming Homeless refers to the factors which precipitated homelessness for the street people participants, as well as including some of their personal insights about health. In the next section, Existing on the Streets assesses the daily activities of the street people, particularly how their actions and decisions are both enabled and constrained by existing structural forces. The Street Community Facilities and Services section considers street people's attitudes toward these facilities, and salient issues of concern for the agencies in Victoria. Street Health specifically addresses the health issues and concerns of the street community, and how the landscape in which they inhabit contributes to their health. The fifth and last section outlines what is needed in order for street people to find stable housing. This issue is examined from the perspective of the street community, as well as that of the workers in the street community facilities.

The Landscape of Living Death: A Structurationist Model

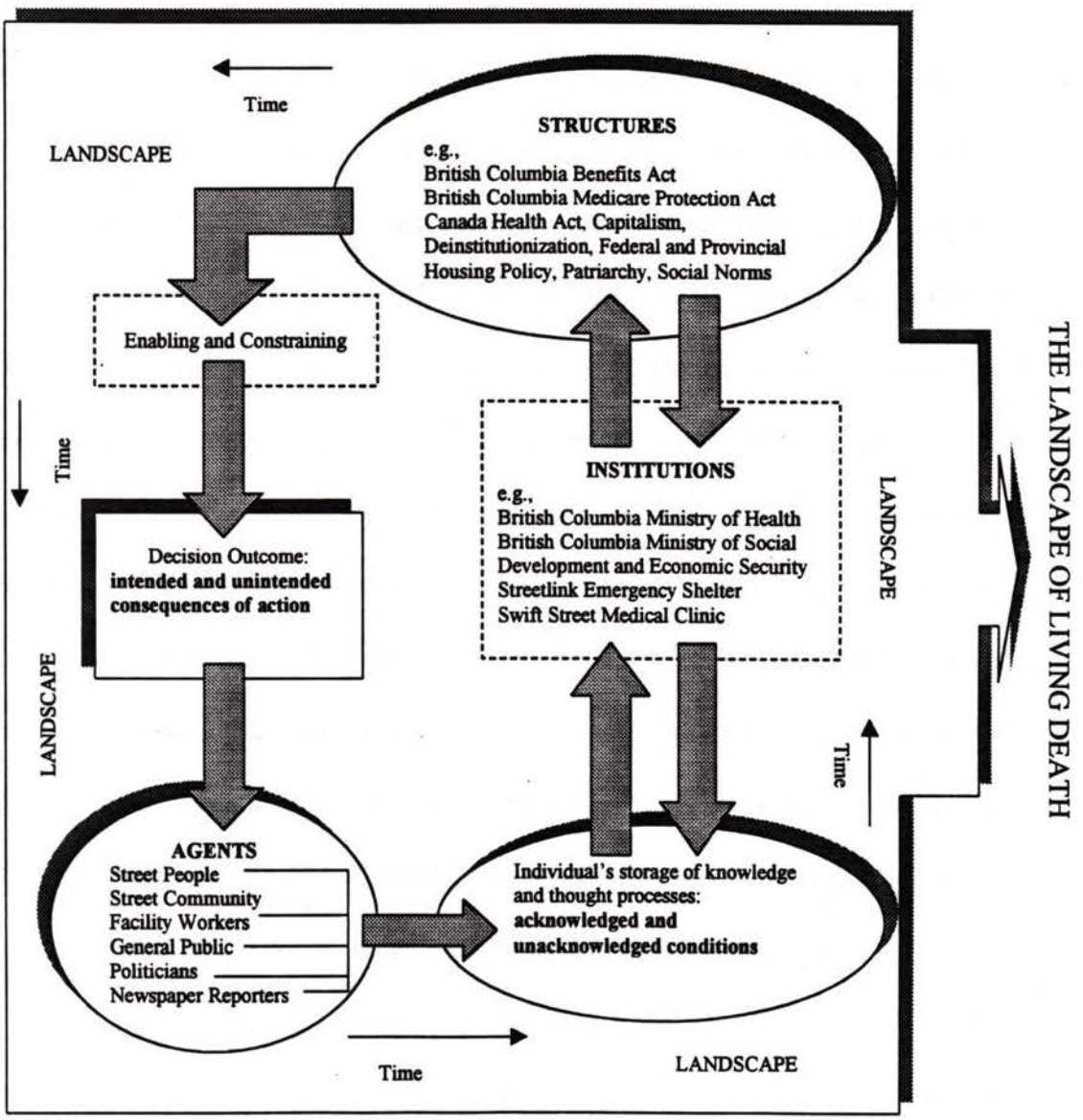
The theoretical framework informing this research is structuration. A model is devised

to illustrate how agency and structure are involved in a recursive process shaping the health experiences of the street community. In this model (Figure 4) outlining the links between structuration theory and the landscape of living death, the agents involved are: newspaper writers, financial assistance workers (FAW) at the Ministry of Social Development and Economic Security, workers at the street community facilities in Victoria, local politicians, citizens, and the street people themselves. Although agents do play an active role in shaping society, their actions and choices are both enabled and constrained by structures. Furthermore, agents' interactions with structures are mediated by institutions, such as the ministry of health, and the various street community facilities (e.g., Streetlink). Structures influencing these agents represented in this model are also identified here. For example, a street person's decision where to sleep for the night is structured by such things as Streetlink's rules governing when and for how long a person can stay at its emergency shelter. But these structures do not necessarily predetermine a street person's actions. The five major themes -- Becoming Homeless, Existing on the Streets, Street Community Facilities and Services, Street Health, and Personal Empowerment and Getting off the Streets -- are the manifestation of the recursive relationship between the various agents and the structures, and are implicated in the (re) production of this landscape of living death. This landscape will be described throughout the discussion of the major themes.

Becoming Homeless

Historically, street people were typically men over the age of fifty, but since the 1980's, the composition of this community has been changing. The proportion of women,

Figure 4: The Structuration Model of the Landscape of Living Death



After (Evans, 1987; Giddens, 1984,1989; Moos and Dear, 1986)

children, and families in the street community is increasing, and the typical age of men and women on the streets is now in the mid thirties (Snow and Anderson, 1993:17). These changes in the composition of the street community are reflected in Victoria as well (Thrasher, 1997). Tables 2 and 3 profile the street community participants in 1995 and 1999 respectively, while Table 4 identifies the elite interview participants from the street community facilities in Victoria in 1999. I guaranteed anonymity and confidentiality to each participant so the names appearing in this table are not their actual names. In addition to this, the pseudonyms reflect the ethnicity as much as possible of the participants. Altogether, I interviewed 32 street people in 1995 and 8 social agency workers in 1999. In addition to this, 10 street people completed journals in 1999. First, I will describe the socio-economic data of the 1995 interviewees. The median age of the female respondents was 29.2 years, while the median age for the men was 31.5 years. Although length of street life varied from 4 months to 6 years, the medium length of stay on the streets was 2.2 years for the females and 1.2 years for the male participants. Sixty-two percent the respondents received some form of government support (e.g., EI- Employment Insurance, GAIN- Government Assisted Income, and IA- Income assistance) while 38 percent either panhandled or prostituted.

Interestingly, the data from the 1999 journals were quite similar to the 1995 figures. The median age of the female respondents was 28.4 years, while the median age for men was 30.2 years. Average length of stay on the streets was 2.7 years for females and 8 months for the males. Sixty percent cited Income Assistance as their source of income, 30 percent mentioned panhandling, and the remaining 10 percent said prostitution was their means of securing income on the streets.

TABLE 2

A PROFILE OF THE STREET COMMUNITY PARTICIPANTS IN 1995

Name	Age	Gender	Presently on Streets	Source(s) of Income
Joan	54	Female	2 months	Income Assistance
Verity	32	Female	2 ½ years	Income Assistance
Jane	21	Female	10 years	None
Sarah	38	Female	1 month	Income Assistance
Tara	21	Female	5 years	Prostitution
Alice	43	Female	6 months	Income Assistance
Kim	20	Female	15 days	Waiting for Income Assistance
Lisa	20	Female	12 days	Income Assistance
Carol	24	Female	3 months	Income Assistance
Kathy	19	Female	2 years	None
Reggie	44	Male	2 years	None
John	39	Male	1 month	Casual Labour/ Waiting for Income Assistance
Tom	30	Male	2 weeks	None
Ken	22	Male	3 weeks	Income Assistance
Dan	35	Male	2 weeks	Income Assistance
Ben	33	Male	1 month	Income Assistance
Pat	29	Male	4 months	Income Assistance

TABLE 2 (continued)

A PROFILE OF THE STREET COMMUNITY PARTICIPANTS IN 1995

Name	Age	Gender	Presently On Streets	Source(s) of Income
Doug	22	Male	3 months	Income Assistance
Lucien	26	Male	1 ½ years	Panhandling/ Income Assistance
Bill	28	Male	3 weeks	Employment Insurance
Joe	23	Male	2 ½ months	Income Assistance
Bob	33	Male	5 weeks	Income Assistance
Stan	38	Male	16 days	Income Assistance
George	44	Male	1 month	Income Assistance
Fred	43	Male	12 days	Income Assistance
Ralph	35	Male	2 months	None
Pierre	32	Male	1 year	None
Al	45	Male	2 years	GAIN
Bruce	23	Male	2 months	Casual Labour
Martin	19	Male	3 months	Income Assistance
Sam	25	Male	1 month	Income Assistance
Ed	26	Male	16 years	Income Assistance

TABLE 3

A PROFILE OF THE STREET COMMUNITY PARTICIPANTS IN 1999

Name	Age	Gender	Presently on Streets	Source(s) of Income
Tina	28	Female	4 years	Prostitution
Janet	24	Female	3 ½ years	Income Assistance
Linda	26	Female	4 years	Panhandling
Susan	31	Female	2 years	Income Assistance
Lanie	33	Female	1 month	Panhandling
Cliff	39	Male	1 month	Income Assistance
Peter	23	Male	2 months	Panhandling
Desmond	19	Male	5 months	Income Assistance
Allan	40	Male	2 years	Income Assistance
Roy	30	Male	9 months	Income Assistance

Homelessness is on the rise in Victoria, and the reasons for this increase are various (Thrasher, 1997). Veronica, who works for the St Vincent the Paul society, offers her perspective on the increase in homelessness in the city:

> *The benevolent climate makes it easier to live on the streets. As well, you can not starve in this city for there are many agencies to assist you. But there are other reasons for the large numbers of homeless in Victoria. People have also come here because of the economic changes. The decline in forestry jobs in many (Vancouver) Island communities has brought people here in search of work. But this city is expensive, and so is the housing. Affordable housing is crucial.*

Indeed, Victoria does have one of Canada's best climates, and it also is a city with a variety

of services for the street community. According to Victoria Cool Aid's brochure entitled *Surviving In Victoria: Meeting Your Basic Needs,* there are seventy-one services, facilities and agencies that provide some type of basic need for city residences (Victoria Cool Aid Society, 1999).

Table 4
ELITE INTERVIEW PARTICIPANTS FROM STREET COMMUNITY FACILITIES IN 1999

Name	Social Agency	Programs
Monica	Open Door	Drop-In, Counselling, Advocacy
Matthew	Upper Room	Meals, Supportive Housing, Counselling
Wayne	Streetlink	Emergency Shelter, Meals, Counselling, Referrals
Florence	Swift Street Medical Clinic	Health Services, Referrals
Edith	Street Outreach Nurse Centre	Health Services, Referrals
Ann	Salvation Army	Emergency Shelter, Meals, Counselling, Referrals
Sandy	Sandy Merriman House	Women only Services: Emergency Shelter, Meals, Counselling, Referrals
Veronica	St. Vincent De Paul	Referrals, Advocacy, Clothing, Supportive Housing

Although this brochure is not solely intended for street people, according to Cliff it is an "essential guide for surviving on the streets." Many streets people concur with Veronica about the positive aspects of Victoria for street people:

Victoria is good for the homeless because of the excellent weather and no winter really. It is ok to sleep rough here, not like back east. (Pat)

I like the services available here. Lots of them and the people treat you well. Climate is a big plus for me (Roy)

If one must live on the streets, it is better to be in a city where it is "easier" to survive; however, becoming homeless arises because of a combination of factors.

The lack of affordable housing in Victoria has contributed to the rise in homelessness in the city. In fact, Victoria is one of the most expensive cities in Canada in which to live (Thrasher, 1997). Housing costs are so high that many people can not afford a mortgage to purchase a home. Only 28 percent of renters could actually afford to buy a starter home. In fact, 37 percent of Victoria's citizens are renters (Community Social Planning Council, 1999:21). In practice, social housing is designed to ensure that there is affordable housing in cities. In 1992 the federal government devolved social housing programs to the provincial and territorial governments. Although the federal government no longer builds social housing, it is active in housing policy for the homeless through the Canada Mortgage and Housing Corporation (CMHC), the National Housing Research Committee (NHRC), and through a minister responsible for homelessness (Claudette Bradshaw). In 1994, the National Housing Research Committee established a sub-committee on homelessness. Its mandate is to accumulate information on homelessness from various Canadian regions in order to identify housing options for homeless people and to eradicate homelessness in the country. The CMHC is currently working on the Homeless Individuals and Families Information System (HIFIS) for Canadian shelters. This data collection system is designed to facilitate the

collection of data on homeless people staying at shelters. The HIFIS will keep track of services most frequently used by the homeless and the paths that lead individuals to homelessness. The goal is to expedite the process of assisting homeless people find housing (CMHC, 1999).

In 1999, attention was focused on the homeless issue in Canada through a report issued by the City of Toronto. This report entitled *Taking Responsibility for Homelessness: An Action Plan for Toronto* proposed 105 recommendations for solving the homeless situation in Toronto. Many of the recommendations were critical of the federal and provincial government's lack of social housing policy. In response to media criticism and public opinion, the federal minister for homeless announced that the federal government would spend over $700 million on Canadian Homeless Programs. This money is to be allocated to develop local shelter programs across Canada, to improve existing low-income housing, and to construct new shelters (*Times Colonist*, December 18, 1999).

Despite the federal government's initiatives in homeless programs, responsibility for social housing actually lies with the provinces. As of 1999, British Columbia was one of only two provinces (the other is Quebec) still involved in the building of social housing (British Columbia, Ministry of Municipal Affairs and Housing 1996a; *Times Colonist*, August 31, 1999:C1). Homes BC started in 1994 in response to the federal government's withdrawal from social housing. Its mandate is to co-operate with non-profit societies and co-op associations "to develop affordable housing for low and moderate income British Columbians" (British Columbia, Ministry of Municipal Affairs and Housing 1996a: 1). There are two areas of housing policy that address homelessness in British Columbia. First, the

Homelessness/At Risk Housing program, initiated in 1992, has built sixteen community housing projects (Ministry of Municipal Affairs and Housing, 1996b). Second, the *Nowhere to Live Report*, and *Nowhere to Live: Next Steps* identify areas in which the government can best assist lower income urban singles. These reports recommend: the creation of new affordable housing through new partnerships; broadening the choice of housing options; putting some financial measures in place to maintain affordability for people; and preserving and maintaining single room occupancy hotels (British Columbia, Ministry of Municipal Affairs and Housing, 1996a,1996b). In Victoria, there are over 6,000 social housing, units, but there were still 1,526 households in June 1999 on the waiting list for this type of housing. The provincial government of British Columbia recognizes that access to stable housing is important to the well-being of individuals, and this position is reflected in a report, "Strategies for Affordable Housing":

> *Safe, affordable and appropriate housing is a basic foundation which individuals and families must have in order to build stable and productive lives. (Ministry of Municipal Affairs and Housing, 1996a: 1)*

Stable housing is a precondition to good health, a fact that has been acknowledged by the Canadian Public Health Association (CPHA) and by many academic studies (Thrasher, 1997; Hyndman, 1998). For example, a study conducted in Victoria revealed that access to permanent living accommodations demonstrated an improvement in the health of former street people (Norman and Schwandt, 1993).

Lack of social housing is intimately linked with economic changes, the reorganization of the welfare state, and ultimately, health issues (Dear and Wolch, 1987; 1993; Fallick, 1988; Takahashi, 1996; Daly 1996). The period from 1945 to the early 1970's was an era in which

both the federal and provincial governments increased funding for social policies to promote economic growth. During this time, the economy prospered and poverty levels began to decline in Canada (Fallick, 1988:114-117). However, the recession of the early 1970's undermined the credibility of governments to manage the economy. Social policies were criticized as being a hindrance to the economy, instead of improving it. Deficits began to increase as governments tried to deal with the rise in people seeking unemployment benefits and social assistance. By the 1980's, when another recession had affected Canada, the political atmosphere began to swing to the right, advocating less governmental control over the economy by reducing social policy funding and by allocating those social funds to combating the growing federal and provincial deficits (Fallick, 1988; Takahashi, 1996, Daly, 1996). From 1966 until 1996, the Canada Assistance Plan (CAP) provided a portion of social assistance and social service payments to the provinces. In 1996, the Canada Health and Social Transfer (CHST) replaced the CAP, which is a "block" payment to the provinces covering social assistance, medicare, post-secondary education and social services. Altogether, the federal government's contribution to these funds decreased by 9.4 percent in the 1996-1997 fiscal year and decreased another 6.2 percent in the 1997-1998 fiscal year (National Council on Welfare, 2000).

At the provincial level, the British Columbia Benefits Act guarantees income for eligible people. Eligibility was defined by a specific monetary amount established for various family and health situations under the Act. In response to reductions in the federal government's social funding, eligibility requirements were tightened. For example, recipients have to prove they are looking for work by filling out forms listing businesses they have

contacted. Failure to provide this proof of a job search usually results in the termination of benefits (*Times Colonist*, January 24, 1996:A1). In addition to this, social assistance benefits were reduced by $46 a month. Presently, the income assistance rate for a single employable individual is $500. Of this amount, the shelter allowance is $325 (*Times Colonist*, August 31, 1999:C1), which is far less than the $600 which is required for the average rent in Victoria for a one bedroom apartment.

While governments were changing their focus on social spending, the economy was undergoing drastic changes. The global restructuring of capitalism in the past twenty years has resulted in large-scale deindustrialization. Manufacturing jobs have been lost to developing nations and have been replaced by an expanding service sector. These jobs are generally low-paying and low-skilled (Mair, 1986; Takahashi, 1996; Wolch and Dear, 1993). Within twenty years, Victoria's forestry industries have all but vanished and have been replaced by knowledge and people-based industries. Only 5.3 percent of the labour force works in manufacturing today (*Times Colonist*, December 13, 1998:A1). These changes in the local economy resulted in an increase in the unemployment rate. More than 15 percent of Greater Victoria's population live below the poverty line (Times Colonist, March 2,2000:A1)

Changes in social housing, in the economy, and in welfare reorganization have contributed to the homeless problem in Victoria. However, as Matthew, who works at the Upper Room Society indicates, there is another reason:

> *There is lots of mental illness in Victoria. I myself have lots of difficulty with deinstitutionalization. There were promises made to have an efficient monitoring network but the government is not following through with these*

people. As a result, there is a mental health problem here (Matthew-Upper Room Society)

Deinstitutionalization refers to the discharge of psychiatric patients from mental health facilities to community care and it was incorporated into policy in British Columbia in the late 60's and early 70's (City of Victoria, 1990:3). It is also a reflection of other factors. Advances in psychotrophic medication revolutionized the treatment of people with mental disorders, allowing many residents to be discharged from institutions. As a result of this policy, mentally ill patients became "legal persons" and gained some personal autonomy (Moos and Dear, 1986). Individuals needing psychiatric services are guaranteed such services under the Mental Health Act. In 1955, the Riverview mental health facility in Vancouver had 5,000 patients. By 1996, the number was down to 800. When the Eric Martin Pavilion opened in Victoria in 1971, there were 108 beds. Now there are 83 (City of Victoria, 1990; Thrasher 1997; *Times Colonist*, January 9, 1998:A1). While the provincial government sought to replace these facilities with community care, there has been a gap between policy and practice. The city lacks adequate community resources for all of the discharged people. Presently, there are approximately 400 – 500 people living on the streets in Victoria and one- to two-thirds of this group has some form of mental illness (*Times Colonist*, January 9, 1998:A1; *Times Colonist*, August 31, 1999:C1). A recent change to the Mental Health Act in British Columbia suggests that the province is responding to the growing numbers of mentally ill people living on the streets. An amendment to this act expanded conditions under which a person could be held at a hospital. Now a doctor can detain people to include situations where the individual is "likely to suffer from substantial mental or physical deterioration (*Times-Colonist*, November

15, 1999:D3).

The preceding structural forces contributing to homelessness do not address what actually causes some people to become homeless and others to remain off the streets. For many of the street people in this study, for example Susan, the state of street life is described as "reaching rock bottom." Reaching this point of feeling downtrodden is the culmination of a series of adverse conditions and events in a person's life (Dear and Wolch, 1987; Takahashi, 1996). There are five main events that precipitate homelessness: eviction, domestic conflict (family violence) loss of job, discharge from an institution, and loss of welfare support (Dear and Takahashi, 1992). As indicated in Table 5, eviction was mentioned by 60.5 percent of all the participants as the reason for living on the streets. The path to eviction differed for many people. Some participants cited the loss of a job, drug problems or affordability issues as leading to their eviction.

Bob (who earns $500 a month from Income Assistance) is living on the streets because the hotel where he was living switched to the expensive summer rates which he could not afford. He also blamed losing his job for contributing to his present situation:

> *I lost my job and things fell apart after that. Now, everything is lost to me at the moment. What the hell am I going to do? I am looking for direction, a place, a job.*

Another individual named Stan blamed the Ministry of Social Development and Economic Security for his eviction because they did not send his income assistance cheque to him to pay his rent on time. He summarized how he felt in these words:

> *What am I going to do? What is going to happen? I am trying to find a job? I volunteer in the kitchen (at Streetlink). It is an incentive program through welfare. I want to improve (my) skills, go to Camosun for cooking.*

Others described the "vicious circle" of street life, including the lack of an education that hinders employment opportunities, which in turn makes it hard to find a place to live:

> *It is easy to say get a job. It is a hard vicious circle. I need to finish grade 12 first and it's hard to find work. (Lucien)*

Kim sums up the situation with this comment:

> *No job, no money. I don't have a grade 12 diploma. I worked 2 weeks my entire life and went on welfare when I was 20.*

Table 5.
REASONS GIVEN BY STREET PEOPLE FOR BECOMING HOMELESS

Reason (N=38*)	Frequency
Eviction	**23**
a. Unemployment	12
b. Drug/Alcohol Problems	7
c. Can't Afford Rent	4
Domestic Conflict	**11**
a. Unstable Family Life	6
b. Marital Problems	5
Mental Illness	**4**
a. Discharge from Eric Martin or Riverview	4

* 4 people refused to mention how they became homeless

Without the proper skills and education, finding a job today can be very difficult. This becomes exacerbated when an individual is simultaneously trying to find a place to live as well.

Others cited familial problems as the reason for street living. Six participants said they had had problems with their parents, while five people mentioned domestic disputes with a partner. Tara ran away from home because she believed her parents were going to sexually abuse her and Tammy described why she "chose" to live on the streets:

> *My parents were into drugs and I couldn't stand it.... street life is not stressful to me. Life was a lot more stressful with my parents.*

Escaping a bad situation was the primary concern for both Tammy and Tara. While they "chose" a life on the streets, the alternative sometimes is much worse. Street life then becomes a "choice of the lesser of the two evils" (Snow and Anderson, 1993:255). Life on the streets was an "improvement" from what was experienced at home. In contrast, Tina and Janet mentioned how poor life choices contributed to their homelessness:

> *I am 28 years old with an education of three years in University. Now look at me! I meet the wrong guy, a junkie. I fell in love and catch myself in the same boat. All that for nothing. I had it all! A nice apartment, a lot of furniture and other necessities to provide a nice apartment. Now I am busy trying to figure out when my next shot would be and where the hell I am going to spend the night. (Tina)*

> *I have lived on the streets in Vancouver for 2 1/2 years and now Victoria for a year. Outside the streets seems a challenge. If my life is easier growing up I would have a complete education myself, and work. I got depressed and turned to pot and got to this point. (Janet)*

Both Tina and Janet mentioned how drug abuse was a contributing factor to their homelessness. Tina described her predicament as an error in judgement, while Janet turned

to pot in order to escape her depression. According to Snow and Anderson (1993), drug abuse is an example of a "personal disability" which make people like Tina and Janet more vulnerable to becoming homeless. This personal disability is attributed to a person's ineffectiveness of utilizing services such as income assistance and social support networks (i.e., friends and family).

Several other people talked about horrible circumstances that led to street life. Bruce's friends were using his place for the drug trade, and he was evicted when someone got stabbed in his apartment after a bad drug deal. Bruce is a manic-depressive and is trying to get involved with the Royal Jubilee Hospital's program for manic depression. Others blamed a drinking or substance abuse problem for their street life. Bill, a 28 year old, is a cocaine addict who occasionally uses marijuana. He chose the streets in an effort to kick his drug habit:

> *My room mate is taking cocaine and I am trying to clean up. It is dangerous to my health.*

Alcohol abuse was another problem mentioned by the participants. Fred said he had a drinking problem and was about to join a recovery program. According to Streetlink Emergency Shelter, 70 percent of their clients have a substance abuse problem of some kind. The Gateway is an overnight shelter for public inebriates and is often full of street people

Tom who had been living on the streets for 2 weeks, recalled the onslaught of anxiety and panic when one becomes homeless:

> *What is going on? I am trying to find a job. At night in the shelter, I lay in the bed and think: What am I going to do next? What is going to happen to me? I am freaking out.*

Tom's concerns demonstrates psychological trauma which refers "to a set of responses to

extraordinary, emotionally overwhelming, and personally uncontrollable life events" (Goodman *et al.*, 1991: 1219). The possible trauma of becoming homeless could be detrimental to one's health. Tom knows that he needs to survive, but surviving on the streets brings a different set of challenges.

Existing on the Streets

> *When you are on the streets, you are in a never-ending circle. What is the point of getting up? I must have a purpose - if you don't, you will go nowhere. (Roy)*

The prospect of another day on the streets can be viewed as daunting and overwhelming. While the nature of street life can appear to the outsider as unstructured or disorganized, many street people do have a routine. In fact, street life is a significant part of the street person's identity since it serves a number of functions for street people. Although each person places a different level of importance on their daily activities, street people's routines mostly involve the search for basic necessities. Street community facilities (which are characterised as institutions, according to Giddens) and the services that they offer shape the behaviours and routines of street life. This consisted of going to soup kitchens, frequenting drop in centres, panhandling, looking for work and a place to live, socializing, and walking around (Rowe and Wolch, 1990;Snow and Anderson, 1993;Wolch *et al.* 1993). The daily life of several of the participants was similar to that described by Pierre and George:

> *I look for work, hang out, panhandle. I walk around visiting friends and hang out there (Pierre)*
>
> *On the street, you just walk around, go to drop-ins. (George)*

Hanging out at street community facilities was one part of the "structured" routine of street life. For those individuals with a drinking and/or drug abuse condition, a different pattern emerged:

> *I sit on the beach smoking pot all day. (Jane)*
>
> *I eat breakfast when I can have it. Then I walk around, trying to pick up cigarette butts, trying to get high. I go to do that downtown near the whale mural. (Sam)*

While some of the street people interviewed confessed to drinking and/or taking drugs, getting high from either drugs or alcohol was only a priority for two: Jane and Sam. Others, like Dan and Bill, who both admitted to taking drugs, had other priorities: Others, such as Linda, discussed street life by describing its difficulties and how it affects people like herself:

> *Being on the streets is very hard. There are things I have to do that I don't really like, things like going to the food bank and camping at friends homes, not knowing where is the next meal or bed coming from. On the streets you deal with people of all walks of life. I never worked the streets as a prostitute, but at times I have thought about doing this because I don't get the right amount of money. At times I had to panhandle which did not do any good for my self-esteem.*
>
> *Trouble of finding food, clothing and shelter are an everyday task. I hook a lot, mostly for a place to stay the night, mind you I get my head kicked in for not showing up an hour after a trick. I am trying to survive out there. (Tina)*

While street life does consist of a routine for Linda and Tina, it is also a very stressful situation. Gender relations play a role in shaping the street life of women. According to Giddens, gender is "constructed in the flow of interaction in day to day life" (Giddens, 1989: 285). Traditionally, men have been involved in determining the role of men and women in

society. Women have been treated historically as objects of desire, and prostitution was a means of legitimating this ideology. In the street community, prostitution is a coping mechanism for some of the women: they trade their bodies for the guarantee of shelter (Snow and Anderson, 1993: 154). This idea had crossed Linda's mind, while Tina actually engaged in prostitution as a preventative measure against sleeping on the streets.

In contrast, a few people had a different outlook on street life.

> *Living on the streets doesn't affect my life. I choose therefore I am. I am happy and sad just like you and everyone else. I live for myself and no one else. If something happens, it happens. When you gotta go, you go. (Susan)*
>
> *One person said to me that I had not a hurtful bone in my body. I am very mellow, will not let things get to me. (Reggie)*
>
> *I enjoy life. You should not get stressed. It is not worth it. I refuse to let things bother me. I am flat ass broke for a week, and must live on the streets. This is life. I am not an aqua- velva drinking man. It is easy to take care of yourself. You must learn to take care of yourself. (Al)*

Unlike Linda, Susan, and Reggie, Al did not mention any negative aspects about living on the streets. Linda associates her feelings of happiness and sadness to those experienced by people in the domiciled population. In fact, she dismissed any difference between the two living conditions. George accepted his condition, and made sure he distinguished himself from the chronic alcoholics (an aqua-velva man). It seemed that these three individuals adopted a complacent approach to street life. This is reflected in duration of time on the streets. People who live on the streets for long periods (usually two years or more) begin to "embrace" it. All four individuals have been living on the streets for two years. Instead of fighting the existence of street life, their attention and focus shifts towards survival on the streets. (Snow and Anderson, 1987: 1343). Despite these comments on the nature of street

life, Susan, Reggie, and Al mentioned that street life could be "stressful" when they responded to other questions. Complacency is their means of coping with street life.

While Allan has also been on the streets for about two years, he expressed his daily life in terms of goals. He "strives to find part-time work and to get food in order to eat." Others mentioned similar goals:

> *I spend my day trying to keep busy. My main concern is finding a comfortable place to live. (Dan)*

> *I am looking for a place and a potential roommate. I do not want to associate with drugs anymore. (Bill)*

Finding a place to live and/or a job was the main priority for twelve of the people interviewed. Joan and John' s activities were typical of this group of street people. During the day, they were looking through the newspaper trying to find a place to rent, constantly using the phone, inquiring about apartment vacancies. One individual named Bruce was living on the streets while waiting for a hospital program for manic-depressives at the Royal Jubilee Hospital. He spent his days "bumming around, going for walks" until he could be admitted into this program.

Another part of the street life routine is the social interaction with other street people. Linda pointed out the importance of this:

> *I know what they have been through. I talk with them. We tell each other stuff to help out, like someone told me where a mattress was stashed It helps me find where things are.*

There was a sense of camaraderie because of a "shared fate of survival problems and unique set of behaviours" in the street community (Snow and Anderson, 1993, 39). While there was a sense of camaraderie, hanging out with friends also functioned as a means of

exchanging valuable information for daily survival (Wagner, 1994). As Reggie pointed out, friends have other functions as well:

> *Friends help you find stuff, like where to eat or crash for the night without getting harassed by cops. They are like protection. You can hurt one, but not a group.*

Fear of attack is prevalent among the street community (Snow and Anderson, 1993;Wolch and Dear, 1993; Wagner, 1994; Daly, 1996) and friends can watch each other's back to ensure their safety.

A large portion of the day was spent looking for basic amenities, such as food. As early as 7:00 A.M, street people can start to get free food by going to the "9-10 Club" soup kitchen in the basement of Saint Andrew's Cathedral. From here, they can go to the Open Door and to facilities such as the Upper Room for dinner. Finding food in Victoria is not a difficult task for street people. According to Linda, "it is hard to go hungry here." Reggie went even further and said, "there is good food in the shelter and other social agencies." Others agreed:

> *I go to the Upper Room and pay $1.00 for good food, good portions. (Joe)*

> *I eat 2 meals a day. There is good food here at the shelter. (George)*

In fact, nearly all of the participants (n = 34) eat at least 2 meals a day; however, there are some concerns about the food available to them:

> *I would like to eat better. I do not want doughnuts and coffee, there is no choice for food. (Lucien)*

> *Food in shelter is good, but I would like more variety. (Bill)*

> *If you are hungry, it is good. (Pierre)*

Access and availability of food is not a problem, but the quality of it is. Receiving a nutritional and balanced diet while living on the streets can be difficult, since not all the agencies supply adequate meals.

> *Lack of food, especially nutritious food has been an on going issue for me and my health. I have iron deficiency. I never have enough meat servings. I eat meats about 3 times a week. According to the doctor, my iron deficiency is due to the lack of protein in my diet. To me, dairy products is needed, but it is also a luxury. (Susan)*

> *In most settings I've been in, donated food is high in carbohydrates and fat (usually breads and donuts are plentiful). There is no choice for food, and It is hard to eat better. Fruits and vegetables are hard to come by. They are a luxury. (Peter)*

> *I am a vegetarian, and finding food is very difficult. (Al)*

Matthew, who works at the Upper Room, discussed the problems street people encounter because of this lack of nutritious food:

> *Lots of health issues for the street people stem from an improper diet. Their immune system is so depleted that viral infections become rampant.*

Food is essential because malnutrition can contribute to many health problems, such as a weakened resistance to infections and deterioration in mental development (*Red Zone,* May/June 1996:15).

While street people make use of the food services available to them, some people, such as Janet, are "dumpster divers." They search for food in garbage cans on street corners and in restaurant dumpsters:

> *When Kentucky Fried Chicken closes at night, if you know how to break into their secured garbage... there is free food at night. It has only been in the garbage for 2 to 3 hours, so it should be edible still. You do it because you are hungry. Wouldn't you?*

While there is free food available in the city, Janet and others still rely upon dumpster diving to meet their needs.

Although 60 percent of the street people in this study received some form of income assistance, many street people discussed that it is not enough and described how they "try to make ends meet", as expressed by Lanie. Street people are engaged in what has been described as "shadow work", and there are two types of this work: the informal economy and the illegal one The informal economy consists of day or so casual labour, and collecting and recycling cans (Wagner, 1994; Takahashi, 1996). Roy is involved in the informal economy:

I collect pop and beer cans to make some extra money, but it is not much.

The illegal economy refers to prostitution, selling drugs, and in some jurisdictions, where it is not permitted, panhandling. Since 1997, two amendments have been made by city council to the Streets and Traffic By-law, which have had consequences for the street community. Amendment 37 prohibits people from sitting, lying or obstructing a public sidewalk from 8:00 A.M. to 9 P.M. within the downtown area "bounded by Cook, Pembroke, Store, Wharf, Government, Superior and Southgate Streets" (City of Victoria, 1997:1). In 1999, Amendment 42 became law, which levies fines between $5 - $10 for offences which include, "aggressive behaviour," panhandling within six metres of automatic teller machines (ATM), and panhandling before 9:00 A.M. and after 9:00 P.M. (City of Victoria, 1999a:1). These By-laws in effect, are trying to control and even to eradicate street life by criminalizing it in order to "present Victoria as a safe and pleasant place to be" to citizens and to tourists (Mitchell, 1997; *Times Colonist*, April 14, 1998: A12).

Although nobody admitted to selling drugs, 45 percent (n=19) stated that they use

illicit drugs such as marijuana, and crack cocaine. One person, Tina, did indicate she was a prostitute. Sandy, who works at Sandy Merriman House (a shelter for women) described the limitations of choices for women living on the streets.

> *Street life is not a choice for women. Nobody wants to be selling her body. It is all they know. There is no support for them so the women do the best they can to survive.*

Prostitution is a way of getting off the street, albeit a temporary one, but it also provides women like Tina with some money in order to survive. It also contributes to health problems, such as HIV and sexually transmitted diseases (Snow and Anderson, 1993)

At night, street people who are not "hooking" must turn to a shelter or find some other place to sleep. The Salvation Army, Sandy Merriman House, and the Streetlink Emergency Shelter are three important services and facilities in Victoria.

Street Community Facilities and Services

Figure 1 shows the geography of street community services and facilities in Victoria and how they have been categorized into three groups. The categorization is based upon the work by Lee *et al.* (1998). The first group, gatekeeper services, refers to services for those that are homeless and provide services such as emergency accommodation (e.g., Streetlink). Second, coping services assist people with street life through such programs as counselling and health care. Finally, there are other human services for street people and the general population, such as the income assistance office and food banks (Lee *et al.*, 1998). Funding for the gatekeeper and coping facilities come from a variety of government departments at both the provincial and municipal level. The major contributors to the facilities are: the

Ministry of Social Development and Economic Security, the Ministry of Health, the Ministry of Human Resources, the Capital Health Region, and the Capital Health Region: Mental Health Services. Despite the wide range of financial support, the majority of the street community services rely upon several government ministries for their operations. Changing initiatives at these government ministries can jeopardize their existence. Matthew, who works at the Upper Room Society said, "there are too many problems with government funding, too much bureaucratic red tape." In fact, this facility did not receive any form of government assistance. Matthew added that this situation "makes it easier for us (the Upper Room Society) to decide for ourselves what we think is needed to help the street people."

Table 6 indicates the number of emergency shelter beds for the street community in Victoria. According to the participants in the thesis, Streetlink Emergency Shelter is the focal point for the street community. It is both a gatekeeper and a coping service facility such that it offers a variety of services: a drop - in, a soup kitchen, a medical outreach program, and a counselling centre. When I asked the participants to talk about their experiences at Streetlink and the other emergency shelters in Victoria, their attitudes varied from indifference to satisfaction:

> *It is good here (Streetlink), they give you a bed, food, they are nice to work with. (Ralph)*

> *Shelters here are great. They are well run, and the staff are supportive (Cliff)*

> *The shelter is not a bad experience. There are no feelings of uncomfortableness to make you get a place. (Martin)*

TABLE 6

NUMBER OF EMERGENCY SHELTER BEDS FOR THE STREET COMMUNITY IN VICTORIA

Facility	Men	Women
Streetlink Emergency Shelter	44	11
Salvation Army	24	0
Sandy Merriman House	0	15

Source: (Community Social Planning Council of Greater Victoria, 1999: 28)

In fact, Martin's views were echoed by the majority of the participants (n = 24). Several street people were appreciative of the staff's treatment of them and had no complaints about the shelter. It differed from the "outside world" or the "normies" as Bill called it since the shelter lessens feelings of isolation and abandonment. As Bill put it, "they (the Streetlink staff) treat you well." Verity and others said it was their favourite place to "hang out."

While many had good things to say about the staff treatment at the emergency shelters, not everyone shared those views.

> *The environment here causes me to feel anxious. It is not clean.*
> *Men bug you,trying to get down your pants. Yes, guys harass you. (Carol)*
>
> *I am scared a lot, scared of rape. (Tara)*
>
> *Guys approach me and are persistent. I get harassed a lot by men. (Sarah)*

Shelter experiences differed for each gender. Issues of safety and security are the most salient issues for women living on the streets. To address the needs of women, the Sandy Merriman

House, an emergency shelter and counselling facility for women opened in December 1995. In the first two years of its operation, 451 different women have been helped. According to Sandy, there is still "a greater need for services for women living on the streets."

Other types of criticism about the shelters pointed toward the issue of hygiene:

Lots of germs at shelter. (Dan)

I got scabies from staying here. (Carol)

The washroom is filthy during the daytime. (Al)

I have been scratchy since being here. (Joe)

Al was very vocal about his concerns with the shelter:

> *It is not safe at the shelter. People show knives to sell, needles are lying around. People wake you up to talk about drugs. Hookers sleep here and frail old men get kicked out.*

Others realized there were problems at the shelter, but have learned to accept them, considering the alternatives:

> *I have a good place to sleep. You get used to the arguments, people's bullshit. (Ed)*
>
> *I stay in the shelter. It is unsafe on the streets. (Bob)*

In other words, many street people will accept the poor hygiene, the arguments, and other problems because the alternative is worse: the streets. Bob says it is safer in the shelter than on the streets, and it is better than "sleeping rough." He, like Ed, "gets used to" the problems. While some people might consider people screaming and yelling while trying to sleep as a nuisance, most street people stoically accept these conditions and are thankful for what the shelter does provide: a place to stay for the night. On the other hand, Linda did not like to

stay at shelters at all because she "does not like how she feels about herself when she stays there". Prolonged periods of time at these facilities can lead to a state of "shelterization" whereby street people feel isolated and ostracized from society. Staying at a shelter, with its rigid structure consisting of curfews and rules for length of stay and times of entry and departure, reduces the street person's control over his or her own life. Shelters are examples of "environments of low control" which can lead to passivity on the part of the street people (Burns, 1992). They become disenchanted with their situation and become resigned to the fact that street life will remain a permanent existence (Rollinson, 1998).

For example, Streetlink allows people to stay at the shelter for up to seven nights free. Inside this facility, there is a large ominous sign with red lettering above the front desk advising people to sign up for any vacant beds starting at 4:00 P.M. Street people must put their name on a waitlist since space is limited to 55 beds. Every night, at 8:30 P.M. Streetlink workers use this list on a first come first serve basis. People who are under the influence of alcohol or drugs are refused admission, and must try to find a place at Gateway, a shelter for public inebriates. Once the fifty-fifth name is called, the remainder must leave and they are left to their own devices. The maximum amount of time a person can stay at Streetlink each month is two weeks. As a result, some people, such as Martin, moved from shelter to shelter in order to have a place to sleep:

> *I stay at the Salvation Army, at friends as well, and Gateway* (An alcoholic detox centre) *too.*

However, many at one time or another have had to sleep on the streets. Necessity has caused these individuals to consider many diverse places to take shelter for the night:

Parkades are good places to sleep. Police don't bother you too often there. (Tammy)

In the summer you can camp on the beach. I can't sleep inside anymore. I am not used to it.(Tom)

I look for a place to crash in the evening. (Al)

Abandoned buildings, alleyways, and staying with friends were popular places to sleep at night. Sleeping in some of these places though, exposes street people to the elements, and makes them susceptible to poor health.

Street Health

Health is an interesting word. I vaguely have good health. I always feel ill or sick. I am in more pain that they have pills for. (Tom)

According to Ambrosio *et al.* (1992), there are four issues pertaining to health of street people. First, street people exhibit poorer health status than those who do have shelter. Second, health problems of the street people are more severe than in the general population. Third, street people infrequently seek medical advice. Finally, women who live on the streets have additional health problems.

There is a high prevalence of health problems in Victoria's street community. Florence, who works at Swift Street Medical Clinic, and Edith, who works as a street nurse identified the most common health concerns in the street community.

There are many health issues on the streets. They include Hepatitis C, Tuberculosis, HIV, Pneumonia, athlete's foot, drug addictions and alcoholism. Schizophrenia is another concern. (Florence)

HIV and Hepatitis C are major health issues. General hygiene problems are

> *issues too since they have no place to wash. Scabies and wounds are common. There is lots of depression, schizophrenia and paranoia. Street people are emotionally strained; they can't make their ends meet. (Edith)*

In my research, street people mentioned nineteen different health conditions that they have experienced on the streets. Stomach pains, pneumonia, and colds were the most common problems reported (See Table 7).

Individual feelings of health take on a different meaning for street people. When asked to describe their health, six responded by stating how they try to maintain health.

> *Healthy? Yes. I am still living, talking. I maintain my weight, drink water. (Lisa)*

> *I take care of myself. I exercise, eat well enough to stay healthy. I got a good immune system. (Martin)*

> *I am healthy enough, not excellent. Living on the streets makes it not excellent. I eat, exercise, walk, sleep. (Jane)*

Many attribute their lifestyle, which involves lots of walking around during the day, as the reason behind staying healthy. As Jane and Ben point out, they both walk everyday. Ben boasts of walking "two miles every day." At the same time, these accounts show that maintaining health on the streets means you are alive, are able to perform these basic tasks (such as walking) which the majority of domiciled people take for granted.

Some participants describe health in terms of their symptoms and their immediate problems.

> *Health, well my back is in very poor shape and when it gets cold at times I can barely walk. My teeth are broken. I'm in constant pain. I've lost my*

TABLE 7
HEALTH CONDITIONS REPORTED BY STREET PEOPLE (N=42)

Health Condition	Sample
Colds	21
Stomach pains	19
Pneumonia	15
Athlete's Foot	12
Cavities	10
Sore Teeth	8
Depression	5
Sore Back	5
Scabies	4
Schizophrenia	4
Anemia	3
Arthritis	3
HIV +	3
Liver problem	3
Swollen legs	3
Asthma	2
Hepatitis C	2
Manic Depressive	2
Kidney ailment	1

TABLE 7 (continued)
HEALTH CONDITIONS REPORTED BY STREET PEOPLE (N=42)

Health Condition	Sample
Nervous Break Downs	1
Sciatica	1

glasses so I find it hard to see with any definition. (Allan)

I am anemic and have severe seizures. Not to mention HIV positive, probably from needles. I hate feeling sick all the time and getting bed shakes. (Tina)

Others, such as Desmond, equated health with emotional well-being:

Do I feel healthy? What kind of question is this? I don't remember feeling healthy in my life. To be healthy is to have the ability to walk around with my head high and a smile on my face. Energetic. To jump at an opportunity to take part in a festive celebration. Knowing I can wake up in the morning, God knows where, and feel exhilarated. I am depressed because I am on the streets. I feel like shit.

Health is equated with self-esteem and a sense of self-worth, and Desmond felt as if he does not have this at all. In fact, he blames street life for his depressed state. He adds that he has additional health problems such as scabies, asthma, "lots of colds", and a sore back.

Other participants, such as Cliff, blamed the streets for his poor health:

My health is worse since living on the streets. It is not a proper environment to be living in. Easy to gets colds, and other bugs.....Not knowing where you going to end up is scary, it gets me down a lot. (Cliff)

Several participants claim their mental state has deteriorated from living on the streets. Alexander said "On the streets, you get mental from the stress and shit." Cliff's response is testimony to the conditions of street life reported in many studies. Health conditions are

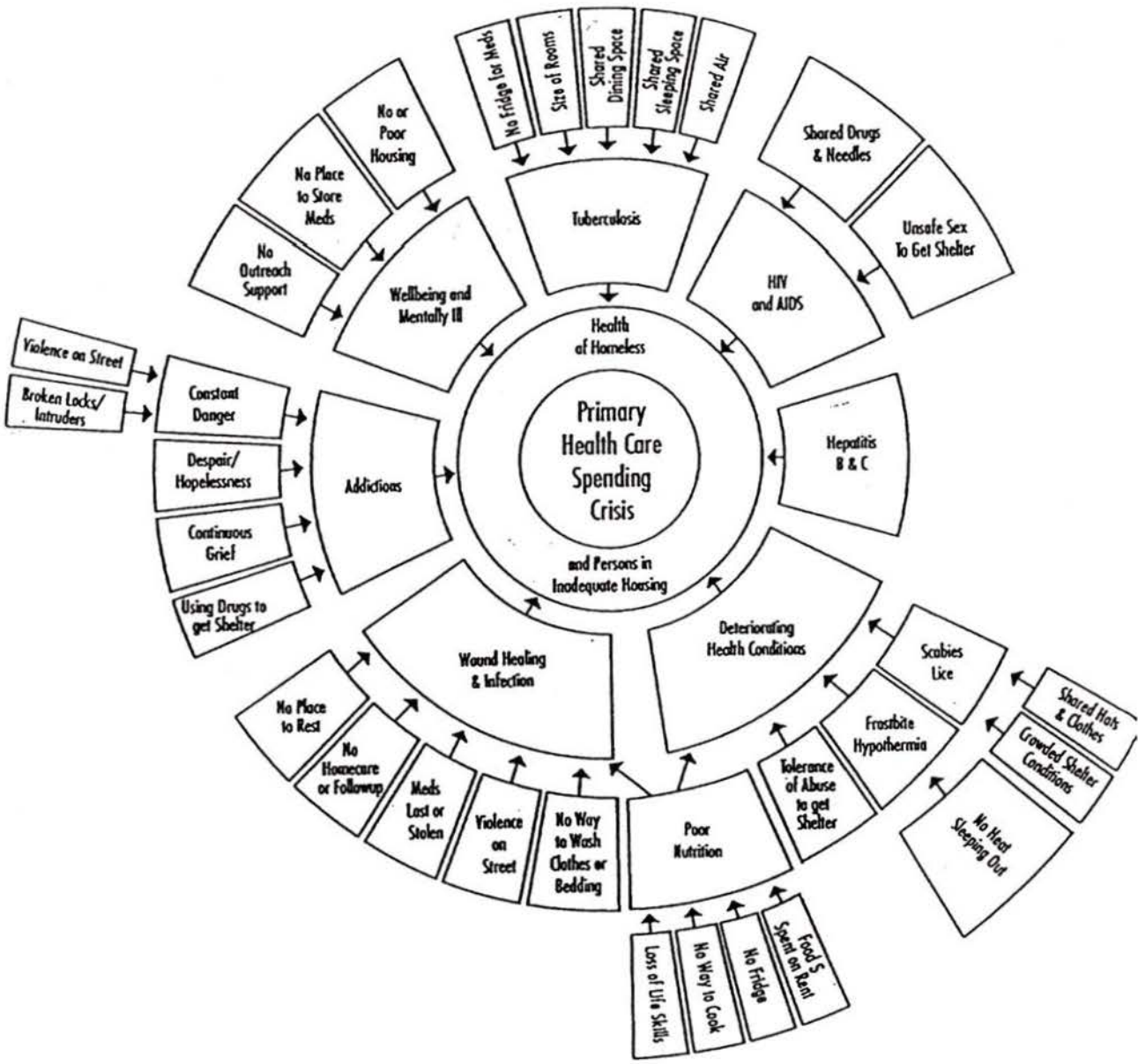
directly linked to the lifestyle of the street person. Living on the streets means exposure to all kinds of weather conditions causing many physical ailments (e.g., bronchitis, colds) and complicating treatment of them as well. Due to the exigencies of street life, treatment of health problems often becomes a complicated task. In addition, the uncertainty of life--where will one find food and shelter for the evening --affects the mental state as well. High levels of depression are often reported in street people (Wright and Weber, 1987; Wright, 1990; Jahiel, 1992; Ambrosio *et al.*, 1992). As a result, street life has taken its toll on many street people in the city. In 1998, 4 street people were dying each month in Victoria, compared with 1 per month in 1991 (City of Victoria, 1999b).

Figure 5 shows the multiple factors contributing to the health of street people. While there are many health concerns on the streets, some street people like Peter say that they "cope with it". In fact, coping has a different meaning on the streets:

> *First of all, I have no money and I am desperate. Bigger problems for me. If I go (for health advice), I go when my health affects how I live. (Desmond)*
>
> *I hate feeling sick all the time and getting the bed shakes. It has taken me a total of 6 months to come to the realization to figure out my illnesses and accept them. My health is always bad, but when I can't function properly, I do take advantage of the (Swift Street) clinic at the shelter. (Tina)*
>
> *I don't have time for health problems. I live with it. That's how it is on the streets. When I go to the (Swift Street) clinic, it's for a good reason, like I am puking or got blood coming out of me. the problem has to be slowing me down, getting in the way of my life. (Allan)*
>
> *I go when my plans are being interrupted by my health. There are other problems that I am trying to deal with because I am on the street. (Martin)*
>
> *I must be really sick, bleeding, not being able to function. You know, not being able to handle all the other crap of being homeless. (Sam)*

FIGURE 5

FACTORS CONTRIBUTING TO THE HEALTH OF STREET PEOPLE



Source: (Thrasher, 1997: 59)

If I am ill, I go to bed. To visit a doctor, I gotta have a temperature 106, fainting, falling down. (John)

I sweat it out, put 3 blankets on me. I visit a doctor when blood is coming out. (Ben)

I do not get sick, just colds, coughs, shake it off in a couple of days. I will go for help when I have extreme pain, peculiar, not felt before. (Joe)

Coping needs can be divided into five categories: food, shelter, income/employment, health care/human services, and social interaction and support (Kearns *et al.*, 1987). Street life consists of a 'hierarchy of needs' and a 'hierarchy of problems," in which looking after one's health is near the bottom of the list. Coping with life on the streets requires a great deal of energy and time (Daly, 1998:124) and the participants often ignore or dismiss health concerns until they can no longer cope. Only when some street people are facing extreme conditions will they consider seeking medical attention. Once their health begins to interfere with their daily routine, it becomes an issue. Coping strategies are intimately linked with the personal characteristics of the street individual. It determines how effectively he or she "uses coping resources and develops coping mechanisms" (Wolch and Dear, 1993:40). These coping strategies are predicated upon two factors. Adaptive strategies are "cognitive and psychological adjustments that help the homeless person adapt emotionally to the degradation of street life, " such as health issues. Material strategies are "adaptations to physical deprivation," such as seeking food, clothing and shelter (Wolch and Dear, 1993:238-239). In Victoria's street community, material strategies take precedence over adaptive strategies.

The Canada Health Act (CHA) is the foundation of health care in Canada. This act was designed to ensure that all Canadians, including street people, have access to "necessary

health care" in all the provinces and territories. One of the most important criteria of the CHA was the concept of universality. This guaranteed all Canadians the right to receive public health insurance (City of Toronto, 1999). The complimentary act at the provincial level is the Medicare Protection Act (MPA) of British Columbia (Thrasher, 1997).

However, going to a doctor or to an ER in British Columbia requires a B.C. Care card. Only 35.7 percent of the street people in this study have this card. Obtaining one is often a laborious process involving the completion of many forms and sometimes the payment of fees. Many street people do not have proper identification, so this complicates the process of obtaining a B.C. Care card (Ambrosio *et al.*, 1992; City of Toronto, 1999). This is one of the reasons why street people, when seeking health care, frequent the outreach facilities (Ritchey *et al.*, 1991; Snow and Anderson, 1993; Daly, 1996). In Victoria, many street people go to see the street nurse, or visit the Swift Street medical clinic.

> *When I need help, I go to Swift Street. They just accept me for who I am. No questions, no BS, just there to help you out and make you feel better again. (Susan)*

> *I have to give a lot of credit to the street nurses. There's a true smile and a warm heart with them. I can relax and feel positive. They don't make you feel like crap, and don't ask you why, why did you let get this way? Doctors make me feel inferior. (Peter)*

> *...Swift Street and the street nurses accept you. I got no problems with them. They let you cry on their shoulder if you need to and you get treated like a person and not some number. (Peter)*

> *It is a free clinic downstairs (Swift Street) and they don't ask you questions. (Tara)*

> *I go downstairs (Swift Street). I trust the doctor and they treat you well. (Al)*

Downstairs (Swift Street) is where I go. It's convenient and a place you can be comfortable. They treat you well there. (Dan)

I always go downstairs (Swift Street). It is free and I like how they run it, you get treated well. (Verity)

The outreach medical facilities create a supportive, non-judgemental environment for the street people to discuss and inquire about health issues. This assistance goes beyond physical health needs; it is applied to their emotional concerns as well. It is one of the few places where street people are not marginalized or stigmatized, but treated with respect.

Swift Street was praised for its treatment of the street population and its easy accessibility. In fact, thirty respondents said they frequent this facility when they seek medical assistance. Anonymity provided by the clinic's staff also creates a sense of comfort that is important for this community. Many people visit the street nurse if they have health concerns and some of the respondents (n = 4) said they will go to the emergency room at Royal Jubilee hospital. Five participants said they would refuse to seek medical treatment for a variety of reasons.

I don't go. I don't like doctors, don't trust them (Pat)

I have been discouraged by past experiences.. got treated badly. (Lucien)

I do not go to the doctor, not sure about medical coverage. I do not want to take a chance of a bill. I do not go. I let it go away. (Bill)

Previous bad experiences have affected how some street people view accessing health care. Although both Swift Street and the street nurses' health facilities are free, not everyone knows that the health services are free at these two places. Bill was one of those who did not know this.

Many blamed the streets for their health problems conditions:

Not enough nutrients, I get lots of colds, foot sores, athlete's foot. 3 times, I got bronchitis. You are outside and walking all the time. (Ken)

My legs swell and my back is sore from walking 18 hours a day. My ankles swell as well. (Joan)

I got a kidney ailment from sitting down too much. (Pierre)

My health has definitely become worse since living on the street. I think its because we are outside all the time, exposed to weather and stuff. (Tammy)

You are not eating properly, being exposed to elements. I had lack of proper clothing. (Bob)

Your physical health suffers. You are not looking after yourself. (Martin)

Health conditions are directly linked to the lifestyle of the street person. Living on the streets means exposure to all kinds of weather conditions causing many physical ailments (e.g., bronchitis, colds) and complicating treatment of them as well. However, others tell a different story:

My health is better now. I know I can get 3 meals on the streets. (Bill)

Yes I am healthy. I get food (Kim)

For Bill and Kim, life on the streets does provide another type of "stability". It is stable in the sense that they know there are opportunities for them to eat three meals a day and to receive other services.

Another facet of street life that had health implications is the attitudes and treatment by the general population to street people. Joe and Cliff spoke of their experiences with the general public.

> *Normal people run around in suits, going to work or coming downtown. They do not even notice people like me, just walk around me, continue going to work, no big deal for them. I am not worthless like they think I am (Joe)*

> *People look down upon you and you feel like crap because of it. I feel like a street bum, and I do not want to feel that way. It is easy to say get a job, but I have no education (Cliff)*

Joe and Cliff's feelings of low self-esteem and low self-worth were associated in part with the general public's treatment of them. Attitudes toward street people were also described in the *Red Zone* magazine.

> *We are not the stereotyped lazy, beer-drinking, drug addicted, derelict good for nothings that we all too often get viewed as.* (*Red Zone*, April 1998: 26)

Street people are usually characterized as being deviant, dangerous, mentally unstable or criminals. The process of stigmatization of street people is grounded in the fact that they are perceived as being different from society, in that they do not conform to "socially established norms" (Takahashi, 1997:907). Street people carry out their personal activities, such as sleeping, in public spaces, and this contradicts society's structures of social norms and values (Creswell, 1996).

While street people face stigmatization from the general population, there are also other concerns that affect one's self-esteem while living on the streets.

> *Only got a few days of work and I have a great letter of recommendation from a boss. Looking for work and a place is pretty damn stressful. (John)*

> *I feel confined here (at the shelter). I want to get out and get my own place, feel good about Victoria. Too much negative energy at the shelter. (Joe)*

> *Stressful, yes. No financial stability. I lack money and no emotional stability too because you hang around strange people. (Martin)*

Participants' anxieties originated from a lack of control over their own lives. Having no financial security and no shelter creates tension and stress exacerbated by living at a shelter where some people have mental health problems.

For some of the female participants, there is another type of stress of street life.

Stressful here. Guys approach me, persistent. I am harassed a lot by men. (Sarah)

Guys harass you. (Carol)

While being homeless is stressful enough, the street women must endure sexual harassment from the men who live on the streets, creating additional problems when the women are deciding upon sleeping accommodations for the night. As previously mentioned, some people, such as Tina, turn to prostitution to secure shelter for the night.

Living on the streets, according to some street people, has had consequences upon their mental health

You are more tired out, suffer from trauma. You feel as if you can't move forward of backward. (Joan)

My mental health is affected by living on the streets. I am picking up butts off the streets. I would never do that before. (John)

Mentally it stresses you out, do not think properly, get negative about yourself. (Joe)

I am not losing it, no mental illness, just depressed. (Cliff)

I went mental. I have trouble with schizophrenia, no medication. Streets did this. I didn't have it before. (Alice)

I get depressed sometimes, not suicidal, but I think about it. (Kim)

Several participants believe that their mental state has deteriorated from living on the streets.

In fact, Alice is convinced the streets caused her schizophrenia. Evidently, street life has had a detrimental affect upon these individuals. Whether or not it caused mental illness is uncertain. Ralph summarized what he believes would improve health for street people.

> *Health would be better in an apartment, more comfortable. No stress, nobody would steal my stuff. I like privacy and can cook for myself.*

Personal Empowerment and Getting off the Streets

> *I want my own place so I can be allowed to live. (Joan)*

Having a place to live affords stability and releases street people from a life of dependency on facilities and services. Moreover, permanent shelter gives them the freedom to plan their own lives. A few street people elaborated on the freedom and stability gained if they had adequate affordable shelter.

> *I would feel more confident, free to do things. (Doug)*

> *It means a more regular life. You sleep, have a job, have a routine. (Lucien)*

> *In a place, I would feel better. My own private space where nobody can bother me. My place would be clean, have food and I would eat there too. (Carol)*

In other words, having shelter means having a routine, but a different one than that which is experienced on the streets. This type of routine is related to a sense of economic and personal security. For Carol and other street people, "a place to live" is in itself a confidence booster that contributes to improvements in self-esteem and mental health.

Finding accommodation in Victoria can be difficult for street people, and many of

them have encountered barriers from both Financial Assistance Workers (FAW) at the ministry of social development and economic security, and from landlords when trying to find a place to rent. People applying for income assistance (IA) speak first with a FAW, who also assists individuals in filling out forms. Commentary on a FAW in the *Red Zone* from a street person focused on the indifference of these people:

> *I would like to thank you for your lack of caring and compassion that you have shown towards me. I now understand why I always feel the way that I do simultaneously suicidal and manic-depressive. I feel this way because of the peons like yourself that perpetuate an uncaring and inefficient government bureaucracy that is obsolete upon human beings like myself who you are theoretically trying to help. You are a cog in the wheel of the machine that grinds people like me down to death.* (*Red Zone,* December, 1995:5)

According to Wayne, the director of Streetlink, street people are "fed up with all the bureaucracy". Several street people described their difficulties with their interaction with an FAW. Susan and Peter elaborated on this frustration:

> *In the beginning I had a lot of trouble with Social Services. They told me they can't help me because I had no ID. I then had to run around town to get the documents. The attitude was not so nice with Social Services. (Susan)*

> *Welfare is a joke! They shove you out of there and tell you they need a crap load of paper to get anything done. (Peter)*

For street people receiving Income Assistance (IA), a means of securing a place to live is through an "Intent to rent" form from the Ministry of Social Development and Economic Security. This informs prospective landlords that the street person is receiving a guaranteed income that is required to secure a lease. Despite this, prejudice towards street people by landlords is common. An article in the Times Colonist attests to this problem:

> *They treat you like an animal instead of a human being... I went to a place*

> *last week and she slammed the door in my face and took the (vacancy) sign down, but when I went back 20 minutes later the sign was back up.* (*Times Colonist,* September 26,1993:A6).

In addition, there are many unscrupulous landlords who do not give street people adequate eviction notices and neglect to return deposit cheques or damage deposits. These landlords know that street people do not have the financial resources available to dispute them (Thrasher, 1997). Some landlords, evict people suffering from mental illness because they do not know enough about mental illnesses and become afraid of the tenant (*Times Colonist*, January 13, 1995:C3).

When street people are able to secure Income Assistance benefits, the amount of money given to them by this provincial ministry is not enough for the average rent of a one-bedroom apartment in Victoria. This leads many street people to seek-out cheap living accommodations, places which are usually unsanitary or in need of repair. One former street person wrote of her friend's experiences with the "seamy underside of housing in Victoria":

> *She stayed one month and described it as being "really gross" with lots of bugs and filth. There was a broken window in the room so it was cold all the time. The bathroom was down the hall and if she had to go in the middle of the night, she felt fearful.* (*Red Zone*, March, 1995:19)

These places described here usually refer to single room occupancy hotels (SRO's). In Victoria, there are approximately 500 units in SRO's with rents averaging $350 a month. (Thrasher, 1997). For many street people, the issue is not just adequate affordable housing, but supportive housing. An article in the Times Colonist elaborates on the goals of supportive housing:

> *The aim of supportive housing is to break the cycle of eviction when a landlord calls police because of bizarre behaviour and the tenant then*

bounces from hospital to the streets. (*Times Colonist*, January, 15 1998:A4)

This type of housing is necessary according to Edith, the street outreach nurse:

> *In a supportive housing environment, it is easier to make decisions around health and life changes.*

Seventy-five percent of all the residents of supportive housing operated by Streetlink suffer from some type of mental illness. Compliance with medications is a problem with the mentally ill of the street community. In supportive housing units, staff assist former street people with medications, and teach life skills, thus helping these individuals find a job, and improve their life. In Norman and Schwandt 's (1993) study of the impact of supportive housing on former street people, their results showed that the health of these people improved in a supportive housing setting. In their findings, Norman and Schwandt (1993) indicated that former street people believe supportive housing was a "positive thing" which increased their "sense of personal safety and security" (Norman and Schwandt, 1993: 41). This supportive housing promoted a sense of healing, and is a type of therapeutic landscape as defined by Gesler (1992) and described in chapter three. Therapeutic landscapes can possibly assist street people in the transition from street life to permanent accommodation.

Summary

Individual experiences, along with socio-economic and political structures, are factors that precipitated homelessness for Victoria's street community. Becoming homeless can be traumatic and have repercussions upon a person's health. In order to meet one's basic needs while living on the streets, street people must move from one street community facility to another. This movement, which becomes part of the routine of street life, is spatially confined

to a section of downtown Victoria (See Figure 1). While trying to survive, street people encounter prejudices toward them.

Living on the streets is accompanied by a variety of both physical and mental health problems. Frequent colds, stomach pains and pneumonia are common, and many street people reported a variety of health problems and believed their health had worsened since living on the streets. According to street community facility workers, there are a multitude of street health problems, with the most serious being Hepatitis C, Tuberculosis, Pneumonia, Athlete's Foot, and alcohol and drug addictions. In addition to this, issues of mental health, such as Schizophrenia, depression and paranoia are of concern. The nature of street life causes many street people to become distressed and disenchanted with their lives.

Survival on the streets is dependent upon coping skills, and street people were generally pleased with the existing facilities and services available to them. A hierarchy of needs has developed in which health only becomes a concern for street people when it interferes with their daily life. When street people seek medical advice, it is usually through a visit with the street nurse or a visit to the Swift Street medical clinic.

Improving health is equated with access to safe affordable housing. However, the shelter allowance portion of income assistance is not enough, given the cost of accommodation in Victoria. As a result, street people try to rent a single room in a single room occupancy hotel (SRO's). Many of these rooms are in poor condition. Street community facility workers, along with street people, believe that more social housing, especially supportive housing which can be described as a therapeutic landscape, needs to be built in order to improve the lives of street people.

Chapter 6

Summary and Conclusions

Located at the corner of Pembroke and Store streets is a Victorian styled commerical building. Here, in an area of downtown Victoria that has not yet witnessed urban renewal, a section "forgotten" by some, the downtown inter-agency group hosts a meeting each week. Here, every Monday at 9:00 A.M., representatives of the street facility workers in the city as well as representatives of Capital Health, Mental Health, and the Ministries of Health and of Social Development and Economic Security come together to discuss specific issues of concern in the street community. It is a client-driven meeting, where the representatives discuss which street people need some extra assistance at the moment. Often, these meetings focus upon health issues: some schizophrenics living on the streets need reminding to take their medications and assistance in administering them; others, who show signs of rapid deterioration in health, such as excessive weight loss, difficulty with breathing, or incessant coughing, need monitoring and if necessary, referrals to medical care.

The building looks weary, like the surrounding landscape. The red stone brick is glazed with a coat of dark brown industrial pollutants. This is the area of downtown not championed by heritage preservation societies, nor included in downtown economic growth and prosperity initiatives, yet a few blocks away, revitalisation and gentrification are pressing forward. At present, this building, as well as its immediate environs, symbolises marginality, but this situation could well change if redevelopment pushes

further north. If change does come, the plight of Victoria's street community will become exacerbated. This area is illustrated in photos ten through twelve.

The high prevalence of health problems among the street people contributes to health being an ongoing issue on the streets, and one that has daily and seasonal experiences. Athlete's foot is an ongoing problem because of a lack of clean socks and inadequate footwear. Poor hygiene is common for many street people who do not get the opportunity to wash their hands or bathe for extended periods of time. During the winter months, social agencies are concerned with hypothermia due to people sleeping outside. When it rains, bronchitis becomes a concern because of wet clothing that is infrequently changed. These are a just of a few of the challenges of health facing the street community.

For most of the street people, the day is spent in motion, moving from one social agency to the next, for food, for money, and for shelter. Before the daily commute has begun, when the downtown is congested with mist instead of commuters, street people have started another day. Life on the streets begins early, around 7:00 A.M., when some of those people who slept outside begin to migrate to the "9 – 10 Club" for something to eat. Those who were able to stay at an emergency shelter for the night are afforded some extra sleeping time, since shelter residents are guaranteed meals. There are many means of survival on the streets, and these activities are dependant upon the coping mechanisms of the street people. Coping is a function of existing and available resources required for survival, and are derived from existing structural forces operating in society. For some, daily life is spent trying to find casual day work in order to earn some money. It may

Photo 10: The sign on the Open Door Drop-In Facility.

Photo 11: The Open Door Drop-In Building on the corner of Store and Pembroke Streets.

Photo 12: The area surrounding the Open Door Drop-In Facility.

include a visit to a Financial Assistance Officer to apply for income assistance or to pick up a cheque. Many engage in panhandling, while some street women partake in "survival sex" to secure food and shelter for the night. Hanging out with other street people is a means of survival too. Talking with others on the street is a means of negotiating one's own coping mechanisms, and learning from others to improve one's own life on the streets. Disillusioned with their predicament, some turn to alcohol or drugs to mitigate the exigencies of street life.

On the streets, health has its own meanings and priority. According to street people, being healthy means he or she is able to function that day. Poor health is a defining characteristic of street life and one that is tolerated until daily routines are impeded. Then, for street people, poor health actually constitutes a "health problem." When this does happen, they visit the street nurse or the Swift Street medical clinic because the nurse and the staff at this facility do not marginalize them.

Existing structures, such as economic (e.g., capitalism, the restructuring of the welfare state), political (e.g., deinstitutionalization, housing, and health policy, city by-laws), and social (e.g., patriarchy, signification of attitudes towards street people) are constantly in the background affecting the lives of street people. Concomitantly, institutions (i.e., Ministry of Health, Streetlink, Swift Street medical clinic, etc.) are always in the foreground, mediating the affect of the structures influencing life on the streets. Most profoundly, structural change affects health and health behaviour in the street community, particularly finding shelter. For example, safe affordable housing has been indicated as a prerequisite for health. While many street people can obtain income

assistance and intent to rent forms from the Ministry of Social Development and Economic Security, the shelter allowance portion of this financial assistance is insufficient for the rental accommodation market in Victoria. Despite possessing an intent to rent form, social norms, which depict street people as deviant, hinder many from obtaining a place to rent. As a result, street people are forced into alternative situations such as renting a room in a single room occupancy hotel (SRO's). Often, they are unsanitary, in need of repair, and possibly detrimental to a person's health. The Homelessness/ At-Risk initiative, was a part of the housing policy structure developed by members of the provincial government (i.e., agents) in an attempt to alleviate the problems street people encounter securing safe, affordable housing. This initiative of the provincial government was partially responsible for the funding of St Vincent De Paul's planned 44-unit housing and for the Victoria Cool Aid Society's planned 45-unit housing called the Mike Gidora Place for low income and homeless people. This is but one example of the interaction between agency and structure and its effects upon health.

In addition, the landscape of the street community becomes implicated in the interaction between agency and structure, demonstrating how health is embedded in the street landscape. First, health is mediated by landscape. Street people's daily routines are a function of the available resources in the landscape necessary for their survival. Mobility patterns reflect those areas in the landscape where basic needs are met. Second, health is constrained by the landscape. Sleeping outside exposed to the elements and exposure to alcohol and drugs make it difficult to maintain good health. Moreover, street life complicates health care because following advice such as bed rest or staying off one's

feet for a few days is almost impossible to maintain. Third, health is constituted in the landscape. Becoming homeless -- and street life itself -- is a form of spatial displacement from private to marginal space. It is an assault on one's sense of self-worth and it is usually a very traumatic experience. A street person is an "outsider", the "other" in the negative dialectic of US versus THEM (Sibley, 1995; Creswell, 1996). This identity also connects with the landscape. Street people have been labelled as dangerous and deviant (Takahashi, 1996). Such labelling has also extended to the landscape in which they inhabit. Street people, as well as their landscape, are therefore stigmatized and marginalized by the domiciled population.

Stigmatization and marginalization help to shape the identity of the street people, and have consequences for health and health behaviour. Street people inhabit a landscape populated by such people as schizophrenics, drug users, and victims of family abuse. Emergency shelters are an essential service for street people, but prolonged periods of stay at these facilities can lead to a state of "shelterization" whereby street people feel isolated and begin to feel that they have lost control over their own lives (Burns, 1992; Rollinson, 1998). Feelings of inadequacy and low self-esteem become associated with their condition and in some cases, depression results. These issues of low self-worth and depression can lead to passivity and an acceptance that street life is the ultimate fate. Moreover, this sense of hopelessness and despair is underscored by the necessity to fulfil basic physiological needs (e.g., food, water, clothing) and psychological needs (e.g., self-esteem, a sense of belonging). Meeting these needs requires coping skills. Sometimes, this requires "sleeping rough" or ignoring health problems because these have a low

priority on the streets. As well, contact with people having tuberculosis, bronchitis, or HIV+ is an everyday occurrence, thus increasing the risk of street people contracting health problems. This landscape is indeed a pathological landscape since both the social and physical environments are associated with disease, illness, unhealthy behaviours, and negative feelings. In particular, it is a landscape of living death in that health is implicated in every decision affecting street life, a life where survival has a sense of daily immediacy.

This thesis examined the health status of the street community in Victoria, British Columbia. The following three research objectives were addressed: The first objective was to describe the personal problems of health and health care experiences of a sample of Victoria's street population. The second objective was to identify the strategies adopted by the street people in dealing with health and health care issues in the context of their street landscape. The third objective was to interpret the experiences of health problems and health care in the street people's landscape from a structurationist perspective, that is, to examine how individual actions interact with wider social-economic structures to produce the pathological landscape, in particular, a landscape of living death. The scope and context of this thesis were established in relation to recent developments in both the geography of homelessness and medical geography, and amendments to contemporary definitions of health. After establishing a context for understanding homelessness in Canada, a literature review placed the thesis' objectives within the context of a "post-medical" geography, albeit one informed by a structurationist approach. The theoretical approach addressed the agency/structure

dichotomy and considered how individual actions and structural processes shaped the experiences of health and health behaviour in the landscape of the street community.

Structuration theory illuminates the complexity of the health experiences of street people and how their agency is both enabled and constrained by structural processes. Reducing health and homelessness to either agency or structure of necessity ignores the multiple determinants of human health. Street life consists of a hierarchy of needs, one in which health can be ignored, dismissed, until its severity forces necessary care. Health is shaped by human agency and the structures embedded in a particular landscape (referred to as a locale by Giddens), one that has been identified by street people themselves as a landscape of living death. Nonetheless, some researchers claim that it is difficult to demonstrate the recursive relationship between agency and structure. It has been called too abstract a theory for empirical research, with ideas and concepts (such as structure, or system) which are either too broadly or vaguely defined (Evans, 1987:122). This thesis shows otherwise. As a theory of action and consequence, structuration is useful for explaining certain social phenomena, such as the landscape of living death (Evans, 1987:123; Dear and Moos, 1994; Husband, 1994).

My research began with an attempt to examine how health is implicated within the landscape inhabited by the street community. I failed to realize how difficult it would be to gain access to this social group. As many social agency workers mentioned, street people are wary of "outsiders," for many have been victimised and betrayed throughout their lives. Qualitative research through in-depth interviews and journals gave a voice to the street community. It allowed the participants to express their views and concerns, as

they understand them. The information gathered from the 1995 semi-structured interviews was less detailed in some areas of questioning, leading to the development and administering of the 1999 street life journals. All data were read thoroughly, coded and analysed using major themes analysis. Five major themes represented the results of this thesis: Becoming Homeless, Existing on the Streets, Street Community Services and Facilities, Street Health, and Personal Empowerment and Getting off the Streets. These major themes are not mutually exclusive, but represent the major issues of street life that have either a direct or indirect impact upon health issues and concerns of the street community as indicated by the street people and the street community facility workers who assist the street community.

Although not an explicitly stated objective of this thesis, the semi-structured interviews, street life journals, and elite interviews provided some insight into directions for policy development. First, it is important to laud the street community services and facilities for they provide the street people with much-needed amenities as well as emotional support. Many street people made positive comments about the programs and staff at these facilities. In fact, some street people, who have used facilities in other parts of Canada, said the services in Victoria were the best available in Canada. However, there are areas requiring improvement. There is a need to increase the stock of affordable housing in Victoria. The 44-unit housing development presently being built is a start, but more units are required to meet the demand in the city. Second, ensuring the continuance of funding to social agencies in Victoria is essential for maintaining the existing services and resources available to the street community. Moreover, this funding must be stable

and secure, for various government ministries and various levels of government currently support programs. This eclectic mix of funding makes agencies susceptible to financial problems if one ministry or department changes their procedures and eliminates financial support. Third, an increase in shelter allowance is needed to reflect the rental market in Victoria. Fourth, job training initiatives, as well as assistance with the search for full-time employment are essential for improving street people's economic circumstances and possibilities for getting off the streets. Fifth, dental care needs to become part of the operations of the outreach medical facilities currently in Victoria. Without proper dental care, eating can become a difficult task, and possibly resulting in lack of nutrition. The infrastructure of existing street community services and facilities are present, but additional programs would enhance existing services for the street community. In other words, existing and future programs and policies aimed at improving the health of street people must consider ways in which the pathological landscape of living death is replaced by therapeutic landscapes, such as supportive housing developments.

The current trends in post-medical geography research are illustrated by this thesis. Place is important in shaping health. The thesis also represents a convergence with the geographic study of homelessness. Further research in other communities will broaden our understanding of the links between health and the landscape of the street community. Subsequent research should continue with qualitative methods, in order to provide in-depth experiences of the street people's landscape. A more comprehensive ethnographic analysis could provide useful information on how health is both understood and given meaning in the daily lives of street people. To further understand the health

status of the street community, a quantitative analysis that measures health status in terms of specific indicators also is essential. The challenge in future research lies with developing research methods that are sensitive to the life conditions of the street people yet substantial enough that policy initiatives can be suggested, and hopefully implemented.

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January 24, 1996:A1 *How will we cope, recipients ask*

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September 26, 1993:A6 *Tenant's tales illustrate home not always sweet, if you can even find one*

APPENDIX 1

Informed Consent to use the "9-10 CLUB" Soup Kitchen for the purposes of conducting a pre-test

Hello, my name is Tony Sansom and I am a student at the University of Victoria, conducting research on the health status and barriers to health care of homeless people. I would like to ask homeless people who frequent your facility if they would be willing to complete a journal about life on the streets. Any individual who agrees to participate in this project will do so on his/her own terms. It is voluntary and they may decline to participate at any time during the process. Anonymity is guaranteed and all information provided to me will be held in strict confidence. I will be the only person using this data.

I, _____ supervisor or co-ordinator of the _____ agency, do hereby permit Tony Sansom to use the before mentioned agency for purposes of conducting research on the health status of homeless people in Victoria.

_____

Signature of Supervisor or co-ordinator of agency

_____

Signature of Tony Sansom, researcher for the above mentioned project

_____

Date

APPENDIX 2

Pre-test Questionnaire

Hello, my name is Tony Sansom and I am a student at the University of Victoria. I would like to discuss with you today your health. I will not be asking for your name at any time. You have the right to refuse to answer any question or withdraw from this conversation at any time without having to state your reasons. Would you be willing to talk to me about your health?

(If the respondent answers YES, then I will begin the interview)
(If the respondent answers NO, then I will make the following statement: I understand your decision, thank you for your time)

First, I would like to ask you a few questions about your housing situation.

1: In the past 30 days:	1st	2nd
: how many nights did you spend in a hostel?	_____	_____
: how many nights did you spend outdoors or in a public place like a park, stairwell, or parking garage?	_____	_____
: how many nights did you sleep at a friend's place because you had no other place to go or no safe place of your own?	_____	_____
TOTAL:	_____	_____

If total is 10 days or more, then proceed with survey/
If the total is <10, then go to Question 2

1b Gender: Male____ Female____

2: In the past 30 days, have you been in some type of institution, such as a hospital, jail, or in an in-patient treatment program?
If YES, then go to next question. If NO then stop conducting the survey.

3: About how many days? _____
If the total is 30 or more then stop conducting the survey.
If the total is < 30, ask question 1 for the month prior to being in an institution to determine eligibility for the survey.

SOCIOECONOMIC DATA

Now, I am going to ask you some general questions about yourself?

4: How old are you? _____ 5. Where were you born? _____
6. How much do you weigh? ____ 7. How tall are you?

8. Which of the following groups best describes your ethnic identification?
Registered status Indian ___ (from what nation? _____) Asian_____
White_____ Black _____ Other (specify) _____

9. I would like you to think about the last place where you lived. Why did you leave that place?

9b. About how long did you live there? _____
9c. How long has it been since you lived in that place? _____

10. I would like to consider the place where you lived before the one you have just mentioned. Why did you leave that place?

10b. How long did you live there? _____

11. How much money do you get each month?

12. What is the source of your earnings? Where does it come from?

13. What was the last job you had?

14. Why are you not working there now?

15. Are you presently looking for work? _____
16. If NO, then why are you not looking for work?

17. Do you have a (wife/husband) or a relationship with someone? _____
18. Where is this person now?

19.Do you have any children? _____ Where are they right now?

PHYSICAL SYMPTOMS

Now I would like to talk with you about your health.

20. Compared to other people your age, would you say your health is generally:

EXCELLENT	GOOD	FAIR	POOR
1	2	3	4

21. What is the hardest part of trying to stay healthy?

22. Have you ever had any of the following health problems since living on the streets?
stress_____ pain around heart_____ high blood pressure_____
fainting or blackout spells_____ trouble sleeping_____ lost/ gained lots of weight __
headaches____ sinus trouble____ sore throat or a repeated cough_____
shortness of breath_____ coughed up blood _____ frequent backaches _____
painful or swollen joints _____ swelling of ankles____ broken bones____
stomach cramps/sore stomach ___ serious gas pains ___ earache____

double vision____ wear glasses____ need glasses____ wear dentures____
need dentures__

23. Have you ever been hospitalized in the past year? ____If yes, for what reason(s)?

24. When was the last time you had a complete check-up? _____

25. Are you presently taking any medication? ____
26. For what condition are you taking this medication?

27. How do you pay for your prescription?

ACCESS TO HEALTH CARE

Now I would like to talk with you about access to health care.
28. Do you have a B.C. care card? _____

29. Where do you go when you are sick or do not feel well? Street nurse_____
Swift Street Medical Clinic_____ family doctor_____ER_____
other (please specify) _____

30. When did you go there last?

31. Why did you go there?

32. How bad must you feel before you go and seek medical care? Why?

33. Since you have been living on the streets, when you went to seek medical care, have you ever been refused it? _____

34. If YES, then why do you think you were refused medical care?

35. What makes it harder to get better on the streets when you have a health problem?

MENTAL HEALTH

Now I would like to ask you some questions about how you feel about life in general.
36. Which of the following things bother you about your present living arrangements?
YES = 1, NO = 2
[Taken from LaGory *et al.* (1991)]
(Physical factors)
crowded___ dirty___ noisy ____ damp____ hot____ cold____

(Social factors)
rules___ the way people act____ lack of privacy____ concerns about safety____

Mastery of Fate Scale YES = 1, No = 2

Please answer yes or no to the following questions:

37. How strongly do you agree or disagree that"

a. you have little control over the things that happen to you? 1 or 0
b. there is really no way you can solve some of the problems you have. 1 or 0
c. you often feel helpless dealing with problems of life. 1 or 0
d. what happens to you in the future depends on you. 1 or 0
e. you can do anything that you set your mind to. 1 or 0
f. sometimes, you feel you are being pushed around in life. 1 or 0

38. Since living on the streets, have you ever gotten depressed? ____ Why?

39. Have you ever been hospitalized for a mental health problem? _____ If so, why?

40. How long were you hospitalized? _____

NUTRITIONAL CONCERNS

Now I would like to look at some questions concerning what you eat.

41. Where do you go for food?

42. How many meals do you eat in a day? _____

43. Are you supposed to follow a special diet for health reasons? _____ if yes, then why?

44. Can you afford to buy the foods that you are supposed to eat? _____

45. Do you have a place to store your food? _____

WOMENS HEALTH ISSUES

46. When was the last time you had a check-up from a gynecologist?

47. Where do you go for your feminine hygiene needs?

48. What problems do women have living on the streets?

49. Beside the health questions already discussed, what health problems affect you as a woman?

IMPROVING HEALTH

50. What do you think is needed in order to improve the health of street people?

51. Thank you for talking with me today. Before you leave, would you like to say anything about your health that we did not discuss?

THE END

APPENDIX 3

Informed Consent to use the Streetlink Emergency Shelter for the purposes of conducting interviews with street people

Hello, my name is Tony Sansom and I am a student at the University of Victoria, conducting research on the health status and barriers to health care of homeless people. I would like to ask homeless people who frequent your facility if they would be willing to complete a journal about life on the streets. Any individual who agrees to participate in this project will do so on his/her own terms. It is voluntary and they may decline to participate at any time during the process. Anonymity is guaranteed and all information provided to me will be held in strict confidence. I will be the only person using this data.

I, _____ supervisor or co-ordinator of the _____ agency, do hereby permit Tony Sansom to use the before mentioned agency for purposes of conducting research on the health status of homeless people in Victoria.

_____

Signature of Supervisor or co-ordinator of agency

_____

Signature of Tony Sansom, researcher for the above mentioned project

_____

Date

APPENDIX 4:
The 1995 Semi-Structured Interview Guide

Hello, my name is Tony Sansom and I am a student at the University of Victoria. I would like to talk to you about your health and how you deal with health problems on the streets. I am also interested in what you think should be done to improve your health. I WILL NOT BE ASKING YOU FOR YOUR NAME. Anything we talk about today will be kept confidential. Would you be willing to talk to me?

If the respondent answers YES, I will begin the interview.

First, I will like to know about your housing situation.

In the past 30 days:

How many nights did you spend in a Hostel? _____

How many nights did you spend outdoors in a public place like a park, stairwell, or parking garage? _____

How many nights did you sleep in a friend's place because you had no other place to go or no safe place of your own? _____

TOTAL: _____

People who have spent 10 or more days at any or all of the above places will be eligible for the interview.

LIFE COURSE/LIFESTYLE

1. Gender: Male __ Female __ What ethnic group do you consider yourself belonging to?
2. How old are you?
3. Where were you born?
4. How much do you weigh?
5. How tall are you?
6. What are your sources of income?
7. Why did you leave your last permanent place of residence?
8. What were the circumstances under which you came to live in the streets?
9. How long have you been living on the streets?

10. Do you smoke? Do you drink? (How often? What do you smoke and drink?)

THE HOMELESS ENVIRONMENT

11. What do you do during the day? Describe a typical day for you. Where do you go? What type of activities do you do?
12. How do you spend the evening hours?
13. Where do you sleep at night? Why do you sleep there?
14. Have you ever slept in a shelter? What is it like to sleep in a shelter?
15. Why do you live in Victoria, as compared to other cities in B.C or Canada?
16. What does Victoria as a place mean to you?
17. What does downtown as a place mean to you?

NUTRITION AND HYGIENE

18. How often do you eat? Do you have a special diet? How do you handle your special diets?
19. Where do you go to eat?
20. Why do you go to these places?
21. How would you describe soup kitchens and shelters as places to go to eat?
22. When and where do you take showers or have baths?
23. What types of dental problems have you had since living on the streets?
24. How would you handle dental problems
25. Do you have any other hygiene problems or issues?

GENERAL HEALTH CONDITIONS

26. Describe your health. Do you consider yourself healthy? Why or why not?
27. How do you take care of your health yourself?
28. Are you presently taking any medication? For what conditions are you taking it?
29. Have you ever been hospitalised since living on the streets? Why were you? hospitalised?
30. Do you have specific health concerns? What are they?
31. How do you handle feminine hygiene needs since living on the streets?
32. What other types of health concerns do you have because you are a man/woman?
33. What changes in (the streets, available services, and the health care system) would you like to see to stay healthy?

ACCESS TO HEALTH CARE

34. What do you do when you feel ill or sick, or when you simply don't feel well?
35. When you are ill or sick, What do you do to deal with it? Can you give examples?
36. How bad do you have to feel before you seek health care?

37. Where do you go to get this help?Why do you go to this place?
38. How often have you gone there?
39. Have you ever been refused health care? Why do you think you did not get help?
40. What did they tell you was the reason they refused you health care?
41. How far along in the process were you before they refused you care?
42. Do you have a B.C. Care card?

PHYSICAL AND MENTAL HEALTH ISSUES

43. How well do you sleep at night? Probe (what problems do you have. Why?)
44. What about stress? Do you feel your life is stressful? Why or Why not?
45. Do you ever feel lonely? What do you do about it?
46. Do you think it is important to have friends when you live on the streets? Why? What do you do with your friends?

THE STREET COMMUNITY'S LANDSCAPE

47. How easy or difficult is it to get better when you live on the streets? Why do you think this?
48. Has your health become better or worse since living on the streets?
49. What types of health problems have you had since living on the streets?
50. Beside health problems, What other types of problems have you encountered since living on the streets?
51. Does living on the streets affect your health? How so?
52. How different do you think your health would be if you didn't live on the streets?

THANK YOU.

APPENDIX 5:

Informed Consent to use the Victoria Street Community Association for the purposes of asking street people to complete journals

Hello, my name is Tony Sansom and I am a student at the University of Victoria, conducting research on the health status and barriers to health care of homeless people. I would like to ask homeless people who frequent your facility if they would be willing to complete a journal about life on the streets. Any individual who agrees to participate in this project will do so on his/her own terms. It is voluntary and they may decline to participate at any time during the process. Anonymity is guaranteed and all information provided to me will be held in strict confidence. I will be the only person using this data.

I, _____ supervisor or co-ordinator of the _____ agency, do hereby permit Tony Sansom to use the before mentioned agency for purposes of conducting research on the health status of homeless people in Victoria.

_____

Signature of Supervisor or co-ordinator of agency

_____

Signature of Tony Sansom, researcher for the above mentioned project

_____

Date

APPENDIX 6:

Questionnaire and Informed Consent to conduct interviews and with Directors of Street Community Facilities and Services

Hello, my name is Tony Sansom (phone number: 881 - 1905) and I am a student at the University of Victoria, conducting research on the Health Status of Victoria's Homeless Population. I would like to ask you questions about your views and experiences dealing with people in the street community in relation to your work at this agency. Your participation will require approximately 30 minutes of your time and the information provided will be used in a report to the Ministry of Health and may be published in a scholarly journal. Participation is completely voluntary and you may decline to participate or answer any question(s) during the process without any explanation. If possible, I would like to use your name or the name of this agency in the write up of my study; however, anonymity is guaranteed if you so desire. The name of my supervisor is Dr. Pamela Moss and she can be reached at 721 -7211 ext 4630 if you would like to discuss further the research itself. Any Data collected will remain confidential and results will be kept locked in a filing cabinet in a locked office. Only Dr. Pamela Moss and myself will have access to this data. If you decide not to use your name, it will not be attached to any published results, and your anonymity will be ensured through coding the material with a number. All written material provided by you for this research will be destroyed upon the completion of my thesis.

Signature: _____

1. Describe the program, including sources of funding.

2 What health issues exist on the streets? Major ones? Minor ones? Which are the most pressing?

3. What health problems do you treat? What is the most common? Do you make referrals? To whom? Where?

4. Do you make referrals for health problems? To whom? Where?

5. Why do you think street people come to your facility?

6. What do you think is needed to improve the health of the street community? Please give examples

7. How does the nature of streetlife affect the provision of health care to street people?

8. How badly must people feel before they will seek health care? Why?

APPENDIX 7:
Street Life Journals

Hello, my name is Tony Sansom and I am a student at the University of Victoria, conducting research on the Health status of Victoria's street population. I would like to answer some questions about your views and experiences of street life through a written journal and questionnaire. The topics include: health, social service agencies, attitudes about the government, etc. The questionnaire will take approximately 45 minutes to answer, while the journal will require approximately 10 minutes each day for 7 days to complete. All information will be kept confidential. Information provided will be used in a report to the Ministry of Health and may be published in a scholarly journal. Your participation is completely voluntary and you may decline to participate or answer any question(s) during the process without any explanation. You will receive $10 dollars for agreeing to fill out the journal and will be paid when you return it. Payment is not based upon completeness but on your willingness to fill out any of the questions or journal. Any Data collected will remain confidential and results will be kept locked in a filing cabinet in a locked office. Only Dr. Pamela Moss and myself will have access to this data. Anonymity will be ensured through coding your answers with a number. All written material provided by you for this research will be destroyed upon the completion of my thesis.

For the next week, I would like you to keep a journal about your thoughts and experiences of street life. There are some areas that I would like you to write about and I have noted them below. Write as much as you would like about these, or any other aspects about living on the streets (on the provided paper). Thank you.

Background – 1(a). Gender: Male __ Female __ (1b) What ethnic group do you consider yourself belonging to (1c) How old are you? (1d)Where were you born (1e) How much do you weigh? (1f). How tall are you?

2. Streetlife - (What do you do, where do you hang out, importance of friendships, etc.)

3. Money - (income sources, how much, what do you spend the money on and where, etc.)

4. Food- (what do you eat, where, and how do you get food, etc.)

5. Health Issues - (nutrition, needles, condoms, on-going health problems/conditions, etc.)

6. Social Services - (attitudes, service, money, how often do you deal with them, how do they deal with you, etc.)

7. Drop - ins and Shelters - (attitudes, service, money, how often do you deal with them, how do they deal with you etc.)

JOURNAL

Please record your activities for each day for one week (Thursday though Sunday can be found on the next page)

ACTIVITIES	Monday	Tuesday	Wednesday
Sleeping Place			
Number of Meals Eaten			
Places Visited			
Sources of Income			
Health Problems			
Street Facilities Visited			

JOURNAL – CONTINUED

Please record your activities each day for one week

ACTIVITIES	Thursday	Friday	Saturday	Sunday
Sleeping Place				
Number of Meals Eaten				
Places Visited				
Source of Income				
Health Problems				
Street Facilities Visited				

APPENDIX 8

Codes and Subcodes for Major Themes Analysis

CODE	ABBREVIATION
BECOMING HOMELESS	**BH**
Street community facility worker's view	BHSCFV
Personal problems	BHPP
Money Problems	BHMP
Health Problems	BHHP
Economic Issues	BHEI
EXISTING ON THE STREETS	**ES**
Wandering around	ESWA
Basic Needs	ESBN
Socializing	ESSO
Panhandling	ESPH
Doing drugs/alcohol	ESDDA
Weather	ESW
Interaction with other people	ESIOP
Keeping to yourself	ESKY
Good food	ESGF
Want more food variety	ESMFV
Exposure to strange people	ESTSP
STREET COMMUNITY FACILITIES AND SERVICES	**SCF**
Positive feelings about shelter	SCFPF
Negative feelings about shelter	SCFNF
Funding	SCFF
Available services	SCFAS
STREET HEALTH	**SH**
Going to medical outreach centres	SHGMO
Going to the ER	SHER
Severe conditions before seeking health care	SHSC
Dismissing health problem	SHHP
Feeling stressed	SHFS

APPENDIX 8 (Continued)

Codes and Subcodes for Major Themes Analysis

CODE	ABBREVIATION
STREET HEALTH	**SH**
Feeling negative/depressed	SHFND
Feeling fine	SHFF
Exposure to germs	SHEG
Pains/aches	SHPAC
Dental problems	SHDP
Mental health issues	SHMHI
Internal organ problems	SHIOP
Colds/flu	SHCDF
Pneumonia	SHPN
Other problems	SHOTP
Nutrition	SHNU
PERSONAL EMPOWERMENT AND GETTING OFF THE STREETS	**PEGS**
No stress	PEGSNS
Routine and stability	PEGSRS
Will improve health	PEGSWH
Looking to improve yourself	PEGSLY
Looking for a place to rent	PEGSH
Supportive housing	PEGSSH
Problems with welfare	PEGSPW

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Title of Thesis:

Health and Homelessness: A Landscape of Living Death

Author [redacted]

Tony Sansom

April 12, 2000