Home Care for the Homeless:
Experiences of Infirmity Clients at the Sherbourne Health Centre in Toronto

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A thesis in partial fulfillment of the requirements for the degree Master of Arts

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Abstract

This thesis examines how being homeless or under-housed can impact one's health. It uncovers the coping strategies and general life issues of individuals who are recovering from medical crisis and have utilized the Infirmary Program at the Sherbourne Health Centre in Toronto. The Infirmary offers 24-hour beds to precariously housed individuals recovering from a medical condition. This unique resource provides a safe environment for people who no longer require formal hospitalization, but who do not have access to an environment in which they can adequately recover from their condition. Data for this project were collected by conducting interviews with 12 Infirmary clients and three Infirmary staff members. This study revealed that a variety of intersecting factors affected their capacity to manage their health issues within the context of being homeless. This thesis is important in understanding how inadequacies in the health care, housing, and shelter systems intersect.

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CHAPTER ONE: INTRODUCTION

This thesis examines the impact of socioeconomic inequality on health. It uncovers the health coping strategies and general life issues of under-housed and homeless individuals in Toronto, Canada, who are recovering from an acute medical emergency. The research project on which this thesis is based explored the obstacles that such individuals face when they are recovering from a health emergency related to a chronic medical condition, recovering from a fracture or surgery, or recuperating after childbirth. Additionally, I investigated what factors contribute to an individual being able to manage their health after they have utilized a public health facility, the Sherbourne Health Centre's Infirmary, which provides an array of referrals and resources to homeless and under-housed clients.

The Sherbourne Health Centre is an urban primary health care facility serving the needs of southeast Toronto. The Infirmary Program occupies one floor of the Sherbourne Health Centre and runs 24 hours a day, seven days a week to assist homeless or under-housed individuals in recovering from a medical condition. The Infirmary is a unique resource which provides a safe environment with beds and health care professionals for individuals who no longer require formal hospitalization, but who do not have access to an environment in which they can adequately recover from a health emergency or medical procedure. As one staff member put it, the Infirmary provides 'homecare to the homeless.' Homeless and under-housed individuals are particularly vulnerable to experiencing health crises if they do not have access to basic living requirements or the

tools to manage these resources. This thesis reveals how a stay at this centre can impact people after they have left, and how Sherbourne's Infirmary has assisted them in managing their chronic health conditions, disabilities, or lives in general. Interviews with Infirmary clients and staff members yielded data that revealed areas where Infirmary services and referral routes may be improved. In this way, this thesis seeks to benefit the Sherbourne Health Centre and its future clients.

Individuals who are homeless or under-housed experience disproportionate levels of illness when compared to the general population. Extreme poverty exacerbates chronic conditions (such as HIV/AIDS and diabetes), makes it more difficult to recover from wounds and fractures, and increases the risk of both infectious diseases and mental illness. Individuals can suffer from multiple 'axes of marginalization' as well as traumatic factors that have occurred throughout the life course that create some vulnerability or disadvantage for the person in achieving good health. Abuse or neglect during childhood, relationship abuse in the past or present, racism, discrimination based on sexual orientation, lack of appropriate housing, lack of financial resources, the absence of steady and meaningful employment, limited access or usage of health and counselling facilities, limited access to medication, medical supplies, and nutritious food, not possessing citizenship, limited cultural, community, or familial resources, and having mental health issues, addictions or learning disabilities, are all examples of factors that can affect one's health and utilization of health care services. In addition, some of these factors can impact one's self-esteem and influence relationships with service providers. These variables can influence whether one is likely to fall into a state of poor health,

especially if a pre-existing illness is present. This thesis reveals which life factors are the most crucial in these individuals' lives, using a 'determinants of health' perspective which takes into account all major social and economic facets of someone's life that may lead to poor health or housing instability. The Public Health Agency of Canada (2009) recognizes that the following key determinants influence the health of individuals and communities: income and social status, social support networks, education and literacy, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture. The Public Health Agency of Canada (2009) acknowledges that these factors are interrelated, and also suggests that social and economic status are the most important determinants of health. Raphael (2004a) adds that social determinants of health are powerful indicators of whether a person stays healthy or becomes ill, and the extent to which a person or community has the material and social capacities to satisfy needs and cope with the environment. Although many of the participants of this study face significant barriers to maintaining their health and well-being, the underlying goal of the study was also to focus on people's capacities, survivorship skills, and resilience.

The public health care system operates on the assumption that individuals have adequate housing when they are discharged from hospital stays. The fact that the Infirmary at Sherbourne Health Centre in Toronto exists reveals that many homeless and under-housed individuals' recovery needs are not being met by the majority of public health care facilities. Poverty and social marginalization make it more difficult to

recuperate from an acute health crisis even after one has been formally treated. Relying on the shelter system or sleeping on the street impedes the recovery process for the individual, which not only reduces the quality of life for these patients, but results in an inefficient use of public health resources. This thesis is important because it reveals how gaps in the health care and public housing systems intersect.

A key message of this thesis is that the Sherbourne Infirmary approaches client care in a way that opens the gates for people to start managing their chronic conditions in constructive, beneficial ways. Most of the clients that I interviewed felt that the Infirmary was so top-notch, and that its approach was so innovative, that it ended up being the springboard for a variety of positive changes in their lives. The Infirmary is often a site of issue resolution—whether it be housing, medical, interpersonal, or self-worth issues—that ultimately paves the way for better health management and improves quality of life for clients. If aspects of the Infirmary’s model of care were incorporated into more public health care facilities, a significant burden would be lifted from the Canadian health care budget and from the shoulders of Canadian health care professionals.

Contextualizing Health and Homelessness within Canada and Toronto

In October 1998, the mayors of Canada’s largest cities, including Toronto, declared homelessness within our country “a national disaster” (Layton 2008). This is

surprising considering that Canada has a reputation for a high quality of life for its citizens. Hwang (2001) reports that tens of thousands of Canadians experience homelessness every year. Hwang et al. (2008) reveal that a staggering 5000 people can be defined as 'homeless' on any given night in Toronto and that approximately 29,000 Torontonians use shelters each year. These individuals are at an increased risk of dying prematurely and face significant barriers that interfere with their access to essential services, including health care. Hwang (2001) also reveals that in many Canadian cities, including Toronto, the number of people who are homeless has increased in recent years. The Toronto Report Card on Housing and Homelessness (2003) reports that in 2001, 552,300 people, or a quarter of Toronto's population, live in poverty and that 22.6 percent of the population was living below the Low Income Cut-Off (LICO). This report also revealed that 31,985 homeless individuals (including 4,779 children) stayed in a Toronto shelter at least once during 2002.

Poverty and homelessness in Toronto should be considered a municipal emergency. Hwang (2001), a physician to homeless persons in Toronto, lists medical problems that are particularly common among homeless adults, including respiratory tract infections, seizures, chronic obstructive pulmonary disease, arthritis, foot disorders, skin infections, and oral/dental complications. Hwang (2001) also states that conditions such as hypertension, diabetes and anemia are often poorly managed within this population and may go untreated for extended periods. This increases the likelihood that the disease will worsen and also leaves the individual more susceptible to secondary disease complications that are sometimes irreversible. Homeless individuals are

particularly vulnerable to contracting HIV through intravenous drug use and unprotected sex, which is sometimes related to prostitution (Hwang 2001). Another Toronto-based study by Dr. Hwang found that the leading causes of death for homeless men aged 18-44 who used shelters were accidents (including falls and being struck by vehicles), poisonings (mainly unintentional drug and alcohol overdoses), AIDS, and suicide (Hwang 2000). Among 45-64 year-old men, the most common causes of death were found to be cancer, heart disease, cerebro-vascular disease, and traumatic accidental death (Hwang 2000). Cheung and Hwang (2004) discovered that homeless women aged 18-44 in Toronto were 10 times more likely to die than their counterparts in the general population, and had a mean age at death of 39 years. Furthermore, homeless women in Toronto were found to have higher rates of major depression than homeless men. The most common causes of death for this segment of the population was AIDS and drug overdose (Cheung and Hwang 2004).

Toronto is the largest urban centre in Canada, with a population exceeding 2.5 million in 2006 (Statistics Canada 2009). It is one of the most multicultural cities in the world and is extremely diverse with respect to the socio-economic status of its residents. Because Toronto is large, diverse, and also a hub for academic and medical research, it contains a wide range of health care, social, community, cultural, and housing/shelter resources. The City of Toronto's Shelter, Support and Housing Administration funds and manages a wide variety of programs that provide support services to help people who are homeless and those who are at risk of becoming homeless. They create supports and work with 90 community partners toward the goal of reducing homelessness within

Toronto (City of Toronto 2009). Together, the City and their community partners provide approximately 3,800 permanent shelter beds for individuals in over 60 locations, including 10 operated by the City. In addition, there are over 40 drop-in centres across Toronto that provide basic services such as food and shower facilities and assistance with finding housing and accessing shelters (City of Toronto 2009). Unfortunately, the demand for shelter/housing and relevant health care services exceeds the current supply. Homelessness is a growing problem in Toronto, and at the same time, many homeless individuals are not having basic life needs met.

The Street Health Report (2007), which surveyed 368 homeless adults in Toronto from November 2006 to February 2007, revealed how poor physical and mental health and high levels of social isolation and assault are affecting a large proportion of this population. It concluded that three-quarters of homeless people in Toronto had at least one serious physical health condition, with over half (56%) reporting experiencing depression in the past year, and with one in 10 attempting suicide in the past 12 months. Violence and sexual assault disproportionately impact this population, with 35% of survey respondents reporting that they had been physically assaulted in the past year and 21% of homeless women reporting that they had been sexually assaulted or raped in the past year (The Street Health Report 2007). More than half (54%) of survey respondents were living with fatigue so extreme that they reported they did not have the energy to walk one block or perform light physical work (The Street Health Report 2007). A significant proportion of the homeless population is chronically sleep deprived, which can lead to or exacerbate a variety of medical and psychiatric conditions, including heart

attacks and depression (The Street Health Report 2007). In addition, hunger, malnutrition, harassment, and bed bugs in shelters are all issues that contribute to the poor physical and emotional health of homeless persons in Toronto and other Canadian cities.

Toronto's climate can have a direct adverse impact on the health of the homeless. It is a city known for its hot and humid air masses during the summer months and frequent snowfalls during the winter months. Summer temperatures have been recorded to exceed 40°C in the summer and to drop below -32°C in the winter (Environment Canada 2009). Exposure to these extremes or even long periods of walking or standing during more tolerable temperatures can be detrimental to one's health. Respiratory distress, dehydration, and freezing deaths are just a few of the issues that have been extensively recorded in Toronto's homeless population. The Street Health Report (2007) states that homeless individuals are exposed to the elements of the urban environment far more than the average person, and therefore have more exposure to dampness and pollution. Because of these environmental factors, the homeless population is at increased risk for developing arthritis, pneumonia, allergies, asthma, and foot problems (The Street Health Report 2007). Frankish, Hwang and Quantz (2005) reveal that long periods of walking and standing and prolonged exposure of the feet to moisture and cold can lead to cellulitis (an inflammatory bacterial infection affecting soft tissue), venous stasis (slowed blood flow in the veins, especially in the legs, that increase the risk of developing a blood clot), and fungal infections. However, shelter environments can pose their own set of health risks. Shelters are often crowded with poor ventilation and house

large transient populations. Because of these factors, clients can be exposed to tuberculosis or infestations with scabies and lice (Frankish, Hwang and Quantz 2005). Bedbug infestations and theft are also commonly reported within shelters. Given the fact that the homeless population has disproportionately high rates of mental illness and substance abuse issues, one must also consider the psycho-social effects that shelters can have on clients.

The Canadian Health Care System

Despite the fact that the publicly funded Canadian health care system provides universal access to health care for citizens and permanent residents of Canada, the homeless actually have the worst access to care that could save or improve their lives. This fact is appalling considering that this population has the greatest need for medical care amongst Canadians. In addition, members of this population are routinely refused services because they do not have a health card and this issue is getting progressively worse. The lack of basic rights and access to essential services is a theme that permeates most aspects of life for homeless individuals and limited access to medical care only highlights this reality. Homelessness is not just a matter of being without shelter; it is the most severe manifestation of marginalization and deprivation in our society. And for many, it is both a cause of and a result of being sick.

Canadians take much pride in their health care system and tend to think of health

as a right. In fact, in a 2004 on-line poll conducted by the CBC, Canadians voted Tommy Douglas, the ‘father’ of Canadian Medicare as the “greatest Canadian of all time.” Shortly after, the Supreme Court of Canada ruled that “[t]he Canada Health Act and the relevant [provincial] legislation do not promise that any Canadian will receive funding for all medically required treatments” (Feldberg and Vipond 2006). This statement was made in regards to the coverage of specialty treatments for autistic children and the court also noted that the *Canada Health Act* establishes that provinces must fund ‘core’ medical services. However, this statement highlights the fact that our ‘universal’ health care system may still be selectively inclusive.

Early into the data collection phase of this project, it became evident that there were very few medical resources in Toronto that tailored their services to the needs of the homeless population. Most of the homeless and formerly homeless interviewees in this study found this reality to be particularly frustrating. They reported that mainstream health personnel frequently made false assumptions about them, were open with harsh judgments towards them, or assumed that all patients had adequate housing and income. These scenarios have the capacity to constrain treatment options and discourage further use of public health care resources. As a result, these individuals were more likely to access health care when their condition had escalated to a point where they required emergency services and usually ended up having longer inpatient stays. This cycle is both unproductive and unnecessarily expensive. This conclusion is consistent with Hwang’s (2001) finding that the homeless population uses health services differently than other Canadians—they have higher levels of service use and often obtain treatment in

hospital emergency departments. They are admitted to hospitals up to five times more often than the general population and have longer stays. Hwang (2001:231) reports:

These prolonged stays in hospital result in significant excess health care costs. Unfortunately, homeless patients are sometimes discharged to shelters, even when their ability to cope in such a setting is minimal at best. One solution to this problem is the development of respite facilities to provide homeless people with a protected environment for recuperation after a stay in hospital.

The Infirmary at Sherbourne Health Centre exists to address this issue in Toronto.

Housing in Canada

Like health care, housing is also recognized as a basic right in Canada.

Unfortunately, this right has not been realized for many citizens. Although the exact number of homeless individuals cannot be known,¹ it is estimated that there are currently 150,000 to 300,000 homeless and precariously housed people in Canada who cost taxpayers approximately \$4.5-to \$6-billion annually (Laird 2007). Layton (2008) reports that the rise of mass homelessness across Canada in the past 20 years can be traced back to the termination of the National Affordable Housing Program and the subsequent affordable housing crisis. Up until 1993, Canada had a successful national housing program that built 650,000 units to house two million people in its near five-decade existence (Layton 2008). Since then, need for affordable housing has drastically

¹ Statistics Canada does not have data on the number of homeless people in Canada. Also, there are challenges with locating, identifying, and classifying the homeless. Counting the homeless is a politically-charged process, fraught with logistical and ethical issues.

outnumbered supply with waiting lists in most big cities averaging five to 10 years. Provinces soon withdrew from social housing as well and downloaded this responsibility to cities, which for the most part, were overwhelmed and poorly equipped to cope with the enormous demand (Layton 2008). Frankish, Hwang, and Quantz (2005) reveal that homelessness is also fuelled by a loss of rental units and a shortage of social housing in large Canadian urban areas. In 2006, the United Nations declared the issue of housing and homelessness in Canada a “national emergency” (Shapcott 2008).

Homelessness: A ‘Life-Limiting Illness’

Because of its devastating influence on health, it is helpful to think of homelessness as a ‘life-limiting illness.’ It is an undisputable fact that homelessness shortens one’s lifespan and reduces the quality of one’s life. This perspective is adapted from social worker Patricia Miller’s (RSW, MSW) concept of chronic homelessness as a ‘life-limiting illness’ (Miller 2009). In her research on palliative (or ‘end-of-life’) care services for chronically homeless individuals, Miller asserts that the disease trajectory is usually quite different for a homeless person, when compared to that of an average, housed individual. She notes some common features of homeless individuals with advancing disease, which include a strong sense of survivorship, a distrust of authority, limited interpersonal relationships, apprehension about being treated in a pejorative manner, a preference for seeking treatment in familiar settings, and institutional and personal barriers to accessing medical care (Miller 2009). Models of health care must

therefore be tailored to the homeless if they are to be effective in treating this population's unique needs. The Infirmary at the Sherbourne Health Centre is the first free-standing infirmary of this sort in Canada and continues to be used as a health care model by health care agencies throughout Canada and around the world. It specializes in providing care to the homeless and takes the common features mentioned above into consideration.

It can be argued that housing is an illness prevention intervention. There are several studies that support this assertion with respect to HIV and diabetes. For example, Elifson, Sterk and Theall's (2007) study reveals that unstable housing is strongly associated with risky behaviours and life situations in women living in inner-city Atlanta. They state that alcohol and other drug use is prevalent among those who lack stable housing. Women's substance use often co-occurs with risky sexual behaviour, violence and victimization, poor social support, and mental health issues. Detrimental psychosocial characteristics such as poor self-control (sensation seeking), depression, lower levels of assertiveness, and low self-esteem have been linked to substance use among women who are homeless. These women are more likely to engage in risky sexual behaviour and drug use, thus putting them at a higher risk for acquiring HIV (Elifson, Sterk and Theall 2007). These researchers postulate that housing status influences levels of psychological and psychosocial functioning, which is directly related to the concept of illness 'risk.' Elifson, Sterk and Theall (2007) report that in their study, women with unstable housing conditions had higher rates of crack cocaine use, were significantly less likely to reduce sex bartering and the number of paying male partners,

were less likely to increase condom use with these partners, and were more likely to have sex with an intravenous drug user (IDU), compared to those who were in a stable housing environment. Clearly, the experience of homelessness impacts both the way that a woman may manage risk towards her body and the likelihood that she will find herself in a dangerous situation. These authors reveal that women who have serious drug problems may have more difficulty *finding* stable housing in the first place (presumably because of behaviour or societal stigma), thus making it more difficult for them to escape the cycle of addiction. To summarize, unstable housing conditions can create structural barriers to HIV risk reduction (Elifson, Sterk and Theall 2007).

Perhaps most revealing is the finding by Aidala and Sumartojo (2007) which states that formerly homeless individuals who obtain housing are more likely to stop or decrease both drug related and sexual risk behaviours, which in turn contributes to decreased risk of acquiring HIV or transmitting it to others. These authors report that HIV risk-reduction interventions that fail to address aspects of housing have found that participants who stay in unstable housing conditions are significantly less likely to change risky behaviour when compared to stably housed participants (Aidala and Sumartojo 2007). In addition, Aidala and Sumartojo (2007) consider the causal relationship between housing, various aspects of social life, and health. They draw attention to the fact that social networks often provide emotional support, which acts as a “buffer” against stress, facilitates the transmission of important information and provides tools for positive coping. They state that stable housing “...provides the necessary social and physical space to develop and maintain social ties and positive social relations which

are strongly associated with a variety of [positive] health behaviours and outcomes” (Aidala and Sumartojo 2007:S4). Although this assertion may overlook the potential sense of community that an individual may have living on the street, it is an indisputable fact that stable housing provides individuals with a much wider range of resources and low-risk environments that can lead to maintaining good health and reduced the risk of becoming infected with HIV. For those who are HIV-positive, housing stability is strongly associated with better health-related outcomes. Leaver et al. (2007) report that HIV is now commonly considered a chronic condition that can be managed through adherence to a healthy lifestyle, medication regimens, and consistent monitoring and treatment. In sum, with the proper supports, HIV does not have to be a death sentence for people who are homeless.

An HIV-positive person’s housing (with respect to quality, location, and affordability) is a powerful determinant of that person’s ability to meet disease management requirements, thereby impacting quality and length of life. When vulnerably housed individuals receive some form of housing assistance, their routine use of primary health care services (first point consultation, usually with a general practitioner) is better (Leaver et al. 2007). This finding has obvious illness management and prevention implications because the homeless population in Canada makes disproportionate use of *emergency* medical services. Leaver et al. (2007) also claim that housing instability is a strong predictor of patient non-adherence to HAART (Highly Active Antiretroviral Therapy—widely accepted to be the most effective HIV treatment) and that better adherence was found for people who lived in stable housing. HAART

guidelines require patients to have access to a nutritious diet and adhere to strict scheduling regimes, both of which may not always be realistic for those who are homeless. In addition, a Canadian study revealed that HIV-positive individuals in stable housing were less likely to be co-infected with hepatitis C (Braitstein et al. 2005); each of HIV and hepatitis C increases the severity and limits the treatment options of the other. Shubert and Bernstein (2007) summarize the ‘housing as disease prevention and health care’ argument by stating that the provision of housing assistance to low-income individuals is important as a basic human right, as a necessary component of managing disease treatment, and as a public health measure to prevent the spread of a variety of serious infections.

Diabetes is a disease that requires stringent monitoring of blood sugar levels and regular medical care in order to avoid serious health issues such as vision loss and blindness, renal failure, heart failure, stroke, coma and even death (Huang et al. 2007). When the disease is well managed, most individuals with diabetes can carry out normal lives and avoid these complications. Hwang and Bugeja (2000) report that the prevalence of diabetes is about 3% in Toronto’s homeless population and that many of these individuals experience difficulties managing their diabetes (72% in their sample of 50 people—44% of which were found to have inadequate glycemic control). The most common barriers to adequate diabetes management were all related to housing and/or income and included difficulties related to diet (either type of food served at shelters or the inability to make dietary choices), scheduling and logistics (the inability to access insulin/other diabetic supplies, and the inability to coordinate medications with meals),

and the barriers that can potentially arise when people are suffering from mental health problems or substance addictions (such as adhering to a monitoring-treatment regimen or having adverse drug-substance interactions), which are more prevalent in the homeless population to begin with (Hwang and Bugeja 2000). This study illustrates how homelessness can directly impact disease management and progression.

HIV and diabetes are just two examples of chronic health conditions whose severity and treatment approaches are strongly linked to housing status and both are discussed with reference to individuals interviewed for this project. However, it is also necessary to discuss some of the other health issues that are associated with homelessness. The key point is that homeless people are much more likely to die a premature death than people in the general population. Gender-specific studies have confirmed this fact in Toronto. O'Connell (2004) states that mortality rates among homeless women aged 18 to 44 in Toronto are 10 times that of housed women in the same location and age group. Frankish, Hwang and Quantz (2005) discuss how homelessness adversely affects health in the Canadian context, reporting that men using homeless shelters in Toronto are two to eight times more likely to die compared to their housed counterparts. They draw attention to the fact that injuries and assaults pose a severe threat to the health of homeless individuals, with 40% of homeless persons reporting assault and 21% of homeless women reporting rape in the past year (Frankish, Hwang and Quantz 2005). When these figures are combined with the evidence that shows that homeless individuals have disproportionately low amounts of trust in and usage of public services such as police (Zakrison, Hamel and Hwang 2004) and health

care, a frightening and dismal picture is painted for those who live on the streets.

The Sherbourne Infirmary's key partners include housing workers, Ontario Works ('social assistance'), and personal support workers. Therefore, Infirmary clients have the benefit of utilizing professional support to gain housing, and accessing economic and long-term medical supports after their stay is completed. Because it strives to improve all major aspects of one's life—including housing—and increases the likelihood that clients will better manage their conditions in the future, it can be said that the Sherbourne Infirmary actually carries out an illness prevention function, in addition to a medical care function.

Political-Economic Perspectives on Health Care for the Homeless

This thesis draws upon a political economy of health perspective which recognizes that complex health issues arise or worsen because of socio-economic disadvantage. This perspective addresses the social production of health and illness, and includes the political economy of illness and the political economy of health care (Morsy 1996). It is an approach that embraces a macro-analytic, critical, and historical perspective for analyzing disease and health services under a variety of economic systems. It tends to emphasize the effects of social, economic and political factors that impact disease and health. It seeks to uncover how the larger global structures (that is to say, within the current capitalist world system) impact one's health, well-being, and

access to health care. This framework allows us to explore what factors contribute to people becoming homeless and sick or injured. Homeless individuals are at an increased risk of dying prematurely and face significant barriers that interfere with their access to essential services. This thesis reveals the ways in which Sherbourne's Infirmity program has assisted clients in maintaining their health status and overall well-being within a socially stratified urban area.

Chatterjee's (2006) approach to suffering and death is helpful when applied to this research on Infirmity client health: the idea that people die (or suffer) because their bodies could not be *inscribed into value* (such as when clients were de-valued because of their addictions or HIV status); the idea that people die (or are left to suffer) because they cannot be *captured inside a frame* (such as when clients felt the health care system was poorly equipped to meet the needs of lesbians who are HIV-positive, or when landlords classified potential tenants as 'undesirable'). These concepts highlight the fact that our bodies (both social and physical) undergo a process of legitimization in order to utilize health services or even to exist. Individuals who experience discrimination due to ethnicity, sexual orientation, citizenship status, socio-economic status, or HIV status may experience public health and housing services differently than the average citizen. This may be a reflection of the values and prejudices service providers sometimes harbour when dealing with marginalized groups. Sherbourne's model of care works to counteract these practices—valuing people by recognizing their individual capacities, and widening the frame of clients they serve by providing support to substance users and embracing the entire spectrum of human diversity.

A discussion of Goffman's (1963) work on 'stigma' is also incorporated into this thesis, as homeless people are often stigmatized for being homeless and/or because of a variety of physical and mental issues that they are more likely to experience. When a negative label is assigned to a particular group of people, the label is often internalized. This is because our identities are, in large part, based on others' responses to us. A 'group' could refer to a particular culture, ethnicity, sexual identity, or socio-economic group, and could be based on the existence of an illness or disability—all things that a person has little control over changing. Labels lead to stigma, which is the widespread devaluation and shunning of individuals in a society with a particular characteristic. Goffman is credited for creating a framework for the study of stigma and studying stigma's effects. In his book *Stigma: Notes on the Management of Spoiled Identity* (1963), he explains stigma as the public's attitude toward a person who possesses an attribute that falls short of societal expectations. Stigma is typically internalized, which creates a 'spoiled identity.' The stigmatized person is dehumanized and is therefore not perceived as a 'whole person.' During this process, a person is reduced to one negative definition—the view of all other personal attributes is obstructed. Goffman (1963:2) observes that, "society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories." This means that the range of acceptable 'normal' behaviour or appearance is understood quite early on as a function of being part of society. Stigma has a discrediting effect, which creates a discrepancy between perceived and actual social identity. I believe that the concept of stigma is particularly relevant to this thesis because it may shed light on why homeless individuals often receive substandard health care, and also why some

homeless people may opt not to utilize health services at all.

The theoretical perspectives used in this thesis permit an examination of health care issues for homeless individuals from both macro and micro perspectives. They help to illustrate the ways in which social inequality and discrimination work to devalue people at a societal level, within institutional policy, and on a personal, face-to-face level. The political economy of health perspective allows us to see that the social and economic organization of our society produces poor health for those who live on the fringes of it. It widens our perspective of disease causation and can remove the blame that is often placed on people for being sick and/or poor. Chatterjee's perspective about suffering and the value of subaltern lives is connected to institutions overlooking or disregarding homeless people's right to health care and more broadly, limiting pathways out of homelessness and poor health. Lastly, Goffman's concept of 'stigma' allows us to understand how labels and discrimination not only limit people's access to care, but may also limit people's ideas about what kind of care they are entitled to receive. Because homelessness has a variety of causes and consequences, an examination of these three layers of forces that influence all aspects of a person's life is appropriate.

Methods

This was a qualitative study that used qualitative, semi-structured interviews as the primary data collection tool (see Appendix B for the interview guides that were used). This type of interview is an ideal method of data collection for this type of study because qualitative methodology strives to achieve an in-depth and detailed understanding of a particular phenomenon or set of related phenomena. It is important to note that not all questions were asked to every interviewee, which is consistent with the semi-structured interview style. The goal of the interviews was to pull out a story and get the ‘complete picture’ of participants’ experiences in life and particularly within health care settings. ‘Probe’ questions were sometimes asked to gain more understanding about a particular event, and also so that participants could discuss their opinions and assumptions within particular scenarios. Qualitative interview data were analyzed by identifying, coding, and categorizing patterns in the data. Findings of this study are not intended for broader generalization in a statistical sense, but they may be useful in the generation of health and housing policy in the future.

This research was conducted with clients, former clients, and staff of the Sherbourne Health Centre’s Infirmary between November 2008 and January 2009. Fifteen semi-structured, one-time interviews were completed for this project. Twelve interviews were with clients or former clients of the Sherbourne Infirmary (four females, eight males) and three interviews were with current staff members (two females, one male). This was determined to be an appropriate number of interviewees because,

although participants shared unique stories, there were many common themes and issues that arose early in the data collection phase of this project. Interviews were carried out at Sherbourne Health Centre or at a place convenient for the interviewee that ensured both privacy and personal safety for both parties (such as a private residence or private room within the Parkdale Activity Recreation Centre). Interviews ranged from 25 minutes to 2.5 hours in duration. Honoraria (\$20) were provided to each participant and all interviews were audio recorded. Participants were recruited from the Infirmary and were selected for convenience (convenience sampling).

My research utilized the expertise of a multi-disciplinary team who work on the unit and who have relationships with interviewees. I worked closely with Alice Broughton (MSW, RSW), program manager of the Sherbourne Infirmary at the time this research was conducted, and Pat Larson (BScN, MA), nurse practitioner and primary case manager of the Infirmary. Both Ms. Broughton and Ms. Larson assisted me in defining research objectives and creating interview questions for this project. Interviewees were selected by Infirmary staff based on their health records and the staff's personal knowledge of clients. To ensure the diversity of the interviewee pool and highlight the issues of certain groups, key characteristics were prioritized when selecting potential interviewees: those affected by HIV/AIDS or diabetes, Aboriginal Canadians, immigrants to Canada, and those who are part of the LGBTQ community. Ms. Broughton, administrative staff, and the Infirmary physician assisted with identifying and contacting clients and former clients. They contacted potential interviewees directly through telephone, community support workers, or in person (as many former patients

maintain contact with the facility). Identification of clients was based on several factors which included having a chronic illness or disability combined with having a particularly illustrative life-story and likelihood that they would want to take part in the study.

Participants ranged from 28 to 63 years of age.

At the time this research began, the Infirmary Program had been in operation for 1.5 years and had records of approximately 200 clients. Ms. Broughton recommended staff members to recruit for interviews. Staff members were interviewed to gain a perspective about their personal experiences as employees, the client successes they have witnessed, and to allow them to comment on any structural limitations they experience while working in the Infirmary. Secondary data were yielded from program handbooks and pamphlets published by Sherbourne Health Centre and researcher observation within the facility.

Participants were categorized based on when they stayed at Sherbourne's Infirmary. In the interview I asked clients when and for how long they stayed at the Infirmary. However, this question tended to be interpreted as, "For how long have you been a *client* of the Infirmary?" This is because the majority of interviewees thought of Sherbourne and its Infirmary as a reliable resource that they could return to in the future if need be. In addition, most clients interviewed maintained relationships with Infirmary staff members and would come back to the facility for informal visits. This fact adds another dimension to the idea of having a 'stay' at a health care centre as these individuals did not feel that a discharge necessarily meant that their ties were cut with the Infirmary

from that point onwards. The clients who reported multiple stays were categorized based on when their *first* stay at Sherbourne's Infirmary took place. This classification determines when the Infirmary first entered their lives as a resource, which is the most relevant piece of information when piecing together life stories and determining the Infirmary's full impact upon people's lives. Therefore, the four categories of interviewees were:

- clients who were currently *and for the first time* staying at Sherbourne's Infirmary (one client)
- clients who had recently stayed at the Infirmary up to six months from the date of interview (four clients)
- clients who had stayed at the Infirmary from six months and up to one year from the date of interview (one client)
- clients who had stayed at the Infirmary at least one year ago and beyond from the date of the interview (five clients)

There was one client who did not share the exact dates of his stay. This individual had a one-time stay for three weeks in the past and was not staying at the Infirmary at the time of the interview. Although two clients were currently staying at the Infirmary at the time of the interview, one of these individuals had stayed at the Infirmary for the first time over a year ago, so this client was included in the 'stayed at least one year ago and beyond' category.

Dividing the interviewee pool in this manner is methodologically useful because it permits an examination of experiences of how client success is affected by length of time away from the Infirmary. In this way, one can see if a stay at the Infirmary has had any lasting influences on the lives of its former clients, if there are common experiences shared by individuals who have left the facility, and if the length of time that they have been away from the centre or referrals that they were given have made any difference in their health or subsistence conditions. It is important to note that out of the twelve client interviews, four clients reported multiple stays at the Infirmary (the most being 4 stays in total) and eight reported that they had a single stay. It is also important to note that several interviewees from both client and staff pools reported that the Infirmary services got better with time—with respect to medical care, psycho-social support, amount and quality of referrals provided, and even food quality. Because of this, the ‘client satisfaction’ data derived from the interviews may be progressively skewed toward more positive results as length of time away from the Infirmary decreases.

In order to paint a complete picture of the daily realities of the urban homeless and under-housed, I felt it was important to understand the structural realities within the urban environment. This provides greater depth to health-related data. Therefore, interview questions sought to determine whether specific barriers exist for these individuals when accessing education, jobs, and housing. Information about life history was also collected from clients and common themes were noted. I determine whether any of these issues are related to one falling into a state in which they can no longer adequately manage their health. An examination of Canadian public housing policy is

also included in my analysis.

Self-care and health-care-seeking approaches were documented. I reveal the options that exist for care and support for the homeless/under-housed community, and what activities are performed when formal routes to health care fail or are seen as secondary. Several interview questions sought to determine the types of formal and informal support structures that exist for clients of this program. I report which illnesses/injuries are mentioned most frequently within this client pool and which are the most difficult to manage. I asked research participants if they experienced discrimination based on illness, ethnicity, gender, sexual orientation, or housing status. Any of these factors would serve as a barrier to accessing health, social, and economic supports. I also report on the degree of success that clients have when the Infirmary has provided referrals to key partners both within and outside of the Sherbourne Health Centre.

This project had certain methodological limitations. Firstly, clients that were contacted by staff for recruitment into this study were likely to have had a good relationship with the Sherbourne Infirmary and its staff. To maximize efficiency and ensure that a substantial amount of data was yielded in interviews, staff contacted individuals who were likely to be eager to participate. Staff selected individuals who were likely to be reliable in keeping an interview appointment, and who were relatively social within the Infirmary unit if they were inpatients at the time of interview or those who maintained regular contact with the clinic after their stay was over. This was also done to avoid recruiting individuals who were reluctant or were likely to feel

uncomfortable with sharing their personal information. Secondly, the possibility that some interviewees were under the influence of drugs or alcohol at the time of the interview cannot be excluded. Several interviewees stated that they were currently using alcohol, marijuana, crack cocaine, or methadone to maintain daily functioning in a comfortable manner, to manage pain, or to alleviate the side effects of prescription drugs.

In addition, some interviewees reported having serious mental health issues such as schizophrenia, which sometimes resulted in them being paranoid about the people around them. Precautions were taken to ensure that all interviewees were both comfortable and able to give a meaningful interview. I did not carry out interviews with people who appeared to be intoxicated or in a state that compromised their ability to make judgment calls. In the case of interviewees with schizophrenia, I verified that neither the interview nor my presence made them suspicious or uncomfortable. Thirdly, because no follow-up data were collected, and because the Sherbourne Infirmary had only been operating for two years at the time of data collection, I am not able to report on the long-term (i.e., beyond two years) impacts that the Infirmary may have on participants' health or housing status. Accordingly, I discuss 'lasting effects' (e.g., if the Infirmary taught clients anything related to health management or had any influence on people securing stable housing) rather than long-term ones. Lastly, I did not have access to any patient medical records. All medical and life history data were provided entirely by clients and therefore could not be verified as accurate by the Sherbourne Health Centre or other service providers.

Outline of Thesis

This thesis is divided into five chapters, including an introductory and a concluding chapter. This chapter has provided an outline of this thesis and framed the research questions. Chapter Two includes a description of the Sherbourne Health Centre and its Infirmary. The chapter also introduces ‘comorbidities’ and ‘syndemics’ as explanatory concepts. Chapter Three outlines the many possible challenges to health management that Infirmary patients face. The chapter also discusses the structural impediments that exist for homeless people who require ‘home care’ medical services. In addition, Chapter Three sheds light on some of the unique issues that are specific to vulnerable or marginalized groups within Toronto and how ‘axes of marginalization’ and traumatic life histories can impact people’s lives. Chapter Four describes potential pathways toward good health management by discussing what has worked for Infirmary clients and how these factors are related to the Sherbourne Infirmary. Finally, Chapter Five provides additional analysis of the fieldwork data, reveals implications of the results of this thesis, and discusses continuing challenges to providing health services to the homeless.

CHAPTER TWO: SHERBOURNE AND THE ROLE OF INFIRMARY CARE IN ADDRESSING THE UNIQUE HEALTH ISSUES OF THE HOMELESS

Poverty is a lack of opportunity, lack of freedom. It is hunger and malnutrition, disease and lack of basic social services. It is a policy failure that degrades people—those who suffer it, and those who tolerate it...Poverty is still the gravest insult to human dignity. Poverty is the scar on humanity's face.

-Gro Harlem Brundtland, prime minister of Norway, 1995 (Hurtig 1999:8).

This quotation is powerful for several reasons. First, it defines poverty as a constraint on one's social and economic capabilities and one's physical being. It is productive to see poverty as a condition in which every facet of a person's existence is devalued and restricted. Poverty does not only refer to an individual's material deficiencies. By expanding our definition of poverty and how it affects people's lives, solutions to poverty can be more clearly conceptualized. Secondly, it sees the source of poverty as rooted in the macro structures of society—a shift from the commonly held 'victim blaming' perspective that many people and institutions still maintain. Thirdly, it views poverty as humanity's responsibility to remedy. 'Humanity' refers to each of us. Many of us derive benefit from the current political-economic system that results in deprivation and sickness for others. Brundtland urges us to acknowledge the basic human rights of *all* citizens and take a shared responsibility for treating individuals with dignity. Yet we are largely failing at this task, especially within the realm of health care. How we treat the most marginalized people reflects the values that we hold as an entire society.

Sociologist Johan Galtung coined the term ‘structural violence’ to describe the very phenomenon that Bruntlandt’s quote captures. Structural violence refers to a form of harm inflicted by social systems that gradually kill people or cause them to suffer by not allowing their basic human needs to be met (Galtung 1969). When this type of violence occurs, its cause is often difficult to visually identify, for no direct physical trauma is inflicted on victims. However, structural violence creates large amounts of suffering worldwide in an insidious manner that is rooted in the organization of particular societies. Galtung (1969) uses the term ‘social injustice’ synonymously with ‘structural violence,’ and warns that the victim of structural violence may not perceive the violence at all—making this phenomenon even more difficult to identify and overcome. Galtung (1969) notes that the formula behind structural violence is inequality. With this definition, it becomes clear that inequality causes sickness in many different contexts. Medical anthropologist Paul Farmer discusses structural violence in the context of the South African HIV/AIDS epidemic:

Their sickness is a result of structural violence: neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress. (Farmer 1999:78)

A form of structural violence is being committed within Canada, and Farmer’s definition is helpful in understanding how this form of cruelty works. Discrimination and oppression are embedded in aspects of Toronto’s public housing and health care institutions, and more broadly, within Canada’s socio-economically stratified population

structure. In this situation, our political-economic structure is conducive to creating inequality, and at the same time, it tends to punish those who are already marginalized. Structural violence works to deny the homeless and under-housed access to services that they have a right to use. Structural violence also denies them respect and basic human rights in a variety of settings, which may discourage people from utilizing services and limit self-care approaches.

When infirmity care is defined, and especially when the Sherbourne Infirmity is discussed, it is my hope that one thinks about all of the ways that severe poverty can impact a person's physical and emotional well-being. Infirmity care is innovative because it fills a gap in the public health care system—the gap that homeless people frequently fall through because it is assumed that patients are adequately housed. The Sherbourne Infirmity approaches care in a revolutionary way that respects people's life histories, preferences, and choices. It is run based on the principles of empowerment and mutual respect to create an atmosphere of peace, comfort and acceptance. This is in sharp contrast to the hazardous surroundings encountered on the streets or in many shelters. It is also in contrast to the mainstream health facilities that this population often avoids. For some, a stay at Sherbourne's Infirmity is the first step toward reclaiming one's dignity and recognizing that one's life has value. This can be a powerful catalyst to improving one's overall quality of life.

Homelessness and Risk

Once a person becomes homeless, a large set of risks become relevant to that person's life. The experience of illness and fear is very different for the homeless compared to that of an average, housed person. As discussed in Chapter One, homelessness magnifies poor health, increases the likelihood that someone will be exposed to a variety of communicable diseases, increases the risk of developing mental or substance abuse issues, can exacerbate pre-existing mental disorders, and makes the management of chronic conditions more difficult. Homelessness can even increase one's risk of having cancer because risk factors such as sun exposure, cigarette smoking, and alcoholism are higher in the homeless population (Schanzer et al. 2007). However, it is necessary to understand that there are two types of risks associated with homelessness. In addition to health risks associated with *being* homeless, there are risks connected to being poor (materially and socially) and subsequently *becoming* homeless.

Frankish, Hwang and Quantz (2005) point out that there is no one pathway to becoming homeless. This is because homelessness is often the result of a complex interaction of factors at the individual level and at the societal level. Individual factors may include harmful or traumatic experiences in childhood, low educational attainment, lack of job skills, family breakdown, mental illness, and substance abuse. Societal factors can include poverty, restrictively high housing costs, labour market conditions, decreased public benefits, racism, and discrimination based on other personal characteristics (Frankish, Hwang and Quantz 2005). Crompton (2003) confirms that

traumatic life events, such as the death of a loved one, divorce, illness or injury, job loss, addiction, pregnancy, or illness of a family member, can have devastating impacts on the lives of people who may be existing at or slightly above the poverty line. These factors can be the final push into an existence characterized by homelessness and/or commercial sex survival. These events can create or increase vulnerability and disproportionately affect the urban poor and other disadvantaged populations. Plumb (2000) asserts that many people in the developed world are teetering on the edge of becoming homeless. A bout of illness or a job layoff often leads to people missing payments that maintain subsistence (i.e., rent, utilities), which can result in physical deprivation or eviction.

Health experts agree that inadequate housing or reliance on shelters/hostels can be associated with an array of health problems. Crowded living conditions can lead to the transmission of infectious diseases, and can increase the risk of injuries, mental health problems, family tension, and violence. However, social stigmatization associated with illness or identity can also impact whether individuals seek support for themselves. Palepu and Tyndall (2005) assert that having a substance abuse issue or being severely impoverished can be extremely embarrassing for those affected and can lead to low self-esteem and social isolation. This can impair one's ability to seek the help that is needed. Being classified as 'homeless' is also a potentially damaging identity that individuals may internalize, and that can lead to the same detrimental outcome. The data in this project revealed that homelessness is often the result of a succession of traumatic events or perhaps even several 'micro-traumas' that have occurred throughout one's life. Major traumatic events such as job loss, childhood abuse, and racism have played a role in

many people becoming homeless. However, micro-traumatic incidents that are more subtle or contained can have a profound effect on one's self-perception and self-esteem. Events that reinforce that somebody is not worthy of care or happiness, or events that imply that somebody lacks intelligence or ability have the capacity to indirectly lead to illness because of poor self-care practices or the avoidance of medical treatment. No two people have the exact same pathway to becoming homeless, but it can be said that a person's emotional state can have a large influence on their physical health.

Comorbidities and Syndemics in Marginalized/Homeless Populations

A comorbidity refers to an individual having more than one disease or disorder at the same time. It may refer to the existence of multiple illnesses at once or the cumulative effect of these conditions. Sometimes, a primary disease exists alongside additional illnesses that may be related to the main diagnosis. Diseases such as AIDS or cancer are examples of diseases that commonly have associated comorbidities which influence treatment options and mortality. This is because there are a variety of secondary illnesses associated with both conditions. A New York City-based study by Schanzer et al. (2007) revealed high rates of comorbidities amongst homeless persons. Significant rates of comorbidity were found between physical medical complaints and major depression, and between physical medical complaints and substance use disorders.

The concept of 'syndemics' is used by medical anthropologists to describe the

“synergistic interaction of two or more coexistent diseases and resultant excess burden of disease” (Singer and Clair 2003:423). The term can be used to describe two or more epidemics interacting together and resulting in an increased burden of disease in a given population. Syndemics occur when health problems cluster in a community, population, or time period and are spread/maintained by forces that tie particular diseases together (Singer and Clair 2003). It also refers to the health *consequences* of and *social contributions* to the biological interactions of certain health conditions, and in this way, expands the concept of ‘comorbidities.’ An example of a syndemic is the existence and accelerated spread of HIV and tuberculosis within many inner-city areas of North America. Coinfection with HIV and MTb (the tuberculosis bacterium) results in a more serious infection of both diseases. Having both infections at the same time accelerates the progression of HIV and increases the likelihood that one will develop active tuberculosis and die from it (Singer and Clair 2003). Coinfection tends to occur in clusters of a population and disproportionately affects people who are economically and/or socially marginalized. HIV weakens the immune system so HIV-positive people are much more likely to develop active tuberculosis (and to die from the disease, which also speeds the development of HIV/AIDS) than people with a healthy immune system.

Similarly, coinfection with HIV and hepatitis C only makes each illness relatively worse and makes treatment of both much more difficult. Soriano et al. (2007) states that the progression to end-stage liver disease happens faster in coinfecting patients and that many antiretroviral drugs have an increased hepatotoxicity risk in people infected with hepatitis C. The Street Health Report (2007) reveals that in Ontario, an estimated 25%

of people with HIV also have hepatitis C. Central to the concept of a ‘syndemic’ is the understanding that there is a biological interaction between two diseases that exist simultaneously in one body. However, Singer and Clair (2003) point out that the concept draws attention to the influences of the *social environment* of individuals and populations. Diseases are manifestations of social conditions just as much as they are the expression of biological mechanisms. They are social entities. Farmer (1999) asserts that one cannot fully understand the spread and effect of disease (and coinfections) without considering the socio-political realities of their sufferers. He asserts that disease explanations that take into account issues of poverty, racism, discrimination, stigmatization, and other forms of oppression are more accurate than biological explanations alone. Major aspects of an illness (risk of transmission, pathogen virulence, and access to health care for diagnosis and treatment) are influenced by social and political forces (Farmer 1999). Singer and Clair (2003) also claim that other aspects that are frequently associated with extreme socio-economic deprivation such as malnutrition, stress, and substance abuse can enhance the physical effects that syndemics have. To summarize, homelessness can drive syndemics because living in extreme poverty can weaken the immune system, encourage multiple disease exposures, and make it more difficult to access and adhere to disease treatment plans.

Singer and Clair (2003) draw attention to evidence that suggests stigma and discrimination are linked to detrimental health effects. They state that being the victim of either of these forms of oppression can cause psychological distress and can raise blood pressure that can permanently alter the body’s functioning. Similarly, biological studies

have found that cortisol, a stress hormone that can weaken the immune system and increase blood pressure, was found to be much higher in the blood of non-human primates who were of low social status (Marmot and Wilkinson 2001). Researchers assert that this evidence can be extrapolated to humans, citing evidence that ill health follows a social gradient in human populations. Evans et al. (1997) reveal the disturbing fact that profound distress is associated with a more rapid progression from HIV to full-blown AIDS. Furthermore, Lesserman et al. (2007) confirmed that HIV advances faster when individuals have experienced a high number of stressful life events, trauma, or depression, and have inadequate social supports. Considering that the homeless population suffers disproportionately in these areas, it can be said that the homeless are truly the embodiment of social suffering. As evidence of this assertion, a Florida-based study by Lieb et al. (2002) discovered that being homeless was the strongest cofactor that predicted HIV-related mortality. It is crucial that health care resources recognize the complex pathways that lead to illness. Inequality does contribute to poor physical health and often constrains treatment options. In addition, a pre-existing mental health problem can be a comorbid condition that contributes to poor physical health. The traditional biomedical approach tends to emphasize physiological routes to illness and medical treatment. However, the combined mental and physical health risks associated with experiencing poverty, trauma, or disempowerment are overwhelming and cannot be overlooked if treatment and prevention methods are to be successful.

Related to the concept of comorbidities, the term ‘concurrent disorder’ is used specifically when an individual has a mental health problem and a substance abuse issue.

Concurrent disorders can be thought of as psychiatric comorbidities that have typically occurred at or around the same time in a person's life (i.e., coexisting at a given point, or both occurring within the same 12 month period) (Currie 2009). However, concurrent disorders may also have existed independently at different times of a person's life. Currie (2009) classifies a concurrent disorder as a mental health problem and an addiction issue in the same individual, and comorbidity as co-existing, non-addictive mental disorders in the same individual. According to Skinner et al. (2004), a person with a mental illness has an increased risk of having a substance abuse problem, and an individual with a substance use problem has an increased chance of having a mental disorder. For many, the two issues are inextricably linked because of one's life history/trauma, coping mechanisms, and treatment options. There are many combinations of concurrent disorders and there is not one symptom or group of symptoms that is common to this group of disorders. However, concurrent disorders can manifest in the following ways: substance use can make mental illness worse, substance use can mimic or hide symptoms of mental health problems, some substances can make psychiatric medications less effective, using substances can make people forget to take their medications which can make symptoms of mental illness re-emerge, and when a person relapses with one problem it can trigger symptoms of the other (Skinner et al. 2004). Skinner et al. (2004) reveal that individuals with concurrent disorders have the most success with treatment when both problems are addressed at the same time in a coordinated way. However, the reality is that sometimes people must turn to one resource for mental health treatment and another for addiction treatment. Treatments for concurrent disorders typically include a combination of therapy and medication.

Homelessness exacerbates concurrent disorders and makes treatment more difficult.

Without a safe living environment or access to regular medical care, concurrent disorders can be life-threatening.

Barriers to Providing and Accessing Health Care

As mentioned in the previous chapter, homeless persons face serious barriers to receiving medical care in Toronto and Canada, even in the context of a universal health insurance system. Underlying this phenomenon, there are multiple barriers at work. The first has to do with health professionals actually providing care and these barriers are rooted in the structure of the Ontario health care system. Hwang et al. (2000) examined patient encounter and billing records of three physicians who provided care to homeless individuals in Toronto in 2000. This research team discovered that these physicians were receiving payment for about half (54%) of their patient encounters. This was attributed to the fact that many of their patients did not have a valid health card. Another issue that arose in this research was that physicians were sometimes subject to a fee reduction for practicing in an 'over-serviced area' (the downtown core is where the majority of homeless people exist, which makes this policy problematic), and the fact that consultations with homeless individuals sometimes lasted longer than average (because many of them have complex medical and psycho-social issues).

Hwang et al. (2000) acknowledge that providing health services to the homeless

can be an intrinsically and professionally rewarding endeavour that addresses an important need in Toronto. However, the ways in which physicians are remunerated, and the ways in which citizens access and retain health cards must be re-examined if the homeless population is to get the most out of the public health system. O'Connell (2004) asserts that 'home visits' by physicians to homeless people (i.e., 'outreach' care) should be carried out more frequently. Unfortunately, the time and mobility required to access this population is rarely funded or valued by care delivery models (O'Connell 2004). Currently, providing care to the homeless is associated with financial *disincentives* for physicians (Hwang et al. 2000). New models of care, financial incentives, and ways of thinking about homeless patients are needed to ensure that this population is able to access appropriate and consistent medical care. O'Connell (2004) points out that physicians face an obvious ethical dilemma when serving the homeless population: their goal is to prevent and treat illness but at the same time they feel powerless to affect the structural aspects—such as housing, or the lack of it—that may contribute to poor health. I argue that, although housing is the overarching factor through which many illnesses and injuries can be prevented, there is also much potential in our public health system for getting people through the day-to-day. Once people's health is better managed and they have the psychological capacities and appropriate resources in place, *getting* housing is actually easier. Although many individuals who are homeless remain at risk for poor health after they have been adequately housed (Frankish, Hwang and Quantz 2005), infirmity care can still increase the quality of such people's lives by teaching self-care techniques, developing disease management strategies, and providing a range of health and social services for the homeless and under-housed to utilize as a first-

line resource.

Other factors impeding homeless people's access to health services have to do with complications stemming from actually being homeless. Not having a permanent address or telephone number compromises continuity of care and keeping appointments is often difficult when there are more pressing or immediate concerns (Frankish, Hwang and Quantz 2005). Homelessness involves a constant struggle for the essentials of life and protecting oneself from trauma and the elements, making disease prevention or health maintenance actions hard to carry out. Frankish, Hwang and Quantz (2005) also report that obtaining prescriptions can be difficult and following treatment recommendations (such as rest, diet, keeping schedules, and medication storage) nearly impossible. It is also important to recognize that self-injection (for diabetes medication or illicit drugs) and wound dressing changes may be difficult to conduct in a sanitary manner when one is living on the streets or in shelters. The problem of access to health services for the homeless is a growing one. According to the Street Health Report (2007), Toronto's homeless population has less access to health care and the homeless are four times more likely to be refused treatment because they do not possess a health card, compared to 15 years ago.

Infirmity Care

Infirmity care is commonly known as 'respite care' in the United States, and this

is where the majority of the academic research on this topic has taken place. Buchanan et al. (2006) state that being homeless diminishes the long-term effectiveness of hospital care, despite the fact that homeless adults are hospitalized more frequently and have longer stays than housed adults. One of the major problems with traditional overnight shelters is that clients are required to leave during the day and only permitted to return for the night. This means that many shelter users are still living on the streets each day (Buchanan et al. 2006). Obviously, this scheduling complicates rest and recovery efforts and makes medication schedules and storage more difficult. Also, this structure does not provide day protection from the dangers of street life (the risks of assault, theft, and exposure to the elements) during times when people are particularly physically and/or psychologically vulnerable. In contrast, Buchanan et al. (2006:1278) state that,

...respite care provides around-the-clock room and board to homeless patients discharged from an emergency room or hospital, encouraging them to comply with posthospital rehabilitation. Many respite services also provide some form of on-site medical care, a range of social services, and transportation assistance to facilitate continuity of care.

Few studies have actually examined the impact of respite care on health outcomes. A Chicago-based study of 225 homeless patients from 1998 to 2000 found that respite care after discharge from a hospital reduced homeless patients' future hospitalizations. In the six months prior to referral to respite care the average patient was a hospital inpatient for five days and had one emergency department visit. It was discovered that the group of individuals who received respite care at a 64-bed respite care centre utilized 58% fewer inpatient days, had 36% lower emergency department usage, and had a 49% reduction in hospital admissions in the 12 months after hospital

discharge (Buchanan et al. 2006). The services offered at this particular respite care facility included substance abuse counselling, case management, and referrals to permanent housing. These researchers concluded that respite care has the capacity to drastically improve health outcomes for hospitalized homeless patients. Furthermore, there is a significant economic implication, according to this study. It was found that respite care was far more cost effective than having the same individual stay in a hospital. On average, \$706 U.S. per day was saved on health care expenses when a homeless person was provided with respite care instead of hospital care. Although this is based on American patients and health care costs, it does demonstrate that respite (or infirmary) services have the capacity to be much more cost effective for 'recovery' care for homeless clients versus a hospital.

Buchanan et al. (2006) claim that it may be difficult to apply their results to other respite settings because patients who suffer from severe psychiatric symptoms or substance abuse issues cannot make use of respite services (because such conditions are incompatible with group living). However, I assert that infirmaries can still offer a great deal from a cost savings perspective by decreasing the average length of stay and future admission frequency of its clients. Infirmaries also have the capacity to reduce strain on hospital personnel (because of patient overcrowding and increased work load and complex case management duties). It is difficult to estimate the true (i.e., 'dollar amount') economic benefit of such a program within Canada, but I believe that the qualitative data yielded from this field project reveals the high value that an infirmary can have on both the lives of clients and medical professionals. Sherbourne Infirmary

does not exclude patients who have psychiatric or substance abuse issues—in fact, Sherbourne staff have been known to conduct (informal) outreach specifically to these groups. The Sherbourne Infirmary assists a wider range of homeless individuals than many of its U.S. counterparts do, which potentially provides more relief and support to both homeless patients and hospitals.

The Sherbourne Health Centre

The Sherbourne Health Centre was developed in response to the Toronto Mayor's Action Task Force on Homelessness funded by the City of Toronto in 1999, which explored the issue of homelessness in the city (see City of Toronto 1999). Three main needs were identified in this report: discharge planning, harm reduction services, and an infirmary. After this report was published, a plan for a free standing infirmary was initiated. Sherbourne Health Centre received approval for a 20-bed infirmary facility intended to serve homeless and precariously housed individuals with a presenting medical condition (Broughton 2009). In addition to the infirmary, the Sherbourne Health Centre provides a family (primary) health team, LGBTQ (lesbian, gay, bisexual, trans, queer/questioning) primary health care, a SOY (Supporting Our Youth) program for LGBTQ youth, an LGBTQ parenting network, mental health services, homeless programs (including two health buses which offer mobile nursing care), chiropractic

services, and a naturopathic clinic.² The major groups of clients that the Sherbourne Health Centre serves are newcomers and immigrants, homeless and under-housed people, and people who identify as lesbian, gay, bisexual or transsexual (Sherbourne Health Centre 2008a).

Sherbourne believes that *where* primary health care resources are located can have a major impact on health outcomes. They feel that such resources should be located close to where people are living which allows for easy and timely access, which in turn promotes health, prevents disease, and provides lower cost alternatives to care (Sherbourne Health Centre 2008a). They state this organizational belief in their *Strategic Plan 2008-2011* publication, which reinforces the assertion that health centres that contain infirmaries are cost-effective. The location of the Sherbourne Health centre is strategic; the neighbourhoods within Sherbourne's catchment area (mainly southeast Toronto areas east of Yonge Street, south of Bloor Street, west of the Don River, and north of Eastern Avenue) are generally characterized as high-density, and diverse with respect to ethnicity and socio-economic status.

Sherbourne's core values permeate all of their programs, activities, and decision-making. Their beliefs and guiding principles are outlined in their *Strategic Plan 2008-2011* publication:

² Naturopathic therapies are offered free of charge to people living with HIV/AIDS. According to the Sherbourne Health Centre (2008b), naturopathic care can improve the quality of life for individuals living with HIV/AIDS and can be used in combination with standard medical therapies.

We believe in the value of diversity and respect for the individual. We believe in equity and an anti-oppression philosophy³ that underlies everything we do. We act with integrity in every choice and decision we make. We consider the whole person and believe that we cannot act alone; we must collaborate with our clients and partners to build the health of our clients and communities (Sherbourne Health Centre 2008a:5).

The Sherbourne Health Centre approaches client care in a way that is patient- centered,⁴ that embraces diversity and that acknowledges the macro forces that influence health and well-being. Sherbourne's strategy for the future is to expand their impact in the community. They strive to expand their clients' access to care by offering unscheduled care, after-hours and weekend clinics, and attempting other innovative models of access that are fitting to many of the people they serve. Sherbourne is original because it approaches client care in an *active* way—they often enter the communities which they serve (e.g., via the health bus or through informal outreach), their services are available when clients are likely to need them, there is an emphasis on illness prevention and not simply treatment, they offer detailed case management plans to clients, and they are continually building partnerships with agencies that will play a part in the care of their clients. This approach is in contrast to the traditional biomedical approach (i.e., largely driven by the physician or the institution) that is present in the majority of public health settings in which homeless health care recipients can fall through the cracks. Homeless people may face barriers to health care because most of their time is devoted to actions that ensure day-to-day survival (Hwang 2001) and this may discourage homeless adults

³ The anti-oppression framework that they refer to comes from Adams, Dominelli and Payne (2002:6) and is defined as, "a person-centered philosophy; and egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives."

⁴ Patient-centeredness is a concept commonly referenced in medical literature (for example, see Stewart et al. 2000) and is considered an ideal for best practices in medical care. According to this model, decisions about treatment are to be made jointly between practitioners and patients, with practitioners providing the information that patients need to make an informed decisions about their care.

from using health care services, especially those perceived as optional, preventative, or far away.

The Sherbourne Infirmary

The Sherbourne Infirmary opened in April 2007 and occupies one floor of the Sherbourne Health Centre. It was created to offer 1) a safe refuge to recover from acute physical illness, injury, childbirth, or surgery; 2) a wide variety of both medical and social resources for homeless or under-housed clients; and 3) relief for acute care centres and inpatient units within hospitals who care for homeless patients. As of Dec. 31, 2008, there had been 286 admissions to the Infirmary and a staggering 15,647 client visits or encounters at the Infirmary. The average client was 51 years old and stayed for 11 days. A total of three (1%) admissions were transgender clients. Although they have 20 beds, a maximum of eight to nine clients occupy beds at the Infirmary at one time (this is because there are only two staff on duty after-hours).

The Infirmary has a combination of single and double rooms and contains two isolation rooms. There are common rooms containing a seating area and televisions outside of each 'pod' of rooms. There is a separate lounge and living space for women only. There is an industrial kitchen connected to a common dining room with a fridge, an exercise/multi-purpose room, and two private medical treatment rooms. There is a nurse's bay in the centre of the unit and administrative offices are also located

throughout the unit. There is a focus on “health teaching and working with clients to improve health” (Broughton 2009:8). The admission criteria for the Infirmary is a presenting primary medical condition requiring a short term recuperative stay and not requiring an acute or rehabilitation hospital bed. Clients admitted must be, for the most part, independent in self-care (they must be able to feed and toilet themselves). This facility is not intended for individuals whose primary medical concern is a mental health crisis or detoxification from drugs or alcohol. Referrals are accepted from health care and community organizations. Self-referrals are also permitted, provided the incoming client has supporting medical information. Non-status immigrants (who do not possess provincial health coverage) are also admitted provided they meet all other standard admission criteria. In these cases, the Infirmary negotiates with staff from other health care facilities to organize the stay and facilitate realistic payment arrangements. Staff work tirelessly to ensure that no individual is turned away because they do not possess health cards or because they do not have status within Canada. In fact, this point is emphasized in the ‘Programs and Services’ pamphlet that is widely available within Sherbourne. It states in bold that “Services are free and confidential” and “Please bring your health card with you. If you do not have one, you can still receive services” (Sherbourne Health Centre 2008c).

In order to fully understand the work that the Sherbourne Infirmary carries out, its three guiding values must be known. Broughton (2009:11) summarizes these values:

1.) *Social Justice*: to help build communities that uphold the right of every individual and group to gain equity and access to the benefits that come to all in a society

2.) *Community and Belonging*: to nurture an environment where people are valued, heard, and respected; where diversity is celebrated, and there is a shared expectation to be social (as one feels comfortable), trustworthy, and cooperative

3.) *Courage*: to promote strength of spirit in self and others, so that all are encouraged to stand up for their beliefs in how staff may make the Infirmary and our communities better places to be.

In these ways, a patient-centered approach is realized. At the Infirmary, health care becomes more of a partnership based on trust and mutual understanding instead of a relationship where the practitioner holds all the knowledge and power.

According to Broughton (2009:12), Infirmary services are directed at “strengthening the capacity of clients to make informed choices about their health and developing the resources and abilities to improve their health and make positive changes in their lives.” Infirmary staff work collaboratively with patients and with resources internal and external to the Sherbourne Health Centre. Key partners include home care (including nursing and wound care, personal support workers, physiotherapy, and long-term care placements), the Fred Victor Centre (which provides housing workers to follow up clients when they leave), Ontario Works (to assist with accessing drug cards and other benefits), women’s shelters, spiritual care providers, and psychiatric consults to clients and staff (Broughton 2009). Referrals are provided to clients for ongoing care (such as general practitioners), counseling (including the unscheduled counseling service available on-site), chiropractic services, and chiropody (to treat and prevent disorders of

the feet). Infirmity staff members aim to increase clients' capacity to make informed choices about their health and also support changes they wish to make in their own lives. Care is tailored to meet client needs and this often means that pain is managed 'creatively' and that substance users are not shut out of the facility (Broughton 2009). Honest discussions occur between Infirmity staff and clients about clients' goals, needs, and behaviour during their time within the Infirmity and after they leave.

Case management (CM) is a key component to care at the Infirmity, that is, if a client wishes to accept it. Kushel et al. (2006) define CM as a care approach that seeks to coordinate medical care for individuals with complex medical problems and health care needs. CM is especially relevant to people who are homeless because they tend to require CM the most, but are often the least likely to receive it. Broughton (2009) reveals that there are a variety of workers assigned to each client at the Sherbourne Infirmity, ensuring continuity and consistency of care: a Case Manager is responsible for coordinating discharge planning and social supports, Registered Nurses and Community Health Workers provide ongoing support and management of issues, and in-house physicians provide consultation, assessment, and treatment. This multi-faceted, CM-based approach can have enormous impacts on Infirmity clients who require long-term medical and psycho-social supports to manage their health. Currently, shelters and hospitals (and especially emergency departments) are largely unable to deliver this aspect of care effectively to homeless persons. CM has been shown to have favourable results in practice. In a study by Kushel et al. (2006) conducted in three San Francisco neighbourhoods between 1996-1997 and 1999-2000, CM resulted in positive outcomes

for persons who were both HIV-positive and homeless/marginally housed. CM was associated with increased adherence to antiretroviral medications, which improved CD4+ cell counts⁵ in study participants. CM can also help manage complex medication regimens, coordinate primary medical care, and assist with referrals to housing, mental health, and substance abuse services (Kushel et al. 2006). These authors believe that their findings are a result of the roles that case managers carry out (such as encouraging their clients to adhere to medication regimens, helping to communicate side effects to physicians, and checking in with clients regularly to make sure medications are prescribed and refilled).

The Sherbourne Infirmary is, for the most part, equipped to deal with complex health problems (such as comorbidities and concurrent disorders) in the homeless population. The Infirmary serves to counteract many of the destructive aspects of extreme poverty and marginalization that degrade people and limit their opportunities. It is evident that Infirmary staff operate with the belief that any individual who desires care also has the right to it, regardless of housing or socio-economic status. This mindset accompanies the biomedical interventions provided at the Infirmary and is key to minimizing barriers to care and the effects of a variety health issues that disproportionately affect the homeless. The services that the Infirmary provides, and the atmosphere that it creates, reduces health risks for its clients. This health care facility provides an alternative to recovering in a toxic environment, thus maximizing the chances that a person will heal properly and minimizing their exposure to additional

⁵ CD4+ cells are white blood cells, or 'infection-fighting' cells. A CD4+ count is a blood test to determine how well the immune system is working in people with HIV.

infections. The Infirmary also minimizes the chances that clients will leave with no plan on where to go upon discharge.

Having adequate housing can accelerate recovery times for the homeless and this resource provides numerous long-term and short-term options for safe shelter. The Infirmary is able to treat individuals with comorbidities through specialized treatment plans and through providing a referral to a family doctor for regular health monitoring. The Infirmary limits the spread of syndemics by limiting clients' exposure to other individuals in 'high risk' categories (i.e., drug users, other homeless individuals who have compromised immune systems or undiagnosed/untreated infections) that could contribute to spreading illness—it provides a safe place to recuperate from illness and offers isolation rooms when necessary. In addition, the high-quality nutrition offered by the Infirmary at flexible hours, and the lower stress levels found in the Infirmary environment can be said to have positive effects on the immune system. The Infirmary also accepts clients with concurrent disorders—individuals who may have been turned away from other health facilities because they were abusing substances, or people who may have had difficulty adhering to substance abuse treatment because of untreated mental health issues.

The Sherbourne Infirmary breaks down traditional barriers to care within health care settings by providing round-the-clock care to all individuals who meet admission guidelines, despite the fact that some may not have valid health cards or citizenship status. The Sherbourne Infirmary is distinctive because of its non-judgmental and

peaceful atmosphere, its focus on continuity of care (by providing referrals to housing and family doctors), its adaptability to the unique needs of patients, and its location (it is situated within a facility that can provide multi-faceted and follow-up care). Clients of the Infirmary are likely to leave in better health and with a clearer picture of what can be done to maintain their health in the future. This facility succeeds because it gets the homeless through the doors, and likely to return, which are crucial aspects of care for this underserved population.

CHAPTER THREE: CHALLENGES TO HEALTH MANAGEMENT

Participants in this study revealed many reasons why managing their health was difficult, either in the past or in the present. Song, Ratner, and Bartels (2005) confirm that there are numerous barriers to medical care for homeless people. Firstly, there are macro-level, structural barriers that exist more broadly within society and its institutions such as discrimination, prejudice, and the effects of having undocumented status or a tenuous legal position if one is running from the law. Secondly, there are micro-level barriers that are characterized as personal barriers such as mistrust, lack of knowledge of the health system, and a resistance to change. These personal barriers do not suggest that homeless individuals are at fault for having decreased access to care, but rather, that there are challenges associated with coping while living on the streets. Lack of trust in a particular setting usually indicates that somebody has previously had a negative experience in such a situation or with a particular group of service providers. Lack of knowledge of the health care system can often mean that a person has consistently avoided or has been denied care, does not possess a valid health card, or has had to deal with competing priorities (i.e., basic survival on the streets), so they lack familiarity with a system that the majority of Canadians are able to utilize. In this way, the homeless and under-housed are deprived of many of the elements that keep the average person well.

Raphael (2004b) reveals that individuals within a society who experience one form of deprivation usually experience other forms of deprivation as well. But what is meant by 'deprivation'? I define 'deprivation' as the absence of something that is

normally considered essential in maintaining an acceptable level of health, well-being, and general functioning. Food and housing insecurity, low levels of education and literacy, and low income are all examples of circumstances that can lead to deprivation (Raphael 2004b). However, there are also social elements of deprivation. At a macro-social level, many forms of deprivation are directly or indirectly caused by governmental policy, institutionalized racism, and social stratification. Raphael (2004b: 233) states that, “social exclusion is about the societal processes that systematically lead to groups being denied the opportunity to participate in commonly accepted activities of social membership.” Certain groups may experience both material deprivation and social exclusion, and there are political, economic, and social underpinnings to this phenomenon.

Galabuzi (2004) confirms that poverty is both a major cause and a major product of social exclusion. Social exclusion exists within Canada, as certain subgroups of the population are unable to access economic, social, political, and cultural resources. Barriers are created by structural inequalities within these arenas, and may work to exclude both groups and individuals. Oppression is often related to race, class, gender, sexual orientation, disability, and immigrant status (Galabuzi 2004). These, in turn, can create powerlessness and vulnerability in a variety of situations. More specifically, homelessness can be defined as “an extreme form of social exclusion that suggests a complexity of causes and factors” (Galabuzi 2004:246). Several study participants shared their experiences of discrimination within a variety of settings, such as within shelters, in hospitals, and in public. I assert that every client participant was, at some

point in his or her life, excluded from society in some capacity. Not every client explicitly articulated this point, however, each story speaks volumes about what it means to be marginalized. The following sections describe the types of barriers that have made it difficult for Infirmity clients to manage their health. I believe that each barrier has unique links to deprivation and exclusion.

Addiction Issues and Concurrent Disorders

The first challenge to health management is addiction and its related issues. A significant portion of clients that were interviewed for this project have dealt with or were currently dealing with substance addictions, which impeded their physical health as well as their capacity to secure and retain housing. Current or past addictions to substances such as crack cocaine, heroin, alcohol, and prescription painkillers were reported by some interviewees. Unresolved addiction issues also had a negative effect on people's decision-making skills, their ability to stay on a medication or stay on a treatment schedule to manage their chronic condition, and their ability to form relationships and keep appointments with service providers. Clients sometimes reported that being under the influence of a mind-altering substance increased their risk of complicating their chronic condition because of the likelihood that they would engage in risky behaviours such as unsanitary drug use or unprotected sex. However, substances were also used to cope with overwhelming emotions (such as sadness or anger) or to help with pain or discomfort associated with chronic conditions. Often, depression and/or anxiety

accompanied substance addiction—people either used substances to manage mental health problems or experienced mental health problems while under the influence or after the effects of a drug had worn off. All interviewees who disclosed that they were substance users confirmed that substance misuse had detrimental effects on their health, well-being, and use of health care facilities. However, some reported feeling powerless in their struggles to overcome addiction. Several clients discussed their experiences with drug and alcohol abuse:

At 18 [years old] I was kind of homeless-couch surfing, but I hadn't nearly hit the bottom I was going to hit. I started using heavier drugs; the more I started to use, the more I would stay away from home, the less I would pay my rent, the more I would say, 'screw this.' So that's the progression. My using and my inability to be at home, I wasn't accepted there... I got made fun of as a kid, I was a target for a lot of teasing... I discovered drugs and honestly that's what brought me out of my shell is that I got high at school and then I got to hang out with all the different crowds because I [realized I] was funny, that's cool. And as the years went on, the party would be over but it wouldn't be over for me and that's the first time I started to realize that the way I used drugs and alcohol was different from the ways my friends did, with the exception of a few who are dead or in jail. I had tried crack for the first time when I was 19 and I was hooked immediately. And the thing about drugs like crack, heroin, oxycodone, is that they create such a false sense of elation that while you're high, it doesn't matter that you're homeless, that you're stuck, that you have problems, that's the amazing thing about these drugs and that's why people are led so much to their detriment, because the high—it doesn't even necessarily take away the pain of what you are feeling—it lets you be in pain and it's all okay. Now how does any service compete with that? The best social workers in the world can't compete with that. If the person themselves loses the choice, then how does anyone else help them choose? (Jo,⁶ 38 year-old female with HIV and hepatitis C, who revealed that while under the influence, she prostituted herself, muled drugs for other people, was beaten, stabbed, shot, and raped.)

⁶ To maintain interviewee confidentiality, all the names used in this study are pseudonyms.

I don't think [starting to drink alcohol] was so much peer pressure, it's just like in my *blood* I guess you could say. The worst part is jumping on the trains and this and that...and after the second time that's what happened to me, I got run over by the train...booze had a lot to do with it, I guess. (Simon, 42 year-old Aboriginal male who, because of this accident, lost his right leg below the knee in 1982 and his left leg below the knee in 1992; Simon's emphasis)

...I didn't really start to get sick [from HIV] until a few years ago. So now everything's just happening at once, you know what I mean? *Everything's* just coming in on me now and I'm just trying to contain it and when you've got a million other things going on in your life aside from your health...to keep it all in focus it's hard *especially* if you're into drugs 'cause you're, you know, you're not thinking clearly. And I don't know if my decisions are the right decisions. I seem to go—most of us [substance users] that are older—seem to go on runs. Three, four days, sleep, come out of it, maybe stay straight for a week or two or three and then go back to it, that sort of thing. That's the way my life goes. And it's not really what I really want but it's as good as I'm gonna get at this point in time in my life with the life skills that I have... (Ray, 55 year-old male with HIV and hepatitis C who has been addicted to heroin for many years; Ray's emphasis)

Dr. Nora Volkow, research psychiatrist and Director of the U.S. National Institute on Drug Abuse, has concluded that drug addiction is a disease of the brain, and is not a personality defect or sign of individual weakness as many still believe. Volkow (2005) believes that repeated drug-induced increases in dopamine, a chemical responsible for pleasure and behaviour reinforcement, results in characteristic behaviours of drug addiction, such as the loss of control and compulsive drug administration. This research sheds light on why individuals such as Jo and Ray find it difficult to refrain from using. Volkow and Li's 2004 study on the brain effects of substance addiction concluded that abnormal behaviour associated with drug abuse should be understood as the result of dysfunction of brain tissue, just as cardiac malfunction is considered a disease of the heart. They discovered that in a drug addicted individual, the tissue of the orbitofrontal

cortex can be damaged, resulting in improper inhibitory control and compulsive behaviour (Volkow and Li 2004).

Gabor Maté, a physician and leading expert on addiction in Vancouver's Downtown Eastside (an area characterized by extreme poverty and widespread drug abuse) discusses how drugs can impact a person's state of mind in his (2008) book *In the Realm of Hungry Ghosts: Close Encounters with Addiction*. He acknowledges that chronic drug addiction is one of the major ways that homeless people cope with violence, trauma, and loss. Maté asserts that addiction encompasses every aspect of a person's lived experience, and has biological, chemical, neurological, psychological, medical, emotional, social, political, economic and spiritual aspects (Maté 2008). He warns that brain function can be severely compromised in people suffering with addictions. It has been discovered that the cerebral cortex (an area of the brain responsible for regulating emotional impulses and making rational decisions) has reduced activity in people with addictions. This reduces their ability to self-regulate, self-soothe, and interact rationally with others (Maté 2008). Perhaps the most disconcerting evidence that Dr. Maté brings forward is his warning that the drug-addicted brain has little chance to be either fully conscious or compassionate toward the self in order to break out of the cycle of addiction. This is not to suggest that recovering from a drug addiction is impossible, but the biological evidence about drug addiction reinforces how difficult recovery can be, and hopefully suggests the need for a more compassionate approach to those addicted. Dr. Maté is in favour of harm-reduction approaches to substance abuse, a subject that will be discussed in more detail in Chapters Four and Five.

Several participants verified that they were suffering from or had suffered from a mental disorder (such as depression, anxiety disorders, or schizophrenia) that coexisted with a substance addiction problem. The two issues were frequently interrelated—people may have developed substance addictions when taking such substances to manage anxiety or depression. On the other hand, being under the influence of a mind-altering substance often obstructed health-promoting behaviours (such as eating properly or taking medications) and in most cases led to health deterioration. A concurrent disorder can impact the severity of other conditions and how they are subsequently managed.

Comorbidities

Several participants revealed that they were dealing with multiple chronic illnesses at the same time. Coinfection with two or more long-term illnesses can increase the severity of each illness and make treatment of both more complex. As a consequence, people who suffer with comorbidities may be more likely to encounter severe fatigue and a weakened immune system, and may be less likely to benefit from treatments. Jo said that managing her HIV and hepatitis infections was a big concern for her. She described this particular method of disease management as a “challenge” because the treatments for hepatitis C can damage the immune system, and the treatments for HIV can damage the liver. She has experienced several bouts of severe side effects while trying to “balance” her medication regimen, which led to depression, addiction relapse, and eventually homelessness again. She explained:

...my health got so bad that they put me on a really aggressive HIV cocktail because my T-cells¹⁴ were dropping dramatically. And I remember one night I was getting really frustrated, and [felt like drinking] and thinking, 'I just can't handle this.' So I go to put my six year-old son into his top bunk and I collapsed and fell over because of [my anti-HIV medication]... the side-effects were just horrendous and I was getting these rashes, I was very sick, I was tired all the time. So I finally had to make the phone call and [my son] had to go live with his other mom for a little while. So my kid wasn't living with me and that was kind of lonely, and slowly and surely I just started to fall off bit by bit and I had to leave my job and I had to stop doing my own work that I was doing independently and then one day I just had a drink [of alcohol]. One drink and next thing you know...and that relapse lasted two years and I was homeless very quickly.

Other participants, such as Mary (who has diabetes and sickle cell anemia) and Ray (who has HIV and hepatitis C), told me that managing comorbidities was not only draining but impeded their ability to earn a living. Furthermore, both Jo and George told me that they contracted MRSA while in crowded environments (hospitals or shelters). MRSA not only exacerbated their pre-existing medical conditions by weakening their immune systems, but also made them apprehensive about utilizing such services in the future.

Toxic Environments

Many interviewees reported that they were exposed to environments that were damaging to their physical health and emotional well-being. I am calling these settings 'toxic environments' because they tend to produce effects that are harmful or deadly to

¹⁴ T cells are a group of cells that carry out immunological functions, and are therefore vital to immune system function. The human immunodeficiency virus (which eventually causes AIDS) infects and kills T cells, resulting in life-threatening opportunistic infections and malignancies.

the individuals placed within them. Prolonged existence in a toxic environment could be a precursor to becoming homeless (such as growing up in an abusive home). On the other hand, there are a variety of toxic environments in which people find themselves when they are under-housed or homeless (such as in inadequate housing, in environments where there is violence or drug use, and in some shelters). Living in a toxic environment can delay illness recovery and jeopardize people's attempts at getting clean. Toxic environments can be physically and emotionally exhausting. This decreases the likelihood that an individual will be alert or willing to trust people in other situations. All of the interviewees reported dealing with living in a toxic environment during at least one point in their lives. The following interview excerpts illustrate how toxic environments can be harmful:

I was in a shelter for a while, after I had my heart attack. Everything was stolen from me and a guy attacked me. I was just sitting there reading my book and the guy comes in [and] attacks me. I'm the one who got kicked out—*without* all of my belongings! He was walking towards me and just punched me in the face. I [defended myself by hitting back] and he runs to the staff and *I'm* the one who got kicked out. So you lose all of your stuff, right, 'cause they wouldn't allow me back in to get my things... That's not a shelter. That's a rip-off, that's what that is. [Shelters] are filthy; you're afraid to go to the bathroom. The places are not clean; the people are not clean. (Frank, 61 year-old male; Frank's emphasis)

One of the reasons you see so many guys on the street ...is that as soon as you mention shelter, they don't want to go. And there's reasons why they don't want to go. And one of them is that they're very poorly run. If you stay there for any length of time, you're lucky if you live. It's very dangerous. You can't even go to bed...you can't even take your shoes off your feet at night and put them beside you, you'll wake up in the morning and they're gone. You've got to practically tie your shoes together on your feet, and even they guys will just cut the laces and take them right off your feet. It happens, believe me. I've lost my [expensive] watch in there. I

knew a guy who had the earrings taken right out of his ears. (John, 60 year-old male with mobility issues and a chronic lung condition)

I basically knew what I had to do once I got out of [the Infirmary] to get rid of some of the situations that were really stressing me out in my life...the people that were coming to my [old] place. I [now] have a very quiet place, a nice place. I love my place and I value my privacy. I don't like to be alone but if I've got to be around people like that or by myself, I'd rather be by myself. You know, they take advantage of your kindness and you can't do enough for these shitty kind of people and they're a very small percentage of the drug world but they still love to hang around people like me because they think they can take advantage of people like me—these [people] who are into the drugs. I mean, I used to live like that; I don't want them around me anymore. They were coming to my door in the middle of the night...they wanted to do their drugs in my place...there was a lot of violence in my building...[some guys] would rob everybody in the place, so you had to be very careful. I've been bullied, and called a f---ing Jew, and an AIDS case my whole life, I've had to battle these kinds of things physically, and it's just started to get to me recently. It's a very hard mental thing to go out and be nice to people that I don't like; I have to be on guard all the time; if I don't give them a cigarette, I'm a 'piece of sh-t,' you know what I mean? (Ray, 55 year-old male)

Obviously when you're homeless you're very scared for your own physical safety...I had to be very cautious—I've been mugged three or four times, I've been beaten up a couple of times on the street and in the shelters—that's why I refuse to go to shelters because I've even been told by the people that run the shelters that I need to change my [clean] appearance because I tried to look after myself physically...I've been told by people who work in shelters that I stick out like a sore thumb—I come in, I'm well dressed, my clothes are clean, I don't curse and swear, I'm not drunk or drugged, and I'm polite. They tell me I'm a target—I've been told to not shave for four or five days, to let my clothes get dirty so I can blend in, for safety... I refuse to ever do it. (George, 56 year-old male who was battling severe depression as well as a series of different skin infections which were related to having a weakened immune system)

These accounts illustrate how toxic conditions can exist on the street, in shelters, and in some housing. Living within these environments can be detrimental to one's

health because they create stress, fear, depression, anxiety and diversions that can all compromise attempts at self-care. Several interviewees in this study revealed that they felt safer sleeping on the streets than they did in a shelter or low-income residence and were willing to endure the physical hardships of sleeping outside. There were many reports of violence and theft within shelters, which not only made people fear for their safety, but also made it more difficult to adhere to medical treatments or regimens. Several interviewees feared that their medications would be lost or stolen within a shelter, especially if they were prescribed pain medication (as these pills have a high street value). Others talked about how they felt unsafe and were not able to rest while residing in ‘drug houses’ or some low income/subsidized housing. A few interviewees felt discouraged from utilizing medical care within shelters (physicians and nurses) because of the lack of privacy and the short amount of time that medical staff could spend with patients (presumably because they were seeing a lot of patients at one time).

All of these toxic environments can raise stress to unbearable levels—enough to push a person to go back to living on the streets or cause a person to move around frequently. This can have negative health consequences for people, however, a choice to return to living on the streets is in some cases also a way to avoid the more pressing dangers of violence, theft, emotional abuse, or drug-infested environments. John, for instance, prefers to sleep at ‘his spot’ at Toronto’s City Hall because he is not usually bothered there and he believes that the security camera that he sleeps in front of offers him some protection from being victimized. In George’s case, the need to ‘fit in’ with other shelter users had clear health implications. Firstly, neglecting personal hygiene is

counter-productive in trying to manage infections, especially open-wound skin infections which he often had. Secondly, George's narrative suggested that his commitment to taking pride in his appearance was one of the ways in which he could combat feelings of depression and maintain a sense of feeling 'normal.' Looking good was an emotional 'pick me up' for him. Also, George's appearance could be interpreted as a way to take the emphasis off of his health problems and impoverishment. George had been known as a stylish, immaculate individual prior to becoming homeless; changing this would have been an insult to his standards and would have also challenged an aspect of his identity.

The connection between environment and well-being is further discussed by Aidala and Sumartojo (2007:S3), who say that, "experiencing a 'sense of home' contributes to ontological security—a sense of order, continuity, and meaning with regard to an individual's experiences and may lead to a sense of personal and social identity and agency that helps build resistance to risky behaviours." They assert that housing is affected by the neighbourhood in which it is situated. The homeless and under-housed tend to be concentrated in urban areas where there are high rates of crime and violence, limited economic opportunities, and poor service infrastructure. Aidala and Sumartojo (2007) reveal that the majority of entrants to emergency homeless shelters have had prior addresses located in areas with higher rates of unemployment, crowded housing, property abandonment, and higher rent-to-income ratios versus other areas. One's residence and neighbourhood can provide comfort, protection, and income/social opportunities. However, residence and neighbourhood can also create environments where a variety of factors external to the individual can create risk and vulnerability (Aidala and Sumartojo

2007). The participants in this study often made the connection between poor health and their toxic and stressful surroundings. Several individuals discussed how their emotional state impacted their physical state. They reported that their wounds and operation sites healed slower and that they were more likely to become depressed when they were living in a variety of toxic environments.

Vulnerability

When one lacks adequate housing and also requires medical care or a setting in which to recover, a unique set of vulnerabilities can exist in one's life. Illness symptoms, medication side effects, sleep deprivation, and being in a state of recovery can all create physical weakness that is incompatible with street or shelter living.

Andrew, a 63 year-old foreign-born male who suffers from asthma and heart problems, shared his experience of recovering from surgery for prostate cancer. He did not expect to come out of the hospital as early as he did (he stayed for three days in a Toronto hospital after surgery before he was discharged). After two days, hospital staff were pushing him to get up despite the fact that it was physically impossible for him to walk two days after surgery. Although he recognized that this may have been a part of the recovery process, he described their approach as "barbaric." He told me:

I couldn't have gone back to the shelter because we weren't allowed to stay in the mornings, at 8:00 [am] you're out of there, you're on your own for the rest of the day until you get back in the evening...One of the things my doctor requested was bed rest—how would I have had bed rest? So that was one of my major concerns.

Andrew did not feel that the shelter would have made an exception and let him stay in for the day, because that was not their policy. He was repeatedly reminded of this policy by shelter staff. On rare occasions, Andrew told me that they may let someone in if they are not feeling well, but even this exception proved to be inadequate. A nurse once let him stay for two hours during the day to sleep, which was not enough time to rest. Shelter staff woke him up and made him leave while he was still groggy. He was still in a lot of pain from his surgery and was also taking strong prescription painkillers (Percocet). The shelter doors opened just one hour later to let all of the clients in. He described that one hour wait as “awful.” He reported that there are medical staff that work within shelters, but his experience was that they only visited once or twice a week and that it was not the type of situation in which the medical professionals got to know patients well enough to advocate on their behalf (for extended bed stays or other medical considerations). The in-house nurse at the shelter eventually told him, “This isn't good for you, you have to get out.” Andrew summarized this experience by saying, “In a sense, I was put out, you know ‘you're on your own now.’ That was bad. That wasn't nice, that needs to change.”

Although rough time limits exist for recovery from certain types of surgery, some hospital staff do not recognize that every patient heals at a different rate. In particular, they may overlook the fact that patients who are homeless or severely impoverished may

have a variety of factors that impact how fast they heal and recover. Stress, poor nutrition, and living in unhygienic conditions can all delay recovery for these individuals. Hospital staff may assume that patients have access to an environment in which they can adequately recover and cope with medication side effects. Hospital policies that are designed to maximize efficiency (such as imposing caps on inpatient stays) can put the homeless patient in a vulnerable position. Prematurely discharging such patients often results in rapid health deterioration, increased risk of infections, and decreased adherence to medication regimens. People may bounce from hospital to shelter or from shelter to shelter and not receive what they really need: a safe place to properly recover. Hospitals and shelters rarely provided temporary or long-term solutions to homeless clients that I interviewed—these facilities usually performed their specific duties and did nothing beyond that. But these types of approaches actually work to the disadvantage of hospitals and shelters. By not adapting to the unique needs of homeless clients, these facilities contribute to repeat admissions and facility overcrowding. In addition, such policies result in a decreased quality of life for clients and a general lack of faith and trust in the services that supposedly exist to help them.

Two interviewees revealed that their medical conditions caused them to ‘blackout’ or come close to losing consciousness. Because they were relatively self-sufficient and on their own for the majority of the time, they feared that this put them in great danger. These interviewees reported that they feared assault, theft, falling, getting struck by a vehicle, and getting lost because of unexpectedly losing consciousness. They both feared that they would be in a situation where nobody would help them to safety.

The following accounts do not include interviewees who had alcohol or drug-related blackouts.

Frank, a 61 year-old foreign-born male, claims that he has suffered from blackouts for the past 25 years and that they were a contributing factor to becoming homeless. He told me that he used to get bad blackouts, where he appeared to be conscious but actually was not. He revealed, “I used to end up in weird places, all over the place.” He would have no recollection of how he got to places and sometimes found himself with no money in his pocket. He once ended up in Barrie, Ontario and had no memory of how he got there from his home approximately 140 kilometers away.

John, a 60 year-old male with mobility issues, a chronic lung condition, and chronic pain reported that he often coughs so hard that he gets dizzy. Sometimes it gets to the point where he is short of breath and dry heaving, which causes stomach aches. His coughing spells come with little warning and are made worse by cold air during the winter months. Sometimes John coughs so hard that he feels like he is going to blackout. He said:

The kind of pain I’m getting now is kind of scary because I might go a day, and nothing, and all of a sudden I might be sitting or walking and it’s just like somebody stabbed me in the chest. And same with my cough...I was sitting and all of a sudden I started hacking.

John also revealed how vulnerability is created because of sleep deprivation. He said that at Toronto’s City Hall, the homeless are not allowed to unroll their sleeping bags

until 11 pm and they have to be off the premises by 6 am. Guards enforce these time limits and often wake people up around 1 am, just to see if they are alright. John felt that it was difficult to get a good night's sleep under these conditions and that sleep deprivation makes it much harder to recover from a health problem. He told me:

When [guards] come to wake guys up in the morning, guys wouldn't get up, they were so tired you know. And of course some of the guards that get down there are getting a little gung-ho, they're starting to kick you in the back, the head.

Sleep deprivation creates vulnerability because if people feel fatigued, groggy or impaired, they are less likely to be able to defend themselves from violence or theft. People who are sleep deprived can also suffer reduced cognitive ability and immune function.⁷ Sleep deprivation was cited as a major problem by several interviewees who were living on the streets, in shelters, and in substandard housing.

Another issue to consider in John's story is the role of the City of Toronto. Obviously City officials acknowledge the presence of homeless people on their property—they send security guards to City Hall and impose sleeping schedules on the homeless that sleep there. They wake people up to 'check' on them, but generally do not provide people with alternatives to sleeping outside. They chase the homeless away when the public is likely to see them (i.e., in the morning when the professional crowd is arriving), but accept that they are there late in the evening and into the early morning. Homeless individuals are simultaneously chased away and viewed as a liability by the City of Toronto. The most frightening aspect of John's account was that guards

⁷ For more on this topic, see Dinges et al. (1995).

employed by the City were sometimes physically abusive to the homeless who slept on Toronto property. I also think that the location of John's story is symbolic. People are choosing to sleep in a location where city officials—people who could effect important changes in the areas of housing, shelters, and medical services—are concentrated. John's story demonstrates that homeless people are regularly victims of intolerance, and exemplifies a clear failure of our system to assist its most vulnerable citizens.

Stigma, Discrimination, and Judgement

Several interviewees in this study reported being stigmatized because they were homeless, addicted to substances, were of a particular religious or ethnic group, were HIV-positive, or identified as gay. Sometimes, people experienced multi-layered stigma because they identified with more than one of these categories. The main theme of 'stigma' is that the person with the illness is somehow seen as responsible for having the illness. Stigma leads to discrimination. Factors such as systemic inequalities (that disproportionately affect some ethnic groups), the reality of normal human variation (with respect to sexual orientation), and the devastating physical experience of the illness (that should elicit empathy) are masked. Aidala and Sumartojo (2007:S3) assert that, "being homeless is literally a mark of failure at the most basic level of adult role functioning" and that the resulting societal rejection, internalized shame, and lack of self-esteem may contribute to people engaging in risky behaviours. They conclude that substance use is often a method of 'self-medication' that can help people escape the

discomforts of stress, depression, or anxiety. Sexual escape may be another way that people deal with these feelings. Both of these coping methods can increase a person's risk of HIV infection (Aidala and Sumartojo 2007).

Stigmatization is dangerous because it affects identity, sense of self, and self-esteem, and may affect one's functioning within society. As Goffman (1963) discusses, when an individual internalizes stigma, it can lead to a 'spoiled identity' where one feels disqualified from full social acceptance and participation. Alternatively, stigmatized persons may voluntarily remove themselves from participation in social life. The stigmatized person is deprived of their actual identity and typically their dignity as well. Because the stigmatized person's characteristics are overshadowed by one attribute (that may or may not be rooted in truth), the basic human rights that they previously possessed are largely erased. Stigma often silences its victims, making it difficult for such individuals to resist maltreatment. In some cases, having a biomedically-defined illness or having lower socio-economic status places moral attributes onto a person. If given an undesirable label because of these reasons, one tends to be seen as 'bad' or 'undeserving' in a variety of other ways. People may accept poor treatment because they have come to believe that a particular stigma is correct or that they are powerless in resisting it. It is essential to note, however, that individuals may also resist internalizing a 'spoiled identity'; alternatively, they may both resist, and simultaneously partially internalize negative feelings about themselves. Both how they are treated by others, and how they view themselves, may influence how they access services or engage in self-care.

Jo explained that homeless individuals may accept trade-offs in certain situations:

...the average person who has lived on the street chronically, they have great sensory perception just because they've had to survive out there. They know when they're being judged, they know when the police are after them, they know when they're being questioned for wrong reasons, they know when someone's playing them 'cause that's what they've had to learn to be good at to survive out there. I think some people pay the price of allowing to be patronized in return for services. I think a lot of clients will [allow people to talk to them in certain ways] if they know at the end of it they're getting a cheque, or access to a food bank, or a bed. But they know they're being patronized, they know there's no real connection there.

An example of a strongly stigmatized disease is HIV/AIDS. HIV/AIDS tends to be associated with people who engage in 'risky' sexual or lifestyle behaviours (such as unprotected or promiscuous sexual practices, intravenous drug use, or commercial sex occupations)—behaviours that people tend to associate with moral or social decay. HIV-related stigma refers to all unfavourable attitudes, beliefs, and policies directed toward people who have HIV/AIDS. Individuals who are stigmatized because of their status as HIV-positive may be rejected by their loved ones and communities and may also lose their homes or jobs. They can lose major forms of support (both social and economic) when they need them the most. For these reasons, HIV-related stigma must be recognized and addressed as a life-altering phenomenon that is harmful to one's health.

The physical symptoms of an illness are often only one facet of the entire illness experience that a patient must encounter. The social aspects surrounding a particular illness often define the ideas, attitudes, and subsequent management of a medical condition on the part of both patient and caregiver. Social stigmatization is a social

process that is characterized by excluding, rejecting, and blaming people with a medical condition for their current state. A moral flaw in character or sense that someone deserved their affliction is common in the discourse of social stigmatization. The process of stigmatization has detrimental effects not only for the individual with the medical condition, but also for their families and social circles. Stigmatization and judgement by medical staff can also create barriers for people using the public health care system.

Jo, a 38 year-old woman who has HIV, hepatitis C, and was at one time MRSA-positive,⁸ experienced many barriers in a Toronto hospital when attempting to get medical treatment for a serious lymph node infection related to her HIV infection. She reported that hospital staff labeled her as a ‘drug user’ and a ‘drug seeker’⁹ and as a result, her medical concerns were not adequately addressed. She expressed to me that, in her experience, many medical professionals did not understand the cycle of addiction and withdrawal. When she first sought medical care for her infection, it was only under one arm, but by the second visit she showed emergency room physicians how it had spread to her second arm. She remembers that the doctor was very casual about her infection—she presented large masses that were hanging from her underarms—and instead focused on the fact that she was in withdrawal. She tried to explain to him, “I’m always going to be in withdrawal—I use. I’m in withdrawal because I’m *not* using right now, because I’m *trying* to get health care” (Jo’s emphasis). This interaction was frustrating for her. Even when she was trying to be responsible about her own health, her concerns were not taken

⁸ MRSA (Methicillin-Resistant *Staphylococcus aureus*) is a bacterium that is resistant to a wide variety of antibiotic medications. It is responsible for serious skin infections and disproportionately affects hospital patients with weakened immune systems and/or open wounds.

⁹ A ‘drug seeker’ is someone who attempts to get prescriptions for pain-reducing medication or methadone (a synthetic opioid) from health care personnel in order to feed their substance addiction.

seriously and her substance addiction quickly became the focus. She highlights the fact that people with serious substance addictions are the least likely to receive urgently needed medical care. She told me:

[Sometimes] you're just so desperate and scared you are going to die, you end up in an emergency room, which is the case for most homeless people. People who are street-involved because of their addiction, especially crack addiction, are not going to sit in a waiting room for five to 12 hours to be seen by a doctor. For me, I seriously thought I was dying—I *was* dying—the pain was so bad, and it wasn't just a matter of them not going the extra mile, it's that *they didn't do their job*. (Jo's emphasis)

Jo's doctor recommended methadone for oxycodone withdrawal, but that did not address the problem she came to the hospital for. Another time, she left the emergency room with a prescription for antibiotics that she had already told the doctor she was allergic to. It was as if the staff had blinders on. The infection soon spread into her spine and lungs. Hospital staff continued to tell her, "There's nothing we can do about that. It has to drain on its own." She told me that if she had let it drain on its own, she would have died because the doctors at the Sherbourne Infirmary later told her that she was septic.¹⁰ It took her four hospital visits to be taken seriously. She spent 10 days in isolation in a hospital intensive care unit, her lungs were bleeding, and she had to have three lumbar punctures. She concluded that "It was just insanity and it all could have been avoided." She viewed this whole situation as a basic rights issue. Jo told me:

¹⁰ She had life-threatening staphylococcal septicemia, which is commonly known as blood poisoning.

Doctors and nurses should not be balancing out in their heads who they think is going to make it and who isn't, and then determining who gets health care. It's so dangerous... 'cause I might live that day and go out and use for a month, but I might live to see the day I get out [of this cycle]. And I might not. But I *still* deserve and I still have a right to health care. (Jo's emphasis)

She felt that biases within the health care system about who is worthy of care, and judgment from medical staff about addicts threatened her life. John and Jo's stories illustrate how stigma can jeopardize one's self-esteem, compromise one's basic rights, and lead to discrimination and substandard care in a variety of settings.

There was a significant amount of discrimination towards drug users, especially if an individual was HIV-positive. In some cases, revealing both to health care staff resulted in judgment or blaming of the patient. Some health care professionals made assumptions about how their patient's HIV was contracted. Jo was extremely offended that a member of her health care team assumed that she contracted the virus through IV drug use, and that there was a 'well what do you expect?' attitude that followed. People were blamed while seeking help for problems they were trying to address.

Jo eventually internalized the poor treatment she received in many situations. She said:

It almost killed me. Because I wasn't housed, I lost a great sense of myself, like I wouldn't bother with things like appointments and health maintenance. I was homeless, right, and I was addicted and even if I was using and I had a home, I may be more inclined to attend appointments because I had a stable ground underneath my feet...so I didn't access much health care because of that, and when I did, I experienced a lot of

sometimes ‘quiet’ discrimination, but it was definitely prejudice, particularly about my addiction, and I just cower... I curl up into a little ashamed ball when that happens to me because I’m agreeing with them, you know, ‘You’re right, I am a piece of sh-t. I’m a mom, I shouldn’t be here like this.

This narrative illustrates how all aspects of a person’s identity can be reduced to one negative label. Jo’s grim housing and income situation affected the way she managed her health and valued herself; being a mother with a substance addiction was the final blow to her self-esteem.

John discussed how he was once embarrassed in public because of ‘homeless stigma.’ John was recently in line to purchase a hotdog from a street vendor, when he heard the vendor say, “Oh here’s another one” (referring to a homeless person begging for food). The vendor said to him, “Why don’t you guys just leave us alone. *All you guys* are the same way” (John’s emphasis). John, who had money in his hand, replied, “Don’t categorize everybody that way,” and the vendor then told him, “All homeless people are the same way—they’re all drunks and alcoholics and [lazy].” John found this interaction to be frustrating and degrading. He told me, “This man really didn’t know the nature of why [people are] on the streets, and number two, I was going to buy a hotdog but I’m not now. I’m not going to be treated like that. It’s just a stigma that’s put on homeless people.” He was appalled that people regularly stereotyped homeless people in this way, especially considering that he is not a substance user and has no history of mental health problems. For someone who took pride in being a self-sufficient and considerate individual, this experience was both humiliating and discouraging. However, John demonstrates that an individual may refuse to accept certain societal stigmas and thus

actively resist internalizing a 'spoiled identity.' Although John disagrees with the logic that underlies 'homeless stigma,' he shed some light on why he thought this stigma exists. He felt that the media over-emphasizes negative aspects of a very small percentage of homeless individuals, and that these stories snowball. As a result, members of the public are inclined to characterize all homeless people as violent, addicted, 'crazy', or lazy and therefore unapproachable and unworthy of care. Evidence from the interviews suggests that health care workers and shelter staff sometimes hold these beliefs and in certain cases, provide substandard care to homeless persons.

Phobia of/Resistance to Health Care

Several participants disclosed that they were afraid or apprehensive about being seen by a physician or entering a medical facility. This is not surprising considering the disproportionate number of emergency hospital visits that homeless individuals make, and the fact that many report they lack legitimacy within health care settings. However, people can have experiences before becoming homeless that make them fearful or resentful within medical settings and resistant to health care personnel. This can put individuals in great danger once they become homeless, because health generally deteriorates when one becomes homeless. John, a 60 year-old man, had an early experience with a physician that tainted his future relationship with health personnel. He told me:

I've had a bad taste in my mouth with doctors for years because I lost my mother when I was 16 and for a long time, I blamed the doctors because I felt like it was misdiagnosis that eventually caused her death. She had her pains in her stomach and lower tract for months...[the doctor] gave her an examination and told her that nothing was wrong. [Weeks later, another doctor] told her she had an [inoperable cervical] tumor the size of a grapefruit and I was livid. I was ready to kill that first doctor. I was so mad and when she died I was much worse. She gave up [on life], she wouldn't eat. I guess part of it was my age because I was only 16...I just couldn't handle it. I was blaming everybody and anything and for a long time...

For John, this event not only shaped his perspective of the medical establishment, but also his personal relationships into adulthood. It took him a long time to recognize that most physicians are competent. He told me, "Over the years, I've gotten to know that doctors, for the most part, know what they're doing." However, there are still limits to his trust in medical staff. He told me that his current medical problems are, in part, related to non-adherence to medical orders and medications (he developed a serious pulmonary embolism from not taking his anticoagulant prescription). John said that he has developed a high pain threshold, and it can be speculated that this is an adaptation to avoiding medical care for so long. John also felt that sometimes medical recommendations did not take into account the fact that people were sleeping on the streets. He discussed a prescription-related side-effect:

The problem was that with diarrhea, when you're out on the street sleeping where I was at City Hall, if you have to go to the washroom in the night, you're stuck. And I had a few nights with that problem and I said, 'no, I'm not going to go through that anymore' and I just quit.

Deb, a 53 year-old woman whose health issues include an extensive substance abuse history, cancer (small cell carcinoma in the cervix, bladder, bowel), hepatitis C,

kidney stones, irritable bowel syndrome, arthritis, osteoporosis, scoliosis, and myasthenia gravis,¹¹ characterizes herself as “hospital phobic.” Her phobia stems from a misdiagnosis of the severity of her cancer, where a resident told her that she had only 10 weeks to live. This was an extremely traumatic event for Deb and she told me that at that point, she gave up living. This negative experience with the mainstream hospital system discouraged her from seeking health care services for years thereafter. Her avoidance of medical care stemmed from fear, lack of trust, and anger. She still harbours a lot of anger over the event, mostly because her daughter suffered emotionally with the news of her mother’s impending death. In addition, the hospital physician prescribed a strong pain medication to her at that time (one he *thought* she needed based on the diagnosis). Because she was taking a large amount of pain medication (that she did not need) and dealing with such upsetting news, drug use became recreational for her. She went from abusing prescription pain medication to abusing crack cocaine, heroin, and methadone. She told me that she was involved in “drug culture” for nine years before (recently) becoming sober. Her story demonstrates how one or several negative experiences within health care settings can make people fearful of entering health care facilities in the future. This phobia can be especially damaging to individuals who are homeless and often in need of urgent or long-term medical care. The ways in which the Sherbourne Infirmary combats this ‘medical phobia/avoidance’ phenomenon in clients is discussed in Chapter Four.

¹¹ Myasthenia gravis is a neuromuscular autoimmune disorder that causes muscle weakness throughout the body.

Loneliness and Isolation

Loneliness is identified as another barrier to health management and is a theme that emerged in several interviews, especially *after* individuals were able to secure housing for themselves. Loneliness can occur when somebody has an inadequate or non-existent social base on which to rely. Clients reported that the absence of friends, family members, or reliable acquaintances in their life combined with mobility issues or fears about their health led to a persistent feeling of loneliness which was often accompanied by anxiety, frustration, and depression. Several interviewees revealed that their families had turned their back on them or that they turned their back on their families to spare them from watching them deteriorate in the context of a substance addiction. Some other participants reported that actually being homeless led to loneliness because they could no longer relate to people who were part of their 'former' lives, or because the dangers of street life made it hard to trust people.

Other participants felt lonely once they were housed because they missed the little bit of social life they had while living on the streets or within shelters. This sometimes led to 'voluntary homelessness.' Some homeless individuals would contend that their health and lives are better managed on the street than in a hospital or within shelter or public housing environments. One informant was homeless by choice and had rejected numerous offers for immediate housing in desirable residences. This person has no history of mental illness and does not drink alcohol or use drugs. He was trying to manage a chronic lung condition and he acknowledged that it was made worse by

sleeping outside. He made reference to enjoying his freedom living on the streets and that he valued the sense of community that street life offered.

Loneliness can make it more difficult to manage a chronic health condition because people feel like there is no social safety net present if they run into trouble. Loneliness may also lead to depression and result in individuals losing motivation to keep on top of managing their health. Ray, a 55 year-old man, revealed that his main fear is dying alone of AIDS. He told me:

What I've gone through and have been going through in the last few years with pain and so on, to go through it by yourself is hard, with having nobody to talk to. I mean I can talk to my doctor, but I have nobody as far as family. Friends I wouldn't count on, I don't have *one*, which is pretty sad in itself. From this point on, my health is not going to get better, it's going to get worse, and when I see what I'm in for as far as [my infection progressing to] full-blown AIDS, it's a horrible disease to die from. My own children don't want [to have anything to do with me]... Once I told my kids that I was HIV+ they said, 'I never want to talk to you again'—like my *own* children, and I just couldn't believe it. That's a heavy-duty thing for me to be walking around with. (Ray's emphasis)

Tal, who is now housed and lives alone, reported that his diabetes contributes to feeling socially isolated. When he first came to the Infirmary, his diabetes was not well managed. When his blood sugar gets low, it affects his mood. He told me that he often gets angry, closes his door, and does not want to talk to anyone in his building. He also worries that he will fall into a coma if his blood sugar drops while he is sleeping. He said that he is depressed, lonely, and cries a lot at home. Tal told me, "If your health is no good, you are not happy, you don't feel like eating or talking to anyone, it affects your brain...it's very hard to bring you back to normal."

Sumerlin (1995) confirms the importance of stable social components, and states that satisfying interpersonal relationships are common pathways to a healthy mental state. This researcher makes the distinction between depression and loneliness, stating that, “depression sometimes implies a willingness to forego relationships [whereas] loneliness indicates a desire for personal contact” (Sumerlin 1995:298). Almost every human being seeks human companionship and wishes to feel connected to others. If loneliness is the need for regular contact with and acceptance from others, then services geared toward the homeless population can counteract loneliness by providing these very things. In this way, understanding the nature of loneliness in people who are dealing with both health and housing issues can have important long-term health implications.

Loss, Grief and Bereavement

Several interviewees revealed that they experienced a major event involving loss. The death of a loved one or losing custody of one’s children were cited as grief-inducing incidents that were related to becoming homeless. This information is consistent with Crompton (2003) who asserts that a traumatic life event such as the death of a loved one, can have an enormous impact on all other aspect of the life of the grieving individual.

Deb told me that the deaths of the three most important men in her life—her father, her husband, and her only brother—in a very short time span were the catalysts to her becoming homeless. This series of traumas is interrelated with her addiction to both

prescription and illegal substances. She experienced a tremendous amount of grief, and was dealing with her own cancer diagnosis during the same time period. All three men passed away shortly after her chemotherapy treatment ended, which made her outlook on the future particularly dismal. Deb told me that she was previously healthy, athletic, and earned a very high salary working in media, before bereavement and illness took away many of her reasons for living. She soon spiraled into a life of addiction and homelessness.

George detailed the sudden loss of his partner of 28 years, with whom he previously lived a fulfilling life in an affluent Toronto neighbourhood. He recalled, “We had a very loving, wonderful, monogamous relationship, we travelled all over the world together.” Approximately four years ago, George was returning from work overseas, and his partner, Terry, offered to pick George up when he arrived back in Toronto. After waiting for Terry for over an hour, George eventually made it home to an empty house. He then received a phone call from the police. There had been an accident on the highway and Terry had been killed instantly by a drunk driver. George was told that Terry was dismembered and died instantly. George had to identify the body. George told me:

...from that moment on, my life changed irreparably—it’s just never been the same. I still mourn today. I went into...they had grief [specialists] try to help me and they said I had post-traumatic grief syndrome; the fact that I had to identify the body and part of his head was missing and...even though they clean them up, you still have to see that—the person you love most in your life. So at this point, all sorts of things began to happen. I got through it...I was very good at taking charge. I was then left with a large amount of money—his life insurance paid a big amount because of

accidental death. I said ‘it’s blood money, I don’t want it’, and I gave it all to [an AIDS charity that Terry and I had supported for many years]. I donated all the money to them, gave them every last dime of it. I asked for more time off from [my job, to which I had put 27 years of service] and they refused in writing. I resigned—the worst, stupidest mistake I ever made in my life. So here I was, I gave all this money away, resigned my job... I had no income because I had no job. I was able to get unemployment but I was even penalized for *that* because I quit. Legally it’s being discussed now, that I may have a case because of my state of mind to go back to [my former job], and that my resignation was given at a time when I was not mentally, fully capable of making these kinds of decisions—these decisions were all being made under...what really happened was I was on the brink of a nervous breakdown. What happened was something went wrong inside of me that I still to this day don’t understand.

George became caregiver to his elderly parents, who both had terminal illnesses, and who both died shortly after the death of Terry. Unfortunately these events struck him all too fast—the three people he loved the most had all died in circumstances that were either sudden or that caused them to suffer. George had a very serious bout of depression, which was followed by a near-fatal suicide attempt. He spent weeks in the hospital in order to save his life after his suicide attempt, and then spent three weeks in a mental health unit. He was given antidepressants, anti-anxiety medication, and counseling. George experienced overwhelming sadness, and subsequently retracted from his social circles and entered into the shelter system. His story demonstrates that people do not always conform to society’s standards of ‘standard’ grieving time or ‘acceptable’ ways in which to grieve, and that this could be a factor that contributes to homelessness. It shows that people may make irrational decisions when they are coping with grief or recovering from trauma. George told me that he enjoyed a happy childhood (and adult life until these events occurred) and held two university degrees. Therefore, his story also shows that even the most stable and affluent individuals can experience life-altering

loss that can lead to homelessness, and consequently an overall decline in health.

Barriers to Recovery: Issues within Shelters and Hostels

Many study participants reported using shelters or hostels when they were sick or recovering from an illness or procedure. There are many reasons why shelters and hostels are generally not appropriate when in these states. Generally speaking, they can contribute to poor health in a variety of ways. First, as previously discussed, shelters (and in some cases, hostels) can be dangerous environments. There is an increased incidence of theft and violence in these establishments, which can increase the likelihood that someone will be harmed through violence or because they have medically-related resources (e.g. prescriptions, money) stolen. Second, shelters and hostels regularly provide refuge to those who use/abuse substances, which is not a productive environment for someone who is trying to maintain sobriety. In addition, some participants voiced that they felt these settings were ‘dirty’ because they witnessed unsanitary intravenous drug use while at a shelter or hostel. Third, many shelters have rigid schedules or rules, which may be incompatible with the scheduling needs of somebody who is in recovery, taking medication, or dealing with a permanent disability. Fourth, several interviewees did not like the fact that they did not have much privacy, especially within shelters where many people slept in the same room or where medical consultations could be heard by other residents. Fifth, such settings increase people’s stress levels—people feared for their own safety and often had higher rates of anxiety within a communal environment

versus sleeping on the streets. Sixth, the vast majority of participants declared that they took pride in being independent and self-sufficient, and that a shelter or hostel environment somehow conflicted with this mindset. Seventh, several clients told me that they experienced discrimination in some capacity by shelter/hostel staff or shelter referral centre employees. They left these situations with hurt feelings, and were discouraged to make use of them again, which inadvertently pushed them back on to the streets or to other potentially dangerous environments. Eighth, many participants told me that they could not tolerate the food served in shelters, saying that it was not palatable nor nutritious. In particular, clients with diabetes found it difficult to follow a diabetic diet with shelter menus that were typically carbohydrate-rich. And finally, two interviewees mentioned that shelters were poorly equipped to serve clients with mobility issues—they had broken elevators, no elevator at all, or unsympathetic staff.

These points are not intended to ‘put down’ all shelters or hostels—many participants discussed how they also appreciated shelter and hostel staff, and how a stay at one of these facilities could lead to beneficial referrals or additional resources. The goal is to highlight the reasons why such places should not be first-line resources for homeless people who have a major or acute health issue. Generally speaking, shelters and hostels specialize in providing *shelter* to those who require it. Given the multiple and complex health issues of many of the clients in this study (and certainly other homeless individuals as well), it is necessary to point out the gaps between the needs of such people and what exists in many shelter/hostel settings.

Jo felt that it was particularly difficult to manage her health conditions (HIV and hepatitis C) in shelters because she would be exposed to a lot of illness and drug use, compromising her immune system and her efforts to stay clean. She reported, “As an HIV-positive person, I’m exposed to a ton of illness. A lot of people with MRSA don’t know they have it, tons of people with HIV and hepatitis C don’t know they have it, and as an addict, there is a lot of using in shelters.”

George said the problem with drop-in centres and shelters is that:

When a health care professional comes in, they come in for two hours. Well, nobody wants to step forward and put their name on the [sign-up] list because, people may have problems with their feet or they’ve got infections or whatever, and they don’t want to share it because you’re in front of everybody.

When I asked if there was any privacy in these situations, George said, “No...well little partition walls or sometimes they put a blanket up, but everybody hears everybody’s business, so you get nobody wanting to go.” He believes that because of this, many shelter users are not disclosing serious symptoms and illnesses—they are afraid to. This fact has significant infection control implications as well. By not providing an environment in which people can confidentially discuss their health concerns, some shelters may be unknowingly contributing to the spread and severity of diseases.

John told me that his health requires constant monitoring. Because he is prone to potentially deadly blood clots, he was put on medication that can make his blood “too thin”—to the point that he could bleed to death. John routinely checks his blood’s

clotting capacity through blood tests that are performed at an external testing facility. His testing schedule is not always compatible with the service hours of shelters. In addition, John has a mobility issue, which stems from a hit-and-run accident that shattered his leg 18 years ago. He never regained full leg function (the bones in his injured leg were mostly shattered and then fused back together incorrectly) and he has difficulty walking (his knee cannot bend).

John shared one shelter experience with me. Not long ago, he went to a referral centre to get into a Toronto shelter on a very cold night. After numerous attempts to enter the shelter by ringing the doorbell, an apathetic staff member finally let him in. John was assigned the top bed of a bunk bed and he told them he was unable to use it because of his fused leg (he could not climb the ladder). He even asked the employee to help him up and the employee said, "If you can't get into the top bunk, we've got nothing for you." He had no choice but to go back outside. At that point it was around 2 am and he knew there would be no beds available. John slept outside that night. The following week, he returned to the referral centre and the same shelter was suggested again. He once again reminded the employees that he could only utilize the facilities if he could get a bottom bunk, but they were generally unreceptive to his request. I asked John if he thought another shelter user would switch bunks to accommodate his disability and he said that was very unlikely. For someone with a multitude of health problems (including a chronic lung condition), this story was particularly distressing. John spent the night out in the cold when a simple adaptation could have been made to accommodate him. This type of scenario was discouraging for John and several other interviewees shared John's

frustration when shelters did not adapt to individual health needs or mobility issues.

Barriers to Recovery: Issues with Access to Health Care Services

Some clients reported that they lacked legitimacy within many of the public health services they attempted to use. There was a lack of understanding about people's complex life histories and medical issues—factors that may have led to or been caused by being homeless. At times, this resulted in medical staff not being 'on the same page' with such patients and consequently providing suboptimal care. Jo recalled her frustrations with medical staff at a Toronto hospital, saying:

I've had two abortions in the past and yeah they were a direct result of my being irresponsible, but still not a great experience to go through. And I had doctors that told me, 'Well it's that you need to get on board with taking the [birth control] pill' and I said, 'but I'm gay' and they asked me, 'well why are you pregnant?' And it's because I use drugs. So not once did any staff member at this hospital ever say to me, 'what can we do about your addiction, what can we do about your health?' It was all just 'you need to take the pill or you're going to keep getting pregnant.' But if I was sober enough to keep up taking the pill, I wouldn't need it because I don't actually have sex with men when I'm not using! You know, there was just no room to tolerate it.

In this case, Jo's health care team had a limited understanding of the complexities of her situation. Her story also reveals that health care professionals may make the mistake of only focusing on one issue and then take a narrow (and ineffective) approach to treatment. Physicians were unable to see the whole picture in this case—her taking the pill properly would be contingent on her not being addicted to mind-altering drugs.

Jo was getting pregnant in the first place because she was using. She felt that if her addiction issue was addressed, she would not need the birth control pill.

Jo also reported that when she was pregnant she went to a Toronto hospital to inquire about prenatal care, and staff completely ignored her same-sex partner. She said, “They were beyond themselves, [their reaction was], ‘you’re HIV positive, you’re a drug addict, you’re all happy that you’re going to have a baby and this is *who*?’” (Jo’s emphasis). When she informed them that it was her partner—the child’s other parent—the staff questioned her even more, asking: “So...are you guys married? Can you guys even *do* that?” (Jo’s emphasis). They were not attentive to her medical needs and very condescending towards her partner.

Furthermore, Jo felt that she was not represented in AIDS campaigns or posters, and asked, “Does a lesbian woman see herself in HIV campaign ads? No. There’s a great assumption that if you’re a lesbian and you’re white that you *work* with HIV, you don’t *live* with HIV. I’ve been told that [I’m in a low-risk category]. We’ll you’re calling me ‘low-risk’ and I *am* HIV-positive” (Jo’s emphasis). She expressed that in order for patients to maximize their use of health services, they must feel like that facility recognizes who they are and is equipped to provide appropriate services and referrals.

Barriers to Securing Income/Employment

Several clients detailed their difficulties with money and getting or staying employed. Economic deprivation can be a barrier to health management for a variety of reasons. Accessing nutritious food, medical supplies, transportation, and safer accommodations are some of the essentials that participants often bypassed because they could not afford them at one time or another. Also, when housing costs make up a large proportion of one's overall income, it can be a challenge to allocate funds to health-promoting purposes. The majority of interviewees reported that Ontario Works (OW) or Ontario Disability Support Program (ODSP) was their main or only source of income. For some interviewees, job loss was one catalyst to becoming homeless. However, injury and illness were cited as major reasons for not working. Opinions about the adequacy of OW or ODSP were extremely varied among participants—some felt that these sources were not enough to live on; others felt that these sources were more than enough to live on. John gave his perspective on the issues of employment and public assistance:

...there's not enough stimulus in the workforce to get the [homeless] to work because our minimum wage is so low, in my opinion anyway, that there are guys that can get more money through social services than they can working. And as long as that happens, you're going to have guys who aren't going to go to work. And a lot of guys—I don't know how they do it but—they'll be on the street cheque which is \$211 and then they stay on it for whatever length of time and then they get transferred to ODSP, and a lot of guys that are on ODSP have no business being on ODSP, and they'll even tell you, 'Oh I pulled one over on them' and it's almost double or triple the money.

Because of what I believe to be an outrageous error on the part of Ontario's

Ministry of Community and Social Services, John is actually put at an economic disadvantage because he has attempted to remain self-sufficient for many years. This actually disqualifies him from receiving financial support from ODSP. For almost two decades, John has chosen to “put up” with severe pain in his legs and limited mobility (stemming from the accident that he was in, which was previously described). John’s physician is aware that he is not taking any pain medication, but this fact works against him because there is no proof that John is in severe pain (even though he actually is). Doctors even told him that cold and damp weather makes the pain worse in his injured leg (because he had reconstructive surgeries that left steel components throughout his leg bones), which results in recurrent episodes of throbbing pain. John was told that no drug could remedy this particular kind of pain entirely. John is obviously suffering and unable to work. He has a permanent disability but does not qualify for ODSP. Again, just as seen with the shelter system, the ODSP system is set up to assist people like John, but in some cases lets them slip through the cracks. Furthermore, receiving ODSP does not necessarily mean that someone escapes living in poverty. According to the most recent ODSP Handbook, an individual ODSP recipient could receive up to \$930 per month to cover shelter and basic expenses (Government of Ontario 2003). However, this amount works out to be well below the widely accepted Canadian Low Income Cut-Off (LICO)¹² of just under \$21,000 per year, after taxes (Raphael 2007). So even if some people are in fact fraudulently obtaining ODSP, it still usually means that they are living on a dangerously low income, particularly given Toronto’s cost of living.

¹² Although Canada has no official ‘poverty line,’ LICO is one way to estimate the rate and depth of low income. According to Raphael (2007), LICO is an income threshold below which an individual will likely devote a larger percentage of their income to basics (such as food, shelter, and clothing) than an average person would. Typically, this percentage is around 60%--that is, it is anticipated that 60% or more of their income will be devoted to purchasing basics.

Mary is a 39 year-old female who came to Toronto in 2000. She is currently without Canadian citizenship status. Mary has been diagnosed with sickle cell anemia, diabetes, hypertension, and uterine fibroids. She described how her declining physical state impeded her ability to earn an income. Every time she had a stretch of employment, she would feel sick and out of energy. Mary attributed her physical weakness to having sickle cell anemia.¹³ She used to work cleaning stores in downtown Toronto, but she had to stop working because she no longer had the energy to pull the vacuum. She then worked as a babysitter, but still felt weak, had trouble climbing stairs, experienced burning feet, and had generalized pain throughout her body while at work—all symptoms consistent with sickle cell anemia. She worked until she could no longer. However, she told her social workers, “I don’t want to go on government assistance. I can help myself.” Her lack of energy and current state of unemployment were quite frustrating for her. She recently had surgery to treat her fibroids, and she attributes her exhaustion to both sickle cell anemia and loss of blood from her surgery. She is unsure as to when she will start working again, but says that she is eager to one day start her own business. Because she does not have status (and therefore lacks health coverage and cannot apply for social assistance), she worries about how she will pay for her basics and prescriptions. She is currently paying back the full cost of her surgery (C\$9000) in monthly increments and has received some help with this from various cultural and women’s centres.

¹³ Sickle cell anemia is a chronic blood disorder that affects the red blood cells. It reduces the flow of blood (and therefore oxygen) to bodily organs and can result in chronic pain and fatigue.

Housing: Barriers and Contradictions

Adequate housing is a key determinant of health, especially for those who are coping with a chronic condition. Several clients reported that they faced discrimination from landlords if they found out or suspected an applicant was HIV-positive. Individuals feel that revealing that they receive assistance from the Ontario Disability Support Program (ODSP) is a double-edged sword: landlords know that the applicant receives a steady income that is enough to cover rent every month, but landlords often want to know *why* you receive ODSP—especially if you appear to be healthy. If it is suspected that an individual is HIV-positive, they may be unfairly labelled as a drug-user or a sex worker (i.e., an undesirable tenant). Housing applicants are not required to disclose HIV status; however, the landlord does not have to provide the applicant with a reason why they have rejected their application either. Jo discussed one situation she faced when trying to secure rental housing in Toronto:

I [met with] a landlord that knew I was coming from an HIV [agency], so he knew I was positive. So first of all, how did this landlord get hooked up with this agency and he discriminates about HIV? One way that these landlords get consistent rent *is* by hooking up with these agencies because if they've got one [tenant] on the way out, they've got one on the way in and it's a good way for them to keep money coming in. But they still have their judgment. So I went to [view an apartment] and I'm referred by an HIV housing agency and I'm with my kid. And the landlord asks, 'So you come from this AIDS place and you have kid, so what's wrong? He kept trying to say to me, 'There's something wrong here.' So you're basically telling me that I'm a mother with AIDS and that's against your [belief system]? He was just looking at me like I was the worst thing on the face of the earth, like it was so clear that he wasn't going to give me the place, but his curiosity was....he was stunned. I was stunned. My son was young enough that he didn't understand it really but he got the gist of it. It's gross. It's lack of empowerment. (Jo's emphasis)

Perspective: Axes of Marginalization and Intersecting Traumas

People may experience different types of disadvantage on a variety of fronts, or ‘axes of marginalization.’ When one belongs to a marginalized group (for example, groups based on socio-economic status, ethnicity, sexual orientation, or disease status), this can place one in a position of social disadvantage and result in decreased access to resources. The consequences of marginalization can then be further compounded by other traumas that result from individual biographies and life circumstances. One major life trauma or a series of micro-traumas can not only impact socio-economic status, but also how the person views themselves, how they make decisions, and how they access health and housing services.

The accounts in this chapter reveal that numerous interpersonal and social factors in a person’s life can influence their health status. These factors are often responsible for putting a person at a disadvantage with respect to their socio-economic status, physical health, and psycho-social condition. The following two stories provide profiles of the lives of people who have dealt with many of the barriers listed in the sections above. These ‘snapshots’ demonstrate how people’s lives are affected by multiple, intersecting factors that can lead to disadvantage.

Kevin

Kevin is a 36 year-old Aboriginal male who came to Toronto 10 years ago, where he was then homeless for a year. He grew up on a First Nations reserve in Ontario and left at age 16. He currently describes himself as adequately housed. This client stayed at Sherbourne Infirmary for three weeks in 2008 primarily because his diabetes was poorly controlled. He has been diagnosed with paranoid-type schizophrenia and also defines himself as having a “serious alcohol problem,” stating that he is “always drinking.” He revealed, “I like my alcohol...like I don’t drink to get out of control; I drink just for that feeling.” Consuming alcohol gets him to the “right place” that allows him to function. ODSP is his only official source of income, however he often needs to borrow money from others to support his addiction to alcohol. He has had numerous run-ins with the law because of his alcoholism. He has been charged with public drunkenness and has been in jail five times as an adult for alcohol-related assaults. Although he did not discuss his past in great detail, he told me, “There’s a lot of bad things that happened to me, like...in my personal life.”

Kevin revealed that there was a lot of violence when he was growing up on-reserve, and that he currently lives in a high-crime building. Theft is common where he lives, and recently someone broke in to his place while he was passed out. He said that he does not contact the police to report theft or assaults against him. He told me, “you don’t do that—when you’re living on the street it’s bad to be called a rat. I can see [calling the police] if I were to come from a middle class family and we actually stood as

a family.” He also fears retaliation from the perpetrators if he were to ever contact the police. However, even if he did call the police to report a crime, Kevin was certain that they would not help him. This distrust stems from a series of past events in his past:

I think [police] are racist towards Aboriginals. Because I’ve been beaten up three times by the police also. The first time was my fault—I sucker-punched one of them and then they put me in handcuffs and booted me and beat me with clubs and their elbows...once I had the handcuffs on...They said ‘assaulting a police officer is a big crime.’ I think that I was just out of control, I think that there’s a lot of Aboriginals getting [in trouble with] the police...when I was in Thunder Bay where I was at, it was pretty bad over there. I got jumped by three white cops too, outside my apartment, they were going to take away my [weapon] and I wouldn’t let them grab it. So they muscled me for it. They took it away from me and left me there on the ground. They had my arms behind my back and they hit me in the back of the head.

In these cases, Kevin acknowledges that he was “out of control.” He does not deny that his intoxicated behaviour and possession of a weapon landed him in these positions. However, these particular police officers beat him up once they had him restrained, and in theory, no longer posed a threat. He felt that they were retaliating against him for hitting one of them. When Kevin discussed these traumatic events, he did not appear outraged or upset. He spoke as if he was able to rationalize the actions of the police officers. He appeared ‘beaten down’ by the people and by the system that have been consistent sources of disappointment. I also believe Kevin was dealing with grief related to not having contact with his children. He has one daughter and one son (ages 13 and 10, respectively) who live with his mother. He chose to leave them with his mother because he did not want his kids to witness his struggle with alcohol dependency and disruptive behaviour. He concluded, “I’m a nice person when I’m sober. But when

you're drunk...can't talk to anybody when they're drunk." He was visibly upset about the fact that his addiction had damaged his relationship with his children.

Kevin was very much aware of his own socio-economic status—his comment about not being 'middle class' demonstrates how he felt his 'class' restricted his use of public services. He told me, "I was too lazy to work." Whether this is the truth or whether it is self-blame for circumstances largely out of his control, remains to be understood. It is possible that self-devaluation was a way to justify the poor treatment that Kevin has received on so many fronts. His experiences with Aboriginal-specific racism, interpersonal and police violence, homelessness, concurrent disorders (having both schizophrenia plus an alcohol addiction), and grief should be taken into consideration before taking such an assertion at face value. Any of these factors have the potential to erode self-worth; the existence of all of these factors likely magnify the impact of each one. A discussion of some of the unique issues of Aboriginal Canadians is found in Chapter Four.

Trish

Trish is a 28 year-old female who came to Sherbourne's Infirmary for acute care after birth. She had a two-week, one-time stay on the unit shortly after it opened. She was living at a shelter at the time and could not go back after she had just given birth. This was her fourth child and he was "taken" from her (Children's Aid picked him up the day

after she gave birth), which made it especially hard for her to cope with her physical recovery. She was suffering from postpartum depression, and she was also bleeding and lactating—symptoms that were overwhelming and would have been very difficult to deal with if she was living with many other women in a shelter. She has four children (ranging from 19 months-old to nine years-old) but currently does not have custody of any of them.

Trish survived a difficult childhood and had a troubled adolescence, finding herself homeless at age 16. This is the same year that she entered the shelter system. When she was just five years old, she was taken away from her biological family and placed into a foster care. She told me, “I came from a broken home, I was abused when I was little, I have a tattoo and I have a new tattoo to cover it up, but under this leg right here there were two dashes and I had that done when I was two [years old] and the guy that did it deserves nothing but pain in his life. I was assaulted and abused in every which way.” After her biological family lost custody of her, she was placed in many foster homes for the next 10 years. When she was 13 she had a serious charge put on her and she was admitted to a treatment centre. Her foster family at the time had infants and could no longer care for her, so they disrupted the placement at the age of 14. There were periods where she lived with biological family members, but eventually entered the shelter system at age 16.

Trish has found it difficult to get an education and to gain employment. In addition to her chaotic and traumatic youth, she has ADHD, which she claims has limited

her educational and earning potentials. She says that she can only handle taking one class per day. She also told me that she never learned basic 'life skills', which has made it difficult to make a home for herself. She said:

In my lifestyle, I don't know how to do certain things in a normal, everyday life 'cause I wasn't taught that way. And I just recently learned how to clean a kitchen sink and counters properly. I just learned what [products] to use for bathroom cleaners, right? So I'm just learning all that. And I don't have a mop and I have hardwood floors. I would like to have a carpet but I'd need all the bugs gone. I live in Toronto Community Housing and our bugs suck because...my kitchen can be spotless and there will be cockroaches all over the place.

I got the impression that there was little stability in Trish's life while she was growing up. She felt that there were gaps in her education and life skills, which created difficulties for her on a daily basis. Even though Trish is housed (in Toronto Community Housing), she acknowledges that she is not living in a good neighbourhood: "There's crackheads everywhere. There's been shootings. It's been very scary around my neighbourhood." Trish sometimes finds it hard to fall asleep because she is afraid that someone will pick her lock and break in. Because of this, she is often awake until all hours of the morning. Living in a 'toxic environment' such as this, combined with not getting enough sleep has significant health and recovery implications. Trish discussed her main coping method:

I try to be because I'm one of those people that no matter how I'm feeling, like if I'm feeling crummy or sad, I won't let people see it. I'll let them see 'happy.' And that's how I deal. And I just act happy even though I'm not.

Trish harbours painful memories of abuse and being ‘passed around’ and unwanted (by foster families and her own family), manages grief over losing her children, deals with living in a dangerous environment, experiences chronic sleep deprivation, and faces educational and employment barriers. She was experiencing both physical and emotional difficulties after giving birth and the shelter where she was living at the time would have not been an appropriate environment for her recovery. There are many reasons as to why it was difficult for Trish to access an acceptable recovery spot. Trish faces marginalization because of her socio-economic status. Her life history, experiences of trauma, educational barriers, and the loss of her children further exacerbate the stress in her life.

Conclusion

From the preceding discussion, one can see how it would be difficult to maintain good health or recover from an illness, injury or childbirth if an individual is homeless. Goffman’s (1963) concept of stigma is important in understanding how a damaged self-identity can impede access to services and how stigma can lead to poor treatment by members of the general public. Chatterjee’s (2006) argument that the subaltern are often left neglected, devalued, and excluded from a variety of health care and social environments helps us to understand the mechanisms underlying such extreme suffering. The participant pool in this study demonstrates that clients of the Sherbourne Infirmary

have very diverse backgrounds and medical issues. However, the participants generally had one thing in common: they were proactive about their own care but in many circumstances they were faced with obstacles that they perceived too large to conquer. Any one of the barriers discussed may be enough to prevent or limit an individual from receiving proper treatment within a health care setting or elsewhere. The reality is that participants were usually faced with multiple impediments to care. To balance this picture, the following chapter discusses the constructive factors for health management for these clients.

CHAPTER FOUR: CONSTRUCTIVE FACTORS FOR HEALTH MANAGEMENT

I went from a couch of some abandoned crack house, to a park bench, to the hospital, to the Sherbourne Infirmary, to another transitional bed, to housing within two and a half months. The key of it was that I was at the Infirmary. This is what sparked it all. (Jo)

As the previous chapter discussed, the participants of this study faced substantial barriers to achieving an acceptable standard of living and good health. However, these individuals also experienced significant improvements in their lives, and physical and emotional states due to a variety of reasons, and the majority of these reasons stemmed from the Sherbourne Health Centre's Infirmary. The purpose of this chapter is not to depict the Sherbourne Infirmary as a perfect resource, as it would be difficult to classify any health facility as without flaws. However, even as a researcher striving to maintain objectivity, it was impossible to overlook the fact that the Sherbourne Health Centre's Infirmary was a key component in improving the quality of life for most interviewees. When clients discussed the constructive factors that helped them with their health or with their lives in general, the Infirmary was consistently cited as the single most important resource. This point is underscored by the interview data: when clients were specifically asked how they would have managed if they had not stayed at the Infirmary, one third of clients (four out of 12) replied that they probably would have died. Other clients reported that they would have likely ended up in emergency departments multiple times or would have still been in the depths of struggles with depression or addictions. In addition, two interviewees revealed that the Sherbourne Infirmary was directly responsible for them becoming suitably housed. What follows in the sections of this chapter is a discussion

about how one health facility has been able to transform clients' ideas about their own health and access to resources.

The Philosophy and Approach of the Sherbourne Infirmary

A central theme of this thesis is that the Sherbourne Infirmary is often a catalyst for better quality of life for its clients. The care approach at the Sherbourne Infirmary tends to have the effect of resetting people's lives and priorities. The intense caring and individualized treatment for the future often leads towards improved self-care behaviour and a changed attitude about oneself and the direction of one's life. In this way, the Infirmary environment facilitates healing. In Sherbourne's Strategic Plan handbook, it states that their beliefs and guiding principles are based on an 'anti-oppression' framework and that they balance their 'multiple accountabilities' to clients, communities, stakeholders, and staff. This mindset was also evident in the 'chart your own course' attitude that Sherbourne staff took with clients (i.e., not forcing care or rigid schedules, but allowing clients to define their own goals), which actually resulted in better long-term health outcomes. This is not being done as a response to any mass resistance by the homeless against inadequate health care services that exist for them in Toronto, but because Sherbourne has determined that it is a far more efficient approach from both quality of life and operational perspectives. They have realized that the hospital and shelter services that exist for chronically ill homeless people are inefficient because of the high emergency re-admission rates for this population. They also tend to phrase ideas and

make decisions based on the 'quality of life' for the client, which sometimes does not mean complete sobriety from drugs or alcohol. An important point to remember is that the Infirmary is not a shelter nor is it a hospital inpatient unit. As previously discussed, shelters are not ideal places in which to recover from a health emergency, and in many cases, neither are hospitals.

Atmosphere of Safety and Acceptance

You see all kinds of stuff [on the streets], and not a day goes by that you don't see something that will literally turn your stomach, I see it everyday. Well, right now I'm not seeing it because I'm in here [at the Infirmary].
(John)

The Sherbourne Infirmary is valuable because it provides its clients with a relief from living in environments that are non-conducive to healing. Such environments may be dangerous, discriminative, or poorly equipped to handle the unique health and life needs of the homeless. Participants went into great detail describing how shelters, the streets, and even some hospitals were in fact toxic to their health and emotional well-being. In contrast, the Infirmary counters this and allows people to get proper rest, recuperate from illness, access both medical and social support, and even learn self-care tools for managing health upon discharge.

Trish recalled how the shelter environment she was previously in negatively affected her mood and her health. She also highlighted the importance of recovering in a

low-stress environment. Trish had a long history of involvement with the Toronto shelter system. At the time she was admitted to the Sherbourne Infirmary, she was dealing with both physical and emotional issues after giving birth and then having to immediately surrender custody of her newborn. She told me:

It was very quiet and calming [at the Infirmary] and the people were very caring. I love this place, I really do. It's like a home away from home. Looking back now, I was really grumpy in that shelter and I feel really bad. I feel really crappy for what I've done to [the shelter staff]. I had an attitude problem, and [now] I'm like, 'I'm so sorry,' you know? So I look back now and it's like wow I've come such a long way.

Trish felt as though she had a transformation while staying at Sherbourne's Infirmary. The caring staff members and effective case management services provided had a positive effect on her life. She liked her assigned room and appreciated that Infirmary staff gave her a thorough tour of the floor and explained how the facility works. She still maintains contact with Infirmary staff. When asked how she would have likely managed if she had not been at the Infirmary, she replied, "I would have been a bitch living at the shelter and lashing out at everybody and if they ever lashed out on me I would cry, because you know, [after pregnancy] your hormones are trying to get back to normal." She praised the Infirmary's peaceful environment, which helped her to keep her mood up, adding, "it really helped me, it really did."

Trish told me that that individuals rarely get their own room in shelters and that all the facilities within such environments (such as bathrooms) are shared. She said:

That's what I like about [the Infirmary]... like you might share the bathroom but it's kind of closed and personal. It's pretty cool; I like it here. Like when I was pregnant I had to use the [handicapped] stall and I had to use a ton of towels...but when you're lactating, your breasts are all swollen, you can't lift your arms. So I couldn't do much, and it hurt, and the [Infirmary] staff would help if they could. I wouldn't have been able to do anything [in a shelter].

A non-judgmental approach was taken with Infirmary clients. Even though the Infirmary is technically a 'dry' house (currently clients are not allowed to use alcohol or illicit substances on-site), no moral judgments are made by staff when a client decides to live as a 'functional' addict, and they will still provide services to that client. Infirmary staff members do not encourage substance use, but they understand that clients may need to or choose to keep using for a variety of physiological and psychological reasons. Clients are permitted to exit the facility to use and then return to make use of the services that the Infirmary provides. Clients who were regular substance users appreciated the fact that the Infirmary allowed them back in and that staff took a non-judgmental approach in their care, even though they were aware that they were using. The Infirmary encourages clients to be up-front about their substance use and practices a harm-reduction approach. Harm-reduction can be defined as a treatment approach alternative to abstinence; people practicing harm-reduction may continue using the substance to which they are addicted, but do so in a way that minimizes the harms associated with using. Harm-reduction approaches can include using syringe exchanges, safer injection sites or the avoidance of dangerous environments, providing (legal) prescriptions for the drug or an alternative, and reducing the quantity or frequency of substance taken.

Jo experienced judgment and stigma on several occasions while using health care

facilities in the past. When she discussed the Sherbourne Infirmary, she said:

I've never felt this place judges a person where they're at, in fact, I think they're quite the opposite here. I think they're very happy to see the same face over and over again because I think their attitude is really, 'well at least she's still alive...she needs a bed right now and she needs health care and we're providing it' and they very much have that attitude... we're all being treated with the same amount of compassion, the same amount of care and that's great, I think that's really wonderful.

Jo also said that, in her experience, physicians make a lot of false assumptions about addicts and what they want, which discouraged her from returning to seek treatment for her addictions or other health problems. Jo reported that she has maintained contact with the Infirmary as an outpatient.

Ray, a 55 year-old client who has both HIV and hepatitis C, shared the reality of his addiction to heroin and crack. Total abstinence from drugs was not an option for him. Practicing harm-reduction was, and it did help him to get to a point where he could pay his rent, buy food, and have a life outside of drugs whereas before, drugs were his whole life. He also uses marijuana on a regular basis because it helps him with his appetite and sleeping, which are related to having HIV and the antiretroviral drug therapies that he is currently taking. He told me that there are very few things that help him cope with these ailments. He appreciated that the Infirmary was not judgmental about his choice to continue using and that his health was actually better managed because of it.

Deb, a woman with a long history of drug abuse, told me that she previously neglected her health because her priority was getting the drugs, not her multiple chronic

illnesses. When asked where she would have stayed or how she would have managed if she had not been admitted to the Infirmary, she answered that she would probably have been living outside until she died. Her path to sobriety was not an easy one—once while she was an inpatient at the Infirmary, she stayed out all night to use drugs and she was relieved that she was treated with dignity when she returned to Infirmary the following day. She gave praise to the Infirmary for their non-judgmental approach and told me that this type of treatment encourages healing for the long-term. This is because clients are likely to return to have health problems addressed and because it counteracts the heavy stigma that is associated with drug users that often impedes care in the mainstream health care setting. She reported that her health was better after a stay at the Infirmary and that she “wouldn’t be this far.” Although she worries that her body is breaking down because of her multiple illnesses (which include cancer and hepatitis C), Deb is feeling positive about the fact that she is now clean from drugs.

Deb also revealed that she generally has trouble trusting people in positions of authority, and that a traumatic incident in her past was partly to blame for her attitude. When she was in jail several years ago, guards suspected that she was hiding drugs in her arm cast. They ripped the cast off and it was not replaced. Her fracture never healed properly and she currently has limited use of that arm. She admitted that her health and addictions were made worse by the fact that she only sought professional care when she was in an emergency situation (or sometimes not at all). This event demonstrates how lack of trust in a variety of contexts is a central theme in the lives of many homeless individuals. Rebuilding people’s trust in health care professionals is one of the

considerations taken by Infirmary staff, and is something Deb personally benefitted from.

Accessing Services: Mutual Respect

Several clients revealed that they were initially resistant or even disrespectful towards Infirmary staff. Others reported witnessing this with other clients. Usually this happened because clients had previously experienced disappointments with health care providers. Hostile clients frequently experienced a reversal in their attitudes early into their stays. Study participants told me that the Infirmary staff's attitude and approach changed the ways in which clients access services. Staff members were respectful at all times and were often perceived as going beyond the call of duty to help clients. This creates an environment of mutual respect, which not only benefits clients (because they are likely to stay longer and address their medical concerns adequately), but also benefits staff members (because it contributes to a more peaceful working environment and ensures that they are effectively carrying out their professional roles). Jo stated:

The nursing staff—I just can't say enough about how human they treated me, and everybody [all the staff]. And I've seen clients here right up in [staff member's] faces and really demanding beyond what they already get here, which is everything—everything you need you have here; you have a digital large-screen TV in your bedroom, like it's really nothing to complain about—but people just live their lives in that kind of anxiety and the staff here is amazing with them. There's kind of an understanding in this place, you know, you don't mess with the staff you know. So the people that come in that want to be adversaries end up being sort of taken in by this energy that it's like [bad behaviour is] not cool here. And the staff created that, and that's a very big deal amongst [clients]. They back down...and they get what they need. Even if you're getting what you

need, if you're in controversy with it all the time, you're never really getting what you need because you can't sit in it and really experience it.

This mutual respect between clients and staff at the Infirmary is one of the key reasons why the Infirmary has been so successful with health management.

Taking Responsibility, Defining Goals, and Empowerment

Sherbourne's Infirmary is unique in the way it frames options to clients, leaving choices up to individuals and not preaching, but working with clients to meet their own goals. In addition, several clients reported that Infirmary staff helped them accept where they were in their lives and focus on the future. Several clients reported that they gradually learned to trust their own decision-making abilities after their stay and this was the first time in their lives that they felt empowered. The homeless population is very resourceful to begin with but this service makes use of their resourcefulness. Perhaps other health resources can learn from the success of this holistic approach.

Infirmary staff are proactive in the way that they approach care but at the same time patient-centered with the way that they provide care. As an example, Deb reported that an Infirmary nurse saw her sleeping on a bench outside and convinced her to come into the facility. This is how she got clean from years of drug abuse. In this instance, the Infirmary took the proactive approach to getting people into their facility. However, the Infirmary staff encouraged her to outline her own health and life goals once she was

admitted and were not judgmental when she had a brief drug relapse during the time she was an inpatient.

Jo had a similar experience. She first came to the Infirmary about one year ago, completed the intake forms, but then left because she did not feel the Infirmary was for her at that time because she was not ready to stop using drugs. She used illicit drugs heavily and often and she felt that this was incompatible with staying at the Infirmary. She “made an unconscious choice to continue using” at that time. After rethinking her options, she called the Infirmary and a case manager came to her the next morning. This staff member sat with her, told her what was expected of her as an inpatient, and also what she could expect during her stay. This was extremely reassuring for Jo, and she responded well to the Infirmary’s focus on ‘next steps’ in one’s life. Jo felt this is an excellent approach because it forces people to be accountable for where they are at in their lives. She said:

I think that one of the things [Sherbourne Infirmary] has in place is that you don’t get in here until you sit down and do a plan of action with [a case manager].” [My case manager] was great because she very gently helped me take responsibility for where I was at... And I truly believe this too—you can’t get to a place of living independently if—it’s kind of a catch 22 because you’ve got to really provide services that people need but at the same time, you don’t want them to need them forever. The idea is to move a person and help them move their life. [My case manager] was really good at sitting with me and helping me see the reality of my situation, and ‘what do you want to do about it’? So I think this place is well equipped to deal with people who have addictions.

Jo discussed how the way she was treated every minute of every day during her stay made the difference for her because it would have just taken a second for her to say,

‘I’m out of here.’ She was proud to report that she is now housed, sober, and is managing her HIV quite well. She told me:

[The Infirmary staff’s approach] builds a person’s sense of self-esteem and sense of okay-ness...the idea is to help us get to a place where [we] are [self-sufficient]. Empowerment—I feel like it was a place for me to get back a sense of self.

Jo felt that as far as services are concerned, there is a fine balance between helping someone and making them dependent:

Instead of pushing them, [the Infirmary] is working *with* them. I don’t think I’ve ever seen a staff modeled quite the same way... when the [Infirmary] staff person got off the elevator, [they had] this energy...and I think if more places did that, they’d have more success with clients. (Jo’s emphasis)

This structure was particularly important to Jo because she was once ordered to take her antiretroviral HIV medication as part of her probation order. She became so sick out on the streets that the police had made this recommendation based on the fact that she might not be competent because she was not treating her illness. This approach did not improve her health; it actually made her threaten to stop taking her medication altogether. She believed her health and the ways in which she managed it was her choice, and imposing that rule and forcing medication only made her more frustrated and angry. She told me that, “It made me want to say, ‘You know what? I’m not even going to take them.’” The ‘forced’ approach just made her more resistant to addressing her health. Jo shared an interesting perspective about health care. She views the client-provider relationship as a partnership, saying that health or social workers should view the people

they serve as their co-workers for the day. This tends to be the approach that Sherbourne's Infirmary employs.

Ray reflected on the long-term benefits of his stay at the Infirmary:

It gave me a chance to clear my head and I can make decisions on my own, where I didn't have to ask someone, 'do you think I'm doing the right thing?' because sometimes I would go to someone else and ask if I was making the right decision...it's not like I had my parents I could go to...it was hard for me at first. Now, no problem, I can [trust my own judgments].

Some client participants revealed that their insecurities about their own decision-making skills developed in childhood. The lack of parental structure or role models, and being rejected or neglected often had lasting effects into adulthood. People were more susceptible to abuse by others because they let other people make decisions for them in their personal relationships. Furthermore, they were more likely to disregard their health because of low self-esteem. A service approach that places power and responsibility into the hands of clients is beneficial because it encourages more consistent self-care and at the same time, makes people less dependent on external resources (e.g., services, other people). Participants usually felt the desire to be proactive and assertive about the way they were treated, but they had not yet encountered an environment that developed or permitted these skills. The 'chart your own course' approach to care found at the Sherbourne Infirmary is effective because it aligns with the pre-existing strengths of many of its clients. A paternalistic or practitioner-driven approach to care can be patronizing or incompatible with the perspectives of many homeless individuals. When

people have a say in their own health care plan, they are more likely to have realistic goals. In addition, they are also likely to adhere to treatment plans because such plans are more meaningful to them.

Continuity of Relationships and Services

The Sherbourne Infirmary provides continuity of care, which can be described as the provision of stable services and ongoing client-provider relationships. Homeless people do not often receive much continuity in their health care. There is often poor follow-up and many gaps between services. In addition, several participants revealed that they had previously been abused by people in positions of power (health care workers, police, family).

Sherbourne's Health Centre has been able to establish a more constant presence in the lives of their clients through a) building relationships with clients, b) providing an array of valuable in-house services to outpatients and former clients, c) providing firm referrals and helping to create external supports, and d) creating one positive experience that builds people's trust with services and providers so that they are likely to continue utilizing the services at the Infirmary or elsewhere. Several clients reported that the care approach at the Infirmary was able to counteract feelings of loneliness and isolation that they have experienced in the past, or expect to experience in the future (post-discharge). In sum, clients were far less likely to 'slip through the cracks' of publicly provided health

services.

Trish's stay at the Infirmary started off on a positive note, which was key to keeping her at the facility to recover from a difficult pregnancy. She told me that her nurse practitioner (who also became her case manager) was extraordinary. Trish revealed that when she was first referred to the Infirmary this staff member said, "yes, we want her!", which was the beginning of a client-provider relationship built on trust and acceptance. Trish said, "every time I see [this staff member] she's still excited. I love it." This approach to providing health services to the homeless and under-housed is important because clients feel wanted, sometimes for the first time in their lives.

Ray, an HIV-positive male, told me that the positive experience he had at Sherbourne's Infirmary influenced him to change his attitude towards his illness. After years of drug use and abusing his body, he finally started to care about his own health. Feeling cared about and knowing that there is a supportive environment available can counteract feelings of isolation and loneliness and can have positive outcomes for the management of chronic conditions.

Andrew is currently housed and reports that he is doing very well. Nevertheless, he often drops by the Infirmary just to say "hello." He told me that whenever he visits, he gets a warm welcome from the staff. "It's like my home away from home. I'm always welcome," he said. This can be reassuring in cases such as Andrew's, where there is uncertainty about what to expect with medical conditions, treatment, recovery,

and the future of one's life.

Jo emphasized the importance of service providers making connections with homeless or substance-addicted clients:

Service users just need to remember that—and it doesn't mean they can solve it all—but just remember that when you're communicating with that [client], if you're trying to make a connection with them, remember that they're probably starving, they're probably irritated and cold, they're probably in major withdrawal because they took the time to come to the appointment and they can't use *while* they're at the appointment. (Jo's emphasis)

She attributes the program structure and the staff at Sherbourne's Infirmary as the main factors that assisted her on her path to sobriety. She believes that the positive personal connections that she made with Infirmary staff and the regular boosts to her self-esteem made the critical difference in her life and led her towards being more independent and proactive about managing her health. She exclaimed:

When the Sherbourne staff see me, they're like, 'Right on man! [and give me] high fives. They ask how I'm doing and [tell me that I'm doing a] good job. That's awesome! You know, they're great and it's a good connection. So it's *the people* that I was connected to, I just slowly started to let go because I couldn't deal with my health situation. What I see now in retrospect is that I didn't have anything in place [before she was a client of the Infirmary]. There was nothing in place. *Now* my doctor doesn't let anything slip through the cracks—I'll hook you up with addictions, with nutritionists, we'll figure out everything' but back then, I just wasn't accessing that kind of support—I didn't *know* what to refer to, I only had myself. (Jo's emphasis)

Kawachi and Kennedy (1997:1038) make the connection between health and

social supports by asserting:

People who are socially integrated live longer. Socially isolated people die at two to three times the rate of well-connected people, presumably reflecting the former's limited access to sources of emotional support, instrumental support (for example, financial aid), and other forms of support.

When these facts are taken into account, the Infirmary can be said to have a mortality-reducing effect for the homeless and under-housed population that utilizes its services because it provides consistent medical care along with meaningful social support to its clients.

Navigation within Systems

The Sherbourne Infirmary often serves as a primary point of contact for people who have been disconnected from health care services. It also assists people in navigating through systems that provided other crucial services (such as temporary and permanent housing) and provides firm referrals to various external resources. Barriers to communication frequently exist between homeless persons and service providers for a variety of reasons (e.g., client intoxication or mental illness, or stigma/discrimination imposed by the service provider). This can lead to clients not getting what they want or need and may result in them returning later or attempting to utilize a service more often. In these instances, inefficient use of public services can be a cost issue as well.

Deb's perspective was that the language service providers use when they interact with clients needs to be simplified—for both homeless individuals and the average citizen. She claims that doctors “become socially retarded” and often used medical language that she did not understand. This made health management more difficult because she did not fully understand her condition or her treatment options. In her experience, doctors at the Sherbourne Infirmary were more ‘in tune’ with patient needs. She told me that she never feels rushed by the doctors at the Infirmary and that they are very thorough. “It’s cutting edge here,” she said.

Multi-Faceted and Flexible Approach to Care

Participants appreciated that the Sherbourne Infirmary did not just provide the ‘basics’ of care. Many interviewees said that they appreciated that they were in an environment where they could reconnect with loved ones, reach service providers, and sort out income and housing issues before their stay was over. Access to the phone and internet, and being able to receive phone calls gave people a head start on re-integrating with society after periods of being marginalized. Being able to exercise, read, or do artwork in the activity room was therapeutic for many. Hot pads were always available at a self-serve station, which helped alleviate some of the physical effects of drug detoxification. In addition, a variety of services supplemented the primary health team—chiropractic and chiropractic services were available to Infirmary clients and naturopathic care was available to those who were HIV-positive.

Most client participants were aware of the services that the Sherbourne Health Centre offered in addition to the Infirmary, and many utilized these resources. Care was often flexible and Infirmary staff often made great efforts to adapt services to client needs. Some interviewees reported that they were finally able to access suitable housing or services for the long-term because of the referrals and follow-up support provided by the Infirmary. Several clients revealed that Infirmary services adapted to individual needs, which provided great relief to them in times of crisis. This type of adaptive and personalized care not only has the effect of maintaining continuity of care (by building trust and appreciation), but also counteracts hospital phobia or dislike. The following accounts demonstrate how this aspect of the Infirmary's model of care made differences in people's situations.

I was so fragile when [the Infirmary] took me in and then I went back to the hospital and then they took me in again. And they had never had anyone here that was on that high a level of isolation and they've switched my room around, they've switched around the way they do stuff in the kitchen, like they've just made it work. And now they have a system for a person that comes in with MRSA because they took the time to do that.
(Jo)

John is aware that the maximum stay length at the Infirmary is three weeks, and that staff try to adhere to this limit as often as possible. However, he was grateful that, in serious cases in which people required a stay extension, the Infirmary did not "kick people out" to the street. His case manager at the Infirmary talked him out of leaving once his three weeks was completed. The fact that he still had a poorly controlled medical issue and that it was starting to get cold outside was reason to make an exception. He was currently in his fifth week as an inpatient when he was interviewed.

Because the Infirmary lengthened his stay, he was able to book a potentially life-saving medical procedure (which was going to take place the following week). This modification to individuals needs provided John with long-term and preventative treatment for his medical issue. This was not only beneficial to John's health, but also efficient from a cost perspective—to keep people a bit longer as an infirmary inpatient and see some continuity and long-term solutions in their care actually reduces the likelihood that they will make use of costly emergency or hospital inpatient services in the future. The Sherbourne Infirmary staff sees the whole picture of a person's life, and do not just offer medical services and then 'spit' people out. The theme of patient-centered care comes up in this case as well, because by leaving options open to clients, they ultimately make the final decision about their own health care and are more likely to be proactive and self-sufficient about their own care.

For Andrew, the Infirmary's flexibility spared him from returning to a shelter to recover from surgery. Post-surgery, he was given sulfa antibiotics, to which he ended up being severely allergic. The Infirmary stretched his (planned) one week stay to two weeks because of this setback in his recovery, and Andrew was extremely appreciative of this decision. He also revealed that the Sherbourne Infirmary played a big part in him finally getting housed. He had an external housing worker who worked together with the Infirmary to secure housing for him. He told me:

Care like that is remarkable. I would give [the Infirmary] full marks for what they have done for me here. Anytime I am called upon I would always have something nice to say because I didn't expect treatment like that—it was super, top of the line treatment. The nurses were excellent. Every one of [the staff members] were great.

When Andrew was discharged from several hospitals in the past, he found himself back on streets or dependent on the shelter system. In contrast, when he left the Infirmary, he went straight to his new home, which was set up during his stay.

Infirmary staff members frequently go beyond their formal duties to fill gaps that threaten to impede client recovery. Several clients that were interviewed appreciated the fact that the Infirmary staff will accompany clients to appointments if they are afraid or not physically able to go alone. These clients claimed that they were more likely to follow through with testing and treatment procedures because Infirmary staff were willing to assist clients in this way. Ray appreciated the fact that the Infirmary staff will accompany clients to appointments if they are apprehensive to go alone. Ray told me:

They'll send a staff member with you, like they did with me, to the hospital to make sure you're [okay]. It's scary going to some of these things, getting tests done that you've never been through before, or going into MRI machines... some people are afraid of that. They were very thoughtful and pretty much did whatever they could to help you out, within their own boundaries.

Trish reflected on the entire Sherbourne Health Centre, saying:

They have so many other facilities here, which is awesome. I used to go to counselling on [the floor below the Infirmary]. It's amazing. It's a hospital when you need it to be.

Deb's years of drug addiction put a great deal of strain on her relationships with her two (now adult) children. The Sherbourne Health Centre was instrumental in facilitating a relationship with one of her children. Her 33 year-old transgendered daughter (formerly 'son') utilizes Sherbourne's transgendered-specific primary health care and support services. Deb said that she feels comfortable at Sherbourne because both her and her transgendered daughter have received a lot of care here. Deb attended a program for parents of transgendered children, which helped her through the transition of her son becoming a female. It also strengthened their relationship. She learned a lot about respect and dignity in this program, and had many of her questions answered. Deb told me that she felt that the Sherbourne Health Centre is a "community place." By providing a wide variety of specialized services in-house, and by making solid connections with external partners (such as housing workers), the Sherbourne Health Centre and its Infirmary have been able to meet the needs of the diverse population that walks through its doors.

Independence and Survivorship Skills

Clients appreciated the fact that they were able to retain much of their independence and freedom during their stay and that they did not have to follow rigid

meal or activity schedules in the Infirmary. They were free to move around, have snacks, or go outside when they wished. Maintaining independence was a central theme that came up in the majority of client interviews, even in clients who had the most serious medical and mobility issues. Being self-sufficient was usually a key survival strategy employed while living on the streets or in other toxic or stressful settings. Some clients reported that they did whatever was necessary to survive and took much pride in being self-reliant. Higher quality care was ensured by providing services in way that allowed clients to retain these attributes.

Trish did not like the fact that some shelters prescribed when and how much food was served. She felt this structure was too rigid, which created anxiety for her. In contrast, the food delivery method at Sherbourne's Infirmary was something that she greatly appreciated. She told me, "You can eat whenever you want. They give you a good time slot to come through and it's not just an hour—they'll give you a couple of hours [with some items] and they'll make it when you come."

Trish went into more detail about the Infirmary's unique setup:

It's almost like a hospital setting and they have beds as a hospital but you don't have to be confined to *their* bed. Like you could *walk* to the bathroom, you could *walk* to your dinner, you could *walk* to have a cigarette, you know, like you don't have to ask. But they have the push buttons in case you can't get up. They have the push buttons in case anything happens. And they have them everywhere—they have them in the bathroom, they have them in the showers...and they have a fridge where *you* can go in and *you* can get whatever *you* want. (Trish's emphasis)

I asked Frank what he appreciated most about his stay at the Infirmary and he replied:

As far as health care goes, it's alright because it has a 24-hour staff, but in the meantime, you're still pretty well on your own. If you need help, you yell. They're not going to come in and pamper you. They come in with your medication, other than that, you're on your own. You have to be [mentally competent] to take care of yourself. That's the good part about it—because you are able to take care of yourself. You have to be [independent]; you have to stay that way.

Andrew appreciated the freedom he retained within the Infirmary unit, telling me that clients can access food from a fridge when they feel like it, which maintained people's independence. Most of the time he was able to do things for himself (such as bathing), but if he had a problem he would have no problem getting assistance from nurses, whom he described as “willing and helpful.”

Self-Care: Skills Learned

As previously discussed, a large proportion of participants revealed that they had experienced a variety of barriers with respect to self-care and life skills. The Infirmary staff and program structure taught clients many things that led to better health management and more efficient self-care. This is in line with the Infirmary's emphasis on encouraging people to be self-sufficient. Infirmary staff often provided the tools to meet this objective.

Trish, a woman who told me that she lacked some fundamental life skills, said that the Infirmary staff helped her to become more confident in her everyday functioning post-discharge. “Their help here has really helped me in the real world,” she said.

The staff at the Infirmary taught Andrew how to contract his urinary tract after a surgical procedure on his prostate left him unable to do so. He found the treatment he received at the Infirmary to be very different than what he experienced in shelters, where it was hard to keep a schedule or get enough rest.

When I asked Frank if his stay at the Infirmary influenced how he managed his health after he was discharged or if Infirmary staff taught him anything that he would not have otherwise known, he replied:

Well in a way, yeah. I never used to take care of myself. Even when I was healthy. I always let things go, go, go, and if it got better it got better, if it didn't then it didn't. But the one thing I learned in there is if I don't look after myself, if I get medication and then I don't take it, why bother getting the medication. That's one thing I learned in there—to keep a schedule on this stuff otherwise it's not going to work. That's a very important thing—if you're taking medication, you have to take it on time.

He claimed that his health was “a lot better” after his stay at the Infirmary and that “Sherbourne's excellent.”

I asked Ray what he appreciated most about his stay at the Infirmary and how it helped him to deal with his illnesses (HIV, hepatitis C, and substance addiction). He responded:

Just being around people who were caring and were able to listen to you and give you a direction in your life, even if it was very small, it was still some kind of direction and I basically knew what I had to do once I got out of here—life-skills wise and to take care of myself and to get rid of some of the situations that were really stressing me out...

John told me that he realizes some people may consider Sherbourne's Infirmary to be similar to a hotel, except that clients have to make their own beds. The fact that clients are expected to make their own beds everyday is significant because establishing a schedule and taking care of one's living environment are essential life skills reinforced by the Infirmary. But, he said, clients also understand that it frees staff up to do other jobs. This also reveals the reciprocated respect and understanding that clients have for Infirmary staff members.

When Jo was asked if her experience with Infirmary staff influenced the way she managed her health, she replied:

I have a lot more self-empowerment around my health now. Like I deserve [respect]. If *they* felt that I was worthy of being gentle with...like I'm a little more gentle with my own health now. (Jo's emphasis)

Kevin's diabetes was much better managed after a stay at the Infirmary. He said that his Sherbourne physician put him on Metformin, a diabetes medication, which has improved his health a great deal. Kevin said that he does not have any worries about managing his health condition in the future, "I just know I'm going to start taking my insulin now and start listening to my workers instead of them being concerned for nothing." Infirmary staff also helped him with daily diabetes management because they

showed him how to use a medication-administering pen, which he felt was easier to use than injecting himself with a needle. He still uses the pen today and feels hopeful about his condition because of the clear treatment plan he received at the Infirmary.

Nutrition

A healthy diet is a key component of good health. This is especially true for diabetics (who must often follow a specialized diet) and for homeless or impoverished individuals (who are more vulnerable to infections and less likely to have regular, nutritious meals). Many participants were enthusiastic about the food served at the Infirmary. As previously discussed, the flexible scheduling was appreciated by many. However, the quality and variety of food was a highlight of several people's stays and it had the ability to boost their moods. Not only did this lead to better nutrition, but it also got people 'through the door' of this health facility more often, leading to better health management. In some cases, it was medically necessary for people to stay at the Infirmary for the full duration of their recovery or procedure schedule, or for them to wait for medications to work.

Frank felt the food in the shelters he frequented was so bad that he could not even eat it, and described it as "garbage, disgusting." He would often use some of the money he made panhandling on the street to go to a restaurant. Having good meals at the Infirmary was also a financial relief for him. Similarly, Trish said that the food varied

between shelters, but claimed that sometimes it made her want to leave altogether. She told me, “It’s always fresh food here [at the Infirmary].”

John gave positive feedback about the meals at the Infirmary, saying, “the food’s good, the cook is good. Like you never know what you’re going to get. Last night we had spare ribs with stuffed ravioli—that was good...and the fridge is open 24 hours [a day].”

Kevin appreciated the food the most at the Infirmary, saying that the facility had “good cooks.” His physical condition improved rapidly—he gained 14 pounds during his three week stay. He also attributed this improvement to the Infirmary staff helping him to stabilize his blood sugar.

Giving Back: Leadership and Volunteer Activities

Several interviewees revealed that they currently held leadership positions within the community. These former clients were either members of the Infirmary’s Community Advisory Committee (a board made up of former clients that provides feedback and recommendations on Infirmary services) or they were running their own workshops and guest lecturing to at-risk segments of the population (such as within prisons and youth shelters). These clients derived much satisfaction in giving back to the community and being part of disease prevention and solution efforts. Many felt that

Sherbourne was a place that provided an opportunity for them to give back. Others were inspired to give back elsewhere in the community. The Infirmary tended to foster leadership activities and attitudes. Once people's self-esteem was restored and a sense of purpose was realized, they felt a desire to be productive or repay the facilities that assisted them in harder times.

Trish proudly reported that she is on the Advisory Committee at the Sherbourne Health Centre. She felt that this allowed her voice to be heard on issues that she was passionate about (such as homelessness and health care topics). She also felt it was important to maintain regular social ties to the staff and other clients of the Infirmary, and that having a formal meeting structure facilitated this contact. It is significant that clients such as Trish are proactive about wanting to become involved with Infirmary operations. As discussed in Chapter Three, Trish spent a large part of her life feeling shut out, devalued, and inadequate. She also spent many years in the public shelter system and told me that she acted out on many occasions because she was very unhappy. So, to have a facility that clients not only use repeatedly, but also want to become invested in, is remarkable.

Ray, a current member of the Advisory Board, revealed:

I do a lot of work... I've been speaking with this organization, going into the youth shelters and the jails speaking on HIV and addiction, doing these educational workshops for public health and things like that, to keep myself on the straight and narrow and also hopefully I can help [others], 'cause to me that's where it's at—educating the young kids. You're not going to stop the drugs from coming into the country or anything, so I

think that education is important and I hope I make a difference in what I do.

Deb now has a job writing columns for a publication with over 30,000 regular readers. She works one or two weeks every month and her primary goal is to get others clean from substances, as she was able to overcome her own substance addiction. Deb also works at the Sherbourne Health Centre doing media work. She is trained as a journalist and prior to becoming drug addicted and homeless, had a high-ranking job for a national news agency. So, doing this kind of work also aligns with her pre-existing skill set. Deb is also on the Advisory Board and told me that she enjoys working behind the scenes by giving back to others that are in her previous position. She also felt it was important to give back to Sherbourne's Infirmary as a 'thank you' to them for helping her get her life and health back on track. Clients such as Deb are choosing to repay Sherbourne with their time, commitment, and skills.

Andrew confided, "If [the Infirmary] needed a floor mopped, I'd be there." He feels that he wants to give back because of the care and attention that was given to him during his stay. Now that he has recovered from his surgery and is feeling better, he is involved with volunteer work for a Toronto shelter. He transports blood samples from the shelter to a nearby hospital. The shelter and hospital staff trust Andrew not only because they have long-standing relationships with him, but also because he worked for 28 years as a lab technician in research and development at a Toronto chemical company, so he is trained to handle biological specimens. He asserted that this was his way of "giving back" to services that have helped him and others.

Jo told me that she became involved with the public speaking tour of a world-famous AIDS academic-activist. She did much public speaking herself and conducted her own workshops (which she designed). She said, “My mission, values, objective was to help agencies and service providers reach the people that they’re providing services to, and to help people needing services reach where the services are.” Her goal was to make connections to service providers, so that they could in turn make connections to other service providers and new ways of conceptualizing the services they provide. Her point of view from a service user’s perspective was highly valued in these contexts, which reinforced her self-esteem and allowed her to draw some strength from her past struggles. Many of her workshop points stem from conclusions she made during her stay at the Infirmary.

McCormick and Wong (2006) write about the phenomenon of being selfless and productive when coming out of dire circumstances, calling this process ‘self-transcendence.’ They discuss this concept in relation to Canadian Aboriginals, but I feel this concept can be expanded to include several non-Aboriginal Infirmary clients. They say:

Self-transcendence involves not only the attitude of transcending past traumas [and] present circumstances, but also the expression of this attitude in actions. The human capacity to transcend painful memories and difficult present circumstances provides the basis for freedom and creativity in developing a meaningful future. It can be very therapeutic when counsellors encourage clients to shift from their self-absorption and self-pity to helping others who are worse off. The belief that one is serving a higher cause can also imbue life with meaning. Self-transcendence is demonstrated whenever we embrace suffering for the benefit of others. (McCormick and Wong 2006:527)

This path was empowering for these clients. By engaging in volunteer and leadership activities, they felt that they were able to manage their own conditions better because, not only did they acquire more knowledge about their health conditions, they also served as role models for others. This is also congruent with the attitude of self-sufficiency shared by many participants. As discussed in Chapter Three, several clients had the strong desire to work but were unable to because their illnesses or injuries made it difficult to commit to working shifts or regular hours. They expressed that they did not want to be a ‘drain’ on society by collecting public support cheques or remaining dependent on the shelter system, however, they had a strong need to contribute to society. This need was partially fulfilled through becoming involved with volunteering and leadership activities. Lastly, by establishing an Advisory Board, this facility is seeking to get better over time by continually making improvements based on the feedback of clients.

Unique Circumstances of Special Groups

The Sherbourne Health Centre recognizes that certain groups of clients are disenfranchised in society and therefore have special needs stemming from unique histories and identities. More specifically, the Infirmary has made special care considerations when dealing with clients belonging to such groups. Individuals that belong to such groups—Aboriginal Canadians, non-status individuals, and members of the LGBTQ community—were interviewed for this project.

Galabuzi (2004) confirms that racism is a major source of stress and hypertension in racialized group communities. Newcomers to Canada are generally less likely to benefit from public services and societal benefits. Galabuzi (2004:247) describes the mechanisms behind and consequences of discrimination against both Aboriginals and immigrants:

Everyday forms of racism, often compounded by sexism and xenophobia, and the related conditions of underemployment, non-recognition of prior accreditation, low standard housing residence in low income neighbourhoods with significant social deficits, violence against women and other forms of domestic and neighbourhood violence, and targeted policing and disproportionate criminalization and incarceration define an existence of those on the margins of society, an existence of social exclusion from the full participation in the social, economic, cultural, and political affairs of Canadian society. They are also important socio-economic and psycho-social determinants of health.

The following sub-sections detail the unique issues of such persons and the customized care approach that the Infirmary and the rest of the Sherbourne Health Centre has employed as a response to systemic deprivation and exclusion.

Aboriginal Canadians

Many Canadian inner-city areas (including ones in Toronto) are characterized by a concentration of Aboriginal people. Aboriginal Canadians as a group experience higher levels of disease and poverty than the general population. They are more susceptible to experiencing poverty, homelessness, and unemployment than the average Canadian.

Aboriginals experience homelessness and housing issues within a society that carries out systemic discrimination. Exploring this issue has implications for the health and well-being of this population. Uncovering how urban Aboriginals perceive their own health and existing medical services, and what strategies they employ to compensate for gaps in the wider system can provide a clearer picture of what is required to improve the health status of this group. Although moving from a reserve to a city appears to offer several benefits (such as increased access to social and economic resources, education, and increased employment opportunities), this population, as a whole, has not reached the same levels of socio-economic status and well-being as the rest of the urban population.

This situation can be attributed to, in part, the destruction of Aboriginal culture during colonial conquests and European settlement in Canada beginning in the 17th century, and the resulting relocation onto reserves, destruction of family units through the imposition of the residential school system and other processes of forced assimilation (Waldram, Herring, and Young 2006). The imposition of these systems and the government's failure to fulfill treaty obligations resulted in overwhelming poverty, malnutrition, health complications, and subsequent population decline for Canadian Aboriginal populations. Thus, one can view the current situation facing Native peoples as 'multi-generational poverty.' However, the marginalization of present-day Aboriginals is also a reflection of modern political and social structures within Canada. Native peoples are consistently targets of systemic racism and neglect by governmental agencies and within civil society (Waldram, Herring, and Young 2006).

Choney et al. (1995:80) have characterized the impact of past injustices against Aboriginal populations in the United States (who faced comparable trauma and oppression) as “intergenerational Post Traumatic Stress Disorder.” The non-reserve Aboriginal population represents about 70% of the total Aboriginal population in Canada, or 700,000 individuals. According to Statistics Canada (2001), 56% of non-reserve Aboriginal adults reported that their health was excellent or very good, versus 65% of the total Canadian population reporting the same. Herman (1992) adds to our understanding of the effects of trauma on Aboriginal peoples by stating that trauma destabilizes the basic sense of trust that normally develops in the first few years of life. Future relationships are often affected because the victim is left to deal with feelings of abandonment, alienation, and disconnection into adulthood. Krugman (1997) contends that Canadian Aboriginal people who attended residential schools frequently suffered physical, psychological, and sexual abuse—all experiences which can violate interpersonal boundaries and result in the victim developing dysfunctional coping mechanisms such as hypersexuality, hyperaggression, sensation seeking, and isolation.

Despite these facts, many therapists who have worked with Aboriginal clients feel that they are incredibly resilient. In some cases, Aboriginal people who have survived such abuse overcome their history and become “better and stronger persons,” leading some authors to label this phenomenon “post-traumatic growth” (McCormick and Wong 2006:518). These authors report that this resiliency can sometimes be attributed to several Aboriginal-specific cultural and spiritual factors that facilitate healing. These elements can invoke empowerment, cleansing, balance, and belonging (McCormick and

Wong 2006). Typically, Aboriginal people have a different way of seeing the world and defining ‘healing’—balance and interconnectedness to the world outside the self are important elements of this perspective. Additionally, Aboriginal people often prefer to act as agents for their own healing (McCormick and Wong 2006). There are important health service implications to this knowledge, as service providers should understand this worldview in order to provide culturally appropriate and effective care.

Staff at the Infirmary felt that specific issues existed for individuals who are Aboriginal. These clients are often encouraged by staff members to make connections with Aboriginal agencies as well as to maintain a connection with the Infirmary post-discharge. One staff member revealed that some of these clients have very significant histories of alcohol use, which is usually related to surviving abuse within the residential school system, living on reserves, or being Aboriginal in a large city like Toronto. When asked about how the Infirmary addresses the needs of such clients, she said,

We have a number of folks that have Aboriginal heritage here and we often work with them to look at if they want to make connections with Aboriginal agencies or not. I find for folks who are Aboriginal...if they have a very significant history of alcohol use, it's usually impacted their lives so hugely and we have many people who talk about the impact of residential schools or living on reserves or being Aboriginal in the city and just the disconnectedness that people sometimes have...sometimes disconnected from their heritage but also just disconnected from society. We've had some Aboriginal [clients] who have a huge anger...and I get it philosophically...just an anger with the world and how their lives have been impacted. So we've had a small group of that larger group of Aboriginal people who I would say there's really a bitterness and anger that we've had to struggle with to help people figure out how are they actually going to use this as an opportunity and move on. And no doubt there are many other issues, but it often is really helping people figure out 'if we can re-connect you, where is that going to be?'

Sherbourne's approach with Aboriginal clients is solution-focused and acknowledges complex and often traumatic life histories. Several Aboriginal clients that were interviewed for this project revealed that the Infirmary helped them better manage their diabetes and was the first step in overcoming addictions to alcohol.

Immigrants and Individuals without Status

Beiser (2005) reports that immigrants, as a group, experience better health and lower mortality than average Canadian citizens. However, this author also reveals that there is little official policy in place to help immigrants stay healthy. Not having a valid health card, not possessing citizenship, or not understanding Ontario's health care system are recognized as major barriers to care for those who are new to Canada (who may or may not have health coverage), and were issues that came up in client interviews for this project. In addition, racism and social exclusion can contribute to poor health. One Infirmary staff member discussed how the Infirmary deals with such clients:

Sometimes it's issues around whether they have actual access—do they have a health card, do they have status—or helping people figure out how this system is or isn't put together...often there's a hopefulness, and there may be a bit of depression and I think it's really figuring out the system in a much greater sense...

Another Infirmary staff member shared her perspective on this issue:

[With] new Canadians I find there have been lots who don't have status, some of them don't have drug coverage or health coverage so that's an unfair barrier. I read something about immigrants being allowed into Canada on an extended work permit so that they don't qualify for any health care [services] but they're still allowed to work in Canada—it's really unfair...

Infirmity staff routinely think outside their own work environment. They understand that barriers exist with newcomers receiving health care and other beneficial services for a variety of reasons. The staff participants of this study revealed that a great deal of 'behind the scenes' negotiation occurs between them and other service providers/the Ministry of Health and Long-Term Care to meet the care needs of those who would normally be shut out in other circumstances. One staff member told me that there have been several cases of sick, non-status clients of the Infirmity who later returned—in good health, fully employed, and with a good command of the English language. Getting well and earning an income was sometimes the pathway to reuniting with family members, who were then able to join their loved one in Canada. The Infirmity tends to focus on clients becoming productive members of society.

Members of the LGBTQ Community

Persons who identify as belonging to the LGBTQ (lesbian, gay, bisexual, trans, queer/questioning) community require health services that are attuned to their specific physical, mental, and emotional needs. The Sherbourne Health Centre offers a variety of support services to individuals who identify as belonging to the LGBTQ community that

are offered in conjunction with primary medical care. Counselling services and family programs are run by the Sherbourne Health Centre. However, simply having an accepting environment was extremely meaningful to some LGBTQ clients who had major health concerns. Jo's experience with Sherbourne's Infirmary was different than any previous experience within health care facilities—her same-sex partner was finally acknowledged as a legitimate co-parent at Sherbourne. This led to better health management because she was likely to return to such an accepting environment. In addition, Infirmary staff praised Jo for pursuing neonatal care early on for the health of her unborn child. Her child was born HIV-negative. She summarized, "I continue to be amazingly grateful for [the Infirmary] because [the staff] were wonderful to me and I started to feel better about myself. I was just amazed at the care I got. It honestly saved my life."

Client Snapshots: Full Impact of the Infirmary

The following profiles are intended to provide good examples of how the Infirmary's many benefits (as discussed in the headings above) have had significant and lasting effects on clients' lives.

George

In one way though, I am a success of the Sherbourne Health Centre because I would probably be dead, I would have never have been able to get through the year mentally, physically, and emotionally. (George)

George, a 56 year-old male, had a two week stay at Sherbourne's Infirmary five months before our interview took place. He had experienced a general decline in his health over the past two years. His immune system was compromised, though numerous tests had confirmed that he was not HIV-positive. He also suffered from heart disease, arthritis, and depression. He developed several serious infections as a result of being immuno-compromised, which resulted in numerous hospitalizations (he had five hospital admissions in the last six months alone). His admissions were a result of being diagnosed with severe facial cellulitis¹⁵ and herpetic whitlow,¹⁶ and he became MRSA-positive as a hospital inpatient. George had been living on the streets and in shelters for two and a half years, although when the interview took place, he had been housed for approximately two months.

While homeless, George was told by his social worker that he had to find a safe and secure place to live while he was having antibiotic therapy administered via a PICC¹⁷ line. He was cautioned that it can be very dangerous to live outside with a PICC line because it goes into the heart, and so she told him about Sherbourne's Infirmary. His

¹⁵ Cellulitis is an inflammatory bacterial skin infection that affects the superficial and deep layers of the skin.

¹⁶ Herpetic whitlow is a painful infection occurring on the fingers that is caused by the herpes simplex virus.

¹⁷ A PICC line, or Peripherally Inserted Central Catheter, is an intravenous intervention to deliver fluids to the body for an extended period of time.

admission was approved and all of the medical equipment associated with the PICC line was sent over from the hospital. Infirmary nursing staff provided care and brought in a special IV nurse from a nursing agency who would come in every day to deal with the PICC line. In this case, the Infirmary was able to adapt to specific client needs. George told me:

The Sherbourne Health Centre is an absolutely magnificent place. Because I had come from the streets, first of all I felt immensely safe for the first time in a long time, I felt cared about, every employee I encountered was concerned about my physical health, they spent lots of time [with me], I was always chatting with someone—there's always someone to talk to on the Infirmary. What came out of those couple of weeks was an awareness that there were people out there who...because I had turned away from the whole system two and a half years earlier, it was time...I realized that there was something affecting my health obviously, that something was going wrong or that I was getting to an age where I just couldn't continue to live like this on the streets—I had not come from that background and the things that drove me to the street were something I needed to address, from a mental health point of view—and with the staff here and the support, I set about that. So about the time that I was ready to leave, within two weeks, I had been assigned a case worker, a housing worker, a counsellor who worked with bereavement (because that was one of my big mental health issues), and for the first time in three years got a family physician, based here. So all of a sudden, here I had all these people here to support me.

As George's account illustrates, the Sherbourne Health Centre was able to counteract feelings of loneliness and isolation, and provide long-term care supports for the future. Creating an initial and ongoing point of contact for health care services (i.e., through a family doctor) is a crucial step in 'catching' health issues before they escalate to acute crises where emergency care is needed.

George had several more bouts of poor health and infection after leaving the

Infirmery. He had additional hospital admissions and this was partly because physicians could not figure out why his immune system was failing. He was not housed when he first left the Infirmery, and went back to living on the streets, but this was not permanent. Staff at the Infirmery encouraged him to apply for ODSP because of his chronic depression. He believes that his physical ailments are contributing to his emotional state. He is aware that shingles and other ailments can be triggered by stress. George revealed, “The stress that is in my life on an ongoing basis is almost unbearable. [Sherbourne staff] are trying to get psychological help for me; it’s very hard in this city even to find a family doctor let alone a psychiatrist or psychologist.” His family doctor from the Sherbourne Health Centre has encouraged him to contact Bereaved Families of Ontario, a support group. This physician also recognized the impact that George’s emotional state was having on his health.

When asked what he appreciated most about his stay at the Infirmery and how that helped him to deal with his illnesses, George replied:

Truthfully, I will come to the Sherbourne Health Centre sometimes because I don’t really have any friends anymore—I’ve cut myself off from all my long-term friends who were my other life friends with the nice homes and condos, because I became very critical of their lack of understanding. The fact that I would even consent to get additional care and help, and they’ve become almost like a surrogate family in a way. Just because there are days where I just might be having a bit of an aimless day...I can walk into the building, from the security guard at the door, who I know, I know all of them, to whether I stop up on the Infirmery floor or the second floor, I will run into someone who will give me a hug and tell me I’m looking great. They all know my situation, they know all about my problems, but this has such an emotional healing to it. Whether it’s someone just making a joke that I look like a million bucks or that they thought it was a movie star getting off the elevator, and it’s just

become almost like... if I need a 10 minute bolt of good feelings, of positive reinforcement, I just have to come here for a coffee. So just a 10 minute walk through the building just to say 'hi' and I'm fine for another week.

In this narrative, George demonstrates how the Sherbourne Health Centre combated loneliness and was utilized as an ongoing, informal social support resource.

George also knows that if there was anything more serious that came up with his health, the Sherbourne staff would be there to assist him. The staff was always encouraging about the other aspects of his life, and more recently, about his new apartment. In George's case, continuity of care was provided, which resulted in better health outcomes. He said:

The Sherbourne Health Centre has become a very integral part of my life. Every good thing that's going on in my life right now has come from this centre and I didn't know it existed a year ago. Everybody—whether they're receptionists, people that I'm not even involved with in other services that the Centre provides—are just so pleasant everyday. It's an amazing place. I don't know... if it wasn't here today...I probably just would have jumped off a bridge. Especially when the illnesses all happened, when I started to get *that* sick, and it wasn't like I was by myself anymore. Even when I had to go to the hospital for two weeks, [my family doctor from Sherbourne] would find out immediately and he would mention it to the staff in their meetings. So the minute I would come back here [staff would say to me] 'oh my gosh I heard you were in the hospital' or I'd have a phone call from somebody, you know, right down to the security guard, I mean everybody was very caring. I mean they even gave me my flu shot for goodness sake, you know even made the appointment for my flu shot, and *they* tell *me* the day I walked in the door one day and [told me about my appointment]. (George's emphasis)

George looks optimistically to the future and to becoming a contributing member of society, concluding:

I have a lot of healing to do emotionally and for the first time since [my partner's] death, I have some hopes that I will certainly be in a position to volunteer again. I used to be a very active volunteer; I took a class in my free time in how to make balloon animals and for 10 years I used to go to [a Toronto hospital] maybe twice a month and make balloon animals [for children]. I haven't made a balloon animal in years. So for the first time in all these years I have the hopes that I'll be able to contribute back to society. I used to be a very big contributor, I didn't just take from society, I gave a lot back, and God has allowed me to have a moment of positive thinking that maybe I might be able to work a little bit.

Tal

Tal, a 54 year-old foreign-born man who came to Canada in 1981, spent three weeks at the Sherbourne Infirmary and said that he felt better after just one week. Tal had previously spent one year in a large Toronto shelter with serious leg problems, although he says he was never 'street' homeless. He suffers from a range of health problems, including diabetes, fractures and mobility issues, circulatory system problems, high blood pressure, depression, and anxiety. Tal sustained broken legs from a fight that broke out when he was working at a restaurant shortly after he immigrated to Canada. He told me that he is in constant pain and that he has had three operations plus infections and swelling in the area. He has had steel supports inside his legs for many years. The combination of diabetes, leg injuries, and circulatory issues make him dizzy and make his gait unstable. He also reported that diabetes has damaged his eyesight, and that his leg continually shakes when he walks. Because of these issues, he is prone to falls and has to hold onto things when he walks. In 1994, he slipped in the park and broke his knee. He

recently slipped in the shower, hitting the back of his head and breaking his right shoulder. Tal told me that he has been diabetic for many years and that it is not very well controlled and he frequently experiences blood sugar highs and lows.

Fortunately, ODSP covers Tal's medications and pays for taxis to get to the Sherbourne Health Centre and other medical appointments. He says that he has nobody to help him—no family in Canada and his friends rarely assist him. He currently lives in assisted living subsidized housing, which is positive because he receives assistance with the activities of daily living. However, he said the downside is that all the other tenants (who are sick or elderly) have their own needs so nobody is able to help one another.

His physician recommended that he go to a nursing home, but at \$37.50 per day, this option is impossible for him to afford. Because of his health problems he is unable to work. He has no insurance that covers long-term care, however Tal is supported by ODSP. Aside from the high cost of staying at a nursing home, he prefers not to go to one because he finds them too crowded, which makes it harder to recuperate. His health and financial issues cause him a significant amount of distress; Tal admitted that he is “under pressure” and “thinking all of the time.”

Tal reported that a three-week stay at Sherbourne's Infirmary was instrumental in making him feel that a supportive social network was available for him and that he could utilize a health resource that took his medical concerns seriously. He told me that his health care team at the Infirmary is like his family. He stays in contact with the Infirmary

staff, who told him to stop by anytime he feels like it—especially when he is feeling anxious, lonely, or has any worries about managing his diabetes. He was told that he could come to the Infirmary for a coffee or dinner anytime, and knowing that was very reassuring to him. Infirmary staff told him that he was a good person and not to feel alone, which is in line with their overall approach that emphasizes people's strengths and focuses on positive aspects in their lives. This often acts as a springboard that empowered individuals to manage their own health and to utilize required services more often.

As far as service provision is concerned, the staff at the Infirmary referred Tal to a family doctor that he likes very much and sees regularly. While he was an inpatient at the Infirmary, staff regulated his medications, checked his blood sugar, assisted with showering and shaving (his hand was shaking and he risked cutting himself). When asked if his stay at the Infirmary influenced how he was able to manage his health after he left, he told me that aside from stabilizing his blood sugar and providing an environment where he could rest limbs and reduce his anxiety, the main benefit was just the reassurance of knowing that a supportive resource existed. He told me, "In three weeks, I was completely nice and normal."

Tal noticed a big difference between a nursing home and the Sherbourne Infirmary, which surprised him. The Infirmary was clean, staff listened to him and took his concerns seriously, gave him medications on time or when he asked, and his physician from Sherbourne gave him much more time during appointments and provided

higher quality care. The Infirmary gave him freedom and he had input in his own health care plan. He appreciated the fact that he could get drinks in the kitchen at any time because his medications dehydrated him. He generally felt looked after and understood at the Infirmary. In contrast, his experience in the nursing home consisted of a physician that came once per week and had minimal interaction with patients, and rigid schedules. He disliked the fact that they locked up the kitchen after meals and told him to drink from the bathroom sink.

Tal very much wants to be in good health and feels that once one has good health, one can do whatever they want—it is the path to freedom in all aspects of life. He says that money does not mean anything if one is sick and that all happiness and enjoyment in life comes from having good health. The Infirmary has been the gateway towards meeting that goal for him.

Conclusion

This chapter serves to complement Chapter Three. The Sherbourne Health Centre and its Infirmary aid people on the path to becoming independent and empowered—personal characteristics they desire but have been restricted from achieving for a variety of reasons. Sherbourne's Infirmary is an ideal resource for these individuals because it provides medical care without feeling like a hospital. Clients are permitted to self-refer, and are integrated as members of their own health care team. Since a harm-reduction

approach is taken with substance users, clients can receive medical treatment and at the same time, avoid uncomfortable and sometimes life-threatening withdrawal effects.

Every Infirmary client is encouraged to set their own goals, and a clear, realistic plan for their future that based on individual goals is then implemented. Clients feel respected and are less likely to feel intimidated within this setting. As a result, they often take an active role in managing their health conditions. This leads to better health monitoring and an improvement in overall well-being. The following chapter provides additional staff member insights and a discussion of the implications of the data gathered in this project.

CHAPTER 5: ANALYSIS AND CONCLUSION

The Sherbourne Infirmary addresses a deficiency in the public health and shelter systems by creating an environment where homeless people can self-refer to recover from illness, injury, or childbirth. Its philosophy, structure, and execution are unique. It is accommodating, harm-reduction focused (in certain respects), non-judgmental, and stresses honesty and mutual respect. The previous chapters hopefully present the message that homelessness should be thought of as a major health issue. We should be as much concerned with the thousands of homeless people living on Toronto streets or in shelters as we are when there is an infectious disease outbreak affecting a few hundred people.

Clients of this project generously shared their opinions about health care and housing issues. However, one must understand people's life histories and viewpoints to truly understand where these opinions arise from and to provide better services to this population. The Infirmary's model of care is central to their clients' high rates of post-discharge health improvements and overall life success. By permitting individuals to retain control over service situations and gently challenging them to define their own goals, the Infirmary aligns well with their strengths and preferences.

Several common viewpoints emerged throughout client interviews. There was the overarching mindset in many participants' narratives that life is more of a journey than a destination. By this I mean that, even though most clients discussed long-term goals,

they tended to be focused on small successes and getting through the day-to-day. I believe that this is an adaptation that has developed from existing on the streets or in other hazardous environments, and up to this point, it has ensured their survival. Also, many participants discussed the importance of feeling safe, particularly in the context of recovery. Because clients very often felt vulnerable or had been victimized, it was extremely important for them to find a safe haven to rest and recuperate. Finally, participants did not tend to emphasize material needs not being met. Rather, they tended to focus on improving their own life and health capacities, and other people's understanding of their situations.

Theoretical Insights

The following subsections provide a more detailed discussion of the theoretical approaches to this research that were mentioned in Chapter One.

Stigma

Most client participants were all too aware of the stigma that exists in our society about homeless people, substance users, and people living with HIV/AIDS. Clients reported that homeless people were typically characterized as lazy, unintelligent, and unappreciative by members of the general public; substance users and people living with

HIV/AIDS were commonly thought of as reckless, impulsive, and deserving of their afflictions by certain service providers. Many reported defending their existence in many different contexts—including within health care and shelter settings. Such types of stigma are not rooted in truth. In fact, all of the client participants for this project had a strong ‘anti-laziness’ ethic, and many held the viewpoint that only ‘lazy’ homeless people starve in Toronto because they choose not to make use of the numerous services that provide essentials. They often made great efforts to stay self-sufficient and retain autonomy. Also, many are educated and/or possess an employable skill set or were professionals in their ‘previous’ (pre-homeless) lives.

It is tragic that homeless persons sometimes feel that they must part with their independence or dignity in order to receive essential services. The participants of this study were often not given much credit in their daily lives for their capacities and strengths. They are intelligent decision makers and most of their actions—despite how reckless they may seem to the rest of us—are well thought out or happen for understandable reasons. They generally prefer to carry out their lives and access services with minimal barriers, and in this respect, are very much like the rest of the population. They usually do not pass up opportunities if they are meaningful or valuable to them. The public system has a duty to accommodate all citizens within health care and housing settings, and this means expanding our definition of who a service recipient is and creating environments in which people feel comfortable. Stigma prevents this from happening. Sumerlin (1995:295) acknowledges this fact by stating:

Homelessness challenges survival skills. Adaptation to a homeless experience requires strength because a complex reorganization of cognition, affect, and behaviour is necessary to survive...courage is necessary to live a homeless lifestyle.

Wolitski, Kidder, and Fenton (2007) suggest that some physicians may be contributing to the poor health status of homeless persons living with HIV by prescribing suboptimal antiretroviral treatments or by not prescribing antiretroviral therapies at all because they are concerned that homeless patients cannot properly adhere to medical appointments and dosing schedules. This demonstrates yet another example of stigma; physicians make negative and largely false assumptions about a patient's capabilities based on that patient's label as an 'HIV-positive homeless person.' This devaluation may lead to substandard care and confirms the bias that some participants in this project have already suspected exists in health care settings. Evidence has actually demonstrated that the opposite is true: HIV-positive homeless and unstably housed persons have been shown to greatly benefit from antiretroviral regimens, even when adherence to them is less than perfect (Wolitski, Kidder, and Fenton 2007). Wolitski et al. conclude that health care providers should be assessing and encouraging antiretroviral adherence in such patients and actively working with them to develop strategies for achieving high levels of treatment adherence, which are tasks that Sherbourne Infirmary staff already carry out.

Takahashi (1998) asserts that stigma is produced by labelling, which devalues the individual and separates them from mainstream and valued members of society.

Evidence from this project suggests that this process occurs in some health settings.

Takahashi (1998:55) states that:

Labels are expressions of society's contemporary social and moral boundaries, and are useful in controlling individuals and groups not fulfilling social norms. That is, once individuals are labelled 'homeless' or 'HIV-positive' and enter the social service network to access material and financial support, they become prone to organizational rules and procedures.

I assert that such organizational rules and procedures may not apply to the homeless or fully take their needs into account. In this way, the stigmatized of society (e.g., the 'homeless,' 'HIV-positive,' or 'drug addicted') may be excluded from formal health policy. Furthermore, Gans (1995) maintains that in settings in which services to such stigmatized individuals occur, labelling is developed using what he calls 'imagined knowledge,' or those sets of judgement that are consistent with the pre-existing prejudices of those who judge. I assert that health care workers are not exempt from this phenomenon. In some cases, it is plausible that 'imagined knowledge' is passed off as 'professional' or 'medical' knowledge even though the majority of health care workers have minimal or no training on the unique needs of the homeless and addicted. The treatment that some clients reported receiving in some mainstream health care facilities certainly suggests this.

Goffman (1963) reveals why a spoiled identity may be internalized. He notes that stigmatized persons tend to experience a 'moral career,' or a typical path of experiences on the way to internalizing a spoiled identity. He notes that, "the [first] pattern involves

those with an inborn stigma who become socialized into their disadvantageous situation even while they are learning and incorporating the standards against which they fall short” (Goffman 1963:32). This process may occur when individuals are subjected to discrimination based on ethnicity, class, or sexual orientation. Another pattern of socialization experienced as part of a ‘moral career’ is illustrated by, “one who becomes stigmatized late in life...such an individual has thoroughly learned about the normal and the stigmatized long before he must see himself as deficient” (Goffman 1963:34). This can occur when a person becomes homeless or HIV-positive after a time in their lives when they did not have such an identity. Goffman’s (1963) idea about certain individuals following a ‘moral career’ route shows how self-devaluation can be solidified throughout many years of a person’s life, and why a spoiled identity is so difficult to repair. A moral career shapes people’s interactions with other members of society, and can result in a weakened ability to counteract incorrect notions about one’s character or physical state. These compounded stigmatized identities result in a uniquely devastating illness experience for people who are both homeless and sick.

Beauchamp (2003:270) sheds additional light on the subject of stigma by declaring that:

Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioural failures or deficiencies of the victims. These behavioural explanations for public problems tend to protect the larger society and powerful interests from the burdens of collective action, and instead encourage attempts to change the “faulty” behaviour of victims.

Stigma may not be fully recognized if we are focused on blaming the sick and vulnerable for their situations. The idea that a society may be protected from ‘deviant’ or ‘faulty’ members by blaming them is a fallacy—we all suffer when the needs of certain groups of citizens are neglected. Decreased societal productivity, increased wait times in hospitals, and the spread of infectious disease are just some of the consequence of denying basic rights and services to some groups of people.

Value Inscription

Chatterjee (2006) discusses social justice with respect to a dead child in post-colonial India, whose death was caused by extreme deprivation. While conducting fieldwork, Chatterjee was once put in a position where she was asked to photograph a dead child, but declined. Reflecting on this uncomfortable situation, she says: “I will speak about a Dead Child, unnecessarily dead, who died because her body could not be inscribed into value. I will speak about a Dead Child, unnecessarily dead, who could not be captured inside a frame” (Chatterjee 2006:568). Chatterjee’s interpretation of suffering and death is helpful when applied to this thesis because it provides a new way of thinking about mortality-inducing social exclusion. She writes that death unnecessarily occurs in some instances because certain bodies have little value to others.

I put forward an expansion on this idea by suggesting that suffering also occurs when certain stigmatized or devalued (e.g., homeless or addicted) bodies are not valued

in official health policy or within certain ‘everyday’ settings. In turn, such individuals may learn to devalue themselves. When Chatterjee suggests that people may die preventable deaths because they do not fit inside a frame, it captures the outlook of several client participants of this project who described navigating throughout the public health care, shelter, and housing systems. Such clients spoke of the idea that they were excluded from the boundaries of service provision or of humane treatment. Many public health facilities did not capture people’s complete identities (e.g., a LGBTQ identity may not be recognized or may be underappreciated). Also, landlords may prevent people from obtaining decent housing because they do not fit inside the frame of what a particular landlord determines to be a ‘desirable’ tenant (i.e., not a drug user, alcoholic, or HIV/AIDS sufferer). Such individuals may experience physical, emotional and social suffering—their bodies are ill or injured, they have low self-esteem and depression, and they may be restricted from the benefits of full integration with the rest of society. Through these processes, certain groups of people become worthless and invisible. Their needs are rarely met and they are left with few tools to re-legitimize their existence. Chatterjee’s (2006) perspective provides another dimension to Goffman’s concept of ‘stigma’ because it recognizes that materially and socially deprived people are sometimes made to suffer more when public institutions deny certain individuals basic human rights. The Sherbourne Infirmary is innovative because it places power and self-worth back in the hands of the most deprived individuals who have had such qualities stripped by a variety of macro-level and micro-level forces. This institution acknowledges the unique value of every client (and often allows clients to recognize their own value). The Infirmary also expands the frame of who is worthy to be cared for in medical settings.

Syndemics

There are significant public health implications of this study with respect to syndemics. When there is the concentration of two or more illnesses in a particular population or place, it is usually indicative of not only biological agents, but social mechanisms as well. When individuals fail to treat illnesses or disclose drug use or symptoms, it is possible that they are unwittingly perpetuating disease spread. Facilities such as Sherbourne's Infirmary have the capacity to limit the spread of syndemics because, not only are they thoroughly addressing medical concerns (through an environment that ensures privacy and acceptance, and increases the likelihood of a client receiving continuity in their care), but they tend to place an emphasis on counteracting macro-level mechanisms of oppression and exclusion (by assisting clients in accessing government benefits such as OW, ODSP, health cards, and Native status cards) and provide routes towards accessing the necessities of life. The Sherbourne Infirmary addresses the issue of syndemics by increasing people's access to the agents of health and well-being.

Client Perspectives and Constructive Feedback

Most client participants spoke positively about the help that is currently available to people within Toronto who are experiencing periods of homelessness or low income. Despite the fact that shelter and health care environments were sometimes considered

toxic for a variety of reasons, many clients were appreciative of almost any service that operates to assist their unique demographic. In addition, clients often demonstrated a significant amount of empathy towards healthcare workers and their stresses—despite the fact that this was not often reciprocated. One client reflected on his years of using a variety of Toronto support services: “Other than there not being enough professionals, there’s lots of help out there. I can’t complain; I’m getting four different services coming [into my house].” This client has a housing worker, homecare, and 24-hour staff from his ‘assisted living’ subsidized building who help him with his chores on a weekly basis.

One interview question for this project asked clients if they had any constructive feedback for the Sherbourne Infirmary. Most interviewees were hard pressed to make any suggestions about how to improve the Infirmary because they felt that it was already “top-notch.” Nonetheless, several clients provided constructive feedback in the hopes that it would benefit Infirmary staff and future clients (or themselves in future stays).

One client stressed that she wanted to be constructive about her comments and stated that she had no dislike for the Infirmary. She said, “I think [the Infirmary staff] need to build their capacity around how they bridge people going from here to other places.” Several other clients felt this way, too. They thought that the case management process could be tightened up a bit, so that there is a clearer idea of what is happening after clients are discharged. It would benefit clients to know what kinds of staff are at what places, and what kind of clients tend to go to particular facilities. She said:

That's the thing: they're so good at what they do here and a person feels so in a place of home here and that they're safe and that they're going to be OK for this time. And then they go from that right back to what they were doing; [it] is an awful feeling, and it often makes people just give up because they think, 'I just had the best of everything in that place, and now what good did it do?'

Other clients talked about how the Infirmary provided a brief break from substance abuse, but that they fell back into their old patterns post-discharge. One client reported that he was right back where he started after he left the Infirmary—he started drinking again and he lost the weight that he had gained. When asked if the Infirmary could have done anything more or different for him, he said that they could not have—it was his lifelong addiction to alcohol that led to his relapse.

There were several clients who reported that they would have liked to have their stays extended or be re-admitted at a later time, but were denied. This was usually because they did not meet the admission criteria any longer. This is not necessarily a tragic phenomenon—such clients were often deemed 'well enough' to leave at that point by Infirmary staff. In other cases, staff recognized that certain clients' needs would be better met in a different facility or environment. In addition, Infirmary staff encourage clients to come stop in any time in the future, which maintains social relationships with service providers, and in some cases can better ensure continuity of care.

One client, who had a stay shortly after the Infirmary first opened, told me that she felt that she needed a clearer picture of what was going to happen in her life after her stay was over. After she left the Infirmary, she went to a hostel and resumed taking drugs.

Her story demonstrates that drug addiction is extremely tough to overcome and that relapses are often expected. However, this was a hiccup on her road to recovery, since she is now clean. She identifies the Sherbourne Infirmary as the singular catalyst on her way towards getting clean and improving her health. She thinks that more places like the Sherbourne Health Centre and its Infirmary are needed in Canada, especially in cities. Although the case management services at the Infirmary have become better with time (and would be presumably better at addressing her concern today), her story shows that, in some cases, changing people's entire life course may be beyond the capacity of a short-term stay medical facility.

One client suggested that the Infirmary could provide snacks to improve client cohesiveness when people get together to watch television in the common area. However, he concluded by saying,

As far as improving this place is concerned, you got me. I don't even know what they could do to make it better because it's pretty good ... There's no problems with the way it's run, at least none that I can see. And the staff, some are just exceptional. It's just like night and day—the staff at the shelters, it's just the very opposite.

In sum, the constructive feedback that clients provided was either minor, beyond the capacity of what an infirmary can realistically carry out, or was in the process of improving with time.

Funding Issues

As mentioned in Chapter Two, a maximum of eight or nine beds out of 20 in the Infirmary unit were filled at one time. This was considered full capacity by Infirmary staff. The majority of client participants, when asked, felt that the Infirmary was under-funded. They all described great experiences during their stays at the Infirmary and did not ever say that their care was compromised because of funding. However, they tended to cite two indicators of what they perceived as under-funding: the observed sparse bed occupancy and stressful staff shift changes. This viewpoint was consistent with what staff reported in interviews. The issue of funding was a complex one because two staff members asserted that more money would not necessarily translate into improvements in all aspects of the Infirmary. One staff member revealed that the setup of the unit—the actual physical space and design of it—did not permit any more admissions. A different staff member felt that efficiency was the key issue; they needed to become more efficient with operations, so that communication was better between staff members and so the unit was “running like a machine.” However, both individuals claimed that limited staff impacted the number of beds that could be occupied at one time. One can imagine that more funds would play a significant role in staffing the unit better.

One client summed up the sentiments of Infirmary staff and most Infirmary clients that I interviewed:

One of the things that I noticed was that they are underfunded and that they couldn't even take capacity of what the [unit] is built for as far as the amount of people. And the limitations put on them because of funding as to how long a patient could stay because there's only six beds available, so in a case like mine, they knew I wasn't actually ready to leave but I had to leave because there were so many people trying to get in. I survived and with their support and help—thank goodness, these good people—but I did see all these empty beds day in and day out, walking around the unit and thinking 'oh gosh, how many people could benefit from this place if they just had more money?' They don't have the staff. [It would have been better to have] a couple more days or if they had found me some emergency housing.

Another Infirmity client recognized the value of infirmity services for the homeless and under-housed, telling me, “this place needs to get some more funding... when you have [staff] like that around, it makes you feel great.” He also believes that the Infirmity needs more staff because there were some instances during his stay when he saw that there was no relief for nurses who were coming off shifts, so another nurse had to stay longer. He feels that there should be better coordinating of schedules, and he believes this is a funding issue. During his stay, he also observed that, “there were too many vacant beds and that is something that shouldn't be allowed with this type of care... it should be well funded. It needs to be busier here... more staff, make it easier on the nurses—they deserve that.” For the most parts, clients felt that Infirmity staff were doing an excellent job, and that infirmity care in general needs to be expanded to other places both within Toronto and throughout Canada.

The three Infirmity staff members that were interviewed for this project reflected on Infirmity funding. They all felt that, despite the fact that some clients may want to

stay longer, the three-week stay limit that is usually enforced is a reasonable maximum for the majority of clients and that the vast majority leave the Infirmary in much better health and with a clearer picture of what the future holds. However, staff generally had two concerns that can be connected to funding: stress from the fast-paced and complex nature of their jobs, and staffing issues. When I asked one staff member whether they felt the Infirmary was adequately staffed, they said, “It’s manageable, but it’s not optimal, a lot of things don’t get done or probably don’t get done as well as we would like.” This staff member reported that if a staff member calls in sick, it is difficult to fill that role and some tasks may be put on hold. This employee also said that there is a great deal of electronic work that needs to be done to disseminate information about the services that the Infirmary offers (e.g., website development) and to update medical records. Furthermore, this staff member mentioned that Infirmary staff are often unable to participate in nursing development activities. This employee said, “It’s easy to look at us and say we’re so well resourced when in reality, in order to move beyond what we’re doing now will take more resources.”

The bed issue was complex because more staff and/or funding would not necessarily solve the occupancy issue. This staff member said:

What’s a tough piece is that there are certain pieces of infrastructure that if we add more staff that we actually begin seeing things not go so well. One thing is that when they designed this place, they designed it with us having half of the floor [above] to do program rooms and for staff to have a space to go away from the floor and work in. We have none of that space anymore, except for a storage room. So, space will be a huge issue. Just with the staff we have right now, we often run out of computers and places for people to work. We run out of exam rooms—there are two

exam rooms and if we've got [both rooms being used] a third nurse on or a nurse that comes in from the community to do some specific things, we sometimes run out of exam rooms. So having more staff, we're still going to bottleneck on certain places here. When they designed it, they really thought about what [staff] would do here, so it's been both well designed and poorly designed. What has shocked me is that in the winter right now, we're at the six to eight [clients admitted] point, but there was a point in the fall where we were so quiet and underutilized, at the same time I would be hearing from some of the clients we were admitting from the community had been in hospital but not referred to us.

Staff members discussed stresses in their jobs that were related to having to juggle many tasks and feeling over-stretched. One staff member said:

It can be stressful in a few ways. It can be overwhelming—just the sheer difficulty of trying to run a 24-hour a day program in a community agency that's typically run in the daytime or into the early evening. It affects all of us [staff] in a lot of ways. We have some pretty sick clients and I actually feel comfortable doing that kind of work, but it's hard keeping a handle on keeping ahead of all the different clinical issues. I stay late many evenings [completing tasks that aren't associated with my assigned role] and it's just that the work is never done. We don't have perhaps the resources and the mix to really do what needs to be done in this kind of a program.

Another staff member said that the most stressful aspect to their job is when clients are being admitted and discharged. This employee felt that there was much uncertainty about what happens to clients after they leave and that there is a great deal of thinking ahead, preparation, and anticipation required from staff.

These staff members' accounts of stress suggest that more money or resources could provide relief to Infirmity staff. However, another staff member reflected on job stress that could not be alleviated with material inputs to the facility. This person said:

To know that some people don't have a privileged life or some of the things that people go back to, like with shelters and stuff, that's what I think about often. Or having food insecurity or having to struggle with money. I feel that sometimes for me there is so much guilt almost that goes with [working here] because I have all of these things and it often makes me think a lot when you work closely with people who don't have a lot of these things...that's stressful sometimes, the unfairness of it, like how are some people born into some [situations] and some people born into others. And it's also very stressful when people don't have easy access to housing or sometimes, for example, they're barred from certain services. So for rehabilitation for instance, you need to have an address to receive services, so if you're homeless and you're here and you need rehab you're not eligible for it simply because you don't have an address—that's really frustrating. It's even hard for me to navigate the system; how is it for anyone else like homeless [individuals] or those living in poverty to navigate such a complex system and it's also really stressful... so the system not being responsible or responsive to people's needs is very frustrating. Sometimes people are more isolated so maybe they don't have that much of a support system; sometimes people are really beat down with the services anyways so sometimes you don't know what to ask for or what to advocate for.

To summarize, Infirmity staff members discussed many kinds of stresses at work, and only some could be solved with money or more staff. The overwhelming nature of working on the Infirmity unit and systemic issues external to the facility were important issues identified by staff. These types of stresses and perceived barriers are not unique to this health care facility. Rhodes' (1991) book, *Emptying Beds: The Work of an Emergency Psychiatric Unit* provides a good example of a facility that also operated with structural and economic constraints. This book documents the structural limitations of an inner-city psychiatric hospital in an American city in the 1980's. It examines how staff members dealt with finding alternative care for the severely and chronically mentally ill. Success was often measured by how quickly patients could be moved from the emergency unit to other facilities, thereby "emptying beds" within the unit. Although

there is not the same 'push' to get clients discharged as fast as possible, unit staff described in Rhodes' book are similar to those at the Sherbourne Infirmary because they also experience intense pressure to connect clients to external resources upon discharge. Staff members at both sites struggled with balancing needs of vulnerable clients and navigating through a complex system, and sometimes engaged with the mental health and criminal justice systems. In addition, Rhodes (1991:4) explains that those who treat psychiatric patients are attempting to help the patient "attain lives of greater functioning and ease," which is parallel to the goal of Infirmary staff (and which, consequently, was a source of job stress). To summarize, both units experienced forces that determined how beds are filled and how clients are handled post-discharge.

It is important to note that despite the work-related stresses reported by Infirmary employees, all staff interviewees stated that they thoroughly enjoyed their jobs, that they found working at the Infirmary to be intrinsically rewarding, that there was much cohesion between staff members, and that the Infirmary's atmosphere was usually peaceful and pleasant. They felt privileged to be let in on people's life stories and be a part of a facility that resulted in life improvements for many people, particularly those who had not connected with other facilities. Staff members generally did a great job of managing stress in a professional manner, as all interviewees reported that Infirmary employees were engaged and attentive.

Changes Over Time

When dates in which clients stayed at the Infirmity were compared to their reported experiences, several aspects of services were revealed to have improved with time. Firstly, the food became better with time. Clients who were resident when the Infirmity first opened tended to have negative opinions about the food served at the Infirmity; clients reporting more recent stays tended to rave about the food quality. Food quality and meal composition was quite important to many of the client interviewees, especially ones who had received unpalatable food in shelters or those who had to adhere to a diabetic diet. Secondly, case management services tended to improve with time. Clients with more recent stays reported a clearer idea of where they were going and what resources were available to them post-discharge. This is perhaps due to the fact that Infirmity staff became progressively better connected with and more knowledgeable about other service providers in Toronto. Also, other facilities' knowledge about the Infirmity's existence and services spread with time, which may account for better connections. These changes in service provision can be expected for such a new facility.

Managed Alcohol Program

Several staff and client interviewees mentioned a current and controversial issue within the Infirmity: the managed alcohol program (MAP). The MAP is a program that provides rationed amounts of alcohol in a safe environment to addicted individuals. This

helps such people to function and also aims to avoid the risks of illness or death associated with binge drinking on the streets (such as alcohol poisoning or freezing). Until recently, the Infirmary had been informally providing this type of harm-reduction service to clients. However, staff told me that this program was discontinued because Sherbourne physicians would no longer support the program due to potential issues of “risk, safety and behaviour.” Infirmary staff revealed that the program was stopped because it conflicted with the personal and/or medical values that some Sherbourne employees held. I was told that, even though the majority of Infirmary staff support an MAP, there are no plans to fully implement such a program in the near future. Currently, the Sherbourne Health Centre is re-defining its policy on managed risk. Because staff were so polarized on MAPs, I was curious to find out whether this was an issue that warranted further consideration.

Most homeless shelters ban alcohol use on site and have restrictions on admitting severely intoxicated clients. In 1997, three chronically alcoholic homeless men froze to death on the streets of Toronto. As a result, a coroner’s inquest was launched to investigate these tragedies. The inquest jury made the recommendation to the City of Toronto that a managed alcohol program be established to provide harm-reduction services to individuals who are both homeless and addicted to alcohol. Consequently, The Annex Program was established at the Seaton House men’s shelter in Toronto in 2002, and became the first homeless shelter in Canada to run a managed alcohol program. Typically, while utilizing this program, clients are served one glass of wine per hour and are encouraged to remain on-site. Previously, homeless alcoholics would only have the

option of being on the streets—barred from using shelters and left inebriated and vulnerable. In some cases, homeless alcoholic individuals would consume non-beverage alcohol (such as mouthwash or rubbing alcohol) which tend to be cheap and readily available, but also extremely toxic. This resulted in frequent emergency hospital admissions and an increased risk of mortality. The success of Seaton House's MAP paved the way for other such programs to be established and there are currently several operating in cities throughout Canada. Podymow et al. (2006) note that MAPs are intended as programs with no stop date for the admitted individual and that participants would normally be expected to ultimately die of causes related to their life-long addictions.

Podymow et al. (2006) conducted a study in 2002 with clients at an Ottawa-based MAP that provides beds, meals, and 24-hour medical care, and also distributes pre-set amounts of alcohol on an hourly basis. They studied 17 adults with a mean duration of alcoholism of 35 years that were enrolled in a MAP for an average of 16 months. As a group, participants' mean total emergency department visits decreased from 13.5 to eight per month, and their monthly police encounters from 18.1 to 8.8. Every study participant reported less alcohol consumption while utilizing the MAP and both participants and staff reported improved hygiene, better adherence to medical care, and improved health (Podymow et al. 2006). The total amount of alcohol consumed was found to drastically decrease for MAP participants, from an average of 46 drinks per day to eight. They were less likely to binge drink or go into withdrawal. In addition, compliance with medication (which is defined as taking medications as prescribed at least 80% of the time) was

observed for 88% of subjects—far beyond what one may normally expect within this population. Also, the majority of participants attended their scheduled medical appointments. Shubert and Bernstine (2007) further discuss the topic of MAPs and suggest that housing models for the homeless should incorporate harm-reduction principles in order to accommodate those who are actively using substances. This is particularly relevant to persons who are HIV positive, as they have unique health and treatment needs that require them to be properly housed.

The implementation of managed alcohol programs can have significant positive health implications. Not only are MAP clients less likely to consume lethal non-beverage alcohol and more likely to have a safe place to spend the night, but they are more likely to engage in health maintenance behaviours and more likely to reduce the amount of alcohol they consume. Perhaps most promising is the data that revealed that once stabilized in the program, several participants from the study pool were successfully medically detoxified and subsequently received housing. Podymow et al. (2006) claim that this is likely due to the regularized provision of alcohol in a safe environment, which makes gradual changes in behaviour (including detoxification) possible. Furthermore, Podymow et al. (2006) performed a cost analysis on their data and discovered that there were considerable cost savings associated with the MAP. The mean cost of the MAP was \$771 per client per month and they estimated per-client reductions in the costs of emergency department visits (\$96), hospital care (\$150), and police services (\$201).

I spoke with Dr. Tomislav Svoboda, a shelter physician who was one of the major

players in instigating the managed alcohol program at Seaton House. My goal was to gain more information on this controversial topic and relate that information to Sherbourne's Infirmary. With respect to client health, he told me that he has not experienced any MAP client go into alcohol withdrawal. People's health status generally improves and they have decreased emergency visits and incarceration rates. Also, he has observed liver, gastrointestinal system, and neurocognitive improvements in many MAP clients. He revealed that, in his experience, violence actually decreases significantly in such environments and people are less 'problematic' in their behaviours. He reasoned that this was probably because MAP clients are less likely to be in conflict with staff. In addition, Dr. Svoboda did not believe that the health and well-being of other (non-MAP) shelter residents was impacted very much by the MAP or that its existence added to a stressful or 'toxic' environment. This is because the MAP is mostly separated from the rest of the shelter. Dr. Svoboda reported that legal, insurance, security, and cost issues were addressed when identified and required (i.e., by Toronto City Council or the City's Shelter Division). A 'server intervention model' (like the one used by bartenders) is used to judge cut-off, and sometimes clients have dispensing schedules (timed approach), and sometimes it is negotiated. The goal, he said, is to keep clients happy.

Some physicians may feel that MAPs contravene a 'do no harm approach'. Dr. Svoboda suggested that there may be a lack of knowledge and awareness on the topic of managed alcohol because it is fairly new. In addition, he felt that the issue of licenses and the perceptions from regulatory bodies may influence physicians' stances on MAPs. However, in Dr. Svoboda's opinion, a health care facility is an appropriate site for an

MAP. In sum, the medical community as a whole has not reached a consensus on the efficacy or appropriateness of MAPs, particularly within health care facilities. The establishment of such an innovative program at one location in Toronto did not occur without obstacles, but they were managed as they came up and shelter staff were often guided by what they “felt was right.”

Despite the fact that MAPs offer benefits to many, not all shelter clients are unanimous on whether MAPs are beneficial. John, a client participant in this study (who had no history of substance abuse), told me that he knows of many fellow homeless people who would rather stay on the streets than go to Seaton House, despite the fact that there are often beds available at this shelter. John was personally outraged by the fact that Seaton House staff serve alcohol on one of the floors and felt that this can increase shelter violence because people are getting drunk on-site. Again, the managed alcohol program is a controversial topic because it touches on many of people’s personal values and may conjure up negative memories of experiences dealing with intoxicated persons. However, I feel that it is important to examine the capacity of such programs because they have resulted in marked improvements in people’s health and behaviour in several contexts. One must question whether people are in more pain *off* substances than on them.

One Infirmary staff member summed up the feelings of Infirmary staff members that were interviewed for this project:

[Issues such as addiction and drug use are handled] very thoroughly and with much thought. We also deal with it on an individual basis. It brings up a lot of feelings for people because I think it touches on the values that people have, and so it can create a lot of conflict. We need to know more from the organization and you have to consider that there are different pieces to consider, but the ultimate goal is to make sure people are safe. But it's usually a harm-reduction approach, although sometimes abstinence is the safest, but we mostly try harm-reduction, and to support people's choices and to do plans that are realistic for people. We are not like other facilities in that we're going to give people the boot if they're using substances. We ask people to be up-front and honest about it; we assess people for their substance use before they come in so we understand where they're at and so that we know what to expect...we try to promote an up-front attitude so that we can provide good care for them and safe care.

Currently, Infirmary operations are guided by a harm-reduction principle, and individualized management plans are developed with clients without the dispensation of alcohol.

Implications of Research and Lessons for Service Provision

This thesis demonstrates that certain environments and services exist that are conducive to recovery for the homeless individual. It has the potential to provide insights to further improve Infirmary services and provide former clients with further knowledge about the facility and people who use its services. Although general conclusions about the homeless and under-housed population cannot be made from such a small sample size, this research can add to academic and public knowledge about the challenges of living with both a housing and a health issue at the same time.

The Sherbourne Infirmary has structured its services to provide long-term, informal psycho-social support to its clients, which is an important element in reducing feelings of loneliness in their clientele. Creating relationships and just knowing that non-judgmental providers are consistently available was very important to the clients interviewed for this project. The power of this kind of psycho-social support may be underestimated by other service providers. One of the goals of this thesis is to disseminate knowledge about the way that the Sherbourne Infirmary works so that other service providers may adopt the successful aspects of its approach and learn from its limitations. The importance of providing psycho-social support integrated with services that are not necessarily designed for this purpose (such as medical and shelter services) is an important lesson for those working in other service settings.

Many participants thought that infirmary or infirmary-like services should be implemented more broadly. Some were even insightful about cost-effectiveness and comparing the Infirmary to the rest of the health care system. One client said:

It's like, why is there not one of these in every neighbourhood? I continually hear about the costs of healthcare going up and the lack of funding and seeing cutbacks and bed closures in the mainstream healthcare system—what an exceptional way to offset that, whether or not it should be buildings like this or...they don't have to build a brand new facility like this but to create some kind of centres, even if they're not inpatient, at least they're a health centre.

Another client brought up an important point with regard to housing people who are substance addicted. She feels that often the appointment structure with housing workers is overwhelming for those under the influence of mind-altering substances or

experiencing withdrawal. She said that more patience and persistence is required with such clients, who may not appear to be fully engaged with workers, but often want to be.

She told me:

...especially when you're all sketched out from being on the streets for seven days, you walk in to have your intake interview [for housing] and you get into the place and you're a f---ing mess—you can't keep your eyes open, and that's why you need the place but you can't even get through the administration. And you walk in and take a look around the place and you think, 'I don't think this is for me' and immediately, you're already a person who's on guard because you've had to survive out there. So I think that if housing workers were more apt to go out and meet clients, not necessarily in a crack house because that's not safe for the worker, or made it flexible around how they get through the administrative part of things. I mean I have trouble sitting still and I've been sober for months, it's like I can't imagine—well, I can imagine being in a place where you've stopped using an hour before that and you're dead exhausted and a lot of people just don't have the capacity left in them. I mean maybe a week down the road, they can handle those things, but for now, just let them go to sleep.

A different Infirmary client revealed another barrier to care. She told me that she knows a housing worker who housed a man after he was homeless for 60 years. When he finally got into his new place, he received a brand new sleeping bag and bed. He slept on the floor for a month. He would not take the sleeping bag out of the wrapper, nor would he take the plastic off the new mattress. The interviewee felt that this was just an example of how people's minds get calibrated to the experience of being homeless to the point that they cannot even make use of services or material supports anymore. This client offered some insight when she said, "homelessness isn't just a geography, it's a state of mind" and I think that it is important to remember this when trying to understand how health services are utilized by the homeless. Such individuals may be offered help

that they do not want to take on a regular basis, and this 'rejection' may happen for a variety of reasons: people may have trust or fear issues, they may not want to be looked down upon, they may not want to be a burden or be perceived as lazy, or a particular service may not align with their worldview or the survivorship skill set that has allowed them to survive. Service providers have to be receptive to all of these possibilities.

Social worker Patricia Miller offers a ground-level perspective on homeless clients with addictions, stating that:

Drug addiction is a disease of the soul...a disease linked to human suffering. In order to empower those we serve, we need to have empowered ourselves to break the bondage that social privilege potentially brings to us. If our co-dependency as practitioners is linked to avoiding social truths, we are no less clear of addictive personality traits than those whom we work on behalf of. In self-soothing ourselves within avoidance versus seeking the raw understanding of the chronically homeless, we in turn passively denounce that we value 'ours' versus 'mine.' Liberation invites us to create a collective value system that includes all, not just a select few. (Miller 2009:37-38)

Her message can be adopted by service providers who work with substance using clients. It is evident that many substance abusers are in a state of constant suffering but at the same time feel unable to halt the cycle of addiction. Miller urges service providers to recognize that clients are most often the victims of structural violence, and that structural causes and dignified solutions should be considered. Miller (2009) also claims that if service providers to the homeless lack the capacity to bring change to people suffering from co-morbidities and concurrent disorders, then they also may have little control over circumstances in the environment that continue to induce painful relations and

experiences. She challenges service providers to become a “community of care and concern and in turn service” to better serve those clients who are experiencing both physical and emotional pain.

Continuing Challenges

In this section, I present some cases that emerged from interviews that highlight the complexities of providing care to persons who are homeless. There were two problems that emerged for which I had difficulty imagining solutions.

The first issue is about challenges to providing services for chronically or long-term homeless individuals. Two interviewees (one staff member and one client) told me that sometimes, providing housing or excellent medical care does not necessarily solve homelessness or health issues. A staff member told me,

People say that they’ve never felt so cared for here. It’s both positive and negative...some clients find that so overwhelming—the notion of being cared for—that they actually find it’s not an easy place to be. If you really look at a lot of the experiences people have had – of trauma and of difficulty in their lives—sometimes when you’ve lived your life and you’ve not felt particularly cared for, it can be so overwhelming for people. Some people have said to us that we’re too nice, they’re suspicious, they wonder ‘when is the shoe going to fall?’ Some people cut short their stays because it’s too tough to be around it for too long.

This staff member’s account demonstrates how homeless individuals with extensive histories of emotional suffering and material deprivation can voluntarily opt out of even

the most suitable and compassionate services. It is also possible that some homeless individuals may lose faith in the public system and turn away from it.

The second issue is about the structural limitations that may impede short-term health or life success achieved at a facility such as the Sherbourne Infirmity. One client discussed one of the major barriers to getting people out of the cycle of homelessness:

I don't think anybody really chooses to become homeless or disengaged from society. I think it's circumstances that cause that, it's not like a career choice you make...and I think that people need to be a little more understanding. And that, from a sort of authoritative point of view, there has to be more work done with actually housing these people. Because I have spent time in shelters, of course as soon as you go into a shelter, you're immediately assigned a housing worker and that person's job is to find you permanent housing. The problem in a city like Toronto, and it's an ongoing problem, is that (of course the funding is provided by Ontario Works in most cases unless the person is disabled) the amount of money that's given to you is so minimal, the most you can hope to find is a little furnished room and all of those little furnished rooms are run-down, cockroach and bed bug infested, drug houses. So you get these people going into these facilities or homes for what they think is a chance to get off the street and make a life, and within a few months they're driven right back onto the street because of the neighbourhoods they're in.

This client makes a valid point with respect to toxic environments: where public housing agencies are often placing people perpetuates the cycle of homelessness. This pattern is not productive to getting one's life 'back on track' or to managing one's health. If an individual is chronically homeless, this cycle may be excessively frustrating to experience.

Conclusion

It is important to keep in mind that the Infirmary is only one facility amidst many in Toronto and must operate within this system. The Infirmary has little control over larger issues such as subsidized housing availability, the safety of shelters, nursing home costs, societal discrimination, or the conduct of hospital staff or landlords. However, we can look at the Sherbourne Infirmary as a model: more infirmary facilities should exist to serve Canada's homeless citizens, and health care, social, and shelter facilities stand to learn much from approaching client care in such a humanistic and economical way. When one takes the quantitative data about infirmary care and managed alcohol programs (as provided in Chapter Two by Buchanan et al. 2006, and in this chapter by Podymow et al. 2006, respectively), and combines it with the qualitative data from this project, a clear picture emerges: programs that emphasize acceptance and incorporate adaptability for clients also happen to be considerably cost-effective in their use of public dollars.

Wen, Hudak, and Hwang (2007) further confirm the value of health facilities that promote a feeling of welcomeness to homeless clients. A Toronto-based study conducted by these researchers indicates that homeless people's attitudes toward seeking health care services can be shaped by previous encounters with health care practitioners. Homeless health care recipients were likely to perceive maltreatment and experiences of unwelcomeness as acts of poverty-based discrimination, and in such cases, were far less likely to desire health care services in the future.

Abject poverty and extreme social suffering are still widespread in our society and must be radically reduced before we can speak of progress. Doing this may challenge not only how health and poverty are defined, but also the way wealth is defined and how public services are conceptualized. People should not have to choose between using drugs or alcohol and receiving medical care. Such a predicament has dangerous health repercussions and moral implications. Furthermore, there should be incentives—not drawbacks—to providing health care to underserved or marginalized populations. There are ideas in our public health care and housing systems that there are ‘deserving’ and ‘undeserving’ recipients, and resources are usually designed to exclude the latter, an example of ‘structural violence.’

Bhatia (2003:558) states:

The participation of ordinary people [in institutional culture] requires that they have the capacity to meet basic needs, aspire, organize, deliberate, and choose. Equally it demands guaranteeing that institutions make information available [and] be open to citizen voices. Initiatives in partnership with traditionally excluded populations have become more frequent in public health practice and represent movement toward equity.

In this excerpt, Bhatia draws attention to the fact that improving the quality and efficacy of health services must incorporate the voices of even the most marginalized groups.

Bhatia’s perspective was shared by at least one client participant, who thought of the practitioner-client relationship as a partnership. It is important that service institutions recognize that people who are homeless and/or drug addicted still have unique capacities that can often be harnessed and ‘plugged’ back in to society. Many homeless people are

falling through the cracks because of diminished capacity and constrained options, and not due to a lack of mental competence that is often assumed. The message that can be learned from Bhatia's statement is that health services evolve when they incorporate a diverse group of opinions into their decision-making.

The ways in which many mainstream public health services are run are often not efficient. To have homeless people excessively re-entering care facilities, utilizing a disproportionate amount of emergency services, and having longer inpatient stays all adds up to tens of thousands of health care dollars every year for each individual whose needs are not adequately addressed. However, this is also a quality of life issue. The fact that emergency rooms are utilized as much as they are by homeless people is indicative of the fact that this population is often suffering from critical health emergencies, which is in some cases due to the fact that they are under-using the services of general practitioners (which could prevent health concerns from escalating). One key to caring for the homeless population is getting such people to regularly utilize a non-emergency service. Ideally (and as one can conclude from this project) such a service should provide both medical and psycho-social supports.

On August 25, 2009, I attended the public memorial for Paul Croutch, a homeless man in Toronto who died after being brutally beaten while sleeping on a park bench in 2005. Paul Croutch's legacy has, in part, been transformed into a national social movement that carries the message that our society should never again produce a 'victim of intolerance.' I feel that this message can be applied to this research project, for every

client interviewee stated that they had been, in a range of situations, the victim of intolerance. When such intolerance spills over into health care, housing, or shelter environments, this points to a major societal crisis because people who are most in need of assistance to exit poverty or poor health are barred from doing so. One speaker at the Croutch memorial stated that, “ending homelessness is not just a money issue, it’s a will issue” and I believe this to be true because, as the Sherbourne Infirmary demonstrates, influential people (e.g., service providers) have the capacity to redefine how homeless people are thought of and treated.

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Appendix A: Table of Client Participant Data

Pseudonym	Age	Sex	Health Issues	Stay Category*	Characteristics, Circumstances, Key Issues
Jo	38	F	HIV, hepatitis C, extensive drug abuse history, was MRSA +	2	Identifies as gay, mother of one child, rape and physical assault survivor, experienced mistreatment & discrimination within health care settings
Simon	42	M	Alcoholism, double-amputee, mobility issues	4	Aboriginal, experienced barriers within shelters because of his disability
Ray	55	M	HIV, hepatitis C, extensive drug abuse history, currently addicted to heroin	3	Lived in toxic housing environments, estranged from family, issues of loneliness
Frank	61	M	Experiences blackouts, low blood pressure	4	Assaulted in shelter, physical vulnerability caused by blackouts
John	60	M	Mobility issues, chronic lung condition	4	Some shelters were not able to accommodate his disability, managed medication side-effects on streets

George	56	M	Severe depression and bereavement issues, compromised immune system, skin infections, was MRSA+	2	Lives with constant stress about his physical state, 'pre-homeless' social network collapsed, issues with 'voluntarily' quitting job
Andrew	63	M	Asthma, heart condition, prostate cancer survivor	2	Had issues with recovering from surgery within shelters
Tal	54	M	Diabetes, fractures, mobility issues, circulatory system issues, hypertension, depression, anxiety	n/a	Lives with much stress and fear about his health conditions, often feels lonely and isolated
Deb	53	F	Metastatic cervical cancer, hepatitis C, kidney stones, irritable bowel syndrome, arthritis, osteoporosis, scoliosis, myasthenia gravis, extensive drug abuse history, grief issues	4	Hospital phobia
Mary	39	F	Sickle cell anemia, diabetes, hypertension, uterine fibroids	1	Non-status client, unable to work
Kevin	36	M	Diabetes, alcoholism, paranoid-type schizophrenia	2	Aboriginal, has experienced Aboriginal-specific racism, past involvement with the law, has two children (does not have custody of them)
Trish	28	F	ADHD, experienced post-partum depression, required afterbirth care	4	Homeless at age 16, has four children (does not have custody of them), abusive childhood

*Clients fall under the following four stay categories:

- 1- clients who were currently *and for the first time* staying at Sherbourne's Infirmary
- 2- clients who had recently stayed at the Infirmary up to six months from the date of interview
- 3- clients who had stayed at the Infirmary from six months and up to one year from the date of interview (one client)
- 4- clients who had stayed at the Infirmary at least one year ago and beyond from the date of the interview (five clients)

Appendix B: Interview Guides

Interview Questions for Infirmity Clients

1. BACKGROUND INFORMATION

- a) What would you like to be called?
- b) How old are you?
- c) Are you from Toronto? If not: Where were you born/raised? (place, rural/urban, etc.) How long ago did you come to Toronto (Canada)?
- d) Are you of Aboriginal ancestry?

2. ILLNESS HISTORY

- a) What would you say are your major health issues?
- b) What was the main health condition that caused you to come to Sherbourne (prompt - diabetes, HIV/AIDS, heart problems)?
- c) How long have you been dealing with these health issues? Tell me more about that...
- d) Were there factors in your life that led to your health situation and if so what were they?
- e) Have you experienced any problems getting health care for your problems? How so?
- f) Is/was there anything or anyone that helped you to cope with your situation?
- g) Do you have friends, family members, or people that live near you that help you with your life? Do they help you with your health condition(s)? How does that work?
- h) (If Aboriginal ancestry/new Canadian) Do you think that it is harder for Aboriginals/immigrants to manage their health?
- i) *<if applicable>* Can you talk about why this might be? What are the challenges for this group of people?
- j) (If Aboriginal ancestry/new Canadian) Are there any reasons why managing a chronic health condition would be easier if someone is an Aboriginal/new Canadian?

3. HOUSING AND INCOME SITUATION/HISTORY

- a) How would you currently define yourself: homeless, under-housed *<define>*, or adequately housed? Where do you live, and with whom?
- b) Are you able to describe your history of homelessness/being under-housed? What caused this situation for you?
- c) Where do you currently get your income/money to live? Is it enough money to live off of?
- d) Did your housing/income situation affect the way you managed your health condition(s)? How so?
- e) Have you ever used shelters or hostels? What were the benefits/problems with these around managing your health issues?

- f) How does the lack of housing and using shelters affect someone with a health condition?

4. EXPERIENCE(S) AT SHERBOURNE INFIRMARY

- a) What health services had you used before coming to Sherbourne's Infirmary?
- b) When was your most recent stay at Sherbourne's Infirmary? How long was your stay?
- c) Was this your first time at the Infirmary? If not: Tell me about the previous times.
- d) How did you find out about Sherbourne's Infirmary?
- e) What was the primary reason that you went there?
- f) What did you appreciate most about your stay at the Infirmary? How did it help you to deal with your illness?
- g) What did you dislike about the Infirmary?
- h) Do you feel that Sherbourne's Infirmary could be improved, and if so, how? What help do you think you needed at that time that you didn't get, or that they couldn't provide for you? What other kinds of services/help did you need to deal with your health, housing, money, or personal problems?
- i) Did you/do you plan to maintain contact with the Infirmary staff after your stay was/is over?
- j) If you weren't able to stay in the infirmary, how do you think you would have managed with your health problem? Where would you have stayed and got help?
- k) Is there anything that you would want the staff in the Infirmary to know about your experiences there or since leaving the infirmary?

5. EXPERIENCE(S) POST-SHERBOURNE INFIRMARY

- a) What happened after you left the Infirmary?
- b) Did your stay at the Infirmary influence how you were able to manage your health after you were discharged?
- c) Can you describe how it influenced you managing your health?
- d) Would you say your health was better, the same, or worse after your stay at the Infirmary?
- e) What has made the difference for you?

6. REFLECTION QUESTIONS

- a) Do you have any worries about how you will be able to manage your health condition in the future? What are you feeling positive about?
- b) Is there anything that you would want health/academic professionals or the general public to know about individuals who are dealing with a health problem and housing or income problems at the same time?
- c) How do you feel about the help that is currently available to people within Toronto who are experiencing periods of homelessness or low income?
- d) Is there anything we haven't talked about, that you think I need to know to understand the challenges you have faced?
- e) Is there anything else you think I should know about Sherbourne, or that you think they should be told?
- f) Do you have any questions for me?

Interview Questions for Infirmarary Staff Members

1. PERSONAL/PROFESSIONAL INFORMATION

- e) What is your name?
- f) What is your current job title here? Have you always held this title here or have you worked other roles within the Infirmarary/Sherbourne Health Centre?
- g) How long have you been working at Sherbourne's Infirmarary?
- h) How did you initially come to work at Sherbourne (e.g. job posting, recommendation, referral)?
- i) What health services, if any, had you worked for before coming to work at Sherbourne's Infirmarary?
- j) Do you hold any professional degrees related to your position here?
- k) What type of experience did you have with this type of work/clientele before coming here?
- l) What would you say is the most stressful aspect(s) to your job?
- m) What would you say is most rewarding about your job?

2. THE INFIRMARY

- a) Would you say that the majority of client's health is better, the same, or worse after their stay at the Infirmarary?
- b) What do you think makes Sherbourne's Infirmarary a unique health resource within Toronto?
- c) What is the maximum length of time a client can stay at the Infirmarary?
- d) Do you think this is enough time for the majority of clients to have a successful recuperation from their medical crisis? Have there been exceptions to this time limit? If so, please elaborate.
- e) Do you think a longer stay limit would benefit clients? If so, how?
- f) What do you think would happen to former/current clients if the Infirmarary did not exist? Without using names, are you able to give any examples of client success stories related to Infirmarary services?
- g) Are you aware of the ways in which Sherbourne (and the Infirmarary specifically) gets it's name out to the public or health facilities (i.e. advertising within hospitals, education about this centre to health or housing workers)? Is this sufficient or do you think these routes be improved? If so, do you have any suggestions as to how?
- h) Are there many clients that maintain regular contact with the Infirmarary?
- i) Are clients encouraged to maintain contact with the Infirmarary staff after they leave? (if yes:) Do you feel this benefits their health or well-being? Do you personally maintain contact with any former clients?
- j) What are the greatest challenges you face as an organization in providing the care and services you aim to provide?
- k) Do you feel that the Infirmarary could improve its services in any way? If so, how?
- l) Do you feel that the Infirmarary is adequately staffed? Do you feel that more staff would benefit clients or staff?

- m) Do you feel that the Infirmary is adequately funded? In your opinion, how would additional funding improve the delivery of service to Infirmary patients?
- n) How knowledgeable are you about the other services that Sherbourne offers (e.g. S.O.Y. program)? Do you ever refer clients to these services? (if yes:) Do you know if they had much success with using them? How well do you think these services compliment the services the Infirmary services? How helpful is it to have these other services in the same building as the Infirmary?
- o) How would you describe the Infirmary as a work environment? Is there much cohesion between staff members?
- p) What kinds of professionals (e.g. medical, social work, counselling, chiropractic) are available to clients when they are staying here?
- q) What other staff members work on the Infirmary unit?
- r) Do you think that any other *types* of staff are needed or would enhance client success? (if yes:) Can you elaborate?
- s) What kinds of referrals/supports are given to clients when they leave the Infirmary? How does that work? In your opinion, how well do these serve the clients?
- t) How are issues such as addiction and drug use handled by the Infirmary staff?
- u) Are you aware of any other centres in the GTA that offer this type of infirmary care to homeless/under-housed/income compromised individuals? Do you think there is the need for more of this type of infirmary care within the GTA?
- v) Many homeless/under-housed individuals deal with health emergencies/ recovery in shelters or hostels. Drawing on your experience working here, can you list some ways in which these environments impact someone who is in this position?
- w) In your opinion, what are the biggest strengths of the Infirmary?
- x) What do you hope to see in Sherbourne's/the Infirmary's future? Do you have any concerns? What are you feeling positive about?

3. BROADER ISSUES

- g) In your experience, what factors tend to influence a client being successful (with managing their health, and securing housing and income) after leaving the Infirmary?
- h) In your opinion, do specific issues exist for individuals who are Aboriginal/an immigrant to Canada when they are managing an ongoing medical issue?
- i) How do you feel about the help that is currently available to people within Toronto who are experiencing periods of homelessness or low income?
- j) In your opinion, is the public health system adequately equipped/structured to deal with the homeless or low-income population? Do you recommend any changes?
- k) In your opinion, is the public housing system meeting the needs of individuals who wish to be housed and are dealing with a chronic medical condition or disability? Do you believe it is particularly difficult to get these types of clients housed? If so, please explain.
- l) Drawing on your experience working here, is there anything that you would want health/academic professionals or the general public to know about individuals

who are dealing with a health problem and housing/income problems at the same time?

- m) Is there anything that I haven't asked you that you think I should have asked, or that I should know, or other comments you'd like to make?