SOMEONE TO TALK TO: CARE AND CONTROL OF THE

HOMELESS

by

Thomas Allen

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APPROVAL

Name: Thomas Allen

Degree: Master of Arts

Title of Thesis: Someone to Talk To: Care and Control of the Homeless.

Examining Committee:

Chair: Mark Carter, LL.M.

_____

Robert Menzies, Ph.D.
Senior Supervisor

_____

John Lowman, Ph.D.
Member

_____

Simon Davis, Ph.D.
External Examiner
Coordinator
Inter-Ministerial Program
Greater Vancouver Mental Health Services

Date Approved: 5 December 1997

ABSTRACT

The focus of this thesis is first, how and why specific individuals use the services of a downtown shelter and second, how the practices of care and control compete for space in the placement and management of particular persons. The life experiences of homeless and near-homeless people are framed within the context of a political/economic structure of which the facility is only one small part.

Semi-structured questionnaires were administered and open-ended interview sessions were conducted with 26 residents and visitors of Triage Emergency Services and Care Society, an emergency room, board and drop-in shelter in downtown Vancouver for homeless and near-homeless persons. Using a constant comparative method, emphasizing process and content, common and contrasting themes were developed from interview materials and were connected to participant observation data and the extant literature.

From the interviews emerged lives of poverty, isolation, desperation, homelessness, and marginalization. The participants related how they survived on the streets, in run-down hotels, and in violent or threatening situations, and how conceptions of home and safety organized their coping strategies and their seeking of shelter. It is found that the need for social support, acceptance, and identity of the participants was defined and constrained by scarce resources and was inextricably linked to the demands for control.

Homelessness and the vulnerability to homelessness are shown to be the products of a complex interaction of events and circumstances which can be alleviated by

providing safe and affordable housing, not just in the urban core but throughout all our communities and neighbourhoods. Supportive services that empower and advocate are needed. The homeless and near-homeless must be included in the decision-making process. As the downtown shelter becomes a form of quasi-permanent housing, in which empty beds are a scarce commodity, the concept of housing as a basic right needs to be adopted.

DEDICATION

for

Connie and Audrey

IN MEMORIAM

Troy Bashell, Dean Brown, Tam Chau, Michael Dan, Randy French, Ernie Hannah, Robert Halldorson, Myles Ingram, Monica Lillmeier, Allan Maybe, Tim McBride, Robin McLay, Steve McNeil, Barb Mills, Sean Montgomery, Phil Olaksew, Chico Pastushak, Dayle Paterson, Maureen Riding At The Door, Eric Rockley, Tony Scholfield, Natasha Spearchief, Bearnadine Standing Ready, Paul Thome, Keith Thompson, Clifford Virtue, Richard Wall, Walter West, Michael Whiteloon, Tony Widen, Tony Wilkinson, Bev Wilson.

Now others are coming. Of fewer words. Who have long been forced to eat their own misery and swallow it as bitter dregs.

They have nothing to lose. They *know* how much arrogance and humiliation are contained in the extravagant welfare attitude of the authorities. So now they mean business.

They come from juvenile correctional institutions and prisons, from youth hostels and hostels for vagrants, from condemned houses and slums, from mental hospitals, old people's homes, and institutions for alcoholics, from establishments for handicapped people and for the psychologically damaged, from depopulated areas and Lapp towns, from ghettos for gipsies (sic) and immigrants...

At Kungsgatan in Stockholm they form an enormous parade, which not even the total police force of the city can withstand. The wild horde of psychopaths and habitual criminals (affective, rootless, irresponsible, deceitful, enemies of society) make their way in the first row with bayonets, crowbars, and sawn-off guns. Behind them the deformed and disfigured bang their way ahead in wheel chairs and with crutches. Their weapon is obscene self-abandonment, slanting bodies and blind faces are offered without reserve to the swords and clubs of the police— a lump of plasma made of silent suffering, which after each blow of a club immediately returns to its terrible shape. And when the handicapped are threatened with being massacred by police on horseback, a staggering crowd of vagrants launch an attack with injection needles and old beer bottles. The street whores pull out large knives and prepare to come out of the whole affair with a cock as a souvenir. The gipsies sneak around stealing horses from under the police officers. The mental patients, the unaccountable, those not responsible for their acts, scuttle back and forth and confuse law and order, spitting, scratching, tearing, biting. And the Lapps? Well, they force their last herd of reindeer into an enormous traffic jam at Stureplan...

This is the way it will look when the 'minorities' take power.

When the myth of Social Solidarity finally breaks down and lets in a dawning speck of light in the land.

In row after row they march up to Hötorget with their black banners and posters.
In the first row: EXISTENCE and IDENTITY.
In the second row: EQUALITY and SOLIDARITY.
In the third row: FREEDOM.

Excerpt from Jörgen Eriksson's book <u>Revolt i huvet</u> (Revolt in the Head), Bonniers Publishers, 1970. Cited in Mathiesen, T. (1974:123). <u>The politics of abolition</u>. London: Martin Robertson.

ACKNOWLEDGMENTS

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"The further you dig your way into the system and the more payments you have to make, what are you gonna do if that all falls apart?" (Mark)

"Hope's all these things you grab on to." (Simon)[1]

INTRODUCTION

From "the passage of the English poor law reform in the 1830's, which eliminated 'outdoor relief' in favor of the workhouse" (Piven & Cloward, 1996:76) to contemporary practices of erecting more shelters in the cities, the historical development of poor relief in the Western democracies is one of cost containment and categorical distinction of problem populations (Culhane, 1992; Gounis, 1992; Piven & Cloward, 1993). In Canada, specifically, social cutbacks and retrenchments have resulted in practices that seek to separate the deserving from the undeserving poor in a bureaucratic emphasis on eligibility requirements and individual inadequacies. Affordable housing has steadily dwindled as private business seeks expanding profits. Emergency shelters are increasingly "being used as quasi-permanent residences because the range of perceived solutions is quite narrow and it appears that there are few other choices" (Daly, 1996:162).

In the urban milieu of most large Western cities a nucleus of service institutions shares a territorial base for entire populations of discredited persons and outcasts (Goffman, 1963). Services and agencies proliferate "in a spatially limited zone where individual support is made possible through proximity" (Dear & Wolch, 1987:21). In a

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[1] Simon and Mark are participants in the interview research that comprises this thesis. In order to ensure confidentiality their names are pseudonyms.

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process of "reification of clienteles" (Friedenberg, 1975:1) a cadre of personnel and resources serves the needs of homeless and near-homeless persons who inhabit these areas.

The Downtown Eastside of Vancouver is over-represented by persons who suffer a variety of physical and emotional impairments, poverty, isolation, and neglect. The prevalence of violence, victimization, and denied opportunities, and tragic, sad and abused existences far exceeds the prevalence of these same conditions in the surrounding communities. The concentration of injection drug users in the area has contributed to the highest HIV infection rate among any population in North America and probably the western hemisphere (Culbert, 1997; "The Killing Fields Campaign" Committee for Compassion and Social Justice, 1997).

Service-dependent populations have gravitated to the Downtown Eastside because rents are cheap, services are relatively plentiful, other service-dependent persons hang out, and coping is made easier, or at least possible. In efforts to meet the increasing demands an industry of poverty has proliferated, where service providers expand and set the rules. The professional care-givers, in concert with the community and the clients, have defined the geography of the inner city. This is not necessarily a bad thing because the homeless and near homeless who gravitate to the downtown services are in dire need of support and care. However, it has resulted in a ghetto of poverty and despair, in which many persons' lives have become entwined.

The purpose of this thesis is to explore the phenomenon of homelessness in order to understand the dialectical relationship that prevails between systems of care and control. In a rational, bureaucratic state the designs of care for those who need a helping

hand often compete with the control and containment of problem populations. Service ideals for the poor and homeless often give way to the management of disciplinary space and to practices of convenience when everyday demands are many and the resources to meet these demands are limited (Aulette & Albert, 1987; Belcher, 1988; Blasi, 1994; Christie, 1994; Cohen, 1985; Daly, 1996; Foucault, 1980; Hopper, 1990; Ingleby, 1983; Reitsma-Street, 1989; Stark, 1994; Swift, 1993).

Competing perspectives of homelessness are arranged on a continuum—at one end is the concept of absolute homelessness, namely, that the homeless are those without shelter, staying outside, in abandoned houses or cars. At the other end is the idea of relative homelessness, which includes not just those who are absolutely homeless, but also those at risk, or those vulnerable to homelessness (Daly, 1996). This latter concept, which informs the research depicted in this thesis, allows a consideration of those living in unsafe, dangerous, or precarious situations, in which the threat of homelessness is always present.

Chapter One of this thesis offers a broad historical overview of the development of social welfare in the Western democracies, in Canada, and in British Columbia, in which the present day social welfare system still relies on the early poor law practice of separating the deserving from the undeserving poor. A critical approach is maintained as divergent explanations for the growing numbers of homeless persons are explored. Policies and practices are shown to be results of the individualization of social problems as theories of personalized inadequacy further the interests of cost efficiency and containment. As the building of more shelters becomes an institutionalized response to

dealing with the growing numbers of homeless persons, the gap between those who have and those who have not widens.

Chapter Two details the research method used for data collection and analysis and gives a brief history of the research site, Triage Emergency Services and Care Society. The Downtown Eastside in which most of the homeless and near-homeless of Vancouver are situated is located in geographical space and relevant demographics and characteristics of the area are summarized. This research gives voice to some of those toward, and against whom, the activities of social assistance and state regulation are directed; it advances "knowledge through a process of exploration grounded in the experience of people who have been treated as the objects of research" (Kirby & McKenna, 1989:61). It authenticates, expresses, validates, locates, and organizes the interests and needs of the homeless and those at risk of being homeless. In essence, this thesis is "about people in interaction with each other and finding out about how they understand their reality" (Kirby & McKenna, 1989:97).

In Chapter Three the homeless and near-homeless are given a voice through an exploration of the experiences, thoughts, and observations of 26 persons who used the services of the Triage shelter. Their words are given verbatim, with no correction for grammar or syntax, and are intertwined with my own observations and experiences as a worker in the facility. Previous research and relevant literature are incorporated into analysis of the data.

The participants' responses reveal lives of transitory and abusive relationships, extensive institutionalism, emotional and material deprivation, and recurrent instability, in a game where the field is level but only those who are members of the team can get on

to play. Marginalized and living in precarious circumstances, the participants recount how competing for a safe place to stay organizes their everyday activities. In the absence of family on whom they can depend, shelter and agency workers provide alternative mechanisms of support. Drugs and suicide are a way out.

Chapter Four reflects on these findings and offers some policy recommendations as to what can be done about the "homeless problem." Foremost is the need for a substantial enhancement of the availability of safe and affordable housing and non-judgemental services for those on the streets and in the rooms.

CHAPTER ONE: HOMELESSNESS AND THE WELFARE STATE

The Welfare State in historical perspective

In France in 1757, a royal edict established the "Hopital General" whose purpose was not medical, but confinement of "a population without resources, without social moorings, a class rejected or rendered mobile by new economic developments" (Foucault, 1965:48). In 18th century Europe idleness was seen as the root of all evil, the source of all disorder, and poorhouses proliferated. All those people who were not working had to serve as examples to others who might take the "least eligible" alternative. The practice of charity emphasized the concept of less eligibility—that state assistance should be a choice of last resort for those who are deemed to have chosen an alternative lifestyle to that expected in a capitalist society emphasizing the norms of productivity and individual self-reliance (Armitage, 1975; Barak, 1992; Blau, 1992; Garland, 1985; Hopper, 1990). Since the 18th century the roles of the participants have not changed much except that now we organize complex practices in the ordering of state assistance (Culhane, 1996; Piven & Cloward, 1987). Occupational welfare, fiscal welfare and government mortgage provisions are reserved for the middle and upper classes. Guaranteed income and social insurance programs are for the deserving poor. Emergency shelters and enforced dependencies are for the undeserving poor.

As early as 1793, in France the Declaration of the Rights of Man stipulated that "public assistance is a sacred debt. Societies owe subsistence to unfortunate citizens either by finding them work or by assuring them the means to exist without work" (Ashford, 1986:47). However, in the Western democracies, up to the 19th century the

care and control of problem or dependent populations were primarily the responsibility of the private family and the local community. Not until the development of urbanization and centralized systems of control did the responsibility shift to the state (Armitage, 1975; Ashford, 1986; Donzelot, 1979; Hopper, 1990). The treatment of the poor as deserving or undeserving defined the responses to the surplus labour of industrial capitalism, fueled by ideologies of laissez-faire economics and possessive individualism.

Traditionally, social welfare is about assisting those persons who are unable to keep up. In this culture, the very young, the very old and the mentally or physically disabled are all deemed deserving of state support. Social welfare, however, is also about regulating people regarded as deficient, with the control of the poor being like the judicial ordering of the criminal (Garland, 1985). An exploration of the critical and revisionist literature that pertains to the development of Western institutions of social control, such as the workhouses, the asylums, the prisons, and the organization of poor relief of the 18th and 19th centuries, shows how these early practices of regulation connect to contemporary forms of social welfare and service delivery (Armitage, 1975; Culhane, 1996; Hopper, 1990; Sim, Scraton, & Gordon, 1987).

Starting in the 20th century most western democracies were moving toward the centralized welfare state and responses were organized around an ideology that characterized the poor as deserving. The "old values of private charity and individual self-reliance were no longer adequate policy guidelines" (Ashford, 1986:187) for those who advocated national welfare to deal with the social and economic inequalities of the 19th century. Though a primary concern was with social justice and equality, welfare practice emerged out of the combined policies of liberal and conservative political forces

rather than from social/economic imperatives, at a time when apparent political equality

obscured social/economic inequality (Ashford, 1986; Drover & Moscovitch, 1981). The

emergent liberal state placed equality of opportunity over equality of condition as the

right to pursue economic gain competed with the right to food, shelter, and political

security (Friedenberg, 1975). The individualized rights of the modern liberal state

allowed those with property to accumulate more and more while helping to keep the

really poor poor.

In the contemporary welfare state right-wing policy makers are calling for

retrenchment and curtailments of service for all but the most severely disabled people.

The core assumptions of the welfare state are being rejected and its historical supports are

being dismantled (Armitage, 1975; Blau, 1992; Block, Cloward, Ehrenreich, & Piven

1987; Lang, 1989; Piven & Cloward, 1993; Rekert, 1993; Tiernan, 1992; Wolch & Dear

1993). Proponents of laissez-faire economics tell us that the practices of the welfare state

have entrenched the increasing dependencies of the economically and socially inadequate

(Szasz, 1994). The advocates of deficit and social-spending cuts say that the well of state

largesse has run dry as the business community maintains that its interests are the

national interest (Barak, 1992; Epp 1989; McQuaig, 1995).

The conservative agendas call for a move backward to simpler times of law and

order, authority, and charity and "the sanctity of private property at the expense of human

beings" (Barak, 1991:66) is legitimated. It is an old argument—that the market will self-

regulate and in thin times we just have to tighten up (Drover & Moscovitch, 1981).

In this climate of fiscal restraint, economic retrenchment, and social cutbacks,

these forebears of "the mean season" locate the causes of homelessness and poverty

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within a diverse chronicle of individual defects, lack of incentive and motivation, illicit

drug use, dysfunctional families, and inadequacies in civil commitment laws for the

mentally ill (Blau, 1992; Block et al. 1987; Isaac & Armat, 1990). However, proponents

of "belt tightening" and increased control neglect issues of social justice for those who

are denied equal access to the legitimate mechanisms of ownership, just as they pay scant

heed to the practices that further private acquisitiveness and greed. Calls for

retrenchment and social cuts make sense only to those who stand to profit from the

shrinking pie.

The development of welfare in Canada

In 19th century Canada, provision for the poor and needy was mainly a local

affair, with reliance placed on the individual, the family, and private philanthropy (Dear

& Wolch, 1987; Guest, 1985). In the early 20th century widening state involvement was

mainly regulatory in nature as populations in need of services and control moved from

rural to urban areas. Much of the provincial expenditure was for "institutions destined

largely for people outside the work force, people who, in the broadest sense, were

marginal to early Canadian society" (Mosçovitch & Drover, 1987:20). In the early

1900's relief camps were set up for single employable men and services were kept low

(Armitage, 1975). Women's groups provided residential homes for poor women but

avoided political issues of low pay and inequality, instead organizing around "religious

motivation, awareness of secular problems in society, and desire for a stable social order"

(Mitchinson, 1987:89).

In Canada the welfare state originated in the early 20th century, but it was not until the 1930's that the Canadian state began to take direct responsibility for the provision of services. One of the first programs of state assistance was the Mother's Allowance legislated in Manitoba in 1919. Other categories of eligibility and entitlements followed such as the elderly, the infirm, the mentally ill, and the unemployed (Moscovitch & Drover, 1987). Canadian welfare state practice aimed at separating the deserving from the undeserving poor and emphasized remedial over preventative measures. The concept of "least eligibility" permeated social welfare practice in Canada in that an existence on welfare must be inherently less attractive than that experienced by the lowest paid worker. That is, services were kept low in order to encourage problem populations to conform to the capitalist ideal of work and productivity (Armitage, 1975).

It was not until the 1960's that welfare services in Canada attained the level of development experienced in European countries. In Canada, "during the 25 years following World War II, the role of the state shifted from that of minimal regulation (in the forties) to that of investor-builder (in the fifties) to that of provider of services (in the sixties)" (Dear & Wolch, 1987:90)

In the late 20th century Canada has moved toward a retrenchment of social services for the poor and unemployed. There are demands for fiscal restraint and cutbacks, and that moneys for social programs be used more profitably in the private sector (Dear & Wolch, 1987). Expenditures for social housing and related services have decreased; prison construction has escalated. Federal transfer payments to the individual provinces have been slashed, local governments have been saddled with the burden of providing relief for the poor and needy, and food banks and soup lines have become

alternatives to social security in the privatization of social services (Guest, 1995; Swift, 1993).

The development of welfare in British Columbia

In British Columbia in the early 1900's private health and welfare agencies proliferated, including the development of "missions and hostels for homeless men, homes for the aged and infirm, orphanages, relief societies, YMCA's and YWCA's" (Irving, 1987:161). By the 1920's the state had begun to provide some support for the needy in the form of mother's allowances, poor relief, unemployment programs, and old age pensions. Pressured by the state's need to preserve capitalism and mediate between various class demands, worker and unemployed agitation, women's groups, the CCF, and politicians and civil servants, in the first half of the 20th century British Columbia was developing into a provincial welfare state (Irving, 1987). Nonetheless, the state-supported services were highly restrictive as to eligibility and were organized around categories of class, race, and gender (Daly, 1996). In the 1920's a mother with dependent children could get a mother's allowance but only if she could supply letters of reference as to her moral and upright character, be of three years residency in the province, a British subject, of non-native Indian status, and fit within the guidelines of a means test. Able-bodied jobless men were placed in relief camps, transients from other provinces were denied outdoor relief, and "unemployed single women in Vancouver tacitly were expected by male aldermen to support themselves by prostitution" (Irving, 1987:158). In

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The Cooperative Commonwealth Federation was the forerunner of the New Democratic Party.

the 1930's, "the goal of reforming relief was not to abolish the poor law doctrine of 'less eligibility', but to make it work more effectively" (Struthers, 1987:121).

Sixty years later the situation is similar to that in the 1930's when British Columbian provincial and municipal welfare authorities, faced with dwindling resources and increasing demand, slashed services in an effort to separate the deserving from the undeserving, the needy from the not-so-needy in a "bureaucratic emphasis upon 'classification, determination of eligibility, and routine surveillance'" (Struthers, 1987:112). In 1996 British Columbia cut individual welfare payments and denied service for those without a three month provincial residency.[3] Those persons with specific arrest warrants or who had been convicted of welfare fraud were also denied assistance. In turn growing numbers of service-dependent persons, victims of convenience, cost-effectiveness, budgetary restraints, political maneuvers, and micro-systems of power, migrated to the inner city's "zone of dependence" (Dear & Wolch, 1987:21).

The "new" homeless

In North America estimates of the numbers of homeless persons differ widely according to the method of counting used and the definition employed (Breakey & Fischer, 1990; Daly, 1996; Jencks, 1994; Lang, 1989). This is not surprising, given that homeless persons are often difficult to locate, the condition of homelessness tends to be episodic, and homelessness is an ideologically saturated concept with powerful political connotations.

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[3] On April 1, 1997 the British Columbia three month residency requirement was repealed, primarily through the efforts of anti-poverty and public interest groups.

Counting the homeless is an impossible task (Bassuk & Lauriat, 1986; Blasi,

1994). A narrow definition of homelessness counts only those who are absolutely

homeless while a broad definition includes those who are at risk of being homeless and

who "lack adequate shelter in which they are entitled to live safely" (Daly, 1996). In the

United States estimates of the number of homeless persons vary from 250,000 to several

million (Barak, 1991; Blau, 1992; Grigsby, Baumann, Gregorich, & Roberts-Gray 1990;

Jencks, 1994; Rochefort & Cobb, 1992; Rossi, 1989; Snow & Bradford, 1994; Stone,

1993). In Canada estimates range from 130,000 to 260,000 (Daly, 1996). Although the

reported numbers of homeless persons fluctuate with the research design, it is undeniable

that homelessness is growing (Acorn, 1993; Baxter, 1991). As Rossi (1989) declares

regarding the United States: "Although the numbers issue has been quite contentious, in a

very real sense it does not matter much which estimate is closest to the truth. By any

standard, all estimates point to a national disgrace" (p. 18).

Rossi (1989) distinguishes the "new" homeless from the "old" homeless of

primarily older male, working-class individuals who resided in areas close to transient

labour opportunities such as the docks and the railroads. Most of these old homeless

were invisible, inhabiting skid row areas reserved for the underclass of industrial

capitalism. In the 1980's, however, "with changes in divorce laws, relaxation of society's

attitudes toward independent women, along with education about spouse abuse" (Daly,

1996:160), as well as "erosion of benefits and tightening of eligibility requirements"

(Shinn & Gillespie, 1994:516), new kinds of homeless people began to appear; they were

younger and had a higher proportion of women, children, and families. They were more

visible, lining up at food banks and social service agencies. The new homeless or the

"new poor" are no longer rejects of an industrial order but those displaced out of a post-industrial society where the gap between rich and poor, the have's and have-not's, is widening (Barak, 1991; Blasi, 1994; Blau, 1992; Lang, 1989; Stone, 1993; Tiernan, 1992). The only thing that is common among the homeless today is their poverty and their lack of a safe and secure place to stay:

> Homelessness affects a heterogeneous assortment of people. Among these are: low-income single mothers, battered women with children who have fled their homes, workers displaced by economic change, runaway youths and abused youngsters, elderly people on fixed incomes, those who suffer physical and mental health disabilities, substance abusers, people who are transient as a result of seasonal work, domestic strife, or personal crises, recent immigrants, refugees, and Natives (i.e. aboriginal people) who have migrated to the city in order to find work and to escape problems, ex-prisoners and those recently discharged from detention or detoxification centers or mental hospitals (Daly, 1996:20).

Barak & Bohm (1989) characterize the new poor as "those working people who no longer earn enough money to cover the soaring costs of housing, yet earn too much to be eligible for federal aid or state assistance" (p. 281). For those on the lowest rung of the socio-economic index the situation is even more grim. As the working poor struggle to make ends meet and take up the dwindling supply of social, low cost, or affordable housing, the non-productive are marginalized and neglected. In Canada the situation is comparable to that of the United States though there are some important differences, such as that Canada has a national health care plan, whereas the United States has a federal legislated policy on homelessness (Armitage, 1975; Daly, 1996; Ross & Shillington, 1989; Swift, 1993; Todd, 1993).

Conceptions of homelessness compete with other social issues and shift with public interest and political agendas. It can be argued that homelessness is not new but is an old problem now more on the public agenda; that is, homelessness is now politically

and publicly defined where before the 1980's it was submerged and ignored (Rochefort & Cobb, 1992).

Explanations of homelessness

The causes of homelessness in the late 20th century are in part ideological and can be located within the policies and priorities of the post-industrial capitalist state. Specifically, as the North American economy moves from an industrial to a service economy, wages shrink in proportion with the cost of material items, affordable housing gives way to private profit, and social benefits dry up (Blau, 1992).

The causes of homelessness are a complex interaction of events and circumstances such as globalization, lack of affordable housing, poverty, deinstitutionalization, cutbacks in social programs, and structured inequality (Armitage, 1975; Baker, 1994; Barak, 1991; Baxter, 1989; Blasi, 1994; Daly, 1996; Tiernan, 1992). Such government policies that offer tax breaks to wealthy developers of usable rental housing properties stimulate gentrification[4] of the community and decrease the stock of affordable housing for those of low income (Barak, 1992; Baxter, 1989). Public policy on homelessness reflects cultural conceptions of the individual, community, society, and state. In the United States Rossi (1989) holds that "public policy decisions have in large measure created the problem of homelessness. They can solve the problem as well" (p. 63).

In Canada the liberal state is founded on the assumption that a plurality of competing interests will balance each other out and result in a relatively just social policy

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[4] Gentrification is the process whereby cheap hotels and rooming houses are demolished to be replaced by office buildings, luxury condominiums, and apartments.

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for all (Knuttila, 1992). What the liberal ideal fails to consider is that those groups with access to property and business enterprise will gain dominance and influence legal and social policy that favours their interests. That is, in a capitalist society the demands of the market dominate the activities of government: "The mere possibility that business and property dominate polyarchy opens up the paradoxical possibility that polyarchy is tied to the market system not because it is democratic but because it is not" (Lindblom, cited in Knutilla, 1992:78). Although a solution for the homeless poor would be to find affordable housing, the waiting lists for low cost, subsidized, or social housing are usually three to five years (Baxter, 1989; Lang, 1989). Canada "is one of the harshest places in the industrialized West for those in poverty. Some Scandinavian nations give more than twice as much aid per capita to the developing world as Canada does, while at the same time committing more resources to social welfare at home" (Todd, 1993).

In Canada and the United States the prevailing explanations for and social policy towards the homeless are arranged around the contrasting ideologies of conservatism and liberalism (Barak, 1992; Stern, 1984). Conservative ideology discerns the homeless as victimizers, as the underclass, as the undeserving poor, and advocates a socioeconomic system emphasizing free choice and individual responsibility with minimal state intervention. Liberal ideology locates the homeless among the deserving poor. The causes of homelessness are located in society and precipitating events such as family breakdown or lack of education or training that would enable a person in poverty to get an adequate job. Social policy is organized around the creation or improvement of social programs to alleviate homelessness (Armitage, 1975; Barak, 1991; Blasi, 1994). Liberal

practice, however, ultimately holds the individual responsible for his/her condition by

attributing,

> defect and inadequacy to the malignant nature of poverty, injustice, slum life and
> racial difficulties. The stigma that marks the victim and accounts for his (sic)
> victimization is an acquired stigma, a stigma of social rather than genetic, origin.
> But the stigma, the defect, the fatal difference—though derived in the past from
> environmental forces—is still located *within* the victim, inside his skin (Ryan, as
> cited in Gans, 1996:87).

In a critical perspective homelessness is situated within the overall political

economy of capitalist relations as geared towards the accumulation of private profit. This

political-economic analysis challenges simplistic and reductionist accounts and explains

homelessness and poverty as a cost of making profit. That is, homelessness is a direct

result of a capitalist practice that places profit and accumulation over the care of human

souls. The relegation of non-productive human beings to scrapheaps is a cost of doing

production—the state handles the cost and business activity is legitimated (Belcher &

Singer, 1988).

The capitalist state is expected to legitimate the private accumulation of profit.

This legitimization process of mystification, of obscuring and explaining away the private

accumulation of capital, allows business profits to remain private while the costs of

creating that profit are shared publicly. That is, state expenditures are social but capital

accumulation is private. Because the profits of private accumulation are not socialized,

the state has been left in a fiscal crisis (O'Connor, 1973). In efforts to manage this fiscal

crisis, social welfare and expenditures to aid the poor are cut back. The fiscal crisis of the

state has resulted in increasing poverty and homelessness, as a "crisis in profitability"

(Moscovitch & Drover, 1987:40) produces corporate demands to reduce social spending and expenditures.

Capital wealth is created out of investment. In the 1980's there was a general decline in available housing that rents for less than 40% of one's gross income (Daly, 1996; Rossi, 1989). If one pays a large proportion of one's income on housing there will be nothing remaining to invest and create more capital. The income left over from paying for basic housing is required for food, utilities, tax, education, clothing and medical services. This means that more than one wage earner is usually required for a household of two or more in order to avoid the social costs of not having enough income in a market driven economy. Of course, paying over 40% of one's income on housing should be compared to the customary mortgage rate allowing payments of no more than 25% to 30% of gross income.

Many household units of low income cut into funds for non-shelter necessities in order to pay for their housing, what Stone (1993) refers to as "shelter poverty ... [which] challenges the conventional standard that says every household can afford up to a certain fixed percentage of income for housing. It offers instead a sliding scale of affordability that takes into account differences in household composition and income" (p. 32). Using the shelter poor concept we find that, in addition to those who live on the street or in cheap rooms, many persons live on the edge of homelessness. Countless thousands pay too much relative to income for housing, and non-shelter necessities such as food and clothing are placed secondary to shelter.

In both Canada and the United States the disposable income of the working class is shrinking while that of the rich is increasing (Daly, 1996; Dattalo, 1991; Stone, 1993;

Swift, 1993). For those of low income, more and more of their finite resources are laid out to secure and maintain basic housing. In fact, many persons are paying over 50% of their income for housing. Many recipients of social assistance spend more than their shelter allowance on rent, and are obliged to subsidize their welfare cheques by cutting into their food allowance or finding alternative sources of income such as prostitution, drug dealing or other cash-paying short-term activities such as day-labour pools. Even though 25% to 30% of the homeless and near-homeless are working, job opportunities are limited to low pay, minimal protection, and zero benefits (Barak, 1992; Daly, 1996; Swift, 1993). Often those relying on welfare go hungry because the food money is spent on housing. Moreover, those with the lowest incomes pay proportionately more taxes— principally, in indirect taxes funneled through rents (passed on through property tax of landowners) and regressive goods and services tax (passed on through corporate profits). Homelessness does not so much reflect a flawed individual as it does a flawed system (Baker, 1994; Barak & Bohm, 1989; Baxter, 1991; Belcher & Singer, 1988; Block et al. 1987; Dear & Wolch, 1987; Gill, 1989; Lang, 1989).

In the United States corporate business supports the inequality by patronizing day-labour pools where workers receive minimum wage, get no benefits, and have no security. The corporations, meanwhile, continue to accumulate huge amounts of wealth, pay little tax compared to this accumulated wealth, and benefit from the non-unionized worker who needs enough money to find a place to stay for the night (Armitage, 1975; Barak, 1992; Guest, 1985). "It is not an exaggeration to think of the new subclass of the homeless, including the suppression of their human potential and the perpetuation of their

human misery, as the product of a society characterized by gross structural inequality and social injustice" (Barak, 1991:48).

In Canada day labour pools, such as Labour Ready, are a recent phenomenon but are beginning to proliferate as it becomes cheaper to hire by the day and avoid union contracts that stipulate worker benefits such as medical plans. Workers at day labour pools cannot accumulate enough money to be able to live in decent housing and so they usually stay in run down hotels, in shelters (if there is room), or on the street.

The construction of social housing is not profitable; what is profitable is the destruction of low rental properties, run down hotels, rooming houses, boarding homes and SRO's (single room occupancies) and their replacement with expensive condominiums and office towers. The working and the welfare poor are excluded from this process because they offer no profit. The working poor, let alone the destitute, can hardly afford to buy a house; the poor get pushed out, while the wealthy can buy two or three houses and enjoy a tax break (Barak, 1992; Baxter, 1991; Daly, 1996; Guest, 1995; Lang, 1989, Stone, 1993).

The Downtown Eastside of Vancouver is in danger of being overcome by market-driven speculators who place private profit over the considerations of the interests of the poor, of those people who lack political voice, the disenfranchised. Indeed, a conflict exists between what business will allow and what business usurps—the business sector vetoes social policy that works against its interests, so that solutions to homelessness far exceed what the business community will even entertain (Blau, 1992).

In 1993 on the Downtown Eastside of Vancouver a large department store situated near rundown hotels and services for the needy closed up shop. Community and social

housing activists saw the vacant structure as a wonderful opportunity for much needed low cost housing and lobbied the municipal and provincial governments for support. A plan was forged that would allow for 200 government funded co-op housing units set among 200 market-priced units and retail space. In 1995 the building was sold to a private interest. The activists continued their lobbying but, in 1997, lost the battle when the new owner announced he was pulling out of the negotiations and was turning the whole project into 400 market-priced condominiums and retail space. No social housing would happen at this location. The gentrification of the area would plow inexorably on. (Bula, 1997).

Against this background of systemic problems and social, political, and economic forces, it is wrongheaded to draw cause and effect relationships between homelessness and individual pathology or precipitating circumstance. Among conservatives homelessness is frequently attributed to mental illness, personality disorder, or alcohol and drug use. However, although it may be that many persons so classified are homeless, many are not. Moreover, many people not categorized as such are also homeless (Blau, 1992; Snow, Baker, Anderson, & Martin, 1986).

Homelessness is caused by unemployment, wages shrinking in proportion to the cost of material items, decreasing social benefits, and the declining availability of shelter in proportion to the increasing numbers of homeless persons (Aulette & Aulette, 1987; Shinn & Gillespie, 1994). In fact, "the causes of homelessness may ultimately have much more to do with social facts that account for the distribution of housing and other resources than with facts about individual homeless people" (Blasi, 1990:207). McChesney (1990) compares homelessness to the game of musical chairs in which "the

more people playing the game, and the fewer the chairs, the more people are left standing when the music stops" (p. 195).

Barak & Bohm (1989) list four causes of homelessness: individual characteristics, family disruption, institutional policies, and market forces. First, individual characteristics such as excessive alcohol or drug use and mental illness are undoubtedly a contributing factor in becoming homeless. However, the poorer an individual is, the more likely individual problems will precipitate homelessness, and it is arguable which is cause and which is effect (Daly, 1996; Snow, Anderson, & Koegel, 1994; Wright, 1990). Alcoholism, drug use, and mental illness are not class specific—homelessness is. There are many alcoholics, drug addicts, and mentally ill who are not homeless. Homelessness has to do with poverty and can "precipitate depression or a psychotic episode, lead to poor health or job loss, induce substance use, or deplete coping resources" (Shinn & Weitzman, 1990:6).

Second, family disruption, violence and lack of support limit the options one has in finding shelter. Biographies of neglect, deprivation, and abuse characterize many of those who get stuck in conditions of homelessness and institutional dependency (Fischer, 1992). However, to locate causal factors in family pathology "is to find pathology in the inability of family relationships to survive the extraordinary stress of living for years under intensely pressured and substandard conditions" (Blasi, 1990:213). Baker (1994) found that the resources one has available and one's orientation towards those resources, that is the "webs of relationships" (p. 499) to which one has access, are the most important factors in understanding who becomes homeless.

Third, institutional policies, such as the deinstitutionalization of "widely diverse populations including the mentally disabled, the retarded, the dependent elderly, ex-offenders and substance abusers" (Dear & Wolch, 1997:16) and the failure to provide adequate community alternatives, have contributed to a shortage of community support and housing. That is, homelessness is "not the result of deinstitutionalization per se but rather the way deinstitutionalization has been implemented" (Lamb, 1984:899).

And finally, market forces relate to "housing affordability ... job shortfalls, and tightening criteria for welfare assistance" (Barak & Bohm, 1989:281). However, in the political economy of the modern welfare state a focus on individual characteristics and family disruption is given priority over institutional policies and market forces. This conception must be challenged.

The psychiatrization of the poor

The increasing number of homeless persons fosters an institutional impetus to classify and segment in the call for a specific service response. This process of classification and separation represents an attempt to address the dilemma of the welfare state "between meeting need on the one hand and disciplining, deterring, and (more recently) cutting back costs" (Lovell, 1992:248) on the other. A focus on psychiatric disorder and its classification and treatment "removes from the universe of discourse (social policy) any indication of the macro-level changes that create and affect the day-to day situation of homeless persons" (Lovell, 1992:256).

It is generally accepted that approximately one-third of the homeless in both Canada and the United States are mentally ill (Daly, 1996; Jencks, 1994; Shinn &

Weitzman, 1990; Wright, 1990), though, in the United States, Snow et al. (1986) claim

only 10% of the homeless are psychiatrically impaired and most of these are for

substance abuse. In Acorn's (1993) study of shelter users in Vancouver, B.C. only 19%

of her sample reported a major diagnosis of schizophrenia, manic-depression, or chronic

depression. Mental disorder engenders a vulnerability to becoming homeless but the root

causes are at the broader societal level (Susser, Struening, & Conover, 1989).

Those on both sides of the political divide have been critical of the medicalization

of the poor, the homeless, and the at-risk of being homeless. On the right, Szasz (1994)

argues for minimal government and a laissez-faire, libertarian, anti-collective capitalism,

and holds that the homeless situation has been blown out of proportion in order to support

the political projects of interests who seek to expand the health and welfare net. On the

left, Armitage (1975) suggests that mental health services "addressed to helping the poor

cope with inequality serve to sustain an unjust social order, an order in which the mental

illnesses of the rich (greed, avarice, and delusions of wisdom) are strangely untreated" (p.

156).

The fact that many homeless persons do show signs of serious mental illness, such

as schizophrenia and manic-depression, cannot be denied and policy discussions should

be so informed. However, symptoms of demoralization, acute distress, and multiple

problems are also prevalent (Struening & Padgett, 1990; Susser et al. 1989). These

symptoms are often attributed solely to internal defect rather than to social conditions

beyond free choice (Gans, 1996).

Mental disorder is inversely related to class, possibly explained through

"downward drift, differential diagnosis, and stress" (Simpkin, 1975:60), all of which are

associated with working class life. In the medicalization of the "truly disadvantaged" culturally sanctioned behaviours are ascribed to individual defect rather than to the structural factors and situations that produce, for instance, high stress and physiological arousal. Those without a safe and secure home may show "behaviours from which psychopathology is inferred [but which] might be better understood as behavioral adaptations to the trying exigencies of street life rather than as symptomatic of psychiatric impairment" (Snow et al. 1986:421). For example, circumstances such as having no job, no home, and constantly moving may result in a diagnosis of anti-social personality disorder rather than being attributed to the trials of homelessness and the stresses of managing to survive in substandard conditions. These diagnostic categories are unwarranted when they neglect the socio-economic context. The experience of homelessness,

> is not confined to physical pain, but also includes the psychosocial pain associated with constant denigration, humiliation, neglect, or social and economic isolation. Other significant consequences include: post-trauma physical illness, supranormal experiences, food and sleep disorders, disorientation, phobias, victimization by particular individuals/systems/states, and recidivism. (Barak, 1990:8)

Psychiatry today is almost totally reliant on drug therapy (McCubbin, 1994). For the poor this fact becomes even more significant in the face of limited alternatives. The poor are often dependent on a drug culture that is supported by companies more interested in creating profits than in changing an unjust social order while mental health teams prescribe medications in pursuit of "pharmaceutical management" (Lykes, Banuazizi, Liem, & Morris, 1996:10). In the medicalization of the poor social conditions become secondary to health concerns contributing to "an inattention to the political process, an over-emphasis on the utility of medical science and physician expertise, and a

lack of attention to non-illness related social conditions" (Armitage, 1975:173). All this

activity of medicalized classification individualizes the problem of homelessness and

deflects attention away from the key political/economic causes of poverty and structured

inequality, allowing "government to absolve itself by focusing on personal illnesses

rather than on underlying social and economic problems" (Daly, 1996:122).

Modern medicine accepts the natural order of things, and why persons deviate is

less important than that they do. Issues rooted in politics and social relation are

submerged, for to ask why would force a justification of the inequality in capitalist

society (Pearson, 1975; Miller, 1996). An over emphasis on remedial measures deflects

attention from preventative measures such as safe and secure housing for all and "a

bureaucratic bias towards changing individual clients rather than changing society and its

social institutions is apparent" (Armitage, 1975:95). Whether one is mentally ill or not,

political, economic, and social factors cause homelessness.

The dilemmas of shelterization

Emergency shelters do not substitute for permanent housing but provide a

response that is politically and economically expedient (Blau, 1992; Culhane, 1996;

Hopper & Baumohl, 1994; Lang, 1989). Rather than addressing such issues as lack of

affordable and safe housing the shelter acts as a dumping ground for problem populations

and serves as an overflow site for other agencies in the system such as hospitals, detoxs,

and corrections (Dear & Wolch, 1987). In its techniques of management and control the

shelter is an organizational barrier to, rather than a facilitator towards, ending

homelessness (Stark, 1994). Those shelters more in line with funders' policy

expectations receive most funding, while those who fail the expectation are forfeited, thereby increasing the power to manage by the remaining providers and consuming scarce funds that could be used for alternative programs (Culhane, 1992; Tiernan, 1992).

Gounis (1992) views the shelter as an institutional response to the increasing numbers of homeless persons, expanding the industry of help and treatment in a practice that is regimented and controlling. The shelter lacks the true meaning of "home." "Shelterization describes the complete immersion of a shelter resident into the routines of shelter life. It involves the gradual acceptance of the views about oneself and the institutional appropriation of one's short and long-term objectives" (Gounis, 1992:688). A policy of providing temporary shelter rather than permanent housing "reproduce[s] the prevailing political and economic arrangements" (Barak, 1991:49) of structured inequality inherent in capitalism. The management of individual behaviour is placed over structural change thereby reinforcing the status quo. "Homelessness thus becomes an adopted life-style by the homeless, a way of managing under duress, reorganization of one's attitudes and values, and finally, a change of status and identity" (Barak, 1992:83).

The causes of shelterization must be located in the structural formations of institutional culture, of degrading routines, of the need for "secondary adjustments" to cope with the challenges of shelter living and to avoid being caught up and losing identity in the shelter, to resist shelterization. Gounis (1992) calls shelterization "a state of captivity, not a disease" (p. 692). McMullen declares:

> We want to mobilize and organize a whole generation of dependent people....
> Moving from dependency to independence and empowerment, means moving
> away from the shelter system.... I don't give a damn how well run it is, shelters
> strip people of their dignity. They breed dependence and they cripple people.
> And when people wake up in shelters, they are still homeless (cited in Barak,
> 1992:142).

Harman (1989) reported how a women's shelter reproduced domesticity by creating a reliance on shelter workers in place of husbands. The women's dependency on the men who abused them was transferred to the shelter workers. The shelter reproduced the domesticity of the women as a whole rather than fostering their political emancipation from the patriarchal structures that constrained them in the first place.

Generally speaking, shelters sap the homeless of motivation, cut at their already low self-esteem, and disempower them by locating their condition within personal inadequacy rather than social constraints (Culhane, 1996; Fabricant, 1988). The shelterization process compounds a lack of self worth by attributing the circumstances of clientele to individual pathology or personality weakness.

Shelters for the poor and homeless disempower and depoliticize the residents through a process of social segregation, stigmatization, and dependency (Hopper, 1990; Hopper & Baumohl, 1994; Stark, 1994). In the United States shelters have become big business. Federal and state funding has helped to erect more shelters but has not gone towards the study of subjective causes of homelessness (Bassuk & Lauriat, 1986; Lang, 1989). As cities shoulder more responsibility the shelters are built in the least desirable areas from a profit maker's point of view, contributing to the ghettoization and separation of the disadvantaged from the rest of society and all it offers. As Rossi (1989) explains:

> The prospect that dormitory living for the unattached poor will soon become a fixed feature of the cities is very real. There are many precedents for programs living far beyond their usefulness as they evolve into self-serving bureaucracies with greater stakes in self-preservation than in fulfilling a function. Currently, there is nothing but the streets and public places that compete for the clients of shelters. As serious competitors appear on the scene, emergency shelters should disappear gracefully (p. 55).

Large shelters tend to be dangerous places especially for those who lack the social skills of getting by and surviving in a desperate milieu (Dordick, 1996; Daly, 1996; Grunberg & Eagle, 1990). In Toronto's 600 bed Seaton House, known locally as Satan House, an atmosphere of apprehension and violence is prevalent. In 1996 a young homeless male diagnosed with schizophrenia died as a result of actions by shelter staff (Fruman, 1996).

Many homeless persons avoid shelters because of a fear of mental health committal, because the shelters bar alcoholics and drug users, or because of a dislike of rules and regulations. In the United States Barak (1991) reported that many shelter beds remain unoccupied, sometimes at a rate of one out of three. However, this may not indicate a lack of clients but rather that many choose alternatives (Daly, 1996).

In San Francisco in the early 1990's a candidate for mayor ran on a platform of retrenchment, workfare, and curtailment of service. He proposed that all persons referred to a shelter would be required to have an identification card. Criminal record checks revealing past acts of violence would bar entry to the facility and those with alcohol and drug problems would be denied service unless they consented to a treatment program.

In California, considered a bellwether state when it comes to implementing policy, the response to homelessness has moved away from the ideal of community care towards building more shelters, expanding the prison system, and opening up the state mental hospitals (Dear & Wolch, 1987). In San Diego there is a 350 bed shelter known as the Taj Mahal. Comprising a city block this shelter contains a welfare office, an employment office, a medical clinic, a training and educational centre, a day care centre, and a dining room that serves 1350 meals a day (Coates, 1990). However, specialized

services within a shelter tend to institutionalize homelessness by attributing cause to

personal inadequacies (Culhane, 1992). Furthermore, through professional hierarchies,

political interests, varying objectives and differing salary levels, health and social

services integrated under one roof lead to one being subsumed by the other (Armitage,

1975; Struening & Padgett, 1990).

The construction of more shelters is a short term Band-Aid solution to a pressing

social concern (Tiernan, 1992). It is analogous to the building of more prisons in that it

deals with symptoms and fails to seek causes in the "fundamental structural arrangements

of inequality and privilege in our society" (Barak, 1991:106). Like the prison, the shelter

contributes to processes of institutionalism, "a syndrome characterized by lack of

initiative, apathy, withdrawal, submissiveness to authority, and excessive dependence on

the institution" (Lamb, 1984:900).

Social reformers unwittingly support the interests of business in constructing

shelters for the poor, thereby deflecting critical socio-economic issues of homelessness

·from public view. Poverty and privilege are left out of the public dialogue and the

political concerns of declining wages and low-cost housing are hidden. Barak (1991)

asks whether the growing number of homeless persons will "become subjects of the

repressive-penal apparatus of bourgeois social control or of new forms of welfare and

community development?" (p. 63).

In Canada Baxter (1991) reported that a social service worker said, "if anyone is

without shelter, it is because they (sic) choose to be" (p. 141). This statement ignores the

fact that we do have freedom to choose but not the freedom to control the conditions

under which we choose. Studies have found that the "homeless by choice" or "lazy

shiftless bum" profile fits no more than five percent of all homeless persons (Rochefort & Cobb, 1992; Wright, 1988). For those with inadequate income the availability of affordable, safe and secure housing is shrinking steadily, while for those at the very bottom of the income scale the conditions of choosing are grim indeed (Daly, 1996).

Against this backdrop of welfare state retrenchment, increasing numbers of homeless persons, shifting and competing explanations for poverty and homelessness, individualization of social problems, and the increasing processes of shelterization are how we organize our responses to the very real needs of those without safe and secure housing. As the saying goes, "My life is my responsibility but I can always use a little help." The question is how we organize that help. An understanding of the shelter needs to be located in a socio/cultural/historical context, for "those who wish to change the social order had best know how it is achieved" (Harré, 1993:128).

Shelterization can lead to dependency and disempowerment on the one hand, but on the other the shelter can be a place of care, support, and safety. And this is the dialectic contained within this enterprise—how care and control are embedded within, and transform, each other. When does care move from communal responsibility and social justice for the politically and economically disadvantaged to institutional control and regulation of the socially problematic?

CHAPTER TWO: CONTEXT AND METHOD

The Downtown Eastside of Vancouver

Spread throughout the urban core of the Downtown Eastside are various clinics, shelters, detoxs, welfare offices, drop-in centres, missions, second-hand stores, cheap hotels, bars, cafés, and rooming houses, along with probation and parole offices, a police station with courthouse and jail, and a needle exchange. In this community, surrounded by facilities, services, agencies, and private business, many persons lead lives of poverty, isolation, and fear. For these persons homelessness is a condition, not a temporary phenomenon. For them short-term solutions of temporary shelter and crisis management take precedence over long term solutions of providing permanent and safe housing.

The Downtown Eastside of Vancouver is divided into seven sub-areas: Oppenheimer, Gastown, Victory Square, Chinatown, Thornton Park, Strathcona, and Port/Industrial. The total population of 15,934 persons represents 3.4% of the total population of the City of Vancouver, 73% of the low income, and over three times the overall criminal code offence rate. Of the total number of hotel bar seats that serve alcohol in the City of Vancouver 44.4% are concentrated on the Downtown Eastside (City of Vancouver, 1997). Compared to other neighbourhoods, towns, and cities across Canada, there are disproportionately high rates of HIV, injection drug use, and drug-related deaths recorded in the area ("The Killing Fields Campaign" Committee for Compassion and Social Justice, 1997).

In 1996 the areas of Oppenheimer and Gastown shared 3,627 of the total 5,803 SRO[5] units on the Downtown Eastside. From January 1995 to December 1996 the SRO's in Oppenheimer and Gastown declined though there was an increase in the total population in each area of 30% and 4.7% respectively. The area of Victory Square had an 87.8% increase in population with a 37 unit decline in SRO's (City of Vancouver, 1997).

On the edge of Chinatown is Hastings and Main, known locally as "the corner". Virtually steps away from the corner and the Carnegie Community Centre[6] is the bordering area of Oppenheimer, through which the Hastings Street strip passes by sundry run-down hotels such as the Washington, Regent, Balmoral, Sunrise, and Roosevelt. On this strip one can obtain drugs, sex, and a cheap room at any time of the day or night. It is similar, in many respects, to the Chicago School's inner city transition zone of the 1920's:

> At the very edge of the constantly expanding central business district, ecological theorists observed light industry, warehouses, and 'hobohemia', a place of rootless people, vagabonds, street bums. Immediately beyond lay the interstitial, or transition, zone. In plain language—a slum. In this natural area, the battle of competition-dominance was being fought. Its residents were the losers. Disorganized by rapid change, they were said to experience the highest rates of such measured deviance as delinquency, school truancy, adult crime, serious mental illness, prostitution, gambling, suicide, and taxi dance halls (barlike establishments for the isolated and lonely) (Pfohl, 1995, 149).[7]

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[5] Single room occupancy.
[6] The Carnegie Community Centre, situated at the corner of Main and Hastings, offers various programs for the poor, the homeless, and the near-homeless.
[7] It is important to recognize, however, that "social disorganization" theorists eventually came to recognize that this "struggle for space in the inner city is not independent of the struggle for power, prestige and material well-being in society as a whole" (Taylor, Walton, & Young, 1973:119).

Unlike the Chicago School's "zone of transition", however, the Downtown

Eastside of Vancouver, and areas like it, are a residuum for the poor and dispossessed

rather than a place of transition. Like most global cities in the Western hemisphere

pockets of poverty in close proximity to gentrified districts have resulted from the,

> peripheralization of the centre ... characterized by single-use spatially
> desegregated zones, including areas that are judged to be central and others which
> are peripheral or inconsequential [helping to] define urban space (and its
> occupants), organizing, controlling, and commodifying them to suit the needs of
> capital (Daly, 1996:6).

In downtown Vancouver the numbers of homeless persons are increasing (Baxter,

1991; Acorn, 1993). The cheap rooms and available services in the area attract those

persons of restricted means and limited choice in a market-driven economy characterized

by scarce funds and increasing need: the unemployed, single parent families, elderly

persons, refugees, drug addicts, ex-prisoners, and people released from institutions such

as hospitals and mental health facilities.

Triage Emergency Services and Care Society

Within the region of Port/Industrial[a] is located Triage Emergency Services and

Care Society,[b] a short-term shelter situated within a complex array of interrelated services

and agencies for the poor, the drug and alcohol fixated, the physically and emotionally

disadvantaged, the socially inadequate, and the homeless and near homeless who

populate the urban core of Vancouver's Downtown Eastside.

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[a] Statistics Canada reports the population of Port/Industrial as being insignificant to produce specific
reports (City of Vancouver, 1997). Consequently, those who live in the area's rooming houses and low-cost
housing units, those in the Triage complex, and those who stay under the bridges, in the bushes, and in
abandoned buildings, are ignored as if they did not exist.
[b] Otherwise known as Triage.

Triage originated in 1982 in an abandoned bank located in the Thornton Park area of Vancouver's Downtown Eastside. Within a stone's throw was the Georgia Viaduct, used by commuters traveling from the Eastside to Downtown Vancouver and by homeless persons spending the night or getting into substances such as gasoline, glue or things somewhat more exotic. Occasionally someone perched from the span and attempted suicide. Just across the street from the first shelter was a bushy area informally known as the glue patch; sometimes dead bodies were found there. Down the street was a large collection of empty brick buildings in which homeless persons had set up camps.

Triage developed from the vision of Robert White, who, while with the St. James Social Service Society in the early 1980's, saw many homeless persons wandering the Downtown Eastside of Vancouver. In the 1980's homelessness was popularly believed to be the result of deinstitutionalization (Isaac & Armat, 1990). Accordingly, in efforts to elicit funding, Triage was organized around an administrative mandate of housing and supporting the "mentally ill." However, the program was never intended to be limited to this population only.[10] Those persons with substance abuse problems were also included in the mandate to house and support, but in practice virtually all who used the services of Triage shared problems of poverty and a lack of safe and secure housing.

In June of 1993 Triage moved to its present quarters: two floors and a basement fronting a four-story social housing complex for those with a psychiatric disability. This move was to mark a transition point for the shelter. Physically, the new building was an

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[10] M. Smith, personal communication, March 4, 1997

enormous improvement over the dilapidated, grimy and cockroach-infested hulk that was the old shelter.

The "new" Triage is close to the dockyards, situated beside an industrial viaduct under which homeless persons sometimes sleep. By the shelter's front door human forms are often seen lying under piles of blankets. The door has a buzzer and through the hardened glass you can see those inside, and vice versa. On the glass are sometimes hung signs that proclaim, "no more food" or "visiting hours canceled."

Triage's mandate is to house persons with psychiatric impairments and/or substance abuse problems who need stable housing. Referrals are expected from hospitals, clinics, welfare workers, various social service agencies, or from persons seeking shelter themselves. The shelter is supposed to be a temporary refuge where the client can stabilize and find assistance in fulfilling her/his needs. In the ideal, connections with other facilities are emphasized in the process of returning the client to an organizationally defined level of functioning. Hopper & Baumohl (1994) point out:

> Demand for shelter is essentially defined by default: Who appears at the door and in what numbers depends chiefly on the state of the local labor market, the supply of cheap housing, welfare regulations and sufficiency, police practices, commitment laws and practices, and the tolerance and support capacity of kin (p. 526).

Officially, there are 192 emergency, single adult shelter beds in downtown Vancouver—35 beds for females and 157 beds for males. Catholic Charities, a large barracks style shelter, and Dunsmuir House, a men's hostel with dormitories and shared rooms, provide 110 of the male emergency beds. Both Catholic Charities and the emergency section of Dunsmuir House are vacated from seven o'clock in the morning until four o'clock in the afternoon; clients are given meal tickets to use at designated

restaurants. The remaining 47 male beds are supplied by The Lookout Emergency Aid Society[11] and by Triage. Triage also provides nine female beds and Lookout offers 14, though Lookout can accommodate 42 females by taking from the male side if demand requires. The remaining 12 female beds are supplied by Powell Place, a shelter for single women and women with children. Triage, Lookout, and Powell Place all remain open 24 hours and provide breakfast, lunch, and dinner for the residents. Crosswalk, a late-night drop-in centre, supplies 30 spaces for men and women on couches, chairs and on the floor from midnight to 6:30 in the morning. In a pinch, Lookout can supply four overnight spots on couches. In addition to these official shelter spaces, there are various services, churches, and drop-in centres that frequently provide overnight shelter to the homeless. Only Catholic Charities and Dunsmuir House are located outside the Downtown Eastside.

In 1993-1994 Lookout accepted approximately 2400 admissions and had 1660 turnaways with "a general increase both in number of people being served and the number of people turned away since the late 80's" (City of Vancouver, 1997:7). Lookout had 1,534 more admissions in 1993 than Triage did in 1996 but 965 fewer turnaways.

In 1996 Triage accepted a total of 866 admissions. Of 3,431 attempted referrals 2,565 were refused, of which 2,183 were for lack of beds. At Triage, for every person requesting service, three are denied. Moreover, shelter staff sometimes neglect to record the refused referrals in the staff log; so these numbers are an undercount—there are more turnaways than officially noted.

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[11] Otherwise known as Lookout.

Triage's name originates from the front-line medical practice of sorting the

casualties of war according to the severity of their condition. In the war zone where the

wounded outnumbered the medics a system of prioritization was established. Those

whose wounds were immediately life threatening were given priority over those who

could wait a while longer. A common characteristic is that the casualties of war and the

casualties of an industrialized society are drawn predominately from the poor. The

difference is that in the welfare state the need to sort the casualties of armed conflict has

been supplanted by the need to sort the casualties of private profit (O'Connor, 1973).

Triage, with 28 beds, would be considered small in comparison to other shelters

across Canada and the United States, which average 100 beds or more (Lang, 1989).

Because Powell Place actually has 36 beds when the spaces for women with children are

included in the total bed space, in downtown Vancouver Triage is the smallest of the

shelters for single adults. In addition, Triage has single rooms, whereas at Lookout and

Powell Place the rooms are shared.

Referrals to Triage come from other agencies, facilities and services, the police,

friends or family, the Ministry of Social Services, or self-referrals. Self-referrals are

either by phone or in person at the front counter. When a referral is made and a bed is

available the shelter staff first determines whether the person is an appropriate client.

This "screening process" involves surveying the "barred list,"[12] checking history of recent

shelter use and accommodation, evaluating signs of recent intoxication and possible

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[12] Triage keeps a barred list, on which are the names of those persons who are restricted from the facility because of, for example, thefts, threatening or aggressive behaviour, including verbal or physical violence towards staff, or the possession and control of unauthorized drugs or paraphernalia such as syringes on the premises. The bar can be from one week to indefinite and is occasionally contingent on the barred person regaining compliancy status with psychiatric medications. In 1996 - 1997 it averaged about 30 names long.

effects of withdrawal, assessing the reason for service, and determining appropriateness. In 1996-1997 the medical appropriateness of a referral increased in importance as medical facilities discharged patients to the community early, more from economic pressures than therapeutic directives.

Determining the appropriateness of a referral is a subjective procedure, sometimes involving a collective decision from the workers on shift, and at other times being made unilaterally. When beds are tight a referral is sometimes refused because the person needing the bed is deemed "housing only" thereby perpetuating separation biases in which, "privileging access to a scarce good ... raises vexing questions of equity" (Hopper & Baumohl, 1994:527). Those refused a referral are sometimes directed to another shelter. Some individuals, well known to members of the shelter staff, are occasionally given a bed solely at their request. A few of the staff will accept such a referral on the belief that even one night off the streets equates to another night of staying alive. Blasi (1990) observes about these practices generally:

> In effect we are making a kind of *triage* decision, where some people will simply be left to fend for themselves. We may treat the effects of homelessness, in clinics or in shelters, but we are at best applying first aid (p. 215).

The official statistics on "primary reason for admission" to Triage in 1996 showed that of the 866 admissions 44% were for substance abuse, 30% were for dual diagnosis,[11] 22% were for mental illness, and 4% were for "housing only." However, the official Triage percentages may be misrepresentative, for shelter staff are often pressured to accept those persons with a current psychiatric disorder or substance abuse problem over

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[11] Dual diagnosis is the classification reserved for those with both a psychiatric diagnosis and a substance abuse problem.

those deemed housing only. Although virtually everyone who tried to get into the shelter had a housing problem the pressure to locate cause, to separate the deserving from the undeserving poor, fostered a practice of seeking pathology within the individual rather than within social circumstance.

Emergency shelters, by definition, impose limits on the number of days a client can stay. Coates (1990) characterizes emergency shelters as those with stays of one to 30 days and transitional shelters as those with stays of six to 18 months. The 1996 general statistics for Triage show an average sojourn per client of 12 days. My research sample of 26 persons had an average reported lodging of 13 nights, with a range of three to 33 nights. Over the history of the shelter at least four individuals have remained for over six months. These individuals were deemed at risk in a hotel room or other unsupervised setting, or were difficult to place in alternate housing because of emotional or behavioural problems. As Triage increasingly allows some clients to stay for extended periods of time it performs more of a transitional housing function than that of a short-term emergency placement. In turn there are fewer beds available for those needing immediate shelter and support.

Inside Triage one is first greeted by a chest-high receiving counter behind which the staff is available to give out meal tickets, cigarette papers, matches, band aids, mail, and various other items, to answer phones, help with crises, or acknowledge miscellaneous questions, including whether there are any beds available. Behind the front counter is an inner office banked by some smaller administrative offices and a medical room. From the inner office one can see through the inner courtyard to the lounge area, with a TV and smoking room, and to the dining area fronting the kitchen.

where people line up for meals. Similar to Bentham's Panopticon (Foucault, 1979) this configuration allows optimal viewing of the main floor area. On the second story are 28 rooms for the emergency clients, above which are 27 long-term social housing units for those with a psychiatric diagnosis. In the basement are laundry facilities, building service rooms, a conference room, free-clothing room, a special programs office, and staff parking garage.

On the day the social assistance cheques are handed out Triage is generally empty of clients, residents and visitors alike. Then the stress builds as residents are pressured to find a place by month's end and visitors run out of money. The first week of the new month sees new faces with others hanging on from the month before. Just after cheque issue day the outside food line[14] is short but as the month progresses the line lengthens so that by the second week one has to be at the door an hour ahead of time to get a spot in line.

The total revenue for the Triage shelter in 1996 was about $1.8 million.[15] Of this the largest block of money came from the British Columbia Ministry of Health—about $1.1 million in total. British Columbia Housing provided about $320,000 and the British Columbia Ministry of Social Services about $230,000 on a per diem basis. The remainder of the revenue was made up through rent from Triage's social housing section, Windchimes (about $60,000), donations (about $40,000), assorted user fees ($32,000), catering services and investment income ($23,000).

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[14] From those persons who wait in line outside the front door, Triage takes two for breakfast, two for lunch, and six for dinner. Patrons are restricted to two breakfasts, two lunches, or one dinner per person per week, but if they have the money, they can buy breakfast or lunch for $1.25 or dinner for $3.00.
[15] These numbers have been rounded off to the nearest decimal point.

When the revenue for the Windchimes' section is separated out, and staff wages for the Windchimes' workers and two special-program outreach workers are deducted from the total cost of running Triage, a conservative estimate would be that it cost at least $40,000 to operate one bed in the Triage emergency shelter in 1996.[15]

Generally, those who work at shelters often share the same life experiences as those of many of the residents (Grunberg & Eagle, 1990). The people who work at Triage fit this profile sharing histories of excessive drug and alcohol use, consumptive gambling, homelessness, familial estrangement, childhood abuse, and/or institutional involvement. The staff complement totals about 40 at any one time, but only half of that 40 are front line workers. The other half is involved in management, kitchen duties, maintenance, special programs, or the Windchimes social housing section. About half of the 40 or so employees, whose ages range from 22 to 54, smoke cigarettes. This rate is more than twice that of the general population of British Columbia (Steffenhagen, 1997). Their education levels range from never having completed formal high school graduation to having completed one or more university degrees. Some of the staff have completed certificates in counselling or social service skills and/or Grade 12 equivalency; others have previous experience in care facilities. These varied life experiences result in a diversity of approaches to the troubles encountered in the shelter's everyday milieu.

During the transition from the old building that used to be Triage to the new arrangement an ongoing question was how the ideals of care would interact with demands for control. Community-based practices often place convenience over conscience and

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[15] M. Smith, personal communication, October 21, 1997.

idealist plans often gather dust while other strategies are pursued as expedient (Dear &

Wolch, 1987). Would the new structure with its large inner offices, reception area, and

chest-high receiving counter erode the informal relationships of the old bank and further a

practice of disempowerment and bureaucracy? Would the new shelter produce a

disciplinary practice of surveillance and categorization thereby making more apparent

what had been there all along? Or would it be about empowerment and the production of

mutual attitudes of interpersonal validation, self-worth and acceptance?

Research method

Over the months of December, 1995 to May, 1996, 26 interviews were conducted

with the users of Triage. All interviews were organized on a completely voluntary basis.

No rewards or material incentives were offered for participation. Each respondent was

fully informed of the purpose of the interview and how the resulting information would

be used. All were advised that they could terminate the interview at any time. I

guaranteed them complete confidentiality, except under the two exceptions stipulated by

my university's ethics committee: (a) if they disclosed that they planned to hurt

themselves or anyone else; or (b) if they revealed that a child was being abused or was at

risk of being abused.

My research method derives from the inductive reasoning of Glaser & Strauss

(1967), in which theoretical formulations are allowed to emerge from, and are grounded

in, the narratives and observations of the collected data; the critical social research of

Harvey (1990), in which meaning is located in social relation, social process, and socio-

historical structure; and the active participatory research of Kirby & McKenna (1989), in

which the marginalized, dominated, exploited, and oppressed are given voice and become

subjects rather than objects of the research process. My work focuses on context, content,

and comparison of ideas, and gives expression to voices that are often submerged in a

rhetoric of control, treatment, and care.

> Straightforward notions of causality ... and linear relationships among variables
> affecting homelessness are not necessarily appropriate. The links among poverty,
> economic change, deinstitutionalization, demographic shifts, employment,
> marginalization, and the worlds of homeless people must be clarified (Daly,
> 1996:10).

As one respondent, David, said of the interview process:

> I really feel good, you know, 'cause like I did it more or less out of curiosity.
> 'Cause I didn't think too much of the word interview. I thought it was gonna be
> like those SAT tests. I thought it was gonna be like how much do you make, do
> you qualify for AFDC,[17] questions like that, and that was it. That's what I thought
> it was gonna be. I thought it was gonna be boring and I was gonna try and not
> laugh. But at the same time I put forth something that is worth my time, you
> know, and learn something.

➤ During the interviews some of the participants became quite emotional as they

reflected back on broken promises and shattered dreams. Two respondents broke down

and wept openly over the telling of their experiences and regrets. At these times I sensed

an urgency to disclose repressed emotions and anxieties and how their having someone to

talk to made possible a moment of catharsis.

Data collection

Data were collected from semi-structured interviews, unstructured interviews, and

my own participant observation as a worker at the facility. I have worked for Triage as a

community worker since 1987 so I am in a unique position to record observational data.

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[17] AFDC (Aid to Families with Dependent Children) is a social benefits classification particular to the
United States, where David had spent a significant part of his life.

Many of the participants I know from both previous and subsequent shelter stays and visits. This allowed a longitudinal observation of participants across time as well as an opportunity to get to know them in a special way. My own subjective experience was added to the research process as I made every attempt to fully acknowledge my "conceptual baggage [that is] the record of the experience and reflections of the researcher that relate to the focus of the research" (Kirby & McKenna, 1989:49). Every effort was made to include the participants in the process of thesis development. As the process of data collection and analysis unfolded thematic conceptualizations, alternate inquiries, and contrasting ideas were encouraged.

The respondents were selected according to availability and willingness to participate; there were only two refusals. I used a purposive sampling technique in that certain persons were intentionally selected. The strength of this non-probabilistic technique is that it allowed the research questions to be tailored to certain concepts and the interviews to be organized around particular key persons. The weakness is that the sample is not representative, those unable to converse in English may be excluded, and preconceptions may be affirmed. All the participants appeared reliable except for one whose responses to quantitative measures occasionally appeared inconsistent and improbable.

The interviews consisted of the Emergency Shelter Resident Survey[18] and the Survey of Non-Resident Visitors to a Shelter. The two instruments comprised a structured section, which was adapted from Burt's (1992) United States' shelter survey

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[18] A copy of the Emergency Shelter Resident Survey is provided in Appendix A.

and tailored to a Canadian context, which elicited quantitative data and a semi-structured part which explored qualitative issues. Both of the surveys used in this research were identical to one another except where certain wording was varied to allow visitors to Triage, as well as residents, to participate.

The interview opened with a brief introduction, stating its purpose, a reassurance of confidentiality, and a request for completely voluntary participation. The quantitative section proceeded with the eliciting of demographic data such as history of previous shelter use, type of previous housing and sleeping arrangements, history of familial relationships, employment, income, medical/mental health history, substance abuse (if any), voting behaviour, and history of being a victim of assault or theft.

The qualitative part of the interviews was open-ended, allowing the participants to round out and fill in their own conceptual images. Participant contribution was encouraged. The interview focused on how the participants coped with the demands of living on the Downtown Eastside and what services were available to them to deal with these demands. Specifically, how did those who experienced the human feelings of sadness, loneliness, estrangement and disaffiliation deal with, respond to, or cope with these sensibilities? What did safety and security mean to them? What support mechanisms were available, to whom did they turn, and to whom could they talk? Questions concerned the challenges of living on the Downtown Eastside of Vancouver and the difficulties of finding permanent housing, the quality of formal and informal relationships and the practices of care and control in relation to welfare, homelessness, and social justice, and how these relationships connected to the shelter facility. I attempted to address how the macro structure of the wider political economy organized

the perspectives that emerged from the voices of the research participants and what changes have occurred over time in the practices of control and care as reflected in the experiences of those in the shelter. I tried to determine the quality or extent of empowerment and disempowerment in the life experiences of the research participants as they expressed their concerns to me. I asked participants about their views on the practices of control and care and how they perceived these practices in their own lives and in the ongoing process of life at the facility.

The interviews happened exclusively at the shelter in places where privacy was ensured. They averaged about two hours in length: the quantitative questionnaire took about half an hour and the qualitative discussion, which was audio taped and subsequently transcribed to hard copy, about an hour and a half. Any identifying names were deleted from the manuscripts and replaced with pseudonyms. Each interview was assigned a number to facilitate organization and the audio tapes were erased after completion of the final report. Observational data were recorded across the actual data collection and beyond.

Data analysis

Using the constant comparative method of grounded theory (Strauss & Corbin, 1990), the data that emerged from the interviews and participant observations were pored over repeatedly toward an end of conceptualizing common themes and categorizing convergences and contradictions. There were no formal beginning and cutoff periods for data analysis as the concepts emerged over time in a continual process of unfolding development. In the process of writing, the theoretical formulations were grounded in the

data and the concepts and categories were linked to the literature. Direct illustrations and exemplars were used throughout the thesis in an effort to give voice to the research participants. Biographical information, participant accounts, experiences and narratives were woven together to portray the interplay of agent and agency in institutional practice (Harré, 1993).

My data analysis stresses process and content in the expression of voices and how these voices connect with the practices at Triage and of social welfare generally. Concepts and categories are allowed to emerge from the data in efforts to effect an "emancipatory sociological inquiry" (Harvey, 1990:212). Using the methodology of grounded theory the interview and observational data assembled in this study are comparable because they are "sampled by representativeness of concepts" (Strauss & Corbin, 1990:191).

CHAPTER THREE: FINDINGS

Chapter Three will review and analyze the results of this research by first, cataloguing the quantitative data that resulted from the questionnaires, and then advancing into a qualitative exploration of the commentaries that emerged from the open-ended section of the interviews.

Summary of quantitative data collected on research participants

The interview sessions elicited quantitative data that are summarized in this section. The formal interview sample of 18 males and 8 females had an average age of 33 years with a range of 19 to 51 years.[19] This is in accord with the average age of persons in shelters across the United States and Canada (Daly, 1996). By "race" or ethnicity there were 14 white, 5 native Indian, 4 mixed, 2 black, and one of middle Eastern ancestry. Fourteen had an average of two children under the age of 18, with an average age of seven. Twenty-three of the sample were alone, 13 of whom were single or never married and ten divorced or separated. Four people did not know whether their father was alive or dead. As a child or youth 22 said they had been physically abused and 12 said they had been sexually mistreated.

As detailed in Table 1, 19 of the respondents had been detained in a detention centre or corrections facility one or more times, and seven within the last two years. Fourteen had been in a foster home, 18 in a drug treatment facility, 11 in a residential treatment centre, and three in a residence for handicapped people. Ten of the participants

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[19] This compares with the official Triage statistics for residents in 1996 which list an average age of 37 years with a ratio of approximately two males to every one female.

had been institutionalized in a mental health facility or hospital, three within the last two years previous to the interview.

TABLE 1: NUMBER OF RESPONDENTS WHO SPENT TIME IN SPECIFIC INSTITUTIONS

FACILITY	N	AS A CHILD	AS AN ADULT	WITHIN LAST TWO YEARS
DETENTION CENTRE OR CORRECTIONS FACILITY	19	11	15	7
DRUG TREATMENT FACILITY	18	6	14	10
FOSTER HOME	14	14	0	0
RESIDENTIAL TREATMENT CENTRE	11	3	9	5
MENTAL HEALTH FACILITY OR HOSPITAL	10	4	10	3
RESIDENCE FOR HANDICAPPED PEOPLE	3 *	2	1	1

The average number of grades completed was 10 with a range from having never attended school to completing a university degree. Of the 16 participants without a high school graduation only one had passed a high school equivalency test. Fourteen had never gone to school to learn a particular type of job. Of the 12 participants who had completed training for a particular type of job, 10 said they had held a job that used that kind of training. At the time of the interview only one respondent had a job that had lasted for more than three months. This was a labouring job of 24 hours a week, moving furniture. Twenty-two had not held a steady job for over one year, including two who had never held a steady job or who had never worked for pay. The last job worked for most of the respondents was commonly in the area of construction, labouring, janitorial, waitressing, and service type work. While ten of the participants had looked for work in the six months prior to the interview, five declared that they were not interested in finding employment. Fifteen of the sample had quit a job because of nervousness, depression, or

mental health problems. Table 2 summarizes the three biggest barriers the participants

offered against their getting a job.

TABLE 2: BIGGEST BARRIERS TO GETTING A JOB FOR THE RESPONDENTS

BARRIERS TO GETTING A JOB	N
LACK OF EDUCATION OR TRAINING	10
EMOTIONAL PROBLEMS (ANXIETY, DEPRESSION, ABILITY TO THINK CLEARLY, SUICIDAL, EASILY FRUSTRATED)	7
LACK OF JOB SKILLS OR EXPERIENCE	7
SELF ESTEEM (FEAR OF INCOMPETENCE, LACK CONFIDENCE)	6
DRUG USE	5
LACK MOTIVATION	5
PHYSICAL HEALTH (HERNIA, BACK PROBLEMS, ASTHMA, POST POLIO SYNDROME)	5
APPEARANCE (WORN CLOTHES, TATTOOS, AND TRACK MARKS ON HANDS)	4
LACK OF AVAILABLE OR DESIRABLE JOBS	3
LACK OF MONEY, WORK CLOTHING OR TOOLS	3
HIV/AIDS	2
LACK OF STABLE HOUSING	2
AGE	1
LIVING IN A DOWNTOWN HOTEL	1
CRIMINAL RECORD	1
DISCRIMINATION ON BASIS OF RACE (NATIVE INDIAN)	1
DOES NOT KNOW WHAT WANTS TO DO	1
DOES NOT LIKE STRUCTURE, NEEDS CHANGING TIMES AND PLACES	1
POOR PHYSICAL CONDITION	1
HANDICAPPED (DYSLEXIA)	1
LIFESTYLE	1
LOW ATTENTION SPAN	1
SEXUALITY (TRANSGENDERED)	1
SIDE EFFECTS FROM MEDICATIONS	1

Twenty-five participants claimed they had been assaulted in their lifetime for an average of 30 times per person. Sixteen indicated they had been assaulted for an average of 16 times in the last year. The assaults were spread out between live-in partners, friends, acquaintances, strangers, and others including authority figures such as parents and police officers. Tables 3 and 4 identify the perpetrators of these assaults, both over the respondents' respective lifetimes and during the previous year.

TABLE 3: PERPETRATORS OF ASSAULTS RECEIVED IN LIFETIME OF RESPONDENTS

PERPETRATORS OF ASSAULTS	N
STRANGER	20
ACQUAINTANCE	17
OTHER[20]	17
LIVE-IN PARTNER	15
FRIEND	11

TABLE 4: PERPETRATORS OF ASSAULTS RECEIVED OVER PREVIOUS YEAR BY RESPONDENTS

PERPETRATORS OF ASSAULTS	N
LIVE-IN PARTNER	9
STRANGER	9
ACQUAINTANCE	6
FRIEND	5
OTHER	1

Twenty-two of the respondents said they had had things stolen or taken without their consent in the year previous to the interview for an average of five times, while 15

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[20] Other included authority figures such as relatives, foster parents, and police officers.

reported having something stolen or taken without their consent for an average of two times in the 30 days previous to the interview.

Twenty of the respondents had lived in the Vancouver area for over three years. Seventeen had been without a place to live, not including emergency shelter, for more than a month. Thirteen had been without a place to live, not including emergency shelter, for more than four months. Most were optimistic about finding housing, with 19 declaring that they would find housing within the month.

Twenty-two of the respondents wanted to have permanent housing in Vancouver. Twenty-one said they would be able to pay between $301 and $400 each month for their own place.[21] Although nine had paid over $400 dollars for their last place rented, only five said they could afford more than $400 dollars right now for rent. For 10 of the respondents the last place rented was on the Downtown Eastside of Vancouver, an area populated by welfare hotels[22] and cheap rooms. For 17 the length of stay at their most recent housing was under six months. Fourteen had tried to get into another shelter before coming to Triage. As Table 5 shows, the reasons for not staying in another shelter were varied.

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[21] This aligns with the housing allowance from welfare of $325 a month. It also connects with the usual going rate of $325 a month for a room in a welfare hotel.

[22] Welfare hotels are organized primarily around the concept of providing accommodation to those on social assistance. They are usually selective in whom they accept as tenants and provide a semblance of security with limited services. They are compared to the downtown hotels that rent rooms by the hour, day, or month to whoever has the cash.

TABLE 5: REASONS RESPONDENTS WERE REFUSED SERVICE AT ANOTHER SHELTER

REASONS FOR NOT STAYING AT ANOTHER SHELTER	N
FULL OR NO ROOM	3
POOR CONDITIONS	2
OVER THE LIMIT ON THE NUMBER OF DAYS ONE CAN STAY	2
NOT IN AN ABUSIVE SITUATION AT PRESENT	1
BARRED	1
OWED MONEY	1
NOT WHEELCHAIR ACCESSIBLE	1
REFUSED WOMEN'S SAFE HOUSE BECAUSE ON PSYCHIATRIC MEDICATIONS	1
TOO SOON AFTER LAST STAY AT SHELTER	1
SHELTER FOUND OUT ABOUT FALSE IDENTIFICATION	1
TOTAL	14

For 18 of the respondents, if they could not have stayed at Triage on the night of the interview seven would have tried to get into another shelter, six would have stayed outside, four with friends or relatives, four in a rented room, one at a drop-in centre, and four at an unknown site.

As enumerated in Table 6, in the month previous to the interview 23 of the respondents had received money from welfare; 11 from underground activities that they listed as drug dealing, shoplifting, breaking and entering, fencing stolen goods, and prostitution; 10 from the sale of personal belongings; eight from relatives other than parents and friends; six from parents; four from day labour; three from asking for money on the street; and two from employment.

TABLE 6: SOURCES OF INCOME FOR THE RESPONDENTS

INCOME SOURCES	N
WELFARE	23
UNDERGROUND ACTIVITIES	11
SALE OF PERSONAL BELONGINGS	10
OTHER RELATIVES OR FRIENDS	8
OTHER (SUCH AS MINORITY PROGRAMS AND BINGO)	6
PARENTS	6
DAY LABOUR	4
ASKING FOR MONEY ON THE STREET	3
VOLUNTEER INCENTIVE/SPECIAL EMPLOYMENT PROGRAM	2
STEADY EMPLOYMENT	2
PENSION	1
TRUSTEESHIP	1

The average income from all sources in the month previous to the interview was $888, with a range of $114 to $3400. Among those reporting very high incomes from the previous month the common explanation was that most of their money went for street drugs, predominately cocaine.

As catalogued in Table 7, in the 30 days previous to the interview 22 of the sample had used free or almost free clothing shelves, 21 drop-in centres, 14 free medical clinics, and 13 hospital emergency rooms. Ten had availed themselves of meal programs and 10 had used food banks.

TABLE 7: SERVICES USED BY RESPONDENTS IN PREVIOUS MONTH

SERVICES USED	N
FREE OR ALMOST FREE CLOTHING SHELVES	22
DROP-IN CENTRES	21
FREE MEDICAL CLINIC	14
HOSPITAL EMERGENCY ROOM	13
FOOD BANKS	10
MEAL PROGRAMS	10
FOOD VOUCHERS	5
FREE DENTAL CLINIC	2

All of the respondents had previously stayed in a shelter. Of those who were staying at Triage during the interview session, or who had stayed at Triage before, the average stay was 13 nights.[^] During the month previous to the interview 14 of the sample had stayed in shelters more than three nights per week. When not in a shelter 18 had stayed with friends, 18 had slept outside or out of doors, 10 in vacant buildings or vacant apartments, 9 in hallways, and two in cars. Shelter had been sought in a hospital, jail, or detox centre by 14 of the respondents.

As listed in Table 8 eighteen of the respondents considered themselves dependent on a substance or combination of substances, most commonly alcohol, cocaine, and tobacco, followed by marijuana, prescription pills, heroin, amphetamines, and caffeine.

[^] The official Triage statistics for the year 1996 list the average stay per person as 12.4 nights.

TABLE 8: SUBSTANCES RESPONDENTS WERE DEPENDENT ON

SUBSTANCES DEPENDENT ON	N
ALCOHOL	7
COCAINE -	7
TOBACCO	7
COMBINATION INCLUDING ALCOHOL	3
MARIJUANA	2
PRESCRIPTION PILLS	2
HEROIN	1
AMPHETAMINES	1
CAFFEINE	1

Eighteen people had been admitted to a detox centre, for an average of six times each. Thirteen had been treated in an outpatient alcohol or drug treatment program for an average of twice each.

Twenty-one of the respondents reported chronic health problems as itemized in Table 9.

TABLE 9: CHRONIC PROBLEMS FOR RESPONDENTS

CHRONIC PROBLEMS	N
DEPRESSION	6
HIV/AIDS	6
ASTHMA	4
HEPATITIS C	3
BACK PROBLEMS	3
MOOD SWINGS	2
INSOMNIA	2
ANXIETY	2
SCHIZOPHRENIA	1
LEUKEMIA	1
POST POLIO SYNDROME	1
HEART PROBLEMS	1
KNEE PROBLEMS	1
BRONCHITIS	1
OSTEO ARTHRITIS	1
RHEUMATISM	1
ULCERS	1
EPILEPSY	1
EMOTIONAL PROBLEMS	1
SICKLE CELL ANEMIA	1
TOTAL	40

Seventeen were receiving medical care while 11 said they had not been able to obtain medical care. Fifteen were taking medications for a physical, not a mental, health problem. Sixteen received care in a hospital emergency room in the six months previous to the interview of whom seven were admitted to hospital. Twenty needed dental care of whom eight had tried to get this treatment. Although 24 had needed to see a doctor in the six months previous to the interview, Table 10 specifies the various reasons that 11 gave for why they did not see a doctor or get health care when they required it.

TABLE 10: REASONS RESPONDENTS DID NOT GET NEEDED HEALTH CARE

REASONS FOR NOT GETTING HEALTH CARE	N
AVOIDANCE	1
CANNOT AFFORD TREATMENT	1
SPECIAL SUPPORTS DENIED BY WELFARE	1
LACK OF TRUST IN DOCTORS	1
DOCTOR DOES NOT BELIEVE ME	1
LACK OF TRANSPORTATION	1
NO MEDICAL COVERAGE	1
NO TIME	1
OUT OF PROVINCE	1
OVER LIMIT ALLOWED BY SOCIAL SERVICES FOR DENTAL WORK	1
SCARED OF POSITIVE TESTS	1
TOTAL	11

Twenty-one of the respondents claimed they had an emotional or mental health problem at the time of the interview; the same number added they could benefit by seeing a counselor, community worker, social worker, or outreach worker for any reason. Fourteen declared they were seeing a counselor or physician for emotional or mental

health problems and nine were taking medications for these problems. Fifteen of the sample had quit a job because of nervousness, depression, or mental health problems.[24]

Although sixteen of the respondents said they had had contact with their family or relatives in the month previous to the interview and sixteen reported having three close friends with whom they have regular contact, when asked who were their main sources of emotional and social support, 15 said shelter and drop-in staff, three a doctor, and one a probation officer. Seven maintained they had no one to whom they could turn for emotional and social support. When asked about whom they could turn for comfort 11 replied there was no one.

Pathways to Triage, backgrounds, and histories

In what follows I introduce several of the participants in this research, and in their own words I reconstruct the life conditions and experiences that occasioned their entry into the shelter system. The following narratives and background histories illustrate the many paths leading to Triage and how shared experiences intersect at common points when one falls between the cracks, resources are few, and choice is constrained. In this section the accounts portray the effects of interpersonal conflicts, excessive drug use, suicide attempts, childhood and adult victimization, HIV and AIDS, and the need for safety, support, and stability.

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[24] The respondents in Acorn's (1993) survey of shelter users in Vancouver were predominately young, male, single, and mobile with 50% reporting a current physical health problem, 44% use of non-prescription drugs, 69% use of alcohol, and 19% a current mental or emotional problem. Acorn suggested that the lower rates of mental illness reported in her sample from those studies of United States' shelter users may reflect Canada's increased availability of mental health services.

Tony

⸱ In order to avoid staying in a skid row hotel people often choose roommates to

share with, but these arrangements may not work out because of personality clashes,

violence, overcrowding, or drug and alcohol use. Those persons who lack support from

others in the community often end up in shelters or on the street. Usually, the community

shelter is the only alternative to living on the street or in a cheap hotel where the chance

of victimization increases exponentially (Barak, 1991; Currie, 1995).

Tony, 47, once worked as a skilled tradesman but after a car accident his drinking

escalated and he left his family for the streets. He had an 11 year old son in a detention

centre whom he was not allowed to contact:

> I was self employed for 18 years and been able to, even though I didn't have any
> formal education, I was still able to put together a nice place for myself and for
> my wife and my kids. But all it took was one car accident.... Things just started to
> fall apart. Once I was not able to work any more, things just went to hell pretty
> fast.... And the only way I could handle that was drinking.... If the same thing
> happened again I still wouldn't know what to do except take up drinking.

Tony had not worked for more than four years. His life was one of sleeping in

parks, shelters, hotel rooms, and shared housing: "I was living at an apartment with two

other fellows [and] I had to leave that because my money was stolen and I didn't have

enough money to pay my rent." Tony had made arrangements to share a place with

someone he met at Triage. He said that he had paid the landlord his share of the rent but

his prospective roommate "went out at ten o'clock this morning and when I came

downstairs she still hadn't come back. She was only going for a couple of minutes to get

some cigarettes but if [she] doesn't show up, what am I going to do now?"

Luke

Luke, 31, had stayed in shelters in Ontario, Manitoba, Texas, and Louisiana, and he had stayed outside on the street. He had three children, none of whom was with him. His last job, over one to two years previously, had been moving furniture, which he quit after the company failed to pay him for all the hours he worked. He got by with money from welfare, his parents, and selling marijuana. Support he obtained from friends and his mother.

Luke came to Triage via a hospital's psychiatric assessment unit where he had been taken after an attempted suicide in his shared apartment: "I tried to commit suicide. I was distraught about a few things that had happened in the last year. And I figured it was time to end with my life. And I'm glad it didn't happen." Luke emphasized that Triage was the safest place for him to be at the time.

Simon

HIV positive, Simon sold drugs and shoplifted to support his cocaine habit. With his mother dead and not knowing whether his father was still alive or not, Simon reported his main sources of social support as the Triage staff, his family physician, and the nurses at the needle exchange. Before coming to Triage all the other shelters had been full and he said if could not have stayed here he would have slept outside. Simon said that it is difficult,

> ... trying to get somebody out of downtown. I've been trying it for four or five
> years, and I still haven't succeeded. It's an addiction in itself, the whole lifestyle
> is an addiction. Big time. And that's a harsh reality about downtown.... I was
> living in Coquitlam. I was still coming in three times a day. I'd miss the last bus
> and go to Lookout and sleep. Sleep on the couch. Or I'd go sleep outside in
> somebody's car. It's deep, it's really deep.

Simon had been at Triage for almost a month but had been at the shelter many times before. One of his many times living on the street had resulted in his becoming HIV positive: "That's it. It's over. Spent eight months on the street that time, that's how I got HIV." Previously, he had been living in shared housing that terminated after interpersonal conflicts with his roommate.

Simon was 42 with a grade 10 education, though he had taken some college courses in prison. To Simon structure was very important in his life. While at Triage he would get healthy and then go back at it again after a brief rest from the streets:

> When you walk out the door, any time when you're here, I wonder which way I'm gonna go. Just don't know which way to go sometimes. It's a total confusion. If I had a direction, any direction, that's why the structure that is projected for me here gives me the strength to really think and get some insight into what I really need to do for myself. Sit back and listen. Sit back and listen. And already being aware that I fucked up this many times before just find one little thing that I can maybe grasp onto and go in that direction.

Morris

The people who access the services of Triage are a special sub-group of homeless and near-homeless persons who seek safety and comfort from lives punctuated by powerlessness, violence, and disadvantage. As shown in Table 1 the respondents had life histories of extensive institutional involvement of one type or another and comprehensive backgrounds of government placements and detentions.

Morris, 27, had spent time in foster homes, drug treatment facilities, residential treatment centres, mental health facilities or hospitals, and considerable time in jails and detention centres. His family was unable to control his anti-social behaviours and it was

left to the system to care for his needs: "I spent nine years altogether (in prison), juvenile and FPI,[25] yup."

Since 1988 Morris had stayed at Triage 23 times. In between he would stay in hotels, in shared housing, or outside. At the time of the interview Morris was again a client of the shelter system because his money and valuables had been stolen by a friend and he had no place to live. He evidenced his hostility when, shortly after our interview, he gave me a note on which was written: "There is no object strong enough to pry my fingers from the throat of society!!"

Morris had recently fathered a child for whom he took minimal responsibility, reproducing the patterns of rejection that he had experienced in his own life. When asked about his main sources of emotional and social support, Morris replied there was no one to whom he could turn.

Phil

Phil, 51, had been evicted from a downtown hotel. Run-down and nervous, he needed to get off the street for a while and "heal up to try it again." Phil had been in all the facilities listed in Table 1 except for a residence for handicapped people. In his life he had been assaulted over 20 times by friends, acquaintances, strangers, police, and prison guards. His main support was from Triage staff and clients, a friend, and an AIDS group. Phil explained how important positive encouragement, and being able to stay at Triage, were in his life:

> See I got this thing going for me when people see my record they say, 'hey you're doin' good'. I get depressed and down and really fed up. When I get this positive feed back from everybody, and I know why it is, they say, 'look where you were,

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[25] The Forensic Psychiatric Institute in Port Coquitlam, B.C.

look where you been, you're doing okay. it's not that bad.' In here I get the break to, you know, clean up, read a few books, relax, 'cause I don't do that in a skid row hotel. It's too tense. I don't have time to do that.

Work avoidance can be a response to the alienating and oppressive conditions of work "and to exploitative terms of exchange" (Gill, 1989:42). Phil was one of those who had worked hard labour when younger but who now was able to work only menial jobs with low pay. HIV positive, with hepatitis C, and suffering depressions, he quit his last job as a janitor because, being on disability status, he got more from social services:

"Due to a certain lack of skills, I can get a job that will pay seven, eight dollars an hour, but I'm almost at the point where I would rather stay on handicapped."[26]

Phil explained his status as one of the surplus unemployed of a capitalist economy whose labour power had become redundant:

> I used to be a miner, rough and tough work, twelve hour shifts. Drink with the best, fight with the best, and I'm still doing that, but not with the working class, I'm doing it with skid row. There is physical reasons but part of it is my own mentality.... I've got a real bad hernia. I can't work. I still work part-time, but I can't use a jackhammer, work underground anymore. Moving furniture, stuff like that, used to be the stand by, for between jobs.

Portraying a sense of hopelessness in his being in the downtown area, he had served the wheels of industry in return for big money and transport to the city. He was no longer needed and he was marginalized:

> The whole skid row thing can eat you up.... When I was working, as I say, we'd come out of the bush with lots of money, and I wasn't doin' drugs then but I drank. Thirty days, you know, out drunk for thirty days, livin' in a hotel. And the bright lights, the parties, the bars. Once that job has been gone, I'm still back in the same area. Everything's still there, it's just I don't have the same money anymore that I used to have.... I'm in a position right now where I'm on skid row, my age, I don't qualify for a lot of jobs. I don't have the education. You know when you walk in for the job you ain't gettin' it.

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[26] Those who can document an inability to secure gainful employment because of mental or physical handicap are given social assistance benefits above that of the employable single person.

Bruce

At 32, Bruce had not worked a steady job for almost two years and had not looked for work for over six months. He explained that he had a bad back and the doctor had told him that he could slip a vertebrae if he were not careful: "It's ten millimeters of an inch, or something like that, already out, and he says that we've seen people five millimeters out and they're in a wheelchair. Paralyzed." Bruce used to work in construction but quit his last job because people were getting hurt on the site; he had been nearly killed by a machine operator who had been negligently swinging the bucket on a crane.

Before coming to Triage Bruce had been sleeping outside, using heroin and cocaine. His last residence was on the East Side of Vancouver, which he left because he could not keep up the rent. He stayed on the street because: "I just didn't really want to bother anybody. I just didn't feel like bothering my worker. I didn't feel like putting my hands out and begging." He explained that his father used to beat him up and that he often depended on his sister and his mother for support: "I went to my sister's for dinner in the morning, or for breakfast and that. But she has to work. I couldn't stay there because of the landlord." Run down, tired, and hungry, Bruce found temporary lodging at the shelter.

Mark

Mark, with a degree in social work, had been living in a small town up North, but complications arising from his having HIV required him to come to Vancouver:

I have AIDS and that necessitates me, because of specialists, coming to the city. This is the only place, the Centre for Excellence[27], where I can get any kind of help, in terms of the specialists and that kind of thing.

Mark's last job, from which he had been laid off about a year previously, had been working at a halfway house for ex-offenders. At the time of the interview he was surviving on a social services disability allowance of $771 per month. Facing tough times he had occasionally slept outside and in empty cars, once checking into a drug treatment facility for a safe place to stay. Mark obtained his social support from AIDS organizations and shelter staff, but, for comfort, he claimed there was no one.

Arriving in Vancouver, Mark first stayed at a downtown hotel for $425 a month. However, he soon ran out of money and ended up at Catholic Charities, being kicked out at 7 AM and not allowed back in till 4:30 PM. Because this was a risk to his declining health, his welfare worker suggested he try Triage until he could find more suitable housing. After a month at Triage Mark moved to a cheap hotel so he could have his privacy. Eventually, he secured a subsidized housing unit in a downtown apartment block reserved for persons with AIDS. Six months later, in December 1996, at age 38, with the ravages of his disease overwhelming his remaining defenses, Mark died.

Charles

For many persons, living downtown is about losing self. Except for brief periods of time, Charles had been living in the rooms since he was 17, using and selling cocaine: "Life there in sin city, the drugs and alcohol and all the other crap that goes on downtown, I got sucked into it and wound up and I can't really get away from it." Now

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[27] The B.C. Centre for Excellence in HIV/AIDS is dedicated to the study and treatment of the viral condition.

31, he had come to Triage from the hospital after cutting his wrists in a failed suicide attempt. His first time in a shelter, Charles worked part time in a warehouse.

Charles, with a history of foster homes and prison facilities, needed a safe place to stay, a place where he could get his thoughts together away from the downtown hotels:

> I know what my task is in time to deal with, what I got to deal with, sexual abuse, and why I did the drug scene and alcohol scene, to run away from my feelings.... Kind of numbs the feelings and numbs the cryingness and hurt that's inside of you, but when the coke and alcohol wears off it's still there, no matter what.

Reynaldo

Reynaldo, with four children and a record of jail time, had been staying with his family but interpersonal conflicts required him to leave. At 35, with no money and no housing he slept outside until he got a bed at Triage. Less than six months previously he had had a good job in construction but all his earnings went for drugs. Reynaldo claimed that he wanted counselling and support to help him straighten out his life and regain some stability.

> ... 'cause I know I can take care of myself and get work and stuff. I need mental help, being able to get to see my children and everything else. My life hasn't been together since I haven't been able to see my kids.... It's not money or getting a job, it's getting control emotionally and everything else. I'm very good at what I do, you know. It's not just knowing something, it's being able to do it, to produce.

On Reynaldo's intake sheet[28] the reason for his referral was listed as "drugs." But his problems were much deeper than that. Using drugs was symptomatic of his insecurities and lack of control but taking them away would still leave him homeless. Reynaldo needed a safe place to get his act together, a structured environment of validation and acceptance. However, Triage is a short-term facility in which the clients,

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[28] See Appendix B for a copy of the Triage Intake Form.

depending on their circumstances, are expected to secure alternate housing within a

"reasonable" amount of time. Reynaldo would have to find a place by the end of the

month. Consequently, he secured a room in a cheap hotel, came in for the occasional

meal, and at last contact was living back on the street.

Allan

At 22, Allan had a history of foster homes, residential treatment centres, and

correctional and mental health facilities. Before coming to Triage he had been living in a

room on the Downtown Eastside, where he gave his notice thinking his name was next on

the list for social housing and that he could move into his unit at the end of the month.

Unfortunately it was not ready and Allan, with limited resources, was left out on the

street.

Not having any serious drug problems but experiencing depression, Allan had

been living on his own since he was sixteen. Before that he had been placed in a long-

term foster home where he was physically abused. To keep himself busy Allan did

volunteer work with a local AIDS organization. Allan explained that homelessness can

happen to anyone when circumstances change and one is poor and lacks sufficient

resources to cushion the fall:

> My circumstance was purely accidental. It wasn't on purpose. It happened.... So,
> it doesn't matter where you come from or who you are. It's happening. And I
> think a lot of people take that for granted. That it cannot happen to them. That I
> wouldn't end up like the guy on the corner, or the woman with the bag, or the man
> with the shopping cart. 'Cause it can. And it sometimes happens very slowly and
> then sometimes it happens overnight, and sometimes it's out of your control. Most
> times, when it happens overnight, you don't have any control over it.

Jim

Jim had experienced sexual abuse as a child and, as a teenager, began a long-term involvement with prescription pills, "anything with a 'pam' on the end,"[29] alcohol, heroin and cocaine. He sometimes prostituted on the streets to survive, living in rooms and shared apartments. Jim had stayed at Triage before, ultimately ending up in a downtown hotel. After a month his drug use became too much and he moved into a shared apartment with his sister, but returned to the rooms of the Downtown Eastside after interpersonal conflicts. He soon found himself on the streets again, staying where he could, after experiencing harassment from some of the other residents at his hotel.[30] "I had no place to go. I was literally on the street then. I'd say I overstayed my welcome at a few of my friends. Although they never said it, but I could feel it." Jim sometimes needed to stay at Triage for, "when things get so overpowering the shelter helps me to get things in order." At the time of the interview Jim said there was nowhere else he could turn for emotional or social support.

Jim, one of the lucky ones, eventually moved into a Downtown Eastside social housing unit, where he does not have to walk down the hall to go to the bathroom. He no longer has to deal with the violence, desperation, and constant drug use that occur in the area's cheap hotels (Office of the Chief Coroner, 1994; Currie, 1995). At last contact he was collecting cans for recycling, volunteering at various downtown facilities, including Triage, and having tea at the drop-ins. He said this helps him feel useful and raises his

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[29] Benzodiazepines, such as diazepam, lorazepam, and clonazepam, often have a 'pam' on the end to identify their sedative-hypnotic effect.
[30] Jim experienced harassment rooted in homophobia, which is common in the rooms of the Downtown Eastside (Currie, 1995).

self esteem. At last contact he was still partaking of heroin and prescription pills but was planning on cutting down.

Donna

The homeless have higher rates of victimization than the domiciled, both antecedent to their homelessness, as in early childhood neglect, abuse, and separation from biological parents, and during the homeless experience itself, as in assault and thefts (Fischer, 1992).

Donna, 24, was a First Nations woman who had been raised on a reserve by her grandmother. At six Donna survived a car accident in which her mother was killed:

> I tried to commit suicide about six times. 'Cause my grandma always told me I was no good. She always told me that it should have been you who died in that car accident, and not your mother. They always got that from that. Plus on my relationships, it's always been lousy. The only thing that best happened in my life is my kids.

Donna's father died violently when she was a child, one brother committed suicide, and two other brothers had serious alcohol and drug problems. Her childhood years were spent speaking Sioux and taking care of her sick grandmother. Donna never went to school but learned English watching TV:

> I always got into a lot of trouble. The way my grandma was she always, like everything I did, was something wrong. I always got hit, slapped, coat hangers, you name it. Everything that she can grab, she always hit me with it. I never stayed around. I always ran away.

Donna had spent time in juvenile detention facilities for thefts and breaking and enterings. She was no stranger to getting by in the underground economy:

> We used to steal cars, erase serial numbers on the car and go to this tire dealer who used to take stolen, hot cars. Re-strip it, re-do it and sell it again. So used to get something like five hundred dollars doing that. Stealing cars.

Donna was staying at Triage because she had no place to live and she wanted to get into a treatment centre. She explained that if she stayed at a hotel she would start using drugs again. She had tried to get into another shelter but was denied service because they said she was not a battered woman at the time, even though Donna explained that her ex-partner,

> ... always tells me if you leave me you'll get your kids taken away. And if you leave me, he will always say, he will do things, he'll do things to me, he'll get people to beat me up and stuff like that.

To Donna Triage was a place of safety and security tempered by her own subjective feelings of insecurity and a general lack of safety defined by her own life circumstances:

> If nobody bothers you I feel more secure here. But I don't really feel safe as well, 'cause if he found out where I am now, that's why I'm mostly staying in all the time.... I never feel safe and secure in my life, so I have no idea.

Shortly after the interview Donna departed Triage for a downtown hotel which she soon left because the manager sexually harassed her, a common occurrence for women on the Downtown Eastside (Currie, 1995). About three weeks later she came to Triage with a badly bruised eye and sore ribs, looking for a bed after being beaten up by three women, who took her money and pictures of her children. Unfortunately, Triage was full so she got on the phone to find another facility that might have an opening.

Jennifer

Jennifer was staying at Triage with her common-law partner. They had been living in shared housing but were unable to keep up the rent. As a child Jennifer had dreamed of being a figure skater, but circumstances beyond her own choosing contributed

to a life of hardship and challenge that left little time for artistic pursuits. "My

grandfather, I found out when I was 19, was my dad." Now 23, to my question asking

whether she had ever been assaulted she replied, "once ... by a friend," but then,

throughout the interview, she often referred to her experiences of sexual abuse:

> When I first got here I felt really uncomfortable. Because I didn't know who was
> gonna be coming in and out of my room. And also being in a room by myself.[31] I
> was up there trying to read my book and I could feel myself, just from my
> fingertips all the way up my arm ... starting to shake.... And I'm so used to having
> someone else in the room with me when I'm sleeping. I guess that's mostly from
> being physically and sexually abused. And that's the worst, that being sexually
> abused. and by family too, for me.

Jennifer had a grade eight education; her last job, more than four years previously,

had been as a waitress at a small restaurant. She had more or less given up looking for

work as she explained the hardships of those in similar circumstances:

> I know it's getting to the point now where it's so hard to get a job. Even if you
> have your grade ten. A lot of places you have to have your GED.[32] So I guess
> that's mostly, people, if they're homeless, they have troubles with, like I said,
> clothes and education and skills.

With a history of foster homes, correctional facilities, and three children, Jennifer

explained how she became involved with the Downtown Eastside:

> I just kept coming down all the time. Beer was cheap and I just, like a lot of
> women, it's easier, they can get a beer or get a cigarette in the bars down there. So
> that's basically how I got started. Even if I had five dollars in my pocket I'd come
> down, walk around, bar-hopping.... I moved downtown and it was like a big
> magnet to me. I couldn't get away. I just wanted to be here all the time and ended
> up badly addicted to drugs.

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[31] Although there are those like Jennifer who prefer a roommate, many persons who stay at Triage favour
the single room arrangement. It is possible for residents to isolate themselves in their rooms; in fact, some
persons block the small window in their doors in an effort to create privacy.
[32] General Educational Development or High School equivalency.

Nancy

Nancy had been at Triage for about three weeks; at 32 this was her first time in a

shelter. Trying to handle a cocaine habit, she had come from a recovery house, from

which she had been evicted for drug involvement. Her dream had been to work on a

cruise ship, but instead she had three children in an abusive marriage, and worked jobs

such as waitressing, which she lost because of her drug use. Her unemployment

insurance had run out and now she was on welfare. When asked on whom she could

depend for emotional and social support she listed, besides her best friend, her father,

who had assaulted her as a child, and her spouse, who had assaulted her as an adult:

> So how do you feel safe?.... You know you're supposed to be safe, but you're not
> because you're harmed by them. So how do you feel safe, right?.... You feel safe
> at home, as a child, but you're beat up, so you're not safe. As an adult, as a wife,
> you feel you're supposed to feel safe and secure in your marriage, but you're
> abused. So you're confused. You don't know how to feel safe, so you spend your
> life wondering if you are. But I know the secure part, no way, I never been. See,
> that's what I mean.... But same as here too though ... nobody's going to hurt me. I
> have to go out the door, to wherever it is out there, that it's bad, but I'm safe in
> here.

Women in abusive situations experience denial and lowered self esteem in their

failure to uphold the domestic relationship (Walker, 1984). When they flee the violent

partner and find themselves on the street they contribute to the "feminization of poverty"

(Baker, 1994; Daly, 1996).

> Before, when my husband would abuse me and stuff ... I refused to admit that I
> was a battered woman. Even though I knew I was, but I wasn't going to let the
> world know. Forget it. I'd rather stay. I never stayed because it was my fault, or
> because I figured, okay, I deserve this. It was because, I'd be ashamed, not
> ashamed, I didn't want people to know that that was being done to me. What kind
> of person am I that this has to be done to me. And because I believed in him too.

When asked what homelessness meant to her, Nancy replied that she did not see herself as homeless. In fact she claimed she has never been homeless. Staying at Triage the night of the interview she declared that she has always had a home,

> ... even counting this, 'cause this is where I live, and this is my home.... This is where I live, if I go out there I know where I'm coming home to. It's my home.... I've never been [homeless]. I've seen it, but I don't know what it is, 'cause I've never had to actually do that.

Nancy avowed that Triage "takes care of me.... I live here, I sleep here, I eat here, it's where I live, it's my home." To Nancy home was where one was and did not necessarily connect with feelings of safety when that place had always been unsafe.

During our interview Nancy had said she was going to return to her husband: "This time around is a whole new ball game. We completely let go of each other, and agreed to go and try to recover and do our things. And get back together and start all over again." Two days later Nancy was checked out of Triage for failing to return for two days running.[33] On the third day she returned, saying the reunion with her husband had not worked out, she had spent all her welfare money on cocaine, and she had nowhere to stay. She wanted to stay at Triage again but was denied because her checkout was too recent and she was under the influence of cocaine. Some kind of discipline was required and the desire for control—namely, "the manipulation of conduct toward a desired end (as defined by at least one person)" (Melossi, 1990:46) was placed over the need for care. So Nancy spent the night in a lean-to under the viaduct across the street from the shelter,

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[33] Triage policy is to check out a client who fails to use his or her bed for over two nights. The official discharge sheet records the client as "MIAX2," which translates as "missing in action times two", another term that originates in military medical discourse.

sharing with two other persons, one of whom had recently been checked out of Triage for having drug paraphernalia and another resident's belongings in her room.

Christine

Christine, 27, was staying at Triage with her common-law partner with whom she had been living in a shared apartment, but conflicts over excessive drug use required them to leave. She had been in a detox at least eight times; her drug of choice was cocaine. With four children, all in the care of someone else, Christine had never worked a "straight" job; instead she prostituted and collected welfare. After trying to get a bed at another shelter, and being denied because it was full, she had come to Triage seeking refuge.

In the month previous to the interview Christine had used free clothing shelves, drop-in centres, food banks, and a free medical clinic. At other times she had sought shelter in a jail and in a detox. Sometimes staying outside she had once been without a place to live for over a year. She had been in a foster home as a child and within the last two years in both a drug treatment and a correctional facility.

Christine revealed the dependency issues that were prevalent in her life when she described her relationship to male figures:

> My first husband controlled me with heroin, got me wired to it. He got me wired to heroin when I was fifteen and I was under his thumb. He controlled me 'cause whenever it would come in, he had it. They'd do whatever he done with it and ship it out. And I used to have to wake up in the morning, do you know what a cap of heroin is? I'd have to do five caps before I could get out of bed, that's how badly wired I was.

Sheila

Sheila had left a rented room in Vancouver's Mount Pleasant, a working class area, because the landlord "was trying to get involved with me, like sexually, and I didn't want that, and it got out of hand, got abusive." Her main sources of emotional and social support were herself and the shelter staff. Sheila had tried to get into another shelter but she said she owed them for bus tickets and phone calls, so she came to Triage.

Nineteen years old and never holding a steady job, Sheila reported an income the previous month of $1000, from welfare, the sale of personal belongings, a godfather in Montreal, prostitution, and drug dealing. Physically and sexually mistreated as a child, she did not know whether her father was alive or dead. Sheila claimed that she had been diagnosed in the past as manic/depressive with a conduct disorder, but she reported her current problem as depression. She had been adopted through a church by some people she never lived with, but maintained that she was disowned and rejected by them when she went to jail:

> My mum gave me up when I was two months old. [Then I was raised in] foster homes, group homes, institutions. Obviously it had taken a big effect on my life because I think things would be different for me if I would have had a stable family life and stuff like that.

Those without friends or family to help them with shelter and support end up homeless, often compounded by drug, alcohol, or emotional problems (Rossi, 1989). Sheila had spent time in a drug treatment facility, a residential treatment centre, and a correctional facility. The longest she had been without a place to live was seven to twelve months having slept outside, in vacant buildings, and in post office entranceways:

I think it was really hard on me when I turned 18. My PGO[34] status was up, my guardianship order, or whatever, and it was kinda like I never really learned anything about being independent. It was kinda like, well, OK you're 18. I think that's where I had my hard time. All my life I had somebody there to turn to, and if I needed something I could get it. When I turned 18 it was like fend for yourself.

Sheila's three children, ranging in age from one to seven, were all in foster care. She directed some of her resentment to the social workers who apprehended them, for having a house and a car would not change anything in her life experience, she said, of not having her children:

I think people could have been, like the welfare system in Edmonton could have been more supportive of me and the kids. They raised me, and they put all these different labels on me. Like I'm a misfit, and I'm troubled, and I've got a conduct disorder, and all these different things. I don't blame myself for everything that I've ever gone through, but I've made lots of mistakes in my life. I mean when I was bouncing from home to home to home I never wanted that, but I was too young and I didn't know any better, and I didn't have any say, it just happened.... They just kind of used my past totally against me.

About a week after the interview Sheila left Vancouver to hitchhike up North. A few weeks later she was in a women's shelter up the street from Triage.

Sally

Sometimes, people staying at Triage are awaiting a court appearance for a criminal charge, or they have just been released from prison or jail and need a place to stay until they find stable housing. In this way the shelter is an adjunct to the criminal justice system, housing and containing those on their way in or out of the community.

Recently deinstitutionalized, Sally had been at Triage for most of the month previous to the interview and was looking for safe and secure housing:

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[34] Parental Guardianship Order

Just prior to me being released [from prison], they gave me a two hour leave with a social worker who is connected with forensics and senior citizens' housing.[35] A total of just two hours to look for a place to live just doesn't cut it.

So. at 47, Sally ended up sharing housing with a male who would get drunk and abusive: "I have to have a roommate in order to afford adequate housing. I refuse to live in a cockroach infested hotel. I seem to be making the wrong choices, in terms of roommates." Without a safe place to stay Sally came to Triage.

Prisons, like shelters, offer a form of respite for some of those trying to get by on the street (Office of the Chief Coroner, 1994). Sally referred to her being sent to prison as containing the experience she wanted if not necessarily the form: "It was a funny thing, that it's always said that be careful what you wish for and I wished for a room where I could just lock myself away and be left alone and I was." Sally explained that prison offered her a hiatus from surviving on the street:

> When I was in jail I felt free.... Because my mind was able to, I wasn't worried about what I was gonna eat and where I was gonna stay, or how I was gonna survive. That was all provided for me. It left my mind free to explore other options.

Linda

Linda was staying at Triage because she had left "an abusive relationship" and needed a place to stay. She had tried to get into a battered women's shelter but was denied a bed because she was on psychiatric medications.[36] When asked how many times she had ever been assaulted she said it was too many to count. As Barak (1990) explains:

> The violent nature of homelessness and the victimization of the homeless is
> captured in the experiences of those persons who had previously endured lives of

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[35] On the Downtown Eastside a person is eligible for senior citizen's housing at age 45.
[36] Women with a diagnosed mental disorder or who have a drug problem are often considered "inappropriate" for women-only shelters in which there are children.

poverty, domestic abuse, and/or neglect, only to eventually 'escape' into the world of homelessness (p. 7).

At 36, Linda suffered from post-polio syndrome, depression, and thoughts of suicide. She sometimes asked for money on the street and stayed in apartment stairwells and hallways. Her main support mechanisms were drop-in centres and shelters. Linda had spent some time in all of the facilities listed in Table 1 and in the month previous to the interview she had used all of the services catalogued in Table 7 except a hospital emergency room and food vouchers. She did not know whether her mother or father were alive or dead. Linda was one of two respondents who, within a month after the interview, moved into social housing. She voiced her relief at having found a stable home:

> I'm thankful to be here and being given the opportunity to recognize that my situation that led me to here has been a pattern throughout my life. And maybe now I can break that cycle [of] abuse, homelessness, self-loathing, which leads to drug and alcohol addiction and all the rest of the horrible stuff that comes with it.... I really hope that I will never have to be a resident in a shelter again. Because having my own home will allow me to learn how to better control my own life issues.

Beth

A 28 year old born in the United States, Beth had left her home and family in Ontario because of domestic violence and interpersonal conflicts. She was a visitor at Triage at the time of the interview, but had previously been a resident after escaping the dangerous and threatening milieu of many of the hotels on Vancouver's Eastside (Currie, 1995):

> I was in a downtown Eastside shooting gallery hotel.... I was living there. My privacy was robbed from me. Like, I just couldn't live. Every time I left my room it was broken into by the residents that lived in the hotel. Or people visiting the residents. So I felt that my privacy was violated.

Beth, again living in the rooms of the Downtown Eastside, visited often at the shelter, sometimes volunteering, as she said this helped her stay "clean" and off cocaine: "If I'm having a really hard time dealing with something, I think about using, I'll come here.... It gives me comfort. It gives me support. It's my main support system."

There are many ways that people end up at Triage. Of course, all need a safe and secure place to collect their thoughts and recuperate from the existences they lead, but to suggest, as some people do, that all homeless persons have to do is get a job and secure their own place is to deny the effects of the tragedies and histories of their everyday lives. They can choose to do things differently but they have no choice as to the conditions that circumscribe their everyday choosing.

Images of poverty and "the system"

In 1996 the welfare rates in British Columbia started at the single person monthly allowance of $500—$325 for housing and $175 for support. The support level was higher for unemployable and handicapped singles but the allocation for housing stayed the same. The monthly allotment increased for couples and families with children. Starting in March of that same year, and continuing for approximately 12 months, the government restricted access to welfare services for those who had been in the province for less than three months.[37] Bruce, who was staying on the streets before securing a room at Triage, commented that he saw "people living on the street, that's sad. Like living under bridges and stuff like that. And this new law that's in effect, like the three month residency, putting a lot of people out." In March of 1997, in accord with the

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[37] This law has since been repealed.

cutbacks in social services happening in Canada and other Western states generally, the

provincial government proposed to cut the benefits for single unemployables, that is,

those with a physical, emotional, or mental disability, by $96.[38]

Service provision resentments

Anger and hostility at a system that appears to foster degradation and control is a

comprehensible response when frustration levels overtake the social skills needed to

communicate with the bureaucratic structure of public assistance. Donna expressed

frustration at being denied "a little bit more" which she explained through her

marginalized status:

> So you have to even argue with the workers there, half of the time. Sometimes
> they will call you down pretty badly. Sometimes they tell you you're no good,
> you're no good, you're never going to get anywhere, things like that. Welfare
> workers do tell you these things. If you ask for a little bit more, like you're saying
> that you need your stuff moved, they give you all this run around to do this, to do
> that. And they do call you down. Like, one time there, telling me I was no good. I
> couldn't read, right. You're never going to get anywhere, things like that. One
> worker told me that. Like you feel really low and dirty sometimes, when they tell
> you these things. After they do things like that to you and you complain to the
> supervisor, the supervisor still backs up the other workers so you can't really do
> anything about it. But I live with it. If you've got no income coming, you just got
> to put up with them I guess.

The participants expressed anger and resentment when they explained what they

would have to go through in order to get help with their problems. Because Linda arrived

at Triage on a weekend, when the welfare offices are closed, the staff were able to have

her stay authorized over the telephone through the after hours service. On the next

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[38] The proposed plan, which would have reduced benefits for about 15,000 people, was put on hold at the
last minute.

business day Linda was expected to contact her financial aid worker directly to explain

her situation:

> I heard this expression, many, many years ago, it's not who you know, it's who
> you blow, in order to get ahead in the world. Well, sometimes it feels that way
> trying to get assistance. Like you have to kiss ass in order to get your basic needs
> met, and that's part of the humiliation that I experience.... I came into this
> particular shelter on Saturday evening, and when I phoned [the financial aid
> worker] Monday morning to make her aware of my circumstances and the history
> behind this particular crisis, I was told that I would only be allowed a certain
> number of days at Triage and then to go back to the abusive situation and deal
> with it on my own. And I thought that was totally obnoxious and it flipped me
> right out.... I want to be secure in the knowledge that if I'm crying out for help
> somebody will be there to listen. Sometimes that's so hard to find.

The qualities that conservatives associate with the demoralization and profligacy

of the poor, such as lack of future orientation, inability to defer gratification, inability to

separate wants from needs, and lack of self-discipline are the very qualities that the

consumer society encourages and promotes—the attributes of the ideal consumer

(Ehrenreich, 1987). Beth, referring to another shelter on the Downtown Eastside,

evidenced hostility at having her emotional needs put on hold:

> I experienced, just the staff you know, what they said, a couple of clients came up
> to the desk and they go like 'fuck off, I'm not in the mood right now to deal with
> you'.... Some of the staff, you come to them and you're an emotional wreck, they
> tell you to go see your doctor. Look it, my doctor's not here right now, how the
> hell am I supposed to go see my doctor when I'm here. This is a shelter, this is
> your job, you're supposed to be able, this is what you're supposed to do, is listen
> to me, and hear me out.

In capitalist society dependency has a stigma related to the ethos of individualism

and independence, even though most human beings are dependent somewhere (Simpkin,

1975). Nancy expressed anger at the stigmatization of having to ask for a helping hand:

> I get mad, especially because I've worked all my life and I just asked for some
> help because I need it. So I can better myself, and these people make me feel like
> I'm worthless.... The social services, the welfare. They treat you like you're
> nobody. They want you to work, they don't want you on it, period. They don't

think you should have it. That's how they make you feel.... I don't think it's fair. I've admitted that I have a drug problem and I've asked for help and like I said, I've paid my taxes all my life. So why should that person behind the counter make me feel any different than him or her, because I'm not. You know, other than having a problem with the drugs, I'm as normal as they are, and I work and pay taxes, so I'm not any different than they are, and either are anybody that doesn't work. They have no right to treat you that way.... And then they wonder why people will steal or they'll get their money their own way, because they don't want you on welfare.

For others, choosing to stay outside is a technique of establishing identity and empowerment in order to avoid the indignities of welfare and enduring an existence in the rooms. Tony had direct experience of staying outside under trees and bridges:

> It gets where a person, like so often I think about just, buying yourself a little tent and a sleeping bag and go off into the bush somewhere because it just gets so depressing, on welfare. So dehumanizing. It eats all your self-worth and self esteem and self confidence. Self awareness.

Surviving on social services

In the urban milieu a nucleus of service institutions shares a territorial space inhabited by discredited and discreditable persons (Goffman, 1963). There are about 276 agencies that operate on the Downtown Eastside of Vancouver (Daniels, 1996) and services are plentiful. However, as welfare services are increasingly privatized they are often duplicated and poorly coordinated, producing a rivalry between agencies that is simultaneously professional, political, and economic in form. This may offer more choice for the client but not necessarily a more efficient or effective service, especially when the various fund seekers have to compete for scarce funds (Rekert, 1993). Sally explained that surviving on welfare is a full time job, requiring perseverance and ingenuity to get by on limited resources:

> If you're going to spend all day walking to a foodbank or walking to this place for breakfast and that place for lunch and that place for supper, to all the charities and

standing in line, how do you have time to go look for a job?.... So you know your choices are too limited. You can't be 'a better part of society' because you just can't afford to be.

Being on social assistance can further a cycle of dependency in which self-esteem deteriorates over time. Linda said that welfare "is a humiliating way to live ... having to depend on social services is a very humiliating experience for me." Linda defined her life experience as one of ongoing paternal relationships in which welfare was but another manifestation: "My life has always been empowered by some sort of institution or government agency or marital relationship. I've not yet discovered what it's like to have my own personal power."

The current focus on the poor as undeserving "is an easy political strategy ... [drawing] strength from an inherited political culture, from nineteenth-century ideas about the low morals of the poor and from nineteenth-century schemes to make the poor shape up by disciplining them" (Piven & Cloward, 1986:83). For John, "welfare means, especially with all the media and the like bashing welfare recipients, I think it means once you go in that office and fill out those forms your self esteem, your self pride hits a new low."

Welfare and crime

In a study by Snow, Baker, & Anderson (1989), although the homeless committed a disproportionate amount of crime compared to the general population and had a higher overall arrest rate, the crimes for which they were arrested were relatively minor, and their arrests were more a factor of criminalization of activities, stigmatization, and adaptational processes in a "mismatch between conduct and context" (p. 543). Although

the findings of Snow et al. pertain to activities in a large Southwestern city in the United States, we can cautiously generalize their findings to other locales. Furthermore, the fact remains that the crimes of the homeless are far overshadowed by the crimes of a capitalist state that allows such suffering (Aulette & Aulette, 1987).

The selective transfer of social assistance lacks concealment and legitimacy making certain forms of petty crime, or "remunerative delinquency" such as prostitution, shoplifting, and drug dealing, an eligible alternative (Armitage, 1975:134). Sally commented on the political and media focus of welfare claimants as cheats: "I believe that the fraud that goes on within the welfare department has a lot more to do with the people that are supplying accommodation and services than people who are actually getting a little extra money." Sally is supported by studies that report most of the welfare losses attributed to fraud by clients are actually a result of administrative error and less than five percent is attributable to trickery by welfare claimants (O'Connor, 1973:164; Robertson, 1993). Much more fraud and chiseling occurs in the business and professional realm. The wealthy can manipulate the tax system to their advantage and if discreet are called crafty. If the client exploits welfare, he or she is labeled manipulative and criminal (Simpkin, 1979). Sally observed that being on welfare means "you have to learn how to scam it as much as you can. Just to survive. So that necessarily puts us all in a criminal class. So I don't know if it's, poverty's a crime."

Mark observed how the management of some hotels on the Downtown Eastside take advantage of the system by submitting rent receipts to the social service department that have been purchased for a reduced price on the open market: "You know it's still

goin' on that these hotels have got nonexistent people, nonexistent numbers of the rooms

even."

Many of the participants were cynical about the future of welfare in Canada. Jim

said that welfare in the coming years "won't exist. Crime will go up, 'cause nobody has

money and nobody has means. They're gonna have to find it, somewhere." Brian

compared the erosion of social benefits in Canada to that in the United States:

> Say if we lose our welfare, and our street gets rougher, well a lot of us haven't
> really been brought up like around guns too much. Like we could probably never
> survive in the States, a lot of us. But our country will probably eventually, maybe
> be like the States someday.

Charles maintained that the social cuts are necessary, but the result will be

increasing disorder:

> The States are cutting back on their welfare system and we are too. It's kinda
> unfortunate, but in a way it has to be done, to take care of our deficit that we got.
> But yeah, with the welfare cutbacks it's just gonna mean more and more robberies
> and B&E's, and whatever else.... If you cut something back, something else goes
> up. There's always another side to a flip side to whatever happens, whatever you
> do.

Reynaldo suggested that social assistance to the poor is a technique to keep the

"dangerous classes" from threatening the social order: "It would turn into chaos here if

there wasn't welfare.... There would be more crime and looting." Reynaldo's

understanding is well supported by many academics and researchers (e.g. Piven &

Cloward 1993). Brian continued that state support is "maybe an easy way out, an easy

way to survive.... If it wasn't there I guess most of us would have to find other ways to

support ourself. Whether it be crime, or prostitution, whatever."

Shelter can be obtained under a bridge, in a park, or in a doorway, but denied food

and other necessities of life a person is more likely to resort to theft or other means to

ensure survival. Food lines and free clothing shelves at least offer the poor an alternative.

Sheila, the 19 year old with a history of staying outside, residing in various

shelters, and being placed in institutions, indicated that the cuts to social assistance will

result in increased desperation for those involved in the street:

> I think that the welfare cuts are gonna have a major effect on society. The crime's
> gonna go up, and because people aren't gonna have money for their drugs and
> stuff like that, they are gonna do whatever they can to get money, even if that
> means robbing people, or anything.

Because 50% of street-involved women on the Downtown Eastside "are spending

between $100 to $300 per day on alcohol and other drug consumption" (Currie, 1995:29),

implicit in Sheila's comment is an argument for decriminalization of drugs. Many of the

poor forgo paying rent for a room in order to have money for a temporary retreat. Denied

legitimate means to escape "an environment of social, physical and psychological pain,"

(Office of the Chief Coroner, 1994:40) many choose drugs to cope with their

circumstances. Building more prisons seems to be one policy to deal with the problem,

but another approach attributes many of the social ills and costs imputed to drug use on

the Downtown Eastside to its social interdiction rather than to the drug itself (Alexander,

1990; Boyd, 1991; Brandt, 1996).

The cycle of homelessness

Morris supported the idea that homelessness is a nebulous condition that embraces

a diversity of vulnerable people: "People who are on welfare are basically homeless

anyhow. Most people in the East End, like the poor part of town, they live in hotels and

stuff but they are still homeless." The emergency shelter provides homeless persons a

short-term reprieve from debilitating conditions, but its effects are limited in addressing

the challenges they encounter in their everyday lives. As Mark observed:

> I can see these people are ill prepared for going back out into the street. I mean who is, but in terms of resolving the real issues that probably brought them here I don't see that happening. Straightening them out for a day or two is just basically gonna give them the feelin' back so that they can go out and do it again.

Phil explained that for him the shelter provides a temporary waystation in the

game of surviving on the street and in the rooms:

> You can't send somebody out and say okay, we're going to put you here, you're going to be safe now, 'cause it's a whole self, mental. See I come in here to get my head back on. Go right back out there and if I do that again, next year I'll be here again. I never gained an inch. I lost out there. Picked up a couple of diseases that are terminal. So it eats you up.

Homelessness is interspersed with stays in a wide variety of settings and the more

unstable and less supportive the exit domicile the higher likelihood of "residential

instability" (Sosin, Piliavin, & Westerfelt, 1990:171). Accommodating the poor in cheap

rooms is no solution to homelessness. Jim remarked that the system often fails those who

are homeless, "because there are people that have left here and have gone to hellish

hotels, and it's only a matter of time before they're either dead or back in the shelter

again."

Morris expressed his need for individualized support from his welfare worker.

Unfortunately, large caseloads, increasing demands, institutional pressures, and limited

resources at the welfare department obviate such license. "[Welfare workers] do not

participate in helping people at all. They just give them their cheques, or not give them

their cheques. They don't really help." Edward perceived the system of public assistance

for the very poor as doing little in the way of ending homelessness or of decreasing its

constant threat : "Many times welfare leads you to be homeless. I think welfare

contributes to people being homeless."

For the very poor the correctional system has become a provider of basic services

(Breakey & Fischer, 1990) since "jail can be more of a relief than an incapacitation or

deterrent" (Office of the Chief Coroner, 1994:68). Tony voiced a sense of powerlessness

and resignation:

> I've talked to a lot of people who really get so discouraged, then they talk about
> robbing banks and that sort of thing. Better off being in prison. Because people
> have been in prison and they are, in some ways, better off, you're better off in
> prison than being on the streets on welfare. In prison you feel like, talking about
> the power, you feel like you have more power than you do when you're living
> down in some skid row hotel.

On the role of welfare in his life, Reynaldo observed that financial support is only

part of his problems: "I'm able to work, but I need a little bit of help and unless I get that

help I'm always going to be at the poverty level no matter how much money I make."

Men-only shelterization

Historically, single adult employable men who are homeless are offered minimal

support because they are deemed to be "intentionally homeless" and not deserving of

assistance. As this population grows so do the number of shelters set up to accommodate

them. Large shelters, reserved for single adult men, are impersonal, bureaucratic,

dangerous, and "tend to induce feelings of shame, inadequacy, and hostility" (Daly,

1996:157). The practices of these shelters contribute to the homeless condition:

> These practices include placing a large number of residents in a dormitory-like
> setting; inappropriate short-term limitations on length of stay (which tend to
> induce transience); night use only (residents are forced to leave early in the
> morning); minimal staff-to-resident ratios (which makes it difficult to provide a

secure environment); staff members who adopt a controlling or punitive approach to residents; limited resident involvement in the planning of the shelter or its operations; and only tenuous connections to supportive community services (Daly, 1996:157).

Catholic Charities is for single adult men who need a place to crash for the night and who are unable to get into one of the smaller shelters. Mark had stayed at Catholic Charities and observed that it had,

> ... a real rough crowd in there. I think a lot of guys comin' out of prisons, or just going back in. A lot more people facing issues related to the courts. It's rough. A tough place. A lot of younger guys that are in there, that are being penalized by the social system for having screwed up. So they're extremely resentful. They're in the downtown core where the heroin and the cocaine and the drugs are happening. Very unfocussed, I would say, that place. And the agenda of the staff that's there. I don't know where they come from or what their backgrounds are but very power-mongering type people, when I've been there. They really like people to stand in lines.

Tony pictured Catholic Charities as worse than a prison in the attitude one has to develop in order to survive the "nightmare":

> A lot of people with bad attitudes. Puts people in a certain defensive mode and they start developing an attitude themselves, just to survive. You got to act tough, like you can take care of yourself, because if you don't people are going to walk on you.... It's actually more depressing than prison. I spent some time, a year and a half in prison, and it was much more depressing in there than prison.

Tony explained how Catholic Charities contributes to the homeless condition through its practice of,

> ... sending you out in seven in the morning. Of course everything's closed at seven in the morning, and the restaurants you're supposed to eat at, and so all you can do is walk around and keep the chills away until things begin to open up, the libraries, Carnegie Centre, and that sort of thing.

Reynaldo illustrated how sleeping in large shelters for the night contributes to homelessness and instability when life is organized around basic concerns for shelter, food, and survival:

They made you leave at 6:30 in the morning. You slept in a place where there was 50 beds in one room. Everyone showered in the same place. You got a meal ticket in the morning, you had no time to even contemplate what you were going to do for the day. You were planning on what you would be doing outside at that particular time. Pretty shitty ... worrying about what you're going to eat during the day.

Institutional dependencies

During the month previous to the interview 14 of the participants had stayed in shelters more than three nights per week. The shelter provides asylum from the streets and rooms of the Downtown Eastside but it can also create "cycles of dependency" in that the clients come to rely on the institution to fill the empty spaces in their lives. Morris remarked that Triage "has a lot of people that are dependent on it, it's almost like an addiction. You just get like, it's like a routine, it's like being in prison, you don't know anything else after a while."

For those without stability and formal relationships of family Triage offers a structured institutional environment that Simon described as a,

> ... comfort zone, just like when you're in jail, it is that comfort zone. This is a bigger comfort zone. There's no pressure. There's basic rules, which I respect, you know, I understand it, we all understand it. Some understand it better than others but, we're all lonely you know, at some time in our life, not everyday. We're all lonely before we come here. And you know the catch, and it's part of life when you leave here, whether you're going back downtown, or whatever the situation. Some people are fortunate enough to have family they can go back to, or that sort of thing. I don't have that. So I can prepare myself for the loneliness I know I'll feel when I walk out the door. And it's a harsh fuckin' thing, for lots of us.

Public wants and private needs

On the Downtown Eastside "Mardi Gras Day" is the third Wednesday of every month, when the government support cheques are issued. Luke described it graphically:

I think that welfare day here is insane. There's so many hundreds of people, thousands of people, running around with their welfare cheques. Spending it in two days, three days.... Welfare day is a big party day down here 'cause everybody is so broke, for so long. At the end of the month they get their cheque and they don't know how to handle their money and they go out and whoop it up, drink, whatever they do.[39]

Reynaldo commented on the need for increased support and acceptance to those in poverty and dispossession on the Downtown Eastside: "A lot of people are getting welfare and blowin' all their cheques. So you know it all comes down to helping the people."

In 1994 Vancouver had three detoxs, Vancouver Detox, Cordova, and Pender, which were not enough to keep up with the continuing demand (Office of the Chief Coroner, 1994; Currie, 1995). Then in the same year Pender Detox was shut down, leaving only 42 beds to service the whole of Vancouver. Nancy remarked about there being only two detoxs:

> There's Vancouver and Cordova, and that's it, in all of Vancouver, that's the only two. So what do all these people do? Like I phoned and I waited four days. People wait a long time. If people want the help, the help just isn't there.[40]

Donna, who was staying at Triage to get help with her drug problems, reported a total income for the month previous to the interview of $2000 flowing from a combination of social assistance, drug dealing, and royalties from an Aboriginal settlement. She had previously lived in accommodation that rented at over $500 per month with a male partner and her children, which she left because of a combination of a lack of money, a rise in rent, cocaine use, and assault from her live-in partner:

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[39] On welfare day, and the day after, there is a dramatic increase in drug overdose deaths on the downtown Eastside (Office of the Chief Coroner, 1994).
[40] In trying to obtain information on the closing of Pender, I phoned Cordova Detox but was put on hold; after about five minutes, the line went dead.

> The welfare cut down my support so it was hard to find a place. I get about ninety
> dollars every two weeks, but they still cut me off, about half of it. Not all of it
> though, just some of the support money. So I couldn't find a nicer place. And plus
> they wouldn't take the kids, if it was a one bedroom, and it was hard to find a
> place.

Donna's problems were far more than just economic. She wanted emotional and social

support for herself and her children, but in a climate of dwindling funds and increasing

need the attention she required was subordinated to reduction of risk and management of

crises.

In the welfare state there is a distinction between *want* and *need* resulting in an

over-emphasis on remedial measures and a lack of attention to preventative practices

(Armitage, 1975). Triage is a short-term emergency shelter with institutional pressures to

turn over beds similar to that found in emergency psychiatric units (Rhodes, 1991).

However, at Triage, the responsibility is placed primarily on the client to find his or her

own housing, whatever that may be, except in circumstances where the individual

obviously needs individualized assistance. Donna's want, a safe and secure place she

could call her own, was private and individual. Her need, state assistance and temporary

shelter, was public and social. The system is organized to meet her public need but very

little attention is directed to her private want.

Marginalization, homelessness, and conceptions of home and shelter

The stigma of homelessness and the selective transfer of social welfare

contributes to a lowering of self esteem such that politicization and making a stand

become almost impossible. Simon explained that there is minimal resistance left "when

you come in from off the street, very little self esteem, no confidence, just down and out, feel like a piece of shit, just kind of crawling alone and dying."

Marginalized identities

Role encapsulation is about taking on the identity imposed by others (Lofland, 1969). The marginalized and homeless person is defined through his or her actions of making ambiguous the lines of moral conduct. The homeless and near-homeless individual defines self in interaction with others and "action is built up in coping with the world instead of merely being released from a pre-existing psychological structure by factors playing upon that structure" (Blumer, 1966). Role encapsulation infused every aspect of the participants' lives and was experienced differentially according to gender.

In the "daily round" the stigmatized person manages his discredited or discreditable identity—the frames of reference may change but the management process remains the same (Goffman, 1963:91). John, who had a psychiatric disability and was living in a downtown hotel, was resigned to his marginalized identity:

> When you're on welfare and you're from the Downtown Eastside, if you dare leave then you're going to get a lot of sort of discriminatory glances and what not. People find out, and I have found that is a huge stigma. This area is polluted with the rest of society's stigmas.

Luke mentioned that "some people don't even want to tell their landlord they're on welfare. They won't even go and apply for some places because they're on welfare. They think they won't get in, they won't even try."

Age, race, gender, sexual preference, and class all intertwine to diminish a person's chances of finding meaningful work and a secure place to live (Hoff, 1989). Marginalized persons often experience resistance from conventional normals in being

accepted into their ranks, for example in employment. Donna, a Native Canadian female,

described the obstacles to seeking acceptance when one is of marginalized status,

> ... when you go someplace and even the office people ignore you. And when you
> go find a job, you fill out the application and next thing you turn around, you see
> your application going in the garbage. Sometimes they say, oh we don't need your
> kind here. And I don't understand that shit you gotta put up with.

Linda expressed her need for acceptance and the alienation that comes from being

identified as a welfare recipient:

> When I go to the bank to cash my issue cheque the bank tellers they won't even
> look up and say hello. Whereas the business person standing beside me gets a
> hello, how's your day, you know. And it makes me feel like a lower class citizen.
> You know, that I'm not equal to the rest of society because I have to be dependent
> on social services.

Those who are poor, marginalized, and downtown often generate singular

expectations about their character, contrary to that accorded "conventional" society, as

Jim illustrated:

> There's been times in my life where I've had epileptic seizures, and I was found
> on the street, and I came to, and I was in a drunk tank. And I hadn't even been
> drinking or nothing. And this is my theory—just because I was native, lying on
> the street, in this neighbourhood, that's what I was. No ambulance or nothing, that
> I know of were called.

Luke expressed resistance to the stereotypical label of welfare recipient: "Everybody's

view, they see somebody on welfare, it seems they either think that it's somebody who's

abusing the system, or just another lazy bum, you know."

Christine explained how a gendered role status on the Downtown Eastside

contributes to discrimination on the basis of sex:

> I get discriminated against all of the time. If it's not for being a woman, it's for
> being a prostitute. If it's not for that it's for being a drug user.... A lot of men, you
> wear a pair of spandex and a tight shirt, and I'm sure they've been wrong more
> than once, but they just usually approach you.... I've got guys stop and offer me
> ten dollars for a blow job and I laughed. I just laughed. If I was working, first off

pal, I'd charge you forty. Secondly, don't you think this is a bit rude, I'm carrying school books.

Individualized responsibilities

· Many of the research participants blamed themselves for their circumstances. This general acceptance of individual fault and blame is a form of false consciousness in "the adaptation of the dominant ideology by the subordinate classes" (Collins, 1982:40). That is, the subordinate classes fail to perceive how the apparent equal rights bestowed by the liberal state actually translate into substantive inequality. Armitage writes (1975:30) that "it is typically found that stigmatized populations hold very negative stereotypes of one another. This, in turn, makes it difficult for them to work together politically to obtain change in the society around them." As long as the many who are excluded share the viewpoint of the excluders, the ambiguity of this universalism goes unchallenged (Melossi, 1990:37). This is exemplified in Paul's statement that, "if you're a responsible person and pay your rent, you wouldn't be homeless." However, homelessness is a much more complex interaction of events than just paying one's rent. Beth suggested that "you should never be homeless and never have nowhere to live. That's why we have shelters. That's why we have food lines."

Sheila was able to differentiate between having four walls and living in a home: "I guess I've always thought of my life as always being homeless 'cause even though I had a roof over my head, food, and everything like that, it never was my place to me. Like I shouldn't ever been there, so I never considered anywhere I went my home, it was just a flophouse."

Phil, the ex-miner whom we met earlier, individualized and internalized his experience of poverty and powerlessness and blamed himself for his unfortunate circumstance: "I'm here because I put myself here. I didn't get here accidentally. I earned my place in this world. For being an asshole for a lot of years." Phil is certainly to be commended for "owning his stuff" but we, as a society purportedly concerned with social justice, are also responsible to those who fail to keep up.

Triage staff would sometimes blame homeless individuals for the situation they were in, saying that they choose their situation and they are responsible for getting out of it. Assigning personal responsibility to the individual and neglecting social context helps to keep the marginalized subjugated and deflects attention from the political economy. Often, "anger fomented by social conflict is not directed at economic elites ... but at other groups in the ghetto" (Daly, 1996:6). This is a form of ressentiment, namely,

> ... a free-floating disposition to visit upon others the bitterness that accumulates from one's own subordination and existential guilt at allowing oneself to be used by other people for their own purposes, while one's own life rusts away unnoticed (Friedenberg, 1975: xi).

Marginalized individuals often scorn the stigmatized group to which they belong in the management of their own discredited identity (Goffman, 1963). Bruce supported the ideology of individual responsibility and said that if welfare were restricted,

> ... I think they would change. They'd think twice. It wouldn't be put on a silver platter, put it that way. They'd get up and look for a job. Here's a bus pass. Maybe a bus pass and some food stamps or something like that. Your rent paid for a month, get a job. There is a lot of work out there. But the minimum wage is the highest in the country right now. I mean you can live on seven bucks an hour. You'd be scraping but it's more than welfare. Plus you'd have your self esteem back, you know.

Although Beth supported an ideology of choice she did acknowledge it is easier

said than done:

> If you take the group of homeless people, which is a big group, they choose to be
> out there.... I mean sure there's a lot of drugs and there's a lot of hurting people
> out there, but they keep theirself in that situation, nobody forces them. Not too
> many people are forced to stay in the situation, what I see in Vancouver's
> Eastside. It's their choice. And it's their choice to get out of it, but a lot of people
> are in so far that they can't get out, it's hard. It's really hard to step out of that
> when you're used to it for so many years.

The most effective form of social control is self control through an internalized

acceptance of prevailing dictates rather than a coercion toward normative practice

(Melossi, 1990). For the marginalized poor the acceptance of their condition as self

evident laws of nature organizes their thought toward individualistic explanations of

homelessness. "The poor throughout history have always been taught to accept their

poverty" (Worsley, 1982:66). Beth remarked:

> I'm grateful for the shelters, but I would not want to live in a shelter for longer
> than thirty days. The shelter's only there temporarily. Once they help you get out
> on your own, if you fuck up I don't think you should be helped again, that's the
> bottom line.

Conceptions of homelessness

I asked the participants what homelessness meant to them. Beth described it as

"an awful feeling. I cried. I felt really alone, I really did. I felt total alone. I felt like the

world had abandoned me. That's what I felt like. It's an awful feeling." For Luke

homelessness meant "nowhere to stay, no one to turn to. You know, just being totally

alone. Lost." For Brian it was "being lonely. Scared. Survival."

Paul described the feeling of being homeless as one of abandonment and

isolation:

> Homeless, oh God, that's despair. It means despair, loneliness, what am I going to do, stress and anxiety. Oh God, like walking the streets on a lonely night when I don't know where to sleep, that's homelessness. On a rainy night especially, or a cold night.

Linda described homelessness as "absolute despair. Total and complete depression. A feeling of absolute no self-worth. Being lost."

Allan articulated the sense of hopelessness and resignation that can occur when one lacks safe and secure housing:

> Homelessness can mean a great deal to different people. But to me it means that you're not able to support yourself, whether through physical or mental or even emotional disability, and you don't have the supports in place to get you to where you want to go. And so you're either shuffled off or you just decide that this isn't worth it, you know, this trying to get ahead is not worth it. So I'll stay where I'm at.

Jason, who was HIV positive, observed that to have nowhere to turn when one is poor and without social support is,

> ... very scary. For the first little while my problem, my biggest problem, being positive, I thought there was no other person out there like me. I thought I was going to die in a month, that's what I heard about it until I wised up. It's terrifying of having nobody, it's like being in a round room or a room with the lights off, you can't see fuck all, it's pure black. That's exactly what it feels like. You are a little kid in a little dark room and you are terrified 'cause you think that the boogie man is going to come out. There you go, that's what it feels like.

David was a visitor at Triage who occasionally came in for a meal or clothing from the donation room. At the time of the interview he was staying outside. For David:

> Homelessness means loneliness. It means without shelter, it means poverty, it means struggling, it means living day to day, trying to hand feed yourself, mouth to mouth, you know. Eating at Triage, eating out of garbage cans, eating off the street, literally picking stuff off the street and eating it. You're poor, that's what it is. You're poor, man, that's what it is.

Trying to avoid these feelings of rejection and despair a homeless person may consider activities that are materially rewarding but intrinsically debasing, as Donna explained:

> Homeless means that you have no place to go, that you're out on the street. Selling yourself, to signal a car just to drive around, or things like that.... It feels dirty, disgusting. I got a step daughter who's sixteen years old. She's always kicked out and she's always selling herself down here, so she can have someplace to stay. I see a lot of fourteen, sixteen year olds doing that.

Conceptions of home

Happiness means positive self-image, physical health, meaningful work, and a secure place to live (Hoff, 1989). The social ideal of home has much more meaning than just shelter—it is a place of security where identity is defined and to be without a home extends to fear of abandonment, isolation, and being alone (Stone, 1993). Donna depicted how, for her, a home is more than just four walls but is a place where her needs for acceptance and recognition are validated by a positive other:

> A home is having somewhere you can have your backyard and your own space. A nice place, kitchen, bedroom, living room set, everything else, even your kids there. But I know I couldn't handle it all by myself. I couldn't live, handle it by myself 'cause I'm too lonely.

Tony explained the importance of social support and recognition to those who lack emotional resource:

> Homelessness goes beyond not just having a place where you can sleep for the night, I think it's also having some sort of support from friends and family. I was cut off from that sort of support and I feel that's where the hardest part really is. When you have no one to turn to, to help you. You can just look for moral support, not necessarily financial support, but even just moral support.

The transient lifestyle of hotel living makes the creation of home difficult if not impossible as Phil explained:

What I'm lookin' for is a room that's quiet, where you don't have to put four padlocks on your door.... I was living in a hotel where you have to go down the hall to the washroom. That's not a home, and that's where the tension comes from. And the neighbors, the junkies, the bums, the crooks. So it's not home, it's just an existence. I think that's why the constant moving from hotel to hotel. You get so tired of one place, you accept the same thing, just different people, you know.

I asked the participants about power and what it meant for them in their daily lives. Sally talked about a feeling of impotence that comes from being poor and lacking resources,

... because when you don't have money you don't have a home, you don't have security, you don't have food. Powerlessness means that you have no control over your own future or your own life.... If I were in one of those cockroach infested hotels right now I probably would be right in the thick of everything. In the bar, because where else would I go?

Seeking safety

For many persons who live on the Downtown Eastside safety is a condition that is foreign to their everyday experience (Currie, 1995). I asked the participants what safety meant to them and their responses show how experience can vary according to gender. David described safety as,

... feeling protected, you know. Feeling safe, feeling secure, knowing that you have a house, knowing that you have shelter, that you have food, knowing that you won't run out of food, knowing that you won't, you know what I mean, drown.... Like being able to go to the store with what little I have and being able to bring it home without getting hurt. Just going shopping and not worrying about seeing a robbery or someone robbing me, or an old man or old lady.

Triage provides a safe place where fear of personal threat is drastically reduced, if not made temporarily non-existent. Phil compared staying at Triage to staying in the rooms: "There's not many but there's certain rules. Nobody's getting strong-armed for

smokes or money, or abuse. It's not allowed. So therefore it is safe. Whereas a block

away that's not true." Brian added, "nobody's going to kick our door down here."

To Sally the shelter provided "safety from assault, from sexual assault. Safety

from starvation. Safety from medical neglect. Safety from landlords. Safety from not

being victimized. Safety isn't necessarily having six hundred bolts on your door."

Shortly after our interview Sally left Triage to move into a hotel. When I saw her ten

months later she told me she had recently tested HIV positive.

Although some persons prefer to camp outside rather than live under the

debilitating conditions that exist in many downtown hotels (Currie, 1995), Tony observed

that such sleeping arrangements have certain drawbacks:

> It's against the law to sleep in Queen Elizabeth Park and the police come there
> and they sweep up the area every night. And if you're caught sleeping you're just
> told to pick up your things and move along. But you have to have a place to sleep.
> You can sleep under bridges here, the Georgia Viaduct, but it's very, very
> dangerous. For one cigarette they'll put a knife into you. Really. You got a warm
> jacket, they'll mug you for it.

When Tony suggested Triage is "providing an alternative to the parks ... and to bridges,"

he neglected to mention that Triage is also providing an alternative to the hotels.

Christine revealed how she depended on a male figure to help her survive the

streets:

> My dad used to go to work, he worked for Petro-Can and he'd go out that door,
> like it was shifts. My mom would get drunk and just beat the living hell out of me.
> So I'd wait for my dad to come home; he was my security. So now the man in my
> life I depend on for security [is my partner], 'cause I am very, very insecure. So
> security, it's almost like life and death. I guess that sounds really weird but
> [partner] and I have slept in parks and we've always been side by side, and
> knowing that, I've been able to sleep. He's usually awake making sure nobody is
> coming after us.

Although nine of the respondents paid over $400 for their last place rented, only five said they could afford more than $400 for rent at the time of the interview. This would indicate that some persons are finding the extra money to cover their rent by cutting into their support money or getting it from somewhere outside the welfare service. Christine was able to pay for an apartment through the pursuit of underground activities but evictions were an expected cost of her lifestyle:

> When you're a prostitute, you never have an apartment for very long.... In two buildings they found out I was a prostitute and it was, okay you do me the daily favour, you guys can live here. I was like excuse me, I pay my rent I don't have to do nobody no favours. And we got evicted.

Nineteen of the participants were optimistic about finding housing and said they would find a place within a month. After a week at Triage Christine expressed this optimism by asserting:

> I knock on wood and don't foresee losing an apartment because I won't be working the streets. I'll be going to school, and the way I dress for school is very much different than the way I dressed when I was going to work. So I can't see any landlord thinking any different and making advances or just hating me and saying get out.

Seven of the respondents were not so sure if they would find stable housing in the near future.

The homeless and near-homeless are marginalized in their position of poverty and lack of social resources. For those who live in downtown hotels alienation and isolation are everyday realities and the community shelter becomes a refuge of social support and safety. Not all who come to Triage live in the rooms of the Downtown Eastside, of course, but for those who choose alternatives such as surviving on the street, the costs of living on the edge and accepting the identities assigned can be devastating.

Living on the edge: In the rooms and on the streets

Public places to which anyone has access but which are hidden from view, such as streets, alleyways, and corridors in cheap hotels, are facilitative of dangerous events (Lofland, 1969). The participants talked of the dangers present in some of the downtown hotels and on the streets.

Living in the rooms

Charles had lived in the rooms, off and on, for 14 years. For him, living in a skid row hotel,

> ... is Hell. Nothing but fights and screaming and partying going on down there all the time.... I've actually learned to accept it. Learned to listen to all the bullshit that goes on there. And to think it's normal. And eventually it kinda wears on you, and it doesn't really affect you or bug you any more. As they say there, the longer you stay around the area, eventually you become like the people.

Most of the cheap hotels on the Downtown Eastside are dangerous places to be: sexual harassment, homophobia, and racial discrimination are extensive (Currie, 1995). Twenty-one of the participants said they would be able to pay between $301 and $400 each month for their own place. This accords with the $325 monthly shelter allowance from the welfare department. It is also in line with the usual going rate of $325 a month for a room in a run-down hotel. Donna maintained, "I don't really want to stay in the downtown area but that's the only place that you can find for $325 a month. But I know I'll be doing drugs again if I do that."

Some of the skid row hotels, catering to those on handicapped allowances, rent rooms for more than $325 a month, offering services such as a communal kitchen and 24 hour security. Sally commented:

I find it quite interesting too that I went to the Hazelwood Hotel, which is considered to be a better and more secure building and cleaner than most and houses a lot of people who are on disability, and the rooms are varying in rates of $325 and up. So, they're obviously considering that the people on disability have more money, so we'll take that too.

Luke illustrated the constant comings and goings in the downtown rooms and that life,

... is frantic at times. 'Cause there's always junkies running around all times. You know, I did it myself, running around knocking on doors, can I do a fix in your room for five minutes, I'll be right out. You know, like it's insane down there sometimes.

Charles talked of the lack of safety and security that comes from living in a hotel:

In the downtown core a lot of people keep the keys to the rooms, and they wait till other people rent the rooms, and then they go in there and scrounge through their stuff and steal stuff. That's how I had my stuff stolen last time.

Of course, greed and desire can result in theft and deceit in corporate boardrooms

as well as on the street, but for those without the protection of insulated space illegitimate

techniques are relatively unsophisticated and immediate. As Phil explained:

"Everybody's so busy robbin' each other that nobody's making any money."

Homelessness is about not having a safe and secure place to call one's own.

Many of those who live in the downtown rooms are challenged daily with loneliness and

the fear of invasion and loss of privacy (Currie, 1995). Paul is HIV positive and often

lives in the hotels on the Downtown Eastside when he is not in a shelter:

I'm trying my best to do something to get out of it, and sometimes it's not that easy. It's not that easy, it's not that easy. It's very hard on you. It's very hard on me because all around me is people that are drinking on welfare day, for instance. They're shouting, they're screaming and you're there, just holding, like white knuckling it, trying to stay clean and sober. But it affects you, like it really affects you. And then you just say to hell with it. That's when my addiction just goes.

Living in the rooms and surviving on social assistance can drain a person of

motivation and the will to secure a better life, contributing to an acceptance of one's lot in

life.' Thus the non-productive are contained and forgotten by mainstream society, as

Tony explained:

> See what happens when you get down in these hotels, these skid row hotels and
> everything, even if you've got a job, there's so much craziness happening all
> around you to really be able to, it's hard to get any sleep, for example. And it's
> party all the time, that sort of thing. After you've been on welfare for a while, it
> drags you down, it drags you down. I don't know what it is, you lose motivation
> to work. I just have no motivation whatsoever. Not that I'm unable to work.

Simon explained that for him living in a skid road hotel, close to the street, is only a step

away from oblivion:

> To me, living on the strip, like the Regent,[41] it's the end of the line. I'd rather live
> on the street than in that place. It's just the end of the line. It's just there's no
> where else to go, the next step is death. And that's it, if you have to live there. I
> mean you can live anywhere you want. You can come down there every day. But
> to live right there, next step is death. Fuck the world I don't care no more.... To
> see death. To see death, not murder, but to see people you know that are just
> literally, being totally self destructive. Just don't give a fuck anymore, killin'
> themselves, that's just what they're doing. And just not being able to get out of
> that.... And it's endless, it doesn't matter what you do, it's endless. I mean you're
> at the end, it's just the end as far as I'm concerned.

In describing a chance encounter with someone at the needle exchange, Simon

revealed the everyday violence of the street person who lives downtown:

> I was in the exchange, and she was just comin' out, she just lookin' at me and she
> had tears in her eyes too. Her eyes were yellow, she was jaundiced, beat up. She
> says I bet you any money I'll die before you. And she's livin' in the Regent.
> That's when you know you're there. I mean people have been livin' there for a
> long time. And people know when you're there, that's it. Only next step is death.
> Or you get murdered, or whether just beat, just die.

Coping with drugs

Coping mechanisms such as excessive drug or alcohol use may be a response to

threatening and anxiety-producing situations and therefore adaptive to the psychic

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[41] A run-down hotel on Hastings Street.

assaults that accompany street life (Alexander, 1990; Office of the Chief Coroner, 1994;

Currie, 1995; Snow et al. 1994). One can walk down Hastings Street, around which most

of the dilapidated hotels are situated, at any time of the day or night and be approached by

various dealers inquiring whether you want to go "up or down", selling cocaine or heroin

to guide the way.

Downtown, illicit drugs are cheaper than licit drugs and freely available as Phil

portrayed: "The drugs are cheap. I can buy a hit of coke for the price of a six-pack....

When somethin's buggin' me / go get a hit of down. I want to feel good I go get a hit of

up." Charles explained how he coped with feelings of hurt and illustrated the economy of

the street, hustling for a drug-induced but transient euphoria:

> The stuff in my past started coming up on me. Before I used to do my cocaine and
> that, to kinda numb the feelings. Now I'm not doing that, it like kind of
> overwhelmed me. So I tried to commit suicide. Slicing my wrists. It's like I didn't
> know how to cope with it.... You can pick up any kind of drug that you want
> down here for ten bucks, whatever. Pick up a point of heroin for ten bucks or a
> point of coke for ten bucks. It's cheaper than alcohol and it doesn't give you a
> hangover.... That's why you see most of the people downtown or on that one
> block area there always walking around, doing whatever they can. They'll sell,
> steal, whatever, and sell it to the people in the bars, or whatever. They go around
> selling clothes that they steal to people in the bars for ten, twenty bucks,
> whatever.... They may sell their rent cheque to the hotels or whatever, just so they
> can get their drugs. Every welfare day that comes, they call it Mardi Gras day,
> people are rich for a couple of hours, and they're broke for the rest of the month.
> It's sad to see but it's the nature down there, on skid row. It's the way it is.

Beth was staying in a relatively secure hotel that had surveillance cameras in the

hallways and over the front door that opened onto Hastings Street. Just a step from where

she lived was the street she described as,

> ... hell. For somebody to survive, you would have to be intelligent for one, very
> street wise, and you have to be on guard at all times.... It's a shooting gallery....
> Drugs. And here it's thrown in your face. You ... just have to walk down hundred
> block of Hastings, and it's everywhere.

Brian's transient lifestyle was one of staying in shelters, recovery houses, treatment centres, cheap hotels, and on the streets. He had been in a detox centre at least 24 times, for cocaine, heroin, and alcohol. Brian claimed he had been in jail "about thirty times or something" and had been involved in "selling drugs, B&E's, theft." At the time of the interview Brian had been at Triage for a week and a half, trying to stay "clean and sober:"

> I'm still attracted to the heroin because it seems to substitute the craving for cocaine and alcohol, 'specially alcohol. I said cocaine knowing it stills destroys you. Quicker, especially financially. I mean nights when I probably spent a thousand, two thousand dollars. I mean there's no way possible you would have spent that on alcohol. Sleeping on the streets, spending five hundred dollars to a thousand dollars every day.

Brian's last job, more than four years previously, had been temporary, loading and unloading transport vehicles; he felt the biggest barriers to his finding work were depression, and lack of motivation, job skills, and work experience. Rather than work a regular job he would engage in alternative activities to get by: "Using drugs and alcohol. It means resorting to, if you don't have any finances, you obviously have to commit a crime to either have money for food, drugs, tobacco, alcohol, whatever." Sometimes, Brian explained, he would get depressed but,

> ... usually, I just try to keep to myself. Think crazy thoughts. Not suicide or nothing like that. Sometimes I might think that way, like just go to Hastings and grab a quarter gram of down and hopefully that might be enough to do it ... to commit suicide.

Nancy, into the cocaine, said Triage provided a material security that was compromised because of the temptation to get high: "I mean I can come here so I don't have to be out there so unsafe. But I'm not safe from the drugs because it's right out the door. And in here." Bruce, also at Triage trying to stay "clean," proclaimed that the day

of the interview he had walked along Hastings Street and had resisted the enticements of

the dealers:

> You walk out that door, you know exactly what's there. Like today we went for a
> walk and ... people were going 'up or down?'[42], selling this and that, and 'thanks,
> no thanks'.... Nah, it didn't bother me. It's good though if you can walk through
> there. And not want it. It's in the back of your mind though, but that's what you
> gotta face. You gotta walk through there. If you can keep doing that, and walk
> through there, and keep doing that a few times, that's where you're going to have
> more willpower. Just say no. I think. It helps me.

A short time after the interview Bruce's ability to just say no appeared to have waned for

he was evicted from Triage for possession of drug paraphernalia (syringes) in the

building. After his checkout he came in a few times for a meal, to say he was using

cocaine and living outside.

When one is living on the edge, the price of a temporary escape can be the cost of

a place to stay (Currie, 1995; Office of the Chief Coroner, 1994). As Jim illustrated: "I'm

living around people that are on welfare and are homeless. They hurt, and the only way

they can cover up their hurt is by alcohol or drugs. So they keep on doing it, at any cost,

and the cost at this time is their home."

Dangerous places

On the Downtown Eastside violence is a constant risk to those who are vulnerable

and in unsafe places (Currie, 1995). Jennifer described an incident that happened at a

skid row bar: "Actually, last year I think it was, a year and a half ago, I was badly beaten

up down here [by] a couple of girls." Staying at Triage Jennifer declared that it,

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[42] In street jargon "up" is cocaine and "down" is heroin.

... just makes me feel safe from the streets, 'cause with everything going so crazy in the world today, and with that cab driver[43] too and all the prostitutes, and just all the crazy guys out there. Makes me nervous walking the streets by myself.

On the Downtown Eastside muggings and violent takings are an everyday event.

Luke explained the feeling of vulnerability and lack of security of person after being

robbed of his money:

Being out alone on the street, I've felt unsafe, especially. I'd never been mugged or anything till I came to Vancouver, and like the first —it wasn't the first day, but it was probably the third or fourth day I was here—I got mugged by five guys in an alley. And at that point I don't think I'd ever felt so unsafe in my life.... I was beat, I didn't stand a chance, there was nothing I could do. They took me for the hundred and whatever dollars I had in my pocket and there wasn't a damn thing I could do. I'd never felt so unsafe.

Tony described the constant threat of violence to those living on the street and how

concerns of safety and security organize everyday activity:

Some people like to glamorize it but there's nothing glamorous about it. It's something you have to experience ... there's people who just want to beat somebody up.... People put a knife into you for a couple of bucks.... I spent quite a bit of time on the streets and you're looking more out for your safety than you are looking for a place to sleep for the night.

One resident told me he had once fallen asleep in a large garbage container. He

awoke in the morning as the garbage truck lifted the container with him in it. He yelled

at the driver to stop, narrowly missing being compacted with the trash. For Beth, the

risks of sleeping outside were comparable to the dangers of living in a hotel:

If you're out on the street ... there is no safety.... You have no idea who's gonna come and take your clothes while you're sleeping or stab you while you're sleeping, inject you with something, you have no idea.... Living in those hotels, there's no safety whatsoever.... Same thing. It's like living outside.

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[43] A few weeks before this interview an unknown assailant had killed a taxi driver after allegedly being picked up on the Downtown Eastside of Vancouver.

Linda painted a picture of violence and victimization in the pursuit of tension release and

immediate gratification:

> I've seen bloody bar fights on Hastings Street and young girls having to sell their
> bodies for whatever their reasons may be, drug addiction, the only way they know
> how to survive. I've seen elderly people being abused. Just horrible, horrible
> things.

Brian added: "I see violence. Lot's of people fighting. Stabbing or whatever. Maybe the

odd person getting shot."

On the night prior to the interview with Jason, an unknown male had been found

lying dead on the street up from Triage. Jason had been one of the onlookers:

> I've heard of people dying on the street and being homeless and that and last night
> I had to sit there and watch it. But the guy was already dead. I've heard of things
> like that but I never believed it till last night. No human being should live like
> that. There should be more and bigger shelters for people like that.

Coping with the police

The harassment and criminalization of homeless persons permit the management

of what Spitzer (1975) has called social junk. Simon manifested his anger and hostility

when he told of interactions he had had with the police:

> They know that you have a criminal record and you're in an area where there are
> drugs, they have a right to grab you and throw you up against the wall and pat you
> down. Or when it comes over their phone, he's violent. Or different things that
> they have there. It's their own for themselves, just for themselves. It's not legal at
> all, and they're pieces of shit when they do it. They take advantage of it, they
> want to do it. They'll fuckin' throw you down, we got a right. Their dispatcher
> says approach with extreme caution. Why? Because he's had gun charges. So he
> can jump on ya', shit kick ya', and make sure you're fuckin' gonna stay down,
> pepper spray ya'. And then they ask you questions.

Charles explained that he had seen the police administer vigilante style retribution to

those who got too cocky:

Yeah, I've seen that happen in the Balmoral right in the back there. They drag certain people out, in the back of the alleys, and they kind of give the boots to 'em.... In the cops' reports they'll just say that he was resisting arrest.... And who's going to believe you, some drug dealer or some guy who's drunk or out on coke, compared to a cop and a judge.... A couple years ago I put up my hands and that, but they grabbed me, put my arm behind my back, almost popped out my shoulder. Kind of gave me the billy club to the ribs couple times. Nothing to really mark you up that the judge could see, but enough to kind of see that you're kind of really startled and upset, and that's what happened to me.

Phil explained that the police sometimes choose not to respond to those on the street: "You know somebody's beat up and asking for help. They [the police] know the guy and they take a hike. They ignore him, you know. Because the person's a regular victim, they get tired of it."[4] Paul portrayed safety as freedom from authorities as well as from predators of the street:

Safety means no harm will come to me, like I don't have to worry. I don't have to keep looking over my back if anybody got a knife. Being able to walk down Hastings Street without any worries. Or walking any street and not looking over for any cops. Like that's one thing I've been finding is the cops pull you over for no reason. They check you and what they do, like it just baffles me sometimes. I can understand in a way, that there's people dealing and all that, but...

Homelessness and ill health

The homeless suffer disproportionately high rates of physical disease and poor health; if alleviating ill health is a directive then eradicating homelessness must become a priority (Wright, 1990). Twenty-one of the respondents reported chronic health problems. As listed in Table 9 the most common problems were depression and being HIV positive. Only one respondent reported a major psychiatric diagnosis of schizophrenia. Of course, many of the problems portrayed in Table 9 are inter-related;

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[4] It should be noted that there are some police officers who go out of their way to offer support and recognition to those on the streets of the Downtown Eastside.

for instance, depression and acute distress may be a consequence of being HIV positive, and so on. In turn these conditions are aggravated or even instigated by conditions of poverty and homelessness (Struening & Padgett, 1990; Wright, 1990).

Acorn (1993) noted that among 124 homeless persons who used emergency shelters in Vancouver the highest scores on their Brief Psychiatric Rating Scale were for anxiety, depression, and tension, all associated with emotional distress. Acorn's respondents "were worried and concerned for the present and future, were despondent in mood, and felt a sense of sadness" (p. 856), suggesting a situational cause of their problems.

"Homelessness is bad for one's health" (Blasi, 1990:213). For example standing in long lineups waiting for food or sleeping sitting up can contribute to various ailments.

> In addition to economic deprivation, itself one of the most serious health hazards [homeless persons suffer from a variety of physical ailments including]: tuberculosis, hypertension, respiratory problems, skin ulceration, and a variety of other infectious diseases. Ill health for persons without adequate shelter is attributable in part to institutional and attitudinal barriers to the provision and delivery of health care (Daly, 1996:111).

In urban shelters for the poor there are high rates of infectious and communicable disorders such as HIV and tuberculosis (Wright, 1990). Sally commented on the number of people in poor health who pass in and out of Triage:

> I see a lot of the people who are definitely helpless and hopeless. And I feel that some of them just don't have any other avenues in life. That this is about the end for them. And I see a lot of AIDS victims here. And a tremendous amount of drug abuse. And I understand that because of the helplessness and hopelessness of the people that are here.

On the Downtown Eastside an average AIDS victim has a life expectancy of approximately two years—much less than the average life expectancy of 12 years for

those with AIDS in the "uptown" areas of Vancouver. The downtown services, health

care, and living conditions available to this rejected lot have created a situation similar to

that of a "leper colony" (Office of the Chief Coroner, 1994:61). Noting the number of

persons in Triage with HIV/AIDS, Sally observed that there are pressures to avoid

attachments, consequently,

> one tends to not want to become too attached, or too close to these people,
> because you know that they're gonna die. And you know they're gonna die really
> in unhappy circumstances, because if they were going to die in normal
> circumstances, they'd be dying at home with their families or with friends. So
> they are going to be dying alone, and they are going to be dying in despair, and it
> is a very sad, sad thing.

> Living in the hotels or on the streets of the Downtown Eastside is about getting by

the best one can. John put it succinctly when he said: "Here you survive, day to day.

Much like other people do. The thing is, we don't know if we're going to eat. Or what

we're going to eat. Or how we're going to eat." To manage the tension to body and

psyche from the dangers facing those who are in poverty and deprivation, the homeless

and near-homeless need to develop strategies for survival. The next section explores the

organization of these strategies for getting by.

Getting by

The homeless are subject to processes of marginalization in their quest for safety,

security, and recognition. For these persons a lack of political power and social resource

contributes to isolation, anxiety, frustration and rejection. Subsequently, the homeless

person may accept her/his status and engage in various strategies to get by:

> The survival strategies of homeless people may be regarded as spontaneous,
> random, contradictory, illogical, ill-conceived, or even bizarre. But judgments of
> this sort, exposing the contents of mainstream society's cultural baggage and the
> need to hold the irksome other at arm's length, fail to comprehend the imperative

of adaptation and change in a world which does not conform to dominant conceptions of 'reality.'.... Life on the streets requires adherence to a different set of organizing principles, an alternate reality (Daly, 1996:11).

Needing to belong somewhere

The social isolation and disaffiliation that usually accompany homelessness can contribute to ill health, anxiety, and depression as well as intensify and aggravate individual problems, for "a sense of belonging is as important as the physical shelter in making a 'home'" (Grigsby et. al. 1990:142). In order to cope with disaffiliation and the lack of social bonds and sustenance previously provided by family, friends, or job the homeless person may seek material assistance and emotional support from other homeless persons and networks. These ties may help the person to avoid isolation and thereby function outside traditional social roles, while contributing to an entrenchment of the homeless condition:

> The street offers ... the spectacle of society without integration into its values: proximity, but not participation. It becomes symbolic of their distress.... It belongs to everybody and nobody, and puts everyone on the same footing. It cancels out the past and makes the future uncertain: only the present moment counts (Agnelli, cited in Daly, 1996:136).

Brian pictured the street scene as a place to escape and feel accepted, regardless of one's condition:

> It's not just the drugs and alcohol, it's definitely the lifestyle that I'm attracted to.... Nobody cares I guess. Attitude too.... You can pretty well do anything. You could still walk down the street and find someone to talk to, even though you haven't had a shower for a month. Even though that doesn't include myself but, you know what I mean, you don't even have to worry about nothing like, to care for yourself, your personal hygiene. I know a lot of people do that.

Jason, a 28 year old male with a grade three education, had been at Triage for three days at the time of the interview. Jason had a long history of foster homes, drug and

alcohol treatment agencies, prisons and jails (totaling over 15 years when juvenile as well

as adult incarceration is included), and mental health facilities. At the time of the

interview he had not worked for more than four years, saying what prevented him from

getting employment was his criminal record, and his handicapped status, including

dyslexia. Jason, having a fear of being by himself and needing to be around other people

no matter how tenuous the relationship, romanticized living in the downtown hotels as

providing a sense of belonging and companionship:

> When you go into a hotel ... the reason why people usually do that is 'cause often they've left a shelter. They're used to communicating and living with a lot of people. A hotel will give that. There's always people around you. Even though ... it's a negative influence, they're looking for that support, that family setting which they can find in a hotel. 'Cause there's a lot of people. You talk, you drink, you're around people constantly. You're never lonely. You always got someone to talk to.

Sally provided insight into Jason's idyllic perception of life in the rooms when

she referred to the underlying disconnection of those who end up cycling between shelter

and hotel and back again: "I find that the people that do go from here to the hotels in the

area are back here because they don't have any companionship. And loneliness is

probably the worst thing that can happen to a person."

Desperate lives

Homelessness contributes to a criminogenic situation where crimes are committed

to deal with social and economic strains and otherwise unmotivated people are enticed to

break the law (McCarthy & Hagen, 1991; Snow et al., 1989). The conditions of

deprivation and destitution that characterize homelessness may result in coping

mechanisms and survival strategies that are not in the interests of the community. Rather

than endure an apparently pointless existence a person may resort to unlawful activities in order to get by. When life is solitary, poor, nasty, brutish, and short it is each for him/herself, as Sally explained: "I've gone to people that I thought were supportive friends and I've been hurt by them. I've been ripped off, because they're down here, they're sick, they're dying, and they're so desperate."

Recently arriving from Manitoba, Jason said he had come to British Columbia for his personal safety; he would not reveal what he was running from except that it involved the police, the community, and previous criminal activities. He had tried to get into Lookout but he said he was barred. Jason revealed he suffers from mood swings and is HIV positive. At the time of the interview Jason maintained his main support mechanisms were the staff at shelters and drop-ins. I asked Jason what Triage does for him and he replied: "A lot of homeless people will break the law just to provide shelter, three square meals a day.... They will go out and hurt somebody or take out their frustration 'cause they don't know where to go for help." For Jason Triage is a place of temporary assistance where he can get help to sort out his problems.

The longer one is on the street homeless, the higher the probability of engaging in criminal acts, reflecting processes of survival and adaptation (Snow et al. 1989). As detailed in Table 6 the leading sources of income for the participants in the month previous to the interview were welfare, underground activities, and the sale of personal belongings. The underground activities included drug dealing, shoplifting, breaking and entering, fencing stolen goods, and prostitution. Mark commented: "A lot of the faces I see are workin' the streets, until their bodies give out and they can't do it anymore."

Donna pictured a life of desperation in which human life is devalued and violence and victimization are just another way to get by:

> You'll be out on the streets, you have nowhere to go, you'll be stealing. You'll be selling yourself. You'll constantly do anything to survive. Even if that means taking somebody's life, you will.... I know a lot of girls beat up people, to get money and change, you name it, cigarettes. You see people getting beat up, elderly ladies getting beat up.

A place to stay for the night

Virtually all the research participants said there was no need to go hungry downtown. What was harder to find was suitable shelter. This may be because food is essential for survival whereas shelter is not.

On the Downtown Eastside there are various places where one can camp out for the night. Particular places attract particular people. Christine explained that,

> Oppenheimer Park actually is the best park. But up around where we were, Lakewood and Dundas, it's a bunch of jonesing.[45] People that would sell their mother for a toke. Except there not too many people fix, they smoke, which is worse.

Brian had previously been staying in a downtown hotel but had to leave because he could not pay his rent. In the last year he said he had been assaulted three times, once by a friend, once by an acquaintance, and once by the police. Brian reiterated Jason's statement when he said that the shelter,

> ... keeps us off the street. Keeps us out of trouble. Like most of us, if this shelter wasn't here, we'd be resorting to other ways to survive.... If you couldn't get into another shelter, you'd either be sleeping outside or you'd be robbing or stealing to survive.

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[45] Street term for the habitual use of heroin.

When one is homeless certain facilities are used for purposes for which they were originally unintended. Shelter had been sought in a hospital, jail, or detox centre for 14 of the respondents. Reynaldo, who had failed to make a court appearance, sought shelter at the city jail:

> I had a 'did not appear' charge, and it wasn't like an outstanding warrant. I went down [to the police station]. I was hoping to have a place to stay 'cause I had no place to stay. I could have stayed at my brother-in-law's place, but there's too much stuff happening there. So I turned myself in. I didn't know what to do.

Women often attach themselves to men to avoid the risk of homelessness (Snow et al. 1986). Sally had been sharing a room with a male friend who, when he got his pension cheque, would drink too much and become abusive. The binges would last for a few days and she would clear out of his way or join in. She was at Triage because it was one of those times for exiting the scene:

> I would hate to be in a position that I see a lot of women my age where they essentially are like pets to old men.... They go and live with older men, with old pensioners, because the older pensioners have a little money, and it's not necessarily a sexual thing, it's a companionship thing. I see this happen with a lot of women. And I view that as being just a. other step towards being more and more dependent.

Somewhere to go

John, a visitor on the night of our interview, lived in a downtown hotel a short walking distance from Triage. John had been in a foster home as a child and in a mental health facility as both a child and an adult. Twenty-eight years old, he had worked as a gas station attendant for 2 1/2 years and at telemarketing for five days, from which he was fired because of poor sales. In his lifetime John said that he had been assaulted over 100 times. He said he appreciated "the visiting hours, and the meals, and the sandwiches,

someone to talk to when in crisis." John's account shows the indispensability of shelters such as Triage in the daily survival strategies of many people who live on Vancouver's Downtown Eastside:

> It's a place to go to.... I would dare say, if it wasn't for a place like Triage, visiting hours, or the drop-in, and I had nowhere to go, forgive me for the way it sounds, I would probably be dead. That's how much these places mean to me. If I didn't have, I'd be dead, because I could not stand the loneliness. I could not stand being in a hotel room from day till night. I could not stand it.

Homeless and near-homeless persons use multiple resources and possess skills that they are often presumed to lack in their quest for daily sustenance; their strategies for "getting by" show them to be quite resourceful (Koegel, Burnam, & Farr, 1990; Robertson, 1993). Tony, who often slept outside, described how he used the services available on the Downtown Eastside:

> I would go down and have a shower at the Forty Four[*] and shave there. And then I would leave my backpack at one of the lockers at the Carnegie Centre and I would leave it there all day so I don't have to carry it around with me. And I would just go from soup line to soup line. There's a lot of places to eat around here. A person never has to go hungry that's for sure. A lot of freebies. People are very generous, you know. There's a lot of good, a lot of kindness.

Removal activities

The homeless suffer higher rates of victimization than the general population (Snow et al. 1989). Survival strategies and adaptational processes involve hardening to the violence of the urban area and turning away from threatening incidents, muggings, and assaults. Christine explained why she avoided involved relationships:

> If you show somebody down here that you care, they take advantage of it. They use you like you've never been used. So, sure I had five friends brutally murdered

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[*] The Forty-Four Club, officially named The Evelyn Saller Centre, is a downtown community resource agency offering a low cost cafeteria, a delousing facility, showers, and a drop-in centre to the homeless and near homeless.

last year. I cared. I cried. I guess maybe I done that because I could never show them how much I cared in case they took advantage of it.

In order to survive a process of disengagement takes place, as Allan described:

> I admit that I just choose not to see a lot of it. Mainly because it doesn't have anything to do with who I am or what I'm about. Yes, I still see some of it, but I tend to block a lot of it out.... I just tend to ignore it all. Not because I'm ignorant but just because it has nothing to do with who I am.... So if you're asking about drugs and hookers and that sort of thing I really don't notice it. I don't just because that's not where I'm at, so I tend to block those things out.

Hardening to violence and turning a blind eye is a process of removal in the pretense that it is not really happening. Rather than get involved in someone else's trouble it is safer to look downwards at the pavement and withdraw into a veil of self-deception. David explained that it makes sense to pretend one does not see:

> Sometimes we go down there and we see things but we don't see 'em 'cause it's bad.... We do it all the time man. I know I do. I see things I don't want to see, and wished I hadn't seen 'em, 'cause I don't know what, it stagnates me man, it makes me feel down.

Bruce described how he would walk by an unsettling event and entrench his position of studied disinvolvement in the events going on around him:

> I see people, the drunks. They lay on the sidewalk and then guys pick them up and go through their pockets. And I see it, there's not much I can do about it. I don't want to get over and help the guy and then end up getting stabbed or something. So you just kinda turn your head and like you didn't see it. And you're disgusted, right. And the next two people come by and they try and do the same thing but his pockets are empty. It's happening all the time. Especially if it's just around welfare day.

Jim talked about seeing muggings on the Downtown Eastside and how he learned to mind his own business:

> I was shocked at first, because I'd actually seen that. But the unspoken law of keep your mouth shut is the way it is around here. It's so funny how I fit right in, no problem.... Being able to keep my mouth shut.

Beth agreed that "if you get involved in somebody else's violence.... I mean if I was to jump in and interfere not knowing the situation at all, that would definitely cause a lot of bullshit. So I just pass by." This committed disattachment to what many of us would term public trouble is also characteristic of relations in prisons, jails, and other places of subcultural adaptation.

Putting up a front

Simon explained that a person on skid row learns how to cope with the everyday threats of physical and psychic assault by putting up a front: "On the street it's nobody's gonna fuck with you because they know if they do that you're in that position of power. That you don't have to do anything yourself, it's just gonna be done. Power, it's a strong word." Simon told how he deals with the threat of law enforcement personnel:

> When a cop grabs me for something, the first thing I say is I got syringes in my pocket, I'm HIV positive. And that just takes the edge off, whatever situation right away.... And you just draw on different situations. Even though I got dope on me, I've always carried syringes. I've always had syringes on me. So when the situation ever arises, that's the first thing that comes out of my mouth. I'm HIV positive, I've got syringes, I don't know if the caps are on them or not. I don't have any weapons. I'll open my jacket, you can check if you want or I'll take them out. I'd rather me take 'em out, you know. It just relaxes the whole situation, instead of fuckin' mouthin' off. If you're gonna mouth off, if I call you a fuckin' piece of shit, well you're gonna react.

Tony said one develops a new personality, "in order to survive. You have to sort of act tougher than what you really are. Especially if you're not that sort of personality, you better get it."

The contradictions of these strategies of survival are that they help people to survive the challenges of the street but simultaneously contribute to the conditions of

their privation. Acceptance and resignation become the norm and control is left to those of authority.

Control of the poor, the homeless, and near homeless

The function of status degradation is social control (Goffman, 1963). Social welfare regulates and maintains market discipline by retaining the 18th century concept of less eligibility (Culhane, 1996; Piven & Cloward, 1993). State assistance is meant to be a less eligible alternative to disciplined activity, as the welfare client is degraded in her/his position of having to ask for a handout and in turn is depoliticized and made irrelevant. Luke expressed the ignominy of feeling stigmatized when entering a welfare office: "I've felt degraded going in [to welfare]. Belittled might be the right word."

The contradiction in the stigma of the selective transfer of welfare —which has the effect of lowering self-esteem so that the politicization of the group becomes almost impossible (Armitage, 1975)—is that being on social assistance and living downtown can contribute to resignation and hopelessness. As Phil explained, "The longer I stay here the more I lose the impetus to get out of that system."

The control effect of the shelter is to contain the non-productive for a brief interval, during which time the client is disciplined and returned to the outlying community, perhaps more ordered than when (s)he first arrived. But the community to which the client is returned is the same one that contributed to her/his needing shelter in the first place. As Christie (1994) asks:

> Are inner cities places where those with no aspirations choose to flock together, or are they dumping grounds for those not given an even share of the benefits of modern societies? Meaning given to certain phenomena has consequences for the measures chosen, just as the measures give meaning back (p. 197).

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The shelter has instrumental ends but often the practices are expressive of something else: defining moral careers and creating hierarchies of identification and separation. Its instrumental purpose is to house, stabilize, or treat, but its expressive course may be to attach stigma to those of lost status. The shelter creates "occasions of hazard" (Harré, 1993:205) against or through which the client works and in the process is defined.

Limits to help

Control involves getting residents back out onto the street and into their own housing. In practice this usually means moving into a hotel room in the area or into shared accommodation. Edward explained that shelters promote a migratory lifestyle among their users,

> ... because the way these shelters operate the staff's hands are tied according to certain rules and regulations, and the demand for a large number of people for a place, so they have to move people on.... The demand for people needing shelter all the time creates a situation where you can't stay here. It's not a long term solution. It's a temporary solution. It doesn't deal with the long term problems. 'Cause it's not set up for that. It doesn't have the capacity to go beyond that, so there's a limit for the help that you can get.

When Simon was not staying at Triage he would sometimes come in for a meal, use the clothing room, or just come in to talk. Occasionally, as a technique for controlling interpersonal space, the shelter staff would close down visiting hours. In commenting on this practice, Simon revealed how important the shelter is in some people's lives: "It's like a slap in the head actually when the sign says there's no visiting tonight. A lot of people really count on just that. And it's a let down. So you turn away downtown."

Another resident, Mark, communicated that he would get angry if he came to visit and the sign said no visiting when he needed a time of stability.

Becoming a file

The public welfare apparatus depends on a "reified clientele" (Friedenberg, 1975:1) —those who are conscripted from among the poor and destitute for the purpose of administering services and who provide the raison d' être of its existence. "Conscript clienteles" (Friedenberg, 1975:2) are those pressed into the service of caregivers, professionals, and agencies and who are not free to refuse the service. This reification of clienteles produces an "institutional symbiosis" (Friedenberg, 1975:18) in which the institutions and agencies come to depend on one another for referrals and in which the individual is bounced around like a ping pong ball. Daly (1996) observes:

> Because they lack a collective voice and are not organized, individuals on the street are represented by proxies whose interests may be self-serving. A self-perpetuating network, characterized by common interests, mutual dependencies and benefits, it has fashioned a web of interdependent communities based on self-interest. It includes government agencies and bureaucrats, not-for-profit and voluntary organizations, professional care-givers and shelter operators. While most are well-intentioned they, nevertheless, are motivated by a desire to exercise power and a need for control: the power of the purse strings, the ability to set policy, to allocate resources, to plan and design programs, to decide who will be helped and who will not, to determine whose interests will be represented, and to sanction or condemn certain practices, values, or beliefs (p. 9).

Triage is defined and accepted as a place for marginalized persons. A large sign outside tells passerby and those who enter of the difference. But when a person spends most of her or his time in formally identified places of marginalization identity solidifies. Like homosexuals in a gay bar, like addicts in a shooting gallery, like mental patients in a drop-in centre, they entrench their identity in the place (Goffman, 1963). When persons

are disoriented because of stressful situations and when there is a lack of connection to

normalizing structure they are more amenable to an exceptional category, such as

homeless misfit.

A few years ago a woman at Triage said in a loud voice that she was not a mental

patient, she was a drug addict. It may be that in an effort to define an apparently more

acceptable identity she was letting us know that her personhood was not of a psychiatric

origin but of an alternative culture of her own choosing.

The term "client" is descriptive of a relationship, not a person (Simpkin, 1975). I

asked the participants what this term meant to them. Linda had a long history of being a

client:

> I really don't like that term, because all my life I've been labeled as just a number,
> a file number. A client of the children's aid. A client of the hospital. I have a hard
> time with that label. I would rather be called a person in need rather than a client.

Mark, with previous practice in social work, had direct knowledge of being both a

provider and a consumer of social service:

> Client ... usually denotes that you're the person that's getting something from
> somebody else. They're giving it to you. It's a power thing. Structure. You have
> this, and I'm going to get it from you. Instead of a team sort of a thing which I
> would much rather see. People as being part of it, part of the process. Information.
> We keep information from people as well in social work and that sort of thing.
> Because it keeps them from having the power. And I don't know if that's a
> conscious thing or what that is, but that's there.

Institutions depend on written information for their existence. This process of

categorization and differentiation of "problem populations" contributes to an ideology of

order, discipline, and punitive regulation rather than social liberation (Cohen, 1979). The

official write up is entered into a computer database that becomes a permanent record of

who the person is and what (s)he is about. Acting out can result in a negative notation

becoming a concrete exposition of identity. This can mean that selective attributions and events are used to support the idea that the actor was always like that. These designations are often based on superficial observation with limited awareness of the subjective meaning of the persons being classified in interaction with events and structure. Lofland (1969) recognizes that:

> Models of deviant categories are founded precisely upon the assumption that particular classes of people are more likely to perform deviant acts and to be particular types of deviant persons.... Imputations of actors as deviant can have as much or more to do with who is coding with what category under what circumstances than with simple discernment of specially differentiated deviant persons (p. 144).

When a person is given a room at Triage (s)he is assigned a file number and an intake is done[47]. In a process of categorization the homeless person is "socially identified" and the responses are organized accordingly. In an essentialist endeavor to separate and classify, "pivotal categories" such as alcoholic, drug addict, or mental patient are advanced (Lofland, 1969). This nosological endeavor facilitates classification of people in order to predict, organize, and discipline them (Foucault, 1980). "The fundamental need of social man (sic) [is] to participate in a system of meaning—a system of action possibilities" (Lofland, 1969:277). However, categorial definitions of homelessness fail to address the interrelated needs that pertain to conditions physical, emotional, and material (Fabricant, 1988). "The descriptions used become labels which can pigeonhole individuals in negative ways ... those who are down and out are seen by many as hopeless, a latter-day version of the 'undeserving poor'"(Daly, 1996:7).

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[47] See Appendix B for Triage referral and intake forms.

I asked the participants what they thought of the file system at Triage, that is, what they thought of having written biographies created when they enter as a resident. Some participants did not know of the file system and were surprised when I informed them of this practice. Mark perceived the relation of subject/object when he observed:

> I think files tend to be like baggage that people start carrying around with them, and you become your file. It could be a real bad thing. You know, that they been draggin' this baggage around with them for a long time. You literally get a plastic bag and a file folder. This is who this person is, and I don't think it tells the whole story. any file, any subjective type of recording of one person's opinion about the other person.... What goes in that file is gonna be what the next person sees and it doesn't always tell the picture.

Beth, however, argued that client file documents facilitate institutional efficiency in that the person is catalogued for future identification: "You know, if you come back they have to be able to find you somehow, and that's what the file is for.... They have to be able to find my file. We've got to be filed somewhere."

Hierarchical relationships

The Triage shelter depends on volunteers from the community who come in and help with everyday domestic tasks such as bed-making, laundry, and kitchen detail. In return the volunteer might get cigarettes,[*] a meal, or first choice at clothing donations. The shelter justifies this activity as offering the volunteer a sense of accomplishment and purpose as well as providing a valuable service to the facility. Jim was a volunteer at Triage and commented that, "we've been here a while so we call ourselves the senior clients... it makes us feel good that we earned that sort of respect.... Something that you've earned."

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[*] In October, 1997, Triage discontinued providing cigarettes to the clients.

However, the line between volunteer and staff is clearly demarcated in a process of rational, professional distancing that contributes to the client's isolation (Fabricant, 1988). Limits are organized around the apparent full acceptance of the client and the relationship is constrained by hierarchy in order to avoid embarrassment. Occasionally the helper would cross the line and staff would remark that "so and so" was becoming "pseudo-staff." The volunteer would be brought back into line with a warning to respect the boundaries between staff and client. In turn this would contribute to the client's powerlessness and entrench her or his identity, erecting a barrier to empowerment and collective agency. "Charity is scraps from the table and justice is being invited to the table itself" (Tiernan, 1992:655).

Triage decision making is top-down or hierarchical, moving from the executive director to the coordinator, shift supervisors, and to the community workers. Decision making excludes the residents themselves. Allan expressed resentment against the bureaucratic structure of a shelter system that allows no space for the voices of the clients to be heard: "And that's what bothers me about this place. Is that we're not asked, we're just sort of shuffled along."

Controlling space

Triage has a day program in which those who live in the rooms nearby can come in for meals, get their medication dispensed, or have other needs attended to. For many of these people the shelter is their primary resource. This is a good service but it does little to alleviate the conditions in which the people live. Rather it leads to dependency and regimentation where the marginalized are hidden from public view. As Brian

observed institutionalization is "more or less relying on someone to have your food there, washing your clothes, whatever."

In January, 1996 a day client who depended on Triage for his meals and medication was found dead in his hotel room. This client was a regular at Triage, he loved to talk with the staff and hang around drinking coffee and smoking cigarettes. Sometimes, when his coping mechanisms broke down, he would check into the shelter for two or three days to repair. He loved to talk of when he was much younger and of the cars he had—when he was a professional musician and the effects of his medications for schizophrenia had not yet caused his tongue to swell and his head to permanently tilt at 45° to his body. Living in a nearby hotel this client was sometimes asked to leave after getting his medications and having his customary cup of coffee, because of his taking up limited space[49]. The shelter needed to place control over care.

Clients at Triage often have to wait in line for toothpaste, a towel, or their medications. Most of us do not particularly enjoy standing in lineups but if we are dissatisfied with the service we have a choice of going to another place. A resident of the shelter system lacks this choice. The client can sometimes go to another facility but this is not necessarily a viable option. The client endures the wait for a comb or a cigarette paper sometimes expressing resistance to this humbling ritual through impatience and frustration. As Edward remarked, "seeking a place like this is not a choice. It's not much of a choice, and that's why it contradicts the word 'client'."

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[49] Triage now has an outreach worker who has a small caseload of persons with psychiatric disabilities who live outside the shelter.

Allan expressed anger and resentment at having his life organized according to someone else's schedule:

> I can't take my meds when I want to.... And so that is really demeaning, having to stand there, shove the medication in and have them watch.... I wouldn't want to be dependent on this place for a meal once a week, or twice a week for that matter, or even for my hour of TV everyday. I wouldn't want to have someone telling me that I could come in during these times. To use this type of facility during this time and go down to the clothing room. I wouldn't want my life orchestrated that way.

As Barak (1991) notes, many homeless persons choose alternatives to the shelter because of its structure of containment and order. Donna compared the shelter to a jail:

> So called group homes and shelters, some of the people don't like that word... I know some people don't like to go into shelters. They'd rather stay out on the street than go to shelters 'cause they don't really like being, most people I know, it's being locked up. A lot of people like their freedom... 'Cause it seems like you go to jail or something like that.

Regulating behaviour

Control is infused within the stigma of being poor and homeless. For a time the homeless person is contained behind a locked door (locked to outsiders, not to insiders) of a structure organized around the fundamental principles of asylum. However, it is not just the shelter that contains—it is the urban core where bodies are bought and sold, targets are beaten and robbed, and a safe place for the night is highly regarded.

At Triage, in exchange for the provision of a few days shelter, clients are expected to follow certain basic rules. The possession of illicit drugs or unauthorized medications, the leaving of a syringe around the premises, or the assault of anyone in the shelter results in immediate eviction. However, the rules are in direct opposition to the everyday

activities happening right outside the shelter doors—on the street outside drugs and

violence are everywhere.

Control is organized around a discourse of defending selves against outside

forces, of holding the wolves at bay. Jason supported the idea that the activities

happening outside the shelter doors are out of bounds at Triage:

> Without control in the shelter, fuck it would be chaos. It would be stealing, drugs
> coming in, booze coming in, hookers coming in, people would be getting diseases
> left, right, and center. So you got to have control in a shelter, no control you got
> problems.

Triage has a medication room reserved for the storage and dispensation of various

pharmaceuticals, including sedative/hypnotics, antidepressants, anti-psychotics,

analgesics, antibiotics, anti-virals, and synthetic narcotics. The use or possession of any

drug that is not prescribed by a physician and listed on the resident's medication sheet is

prohibited; a client's infraction of this rule usually results in immediate eviction. Brian

declared:

> I notice the people that come in drinking. The drugs are probably tolerated more
> than the alcohol. That probably discriminates against the alcoholic. But it's
> probably harder to deal with someone on alcohol than it is to deal with someone
> on drugs.

Many of those who access the shelter service have drug problems, but avoid staff

when using for fear of losing their bed. This produces a cat and mouse game where the

skillful are able to avoid detection and the careless get caught. Donna explained:

> Like take this other shelter. They think that if some of you got red eyes or if
> you're tired and things like that, they put you down as, oh probably she came in
> so on and so on and this time she was high or it looks like she was drunk. Things
> like that they put down on the, what do you call it, in the books every night when
> they write things down. And some of the things aren't true that they put down.
> And you feel very insecure about things like that. And you really don't want to
> tell your problems to them, some of these places.

The need for order and discipline at the shelter creates situations in which a client engages in denial and pretense. I have seen residents so obviously under the influence of alcohol or some other drug that they could hardly stand up, but who would vehemently deny their condition. They knew that if they admitted to such use they would be asked to leave the building for a period of time and wait outside until they are not so visibly high. So it was in their interests to deny the reality. As Brian observed:

> How honest can we be with you here? Say if I was out using, I'd been using, whatever, on the street everyday and I came and talked to you and told you, that I'd been using and I feel like I'm abusing this place, would that necessarily mean that you're gonna lose your bed?

Sally illustrated that the very activities that the shelter seeks to prohibit are topics of everyday conversation cultivating illicit desire, "because there are so many people with drug addictions here, that everybody sits around and talks about drugs, and this creates craving, invisible cravings. It's caused me to crave drugs, and I'm a very casual user."

Bruce suggested that those persons who use the shelter as a detoxification centre should have their liberties restricted as well as their use of prescribed medications:

> I think if people are going to come in here to straighten up ... the first seven days they shouldn't be allowed out. Getting straight. Like one girl here she's on the methadone program,[50] I don't think that should be allowed. From my point of view. 'Cause other people see that. The people that are straight. She's kind of miserable now. She was sick for a few days there, now she's ready to go hustling.

The contradiction in Bruce's statement is that the medical use of methadone as a substitute for heroin may be of personal benefit to the addict, but a problem for others in the same social milieu. It is not so much the use of methadone that is problematic but the visible effects of the opiate synthetic. On August 7, 1997, I counted 80 prescribed drugs

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[50] Methadone is a substitute for heroin available through medical prescription.

between 28 residents in the Triage medication room. One resident had 16 different

medications.

Stress and high physiological arousal are interactive with social isolation, urban

environments, racial and ethnic discrimination, and low social position. Homelessness

and the vulnerability to homelessness are associated with structural factors and situations

that produce arousal, and coping mechanisms seeking to reduce this arousal may be

aggressive, independent of psychological/biological factors (Bernard, 1990).

Homelessness and the threat of homelessness can be a traumatic event resulting in

negative coping strategies situated within cultural values and social structure (Hoff,

1989). Mark described an incident in which a person had to be physically removed from

Triage:

> Although it was diffused, they were dragging her out of the building, and it just
> escalates. I think that could have been avoided altogether. If she would have got
> the pants. She's all wet. She's pregnant or whatever. She's got her story. Those
> are her needs at that time. At least some way of being able to put her on hold. But
> putting somebody on hold that's already been on hold for a long period of time, I
> can see where that's coming from. So I don't know exactly how that could have
> been handled differently, but I know that it could have been alleviated, probably.

Emergency shelters for the homeless and near-homeless lack a client advocate for

those discharged on procedural grounds and denied admittance (Culhane, 1992). As

Mark went on to observe disruptive behaviour at Triage can result in the person being

barred,

> ... and they end up losing it because they don't have the skills to say hey look, I do
> have needs too. So in some ways people, like this lady tonight who was venting,
> she was really empowering herself. Though she probably wouldn't see it as that,
> and she's now had something, one of her last bastions of, you know, anything that
> she can handle [removed]. So that now, when these people like that, barred for a
> month or two months, or whatever it is, now where do they go?

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A three-fold division of interests exists in social services: the public at large, the providers of service, and the consumers of the service. The tension between the three interests increases with the amount of regulatory activity, so that maximum regulation, as in criminal captivity, results in maximum dissension between groups about what constitutes social assistance (Armitage, 1975).

In a minimalist welfare state, the poor and the homeless are managed through deviance processing. Deviance and identity are constructed by those in the system and defined and constructed through interaction with others (Harré, 1993; Lofland, 1969). Those perceived as a threat to socially accepted definitions are subjected to some kind of control. The homeless make ambiguous the social division of work and family as they threaten the social order—they need to be responded to through control and exclusion. "The homeless are dangerous to the ruling class because in their struggle to survive they must demand changes that cannot take place without creating a new system of distribution of food and shelter on the basis of need" (Aulette & Aulette, 1987:253).

In the shelter practices of control are often cloaked in a rhetoric of care. The subtlety of control-based practices is difficult to detect, however, for the clients in this study were so grateful to have a safe and secure place to stay that issues of power were located, for them, around the regulation of disruptive behaviour. I asked the participants what control meant to them and how it connected with the practice of care at Triage. Beth stated: "Being able to handle the outbursts and the personalities, just the personalities of each individual client, that's care and control in itself."

Like all institutions Triage is tightly controlled as to its internal structure and the discipline of its bodies. Rules and boundaries are enforced with the threat of ejection

back out into the street. However, embedded within these control-based techniques there is also a practice of care. Control interacts with care in a balancing act in which care is contingent on discipline and orderly presentation. Morris summarized this dialectic: "They control the shelter, so people like, to protect people, and like that shows that they care right there, they're both linked, you know."

Someone to talk to—Care, safety, and support

Virtually all of the research participants confirmed that Triage is a place of safety, an oasis in a savage jungle of violent assaults, thefts, abuse, and deprivation. Theirs is a world of drugs, HIV, psychiatric diagnoses, welfare, hospitals, jails, violence, victimization, loneliness, and desperation. In contrast, the shelter is a refuge of good meals, care, and recognition. Wallich-Clifford (1989:17) describes the need for social acceptance of the homeless person:

> The responses of these latter may not always be 'normal.' Their attitudes may not always meet with our approval. Their behaviour may be asocial or blatantly anti-social. But although living with some of them may be hell and even liking them difficult, it is love that each and every one needs, and in his [or her] own way demands.

The faces come and go—each unique, each special, but what they all need is validation and acceptance.

Reconnecting

When new residents first arrive at Triage they are usually in pressing need. Their only clothes, worn and dirty, are often the ones they are wearing. Hungry and of poor physical health, beaten and tired, they may only want a shower, something to eat, and to go to bed. If they stay at the shelter, after a few days, or sometimes a week, they may

start to feel more secure about where they are and where they are going as they connect

with their surroundings. Mark observed this transformation in some of the people around

him:

> A lot of these people are the most vulnerable within the community. And you look
> at the faces of these folks, when you see them downtown, and you look at them
> when you're in here and it's quite different. I think you see a lot more of who they
> are in here than downtown. I've seen all these faces around.

Triage provides a brief respite for those whose lives are intertwined with the rooms and

the streets on a daily basis. Phil said that Triage gets him,

> ... off the street for a while, for me. I get runnin' around in circles and kind of lose
> sight of what's really happening. And here I get a chance to talk to people, to
> relax, and eat regular meals, get healthy again.

Triage is a time out from living under dangerous or threatening circumstances. At

the shelter, for differing periods of time, the homeless and near homeless eat, sleep, hang

out, and talk. Sleeping outside can be dangerous to body and soul and Morris maintained

that in Triage,

> ... you are not on the street so you don't have to keep your eyes open when you're
> sleeping. When you're sleeping here it's fine but when you are sleeping in an
> alley or something you're going to get robbed or hurt eventually, it is inevitable.

Because Triage temporarily takes care of all of a resident's shelter and food needs the

client is allowed the space to consider alternative possibilities, as Luke explained:

> Being safe here takes part of the problems that I've gone through, makes them a
> little easier to deal with. I don't have to worry about where I'm gonna sleep, if I
> have to get any meals, scrounge for food or anything. It makes it easier to deal
> with my other problems, I can concentrate on them, and deal with them, instead of
> having to worry about other factors.

For those who live in the downtown rooms temporary escape is sometimes sought

in a hospital, recovery house, detox centre, or other care facility. Charles observed that

Triage,

> ... gives me a little bit of peace. There's no screaming or yelling or partying going on. It gives me kind of a inner peace inside of me. I'm not kinda wondering who's going to be kicking in my door, or coming through the door with a key, whoever has a key to my room.

Frequently, people with severe heroin or cocaine habits detox at Triage. Often, a

person wanting to take a break from his or her drug use would come to the facility

seeking a bed. In this manner the shelter serves as a detoxification centre and referral site

for a possible treatment or recovery setting. Triage is sometimes a preferred location,

because of the open door policy, whereas detox requires the person to stay inside. Bruce

explained that even though someone might have a place to stay, the shelter was a place to

dry out from drug use and not necessarily just an alternative to living on the street:

> Like say I was coming off the drugs or whatever and I needed a place and had my rent paid and I needed a place to be around people and I wanted to be straight. Check out the shelter. I'd even put myself under house arrest. Just to show that I wanted to clean my act up. It's like a detox, right.

Triage can be a place where hope is restored and dreams are fostered. It may be

only temporary but at least the homeless and near homeless are given the opportunity to

get off the street and start anew. Christine explained how she rediscovered new meaning

in a life dedicated to getting high:

> They gave me incentive. Actually, the worker gave me the incentive to go back to school.... I learned how to change my clothes every day. 'Cause well, when you're using, sometimes you don't change your clothes for like three or four days. Sometimes even longer. 'Cause you don't have anything to change into.... I've only been back in school for two days, but I feel like I have meaning. You know, people listen to me now. They don't treat me like that stupid little nobody. Like in school if I have something to say, people listen. And nobody comments or criticizes.

For others Triage provides a place where personal troubles are ameliorated when compared with the misfortunes of others in the shelter, as when Linda revealed: "I find a lot of compassion and understanding here. I find that the ability to associate with other people, and see that maybe their misfortunes might be worse than my own, gives me a sense of hope." Sheila added: "I thought I was losing it, like I've got to know why I'm here. I watch other people, and I'm not losing it. I still have a grip on life."

I asked the participants what power meant to them and whether Triage contributes to their own self-empowerment. Tony responded that just being allowed to stay in bed late and being able to do chores for cigarettes alleviates dependency and provides autonomy:

> Power means the ability to keep along the same sort of thought, being able to have your own time to go to bed, to get up. Like for example here they call you once in the morning, breakfast is in five minutes or something like that. You've got five minutes left or whatever. If I don't get up then I know they'll just let me sleep in. So that's very nice. That feels like I have a little bit of power there. I like that we can work for our cigarettes.[51] It gives us a little bit of power, not just leeching a cigarette all the time while we're here. I feel like I'm doing something for it. Makes you feel good.

Triage has visiting hours for two hours twice a day during which time people in the area can use the phone, watch television, access the free clothing room, maybe find a cigarette, a sandwich or a meal, or just hang out and rest. Many persons come to Triage to find refuge, to get off the street for awhile, or to escape the dreariness of their rooms. Such is the cost of living downtown.

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[51] As noted in footnote 46 Triage no longer gives out cigarettes for chores.

The shelter can be an arena "for establishing social relations, practicing coping skills, and empowering people to look out for their own needs" (Shinn & Weitzman, 1990:5). Simon indicated how Triage helped to fill the empty spaces in his life:

> For me there's a lot of hope here. Just to come for a couple of hours and just be able to relax and socialize and just feel you're a part of a good group of people. Then you can laugh and joke around and there's so much sharing and giving, and just caring. In all aspects of it.

Someone to talk to

The opportunity to get off the street for even just a short time can increase feelings of self-worth and acceptance among those with very little social resource. Simon, hardened through many years spent on the street, remarked:

> Knowing you're in a safe place, it's a big thing ... to know that somebody cares. I'm just gettin' tingly, just feelin' it, right now, just talkin' about it right now, and it's the truth. You can't argue with the truth.

Bruce agreed that Triage meets basic needs of sustenance and recognition in providing "good meals and stuff. I mean those people don't eat. They get run down, they get sick. If you got problems and stuff I guess you can talk to the staff, they're there to help you."

Christine noted that the shelter staff "listen, and for me when I'm at this level or the level I was when I came in Friday, I needed somebody to talk to." These sentiments were echoed by Paul, who also stressed the need for someone to talk to when feeling isolated and down:

> It actually kinda relieves my stress, and relieves tension, and relieves my loneliness. I'm surrounded by people all the time. And I find that very comforting, very nice, that I'm not in a room by myself where I can't talk to anybody or anything like that. So it's nice to have some people around to talk to.

Beth mentioned how much she depends on "affection, affection from others, not just meaning your lover or spouse. From others like staff at a shelter. Like the support system that I have, that's all care." Jennifer described it quite simply: "All I need sometimes is somebody to just listen to my problems."

Russell (1990) reported that at the women's shelters she studied the residents highly valued personal counselling from staff but were ambivalent about or not supportive of group or communal counselling. Sheila confirmed the social importance of facilities that serve the disenfranchised when she commented that Triage provides her with "somebody to talk to."

Substitute families

The homeless and near homeless have a high degree of disaffiliation and social disintegration and lack social support both formal and informal. Detached from family, friends, and community, the shelter resident becomes reconnected through her/his feeling of acceptance. The resident adapts to, becomes dependent on, and develops social mastery over the institutional environment (Grunberg & Eagle, 1990).

For some persons the shelter is an idealized substitute for familial social relations in its provision of care and support. "Social support also involves the exchange of guidance, useful information, personal services, and material assistance" (Baker, 1994:496). Jason maintained that Triage,

> ... gives me hope, it gives me everything, it give me friends, it gives me counselors, it gives me somebody who wants to care about me and help me through the tough times, have a place to come when I do need help. It gives you basically like a real home, like your own home, your own family, people that is there 24 hours around the clock for you when you need it.

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The shelter replaces idealized concepts of family for those with nowhere else to turn, as Charles illustrated: "Without them there would be a lot more suicides and deaths. I know I would probably be one of them too, if I never knew about this place. I'd probably be just another number, figure, and that's about it."

To many of the participants social support and validation were very important and went beyond having a safe place to live of one's own. Beth explained this need when she remarked:

> Security to me isn't just me being by myself having a home, having a place to live, having food. That isn't security. I lose my mind if I'm alone, like without support. So I have to have support in the community, outside of the shelter or treatment centre or something, just in the community.

The shelter is a place of recognition and basic care where fundamental human needs of belonging are provided to those who live in poverty and inadequate social resource. For Linda it was a matter of life and death: "I would probably just crawl into a corner and die if I knew that this place was not available for me." Paul maintained that securing a bed at somewhere like Triage means: "I wouldn't sleep outside or I wouldn't have to go out on the streets and risk my life and all that just to get money just to get somewhere to sleep." David compared Triage to a lifeline: "When you are drowning, that's shelter. When someone is going down drowning, if you don't hurry up and get them you know they'll go down. That's what shelter does for a lot of people."

For Edward human connection took precedence over material comfort: "The important need, in my opinion, it's the emotional comfort, the spiritual comfort. I think it's more important than the meals and the bed that you can sleep on."

As noted previously, for every person given a bed at Triage three are denied. The shelter is so often full that when someone needs support and it is not there, the family is seen as unreliable. For Jennifer the only alternative is the street:

A lot of people they'd like to depend on their family but their family, well, you have to try and do it by yourself. And if there's no shelter for them to go to then that's really hard for them. And they have to, if their family can't back them up, then they have no other choice but to sleep the streets, and walk the streets, and stuff.

Relationships of validation

Workers at Triage are similar to those of emergency psychiatric units in that they often interact with their patients' craziness in a manner that is inclusionary and accepting, thereby normalizing the craziness (Rhodes, 1991). Affective bonds are developed between clients and staff through a "cumulative and joint existence ... a high degree of mutual exposure ... a relatively large amount of practical aid ... a reasonable degree of actual or potential peership ... and a degree of understanding and a reasonable amount of warmth imputed to [the client by a staff person]" (Lofland, 1969:275). Having spent a significant portion of his life in institutions, Morris claimed that the staff at Triage are,

... more humane. They treat you like a person. The staff seems like half crazy, so I can get along with them. They're not so judgmental about your situation or whatever. They treat everybody equal, doesn't matter if you're mentally ill or if you're physically ill or whether you're coming off of drugs, they're all equal. They don't treat you like the other places do.

Brian observed that many of the Triage workers had histories of substance abuse problems themselves: "Most of the staff here were probably ex-addicts or alcoholics. Which probably makes it easier for us to talk to, about our problem."

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Luke reiterated how Triage is different from some other facilities in the apparent level of tolerance and acceptance presented by the staff:

> Their attitude is the key factor, that I see. I've come in late and nobody even batted an eye. They never said anything. Sure, they looked to see if I was intoxicated [but] they didn't ask me any questions. There was no pressure there. And that's a different feeling. Usually they grill you, try to see if you're stoned or whatever.

Job stress at shelters, often resulting when workers experience a discrepancy between services needed and resources available, can produce "rigidity of thinking, postponing contact with the residents, and increasingly 'going by the book'" (McKenna, 1986:22). Paul commented on a larger shelter in downtown Vancouver: "You can go stand at the desk ... and they'll say, 'do you mind, do you mind going to the lounge' and all that. Not like here. It's like they have time to talk to you here. They make the time."

Tony illustrated how important just being called by name and validating self is in the lives of those with insecure identities as he compared Triage to a larger shelter in downtown Vancouver: "The staff are just a whole lot better here than over [there]. They're more professional. They use your name. Over at [the other shelter] you could be there months and they don't know your name."

Special cases

Special cases at Triage allow the staff to circumvent or undermine the official mandate of the shelter and thereby justify their practice as one of care and concern instead of the efficient disposition of bodies. Special cases give the staff license to go beyond the "awfulness" of the client to the "awfulness" of the system (Rhodes, 1991). When

appropriate facilities to which to refer a client are lacking, the client may linger at the shelter and become familiar to the staff.

At Triage George is a success story. At the time of the interview he was getting close to being at the shelter for a year, with one or two brief breaks in between to live in a downtown hotel. George saw Triage as a place to temporarily repair, a transitory respite before returning to the rooms: "It gets me back on steady meds and a proper program, food, and things like that. And then I go back into a hotel after that." However, each time George returned to the rooms he became more and more withdrawn, failing to eat and to properly care for himself, sometimes staying outside on public beaches. As George's stay at Triage extended into time he descended into a deep depression; the medications resulted in his sleeping all day and in his getting diarrhea. In desperation, the doctors seriously considered him for electro-shock treatment. Finally, however, through the individualized efforts of a Triage worker, George was located in a board-and-care home outside the downtown area and he began to emerge from his withdrawn mood. George continued to visit Triage, one time bringing over some artwork he had done at the home. The ultimate triumph was when George and the Triage baseball team won the cup from the mental health clinic up the street, from the same workers that had previously considered him for the shock treatment.

There are other stories, of course, such as the woman who could not accept her living conditions anymore and jumped out of her hotel room window—she survived but had to have both legs amputated. A few years later she secured a downtown social housing unit, where she is now living a life much improved over the one of shelters and rundown rooms that she had previously endured.

Triage is a sanctuary where people can dry out from excessive drug use, stabilize on medications, retreat from the streets, escape a dangerous situation, or reside until other housing is found. It is also a place where one can acquire a meal or a piece of clothing, pick up mail, or just find support and recognition.

Triage offers an environment of dignity and residents appreciate the sense of autonomy they are allowed—they feel comfortable in the shelter, night after night. In this manner the shelter functions as a means for handling burdensome populations, avoiding larger political/economic issues, and providing a relatively inexpensive solution to a growing social problem (Bassuk, 1985).

What is to be done

In May 1997 an estimated 160 persons from the Downtown Eastside came to a barbeque and dance at Triage. The "expelled" and "socially inadequate" mixed together in one big happy group. I saw faces smiling and relationships forming. Some wore jeans stained with blood and dirt while others, dressed for the occasion, sported bright dresses and cast-off suits salvaged from donation rooms.

Sylvia,[52] a visitor who was not one of the formal interview participants but who often comes to Triage for food, medical attention, emotional support, or a bed, careened around the dance floor in a wheelchair muttering happily to herself. Sylvia has serious behavioural problems, often getting barred from Triage for such incidents as the threatening of a staff person with a syringe.[53] A local police officer once told me that he

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[52] Sylvia is a pseudonym.

[53] A syringe, contaminated with the AIDS virus, can have the same lethal consequence as a loaded gun.

had known Sylvia when she was 10 and that her mother sometimes sold her to men who

would use her for sex. The night of the dance, Sylvia, who was 21 and ravaged and

scarred from living on the streets, rhetorically asked why coming to Triage made her feel

so much "better." Daly (1996:14) observed that this redemptive experience is

commonplace:

> Homelessness represents a continuum from people at risk to those who are
> without shelter on a temporary or episodic basis, to individuals who are absolutely
> or chronically homeless. Different homeless people have different needs. A
> continuum of needs can be matched with support services to help people, most of
> whom can achieve some measure of independence.

Specialized needs

Triage does little to overcome the basic reasons why people are in the shelter in

the first place, and hence it is implicated in the wider process of shelterization. While

clients are in the shelter counselling and recognition are available, but because Triage

does not have an outreach worker who is generally available to the residents, when it

comes time to leave the shelter most clients are on their own unless they can access an

outreach worker from another facility. "A more balanced approach is needed: one which

emphasizes public and voluntary sector programs that are sensitive to actual needs while

simultaneously fostering an individual's capacity for self-help" (Daly, 1996:3). Simon

explained the need for more attention to specialized needs:

> When we all come in we all have our, what do you want to do, what do you plan
> on doing, or just like to do. [We need] more follow up on that sort of thing. It's
> pretty easy to get carried away when you start walking out the door, forget about
> all that, that's easy to forget. [We need] more one on one.

Sheila agreed that more supportive services that stress positive social interaction

and that go beyond just material help are required:

I think there should be more help. Not just financial assistance. Like, counselling and stuff like that. I've been to the welfare offices here and I've seen a lot of really cold workers. Like they're just there for the dollars themself, right. And that doesn't really help the situation any.

Sheila argued for acceptance of her person regardless of her lifestyle and characteristic , way of approaching life:

Like normal isn't in my vocabulary, you know. Normal is something you find on a washing machine. Everybody is different and some people have more problems than others. I think that people who are homeless shouldn't be looked down on 'cause they're homeless. They're people.

Mark mentioned that he thought the information contained in the 'People's Living in Poverty' handbook distributed by the Carnegie Centre was a good thing and helped to empower people,

... because those are tools people can use. But if you get them in a line and you get them frustrated and you get them standing in the back of the room, what's that doin'? And maybe if they're lucky they'll get something, or they may not even remember, because it gets too many asides going.

The Downtown Eastside Youth Activities Society (DEYAS) distributes a "bad date" list on which are descriptions of dangerous incidents encountered by prostitutes in the area. This list, and other informational documents, were often posted in the staff inner office rather than in the client areas. Sally commented on the need for more information about the services that are available on the Downtown Eastside,

... information sessions on public housing, and subsidized housing, and other organizations that could help them if they're ill. Maybe not everybody is aware of the foodbanks and the things like the Lovin' Spoonful that feeds the AIDS victims and things like that. They need more information on the social services that are available, sessions or material available to the clients, 'cause that was a big one for me.

Community mental health

In the United States the community mental health centre (CMHC) originated in the reformist ideals of the 1960's, emphasizing prevention of illness through community involvement, as prevailing social conditions were seen as a contributory cause of mental disorder. The vision was for the CMHC to become involved in all aspects of the community; politically and socially. The CMHC was to be a central focus in the prevention of mental illness and the promotion of mental health. However, due to competing political, economic, and social agendas the CMHC's did not turn out as originally envisaged (Sparks, 1996; Torrey, 1988). In Canada, although the experience of the CMHC's has been somewhat different, the overall failure of community-based service and housing for the seriously mentally ill is the same (Daly, 1996).

Symptoms of serious mental disorder, such as schizophrenia, chronic depression, or bi-polar disorder, are often difficult to separate from the effects of certain substances. Because many persons on the Downtown Eastside use drugs and other substances to cope with their environment they are often neglected by the mental health team because they are deemed as needing substance abuse treatment which the team says is beyond their scope. The client falls through the cracks and is potentially ignored (Office of the Chief Coroner, 1994).

Two blocks up the street from Triage is a community mental health clinic to which clients are sometimes referred. Allan had tried to access the services of this mental health team but he was told his problems did not fit their mandate. Allan was angry about this and felt they could have been more helpful:

I mean the mental health team does a lot of good work, I'm not saying that they don't. But I just find that they put you in the boxes. They put all the symptoms or situations that they can think of into boxes, and if you don't fit into that situation you're not allowed to access the service.

The fair share approach

The NIMBY (not in my backyard) attitude emanates from the precarious balance between individualism and commitment to community (Henig, 1994). Individualism wins out when social housing projects and shelters for the poor, the marginalized, and the non-productive are opposed by residents of areas outside the urban core, or at the very least subjected to a hierarchy of acceptability where the physically disabled are at the top and ex-offenders and drug addicts are at the bottom. The fair share approach entails the fair and proportional distribution of services and affordable housing across different communities in a fair and proportional sharing of responsibilities by *all* citizens (Dear & Wolch, 1987). Bruce said that the shelter is,

> ... situated in the wrong place of town. Like it's right here. You walk out the doors and there it is. It would be nice if it was up in the upper part of East Van or something like that. You know how bad the streets are. You just walk outside and there it is basically. With all these shelters down here....

Suburban opposition to social and supportive housing is based on the fear that their investment would be threatened; the idea that the poor would be getting government assistance whereas they had to work hard for the same thing; and the notion that new community entrants must *earn* their entry, not arrive through government fiat. However, this thinking shows a poor understanding of the structured economic and social realities that exist for certain segments of the population. As Luke explained:

> There are people out there that have no idea that there could be a homeless person in Canada. Some of them will see somebody who's homeless and say, 'well, they wanted it, they want to be that way.' Where it may be true in some cases but in

some it's not. They don't see any future or anything for themselves.... With the single individuals there's different aspects in their lives. Like somebody could not be educated, not of their own fault. I have friends that can barely write and read. Like maybe at a grade three level. And for an adult, other than their self esteem, that can be tragic. Never being able to work, you can't even fill out a job application to get a job. How's he gonna get a job. And it's really tough.... 'Cause some people couldn't go back to school, no matter how much they wanted to or tried, they can't cope with school. It just doesn't work for them.... More people have to understand what goes on with welfare and with homelessness, being on the street. More than just what it is.

Safe and affordable housing

In June 1997 the City of Vancouver shut down the Roosevelt Hotel as unfit for

human occupancy. Forty-five tenants were displaced by the closure. Morris commented

that the hotels on the Downtown Eastside, although a risk to health and well-being, are at

least affordable and offer protection from the elements:

> There's a big housing problem down here. The places that you can get should be shut down but they can't shut them down 'cause then there would be more of a housing problem.... Like the hotels are rat infested and they are just disgusting. They could close them legally, like the health inspectors could right, but then there would be thousands more people on the street. That's the only reason they don't do it. At least they keep warm or whatever.

Linda expressed a willingness to participate politically in the movement for more

affordable and safe housing:

> I would definitely like to see more shelters and affordable housing. I think 90% of the Downtown Eastside hotels should be burnt to the ground. I mean that would put a lot of people out into the street but it's like, which is the worst of two evils? Do you live in a cockroach infested 4 x 4 closet, or do we fight for the decent housing that we should be allowed to have?

Donna hoped for more community involvement and an altered terminology in the

provision of supportive services and housing for the poor: "I wish we can all work

together. Like talk to everybody, and try and get places, low rent or lower cost housing, and probably someone giving a different name to other than shelters and stuff like that."

A 25 year old transsexual with HIV who sometimes prostituted himself to get by, Paul wanted "something I can call my own. It means somewhere I can sleep and not worry about whether or not am I going to be here tomorrow." When he lived in a quiet neighbourhood outside the Downtown Eastside, Paul explained, his thinking was more clear and he felt better about himself, "instead of waking up in a hotel room, just four walls and looking down on Hastings Street. That's very degrading. It's just not a way to live. I think a better environment would make a person more productable." Reynaldo declared that he wants a life where "people ... ain't gonna rip you off or do anything that you got to worry about. You should be able to not worry about those things, robbery, that kind of stuff."

Community opposition to fairly distributed safe and affordable housing, with supportive services if appropriate, may exacerbate the problems of the homeless by increasing the opportunities and probabilities that they engage in criminal or disruptive activities through the processes of criminalization, stigmatization, and increasing survival strategies. For David the provision of more safe and affordable housing was an imperative: "When you build one, build another, in a different area, but keep them going. That way it'll beat building prisons, 'cause if you don't do that that's what you'll end up doing, building more prisons."

Issues of social justice

The conservative theses that the welfare state discourages investment and the

work ethic, and that it is a luxury the capitalist state can ill afford, have been debunked by

various economists and authors (Block, 1987). The conservatives use statistical data to

dispel the claims of welfare state proponents, but the issue must be examined

qualitatively not quantitatively. For example, a proposed casino and seaport convention

complex in downtown Vancouver was justified through quantitative measures, but when

held to criteria such as how housing and community relationships would be affected, it

was clearly shown not to achieve the goals of social justice in the community. It

translated as a resort for the rich but ignored the needs of the poor. As Linda observed in

more general terms:

> The people who sleep on the streets they seem to get forgotten about. It's like we
> almost become invisible to the rest of society and that's totally wrong. There
> should be more people with their eyes open and, you know, willing to see that
> there's too many of us out there that are looking for a home/looking for
> assistance. Unfortunately ... people's hearts are getting colder. And I guess the
> needs are greatly outweighing the resources.

Identity depersonalization is expressed at a political level and apathy makes sense

for those who live under the conditions described by the participants. Paul explained that

a financial aid worker once called him a "lazy bum" and he has appealed the decisions of

welfare agencies as to his program eligibility:

> I have this side of me that wants to be an activist in some way, to speak out. But I
> back down 'cause I can start things, but I just I don't finish it, I can't finish it.... I
> get very jumbled up with authority figures. So advocacy would be nice.

Work that fails to fulfill social and developmental needs leads to social injustice

and a thwarting of personal development, maintaining inequality and privilege (Gill,

1989). For those who live in the urban core job opportunities are severely limited. John

announced:

> I would love to have that minimum wage job. I would love it. If somebody could
> actually give me a contact, I would not let 'em down. I would bust my ass. I would
> love to be able to have some stature, to know eight hours a day I could do
> something ... and not have to worry about whether I'm going to eat for the next
> three days.

Nancy, dealing with spousal violence and a cocaine habit, proclaimed her right to

state assistance in her quest for a better life:

> The government has no right to say people that can't work can't have any
> money.... We have a right to get money if we can't get it from work. I've worked
> my whole life and I don't feel bad because I can't work right now because I'm
> trying to recover and get off drugs and everything.

Morris called for an increased understanding and awareness by the general

community to dispel the myths surrounding popular conceptions of homeless persons:

> As a community we can educate people who don't understand it, or people that
> are ignorant about it, that think that all homeless people are drug addicts or all
> homeless people are crazy or that they choose to be homeless. A lot of people
> believe that, people that have never been homeless themselves. So I think we need
> to educate people.

Simon wanted an increased sensitivity to the conditions of deprivation and suffering

endured by those on the streets and in the rooms of the Downtown Eastside: "For me it's

people down here, show them, really show them what their fuckin' hurtin' situation is."

Jim, relatively secure in a Downtown Eastside social housing unit, articulated his

responsibility to the marginalized and politically powerless: "I think if I can say

something, then maybe my voice will help somebody else speak up and then, pretty soon,

you've got all these voices speaking. Then something will happen. Strength in numbers

type thing."

Luke reasoned Triage can become more involved in the political/economic issues
of homelessness if it would,

> ... raise more concern with the community about the problems. I really don't know
> how active they are. I've heard of Triage a few times, but I've never seen them
> when there's any problems with welfare and stuff. Not that I can remember have I
> ever seen them mentioned.

Mark expressed the need for more cooperative community activism in dealing with the
diversified problems facing the Downtown Eastside:

> We can have more grassroots organizations, that are more in touch with the pulse
> of what's going on, with downtown issues. Because not all the issues are the
> same, they're not the same on Hastings Street as they are at the end of Powell.
> Grassroots is where it's got to come from, and neighbours helping neighbours,
> and people caring. If you care about the people that are in your environment then
> you should be willing to at least help them to be able to, if not better their lives, to
> at least help them with their problems.

Shelters for the poor and homeless need to be in the business of putting
themselves out of business rather than reproducing the status quo. Edward perceived this
relationship as one of charity versus social justice:

> Having social justice in the eyes of the rich is to provide shelter for the needy or
> the poor. In the eyes of other people, the good thinkers, the really caring people,
> it's having social justice lead to not having shelters and needing such
> organizations to provide support or comfort.... Because the purpose of the shelter
> is to provide care and comfort. So that's not empowering the individual of
> anything.... We need to start from the top, we gotta change the top, or if we don't
> change the top then nothing gonna change at all on this level.

The final observation in this chapter is reserved for Jim, who stressed that the
need for personal validation and acceptance of those who use the Triage shelter must
ultimately align with an increased public tolerance of socially problematic behaviours:

> If you want to have this place as a clean, safe environment, like drug free, you're
> going to turn it into a detox, rather than a shelter. And then people will be
> monitored more. People come in here with very little to hang onto ... so let them
> have that little bit of self esteem. It is little, but it is something. Because

sometimes that's all you have to hang onto. A little bit of self esteem.... 'Cause people need to feel that they belong, somewhere.

CHAPTER FOUR: CONCLUSIONS

In January 1996 a young male was denied a bed at Triage because he said he only needed housing. Within an hour a middle aged male asked for the same bed, but was told by staff that he must have some treatment plan in place. The gentleman replied he had nothing to treat —he just needed somewhere to stay. Further probing by the staff revealed that the potential client may have a drinking problem and he was given the empty bed. During this person's stay at Triage no treatment plan was initiated and after about a week he found his own housing and was never seen again. All he wanted was shelter.

In April 1996 a woman was referred to Triage by a local drop-in for street involved people. Because she was "housing only" and just one bed was available she was refused shelter. The bed remained empty for two days during which time she was referred again and refused again. Another bed came empty, leaving two beds available during the shift. If she had tried the third time she may have gained entry because of the increased bed space.

In the same month another individual, a frequent visitor to Triage who would come in for food, clothing, or a blanket with which to sleep outside, died of a drug overdose. This person frequently turned up asking for a bed and was often refused because he was housing only and, as more than one staff person agreed, he is responsible for his condition and can go to Catholic Charities or Crosswalk.

In the Fall of 1996 SAFE RIDE[54] brought in an elderly man who had been found by the ambulance service sleeping on a public bench in very cold weather. He was in rough shape, a bandage on his leg, crutches, smelling of urine, and very dirty. Because there was only one bed available (and a much younger male had come in looking for shelter at about the same time), Triage refused to give him the space because he needed to have "home care"[55] in place. Because he was not drunk he was not eligible for detox. All the other shelters were full, and the SAFE RIDE driver did not know where else to take him except to the hospital, where he would soon be discharged to an overburdened shelter system or back to the street.[56]

I cite these examples not to show that the workers at Triage are uncaring, but to illustrate what happens when the demand for a safe place to stay exceeds the available supply. So many persons come to Triage asking for a bed, for shelter, for food, for support, that the staff, often overwhelmed with service requests, are forced into a practice that attempts to distribute the scarce goods in a manner in which those deemed to have problems that can be professionally treated are helped first, producing a competition for scarce resources between the hungry, the homeless, and those in need.

At Triage control results from the pressure to separate the deserving from the undeserving in the distribution of the scarce resources, and the obligation of turning over beds in order to justify its funding for short-term emergency and not transitional housing. Control manifests in the arranging and disciplining of space as staff monitor the constant

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[54] SAFE RIDE is a voluntary service that transports the inebriated to appropriate facilities.
[55] Home care is an out service that provides personalized attention to the physically disabled in the manner of bathing and clothes washing.
[56] B. Morgan, personal communication, October 15, 1996.

comings and goings, the flow of bodies. Care is arranged within the spaces of control

when the staff listen, advise, answer questions, acknowledge, repair, reassure, and create

a safe, supportive, and caring environment for those fortunate enough to get in.

Because many residents feel safe at the shelter, and are provided three meals a day

as well as certain bonuses, such as having their clothes washed and having someone to

talk to, it is advantageous to stay as long as possible in order to avoid the isolation and

lack of safety and security in a downtown hotel or other precarious circumstance. "When

criteria for admission to housing and related programs are predicated on illness,

alcoholism, or drug dependency, individuals tend to adopt the behavior patterns necessary

to get them admitted" (Daly, 1996:239). This means that beds are occupied as the

demand for shelter grows—as stated in Chapter Two, for every person given a bed at

Triage three are refused.

On November 9, 1997, a male named Keith, in on the free dinner list which had

started an hour and a half before the door opened, told me how he had worked for two

years as a heavy truck operator, but quit after "a tiff with the boss". Not eligible for

worker's insurance because he left the job voluntarily, he asked social services for help,

but was told he would have to cash his $10,000 Registered Savings Plan contribution.

Unable to access the fund Keith slept outside for two weeks, finally getting welfare to pay

for a cheap room on the Downtown Eastside. Keith said he felt sorry for all the other

persons he saw downtown who were worse off than he.

The 26 participants who were interviewed for this study were well-spoken and

cooperative. Their voices organized themes common to everyone who is homeless or at

risk of being homeless. Out of the narratives emerged themes of poverty and

resentments, homelessness and dependencies, marginalized identities, precarious, threatening, and dangerous situations, institutionalized techniques of care and control, increasingly scarce resources, strategies for getting by, and hopes for the future.

The participants in this study recounted biographies of physical and sexual abuse, familial rejection, and long-term institutional involvement, including foster homes, correctional, mental health, treatment and detox facilities. The majority were single, many with children in someone else's care. All but two had minimal work histories citing lack of education, training, skills, or experience, and emotional problems as barriers to their finding employment. Several reported recurring emotional problems, such as depression, and others cited physical conditions related to HIV/AIDS. Almost all had used services and facilities for homeless and near-homeless persons, such as free-clothing shelves and drop-in centres. A considerable number of the participants reported social service workers as their primary means of support. All of the respondents had stayed in a shelter before. Most of them had previously slept outside. For the majority homelessness was a recurrent condition, with short-term stays in various rooms and residences. Many had been refused service at other shelters for reasons beyond there being no available beds.

The participants described Triage as an oasis in a milieu of social, physical, and psychological pain and illustrated how the shelter organized their strategies for getting by. Their need for safety and support connected with processes of marginalization, stigmatization, and discrimination on the basis of race, class, and gender. Their voices expressed how the shelter provided a place to reconnect with themselves and others, to establish hope, to dry out from excessive drug use, to get healthy, and to find someone to

talk to. Triage was a brief respite, a time out, a waystation in a life of surviving the rooms and the streets. For some of the participants jails, hospitals, and detox centres provided alternative forms of shelter when all other options seemed unavailable.

Their homelessness was organized around a complex interaction of factors, including drugs and alcohol, damaged relationships, abusive situations, attempted suicides, evictions, failures of deinstitutionalization, lack of meaningful or rewarding work, HIV/AIDS, absence of family or friends, and unstable living conditions. Reporting high rates of ill health, they described feelings of rejection, isolation, and despair, and how their quest for safety, security, and personal recognition organized their everyday lives. They recounted the ever-present threat of thefts and violence in many of the rooms and streets of the Downtown Eastside. In the hotels, sexual harassment, homophobia, drug use, and lack of safety and security were rampant. They explained how heroin and cocaine, readily available on the Downtown Eastside, constituted a relatively cheap coping mechanism. They described how they adapted to the trials of street life by putting up a front or inuring themselves to the violence. Loss of motivation to get out of these conditions was prevalent. In concert with service providers many blamed themselves for their circumstances supporting categorizations of differentiation and individualization.

Surviving on welfare is a full time job and, to supplement their social assistance cheques, many of the participants engaged in shoplifting, drug dealing, or prostitution to get by. Women often depended on male figures to help them survive the night. Many of the participants said that cuts to social assistance would result in increased rates of crime.

Their voices addressed a range of focal issues and debates concerning social welfare and social justice in contemporary society. Their words allowed me to shift the

focus away from a concentration on individual inadequacies, economic deficits, and unrealistic belt tightening to an emphasis on social justice and a fair distribution of our resources and social responsibilities. They eloquently demonstrated how homelessness is intimately connected to the practices of the welfare state and of social policy towards the poor and disadvantaged. Research of this kind is all the more pertinent in the context of contemporary calls for welfare retrenchment, workfare, increased prison construction, and cuts to social spending.

Small shelters of no more than 30 residents are better able to meet the diverse needs of the homeless and near homeless. Triage works because it provides a semblance of family in which clients feel accepted, even though their stay is limited. Large shelters encourage depersonalization and merely reproduce the unsafe, unstable, and dangerous conditions on the street and in the rooms. Triage is known on the street as the "Hilton" of shelters, maybe because residents can stay in bed all day, enjoy their single rooms, have their laundry done, and eat good meals. But it may also be about regaining health, esteem, and confidence. For a relatively brief period residents are allowed the space to evaluate their lives and reconnect with a stable environment.

Shelters have to be responsible for finding safe and secure housing for those who stay at their facilities. Because of the pressures to turn over beds residents are left with few options other than moving into a cheap hotel or finding someone with whom to share an apartment. Both of these options contribute to residential instability when hotels are generally unsafe and relationships are fragile. This revolving door pattern is not cost effective. When the exits out of homelessness are precarious, homelessness becomes a condition rather than a temporary phenomenon.

Emergency shelters must be in the business of getting themselves out of business. Until such a time when safe and affordable housing is obtainable for everyone, the voluntary sector, in cooperation with the private and public sector, needs to secure places where safety and recognition, in combination with shelter and food, are *always* accessible. There will always be those who are problematic in behaviour and attitude, and the window of opportunity for these persons must always be open (Office of the Chief Coroner, 1994:24).

An exception to the generally isolating and disempowering conditions in the rooms of the Downtown Eastside, and to those hotels that cater to the psychiatrically well-managed, is the Portland Hotel. A constituent of the non-profit or voluntary sector, the Portland Hotel Society has a unique partnership with the public or government sector and the private or business sector, in that, with the assistance of public funding, it leases 69 rooms in a run-down hotel of which the owners retain the profits from the bar below. Situated in the middle of the roughest neighbourhood in Canada, it houses approximately 70 persons with psychiatric and behavioural disorders combined with substance abuse problems. Run on a philosophy of community tolerance and idealized concepts of family, it is more than just housing—it is a complex relation of individualized autonomy, respect and dignity. The Portland recognizes housing as a basic right and avoids moralistic evaluations or the right to make housing contingent on behaviour.[57] Many of its residents, people with multiple problems, have been living at the hotel for five or more

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[57] L. Evans, personal communication, September 12, 1997.

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years—an unlikely prospect for these individuals in the private housing market. As Daly

(1996) recognizes:

> It appears that a key factor in determining the success of projects for homeless
> people is the degree of power and control they exercise. Included are economic
> power (access to resources and to institutions that provide financing or goods and
> services), political power (expressed through the ability to control the project and
> to make decisions; it may also be expressed through political clout ... the ability to
> make public officials take notice), and personal power (when the individuals
> involved are allowed to direct their own programs) (p. 210).

Services for those in the rooms and on the streets need to be coordinated and

expanded, especially in the areas of literacy and job training, detoxification, alcohol and

drug treatment, recovery, and advocacy. More ongoing and follow up support is needed

for those exiting institutions. Because one-on-one assistance, that is someone to talk to,

is highly valued by many of those on the street and in the rooms, more peer support needs

to be available. Streetwork and outreach services need to be expanded and coordinated,

with opportunities for such work to be made available to the homeless and near homeless

themselves. Many of those on the street solicit help or support from their friends and

peers; providing homeless and near homeless persons skills in peer support training at the

least would help them survive the conditions under which they live (Currie, 1995).

Social service workers need increased training in sensitivity, childhood and adult

violence, abuse, addiction issues, and social service awareness. Service providers need a

firm understanding of how undesirable behaviors can result from the stress and high

physiological arousal of living in the urban core.

Triage excepted, many of the services and shelters organized for the homeless and

near-homeless are unionized, as workers seek a voice for their own interests. There is no

reason why clients should not have this same representation. Advocates representing the

issues confronted daily by the homeless and near-homeless must be readily accessible to those who end up in shelters, in run-down rooms, or on the streets.

Homelessness and poverty involve a complex interaction of events and circumstances which can be alleviated by providing more safe and affordable housing and supportive services, not just in the urban core but throughout all our communities and neighbourhoods. The services of the Downtown Eastside need to be dispersed to outlying districts. Communities with shopping malls could erect low-cost housing units and a service facility as part of their social service mandate. In this way the goal of community care will be realized—through true community integration and acceptance. The poor and marginalized need to be included in the policy-making process. As the downtown shelter becomes a form of quasi-permanent housing, in which empty beds are a scarce commodity, the concept of housing as a right needs to be adopted.

Like all social problems, the public issue of homelessness has been socially constructed (Blasi, 1994). A focus on homelessness as a social problem leads to policies of mass shelterization deflecting attention from the larger issues of poverty, discrimination, and inequality. Solutions to homelessness are contained within the solutions to hunger, poverty, poor health, educational deprivation, violence and victimization, and slum housing conditions, and must address issues of power, social justice, and privilege. Solutions are not within conservative or liberal practices but within a global socialism that decommodifies housing, education, and human labour.

Our response to homelessness can be organized around a "social problem" approach, of treatment and tailoring of services to select populations, or it can be organized around a "social utility" perspective defining adequacy of service in relation to

need and supply and demand. A social utility approach to the provision of social services

uses concepts such as "service need and service standards" (Armitage, 1975:177) and is

grounded on the principles of alleviating hardship and affording universal access. Our

goal should be to redesign and reconceptualize existing social services, moving away

from the discourse of "social problems, treatment, and clients" to a reconceptualized

language of "social utilities, prevention, and citizenship" (Armitage, 1975:176).

Barak (1994) details the evolution of three generations of rights in the

development of the political economies of the Western democracies. The first, as

reflected in the American and French revolutions, can be termed negative as they reflect

rights of freedom *from* state oppression. The second, as expressed in the welfare policies

of the Western states, can be termed positive as they reflect the rights *to* basic human

needs. The third emphasizes universal human rights for all peoples in global cooperation

aimed at solving the problems of poverty, hunger, and homelessness.

Homelessness is a global as well as a local problem. It is intimately connected to

the policies of global capitalism: that is, the accumulation of private wealth. Short-term

solutions, such as more shelters and correctionalist policies, will only institutionalize the

problem and end up costing more in the long run. Government policy must be directed

towards long-term solutions such as the construction of more affordable, low-cost

housing for those persons being threatened with the increasing gentrification of our cities

and towns and safe and secure housing with supportive services for those marginalized by

the drive to create profit. With courageous government policies that address the

fundamental inequality based on the distribution of power and privilege in capitalist

society, Canada could take a leading role in providing safe, secure housing for all its

citizens and alleviating a problem that will only continue to grow without strong

cooperative intervention worldwide.

APPENDIX A

Emergency Shelter Survey[58]

Interviewer Name: _____

Interviewer Code: _____

Shelter Name: _____

Shelter Code: _____

Date: _____

INTRODUCTION:

Hello. My name is Tom Allen and I am a graduate student at Simon Fraser University. I am trying to collect information from the users of Triage that, among other things, will be helpful in planning services for people who need shelter. This research on homelessness and emergency shelter use will go toward the completion of my master's thesis in Criminology.

This research is voluntary. You don't have to be interviewed if you don't want to. If you agree to participate, I will not identify you in any way. If there are questions you don't wish to answer, I will skip them. This study is strictly confidential.

Would you be willing to take an hour or two and take part in the interview?

_____1. Yes   _____ 2. No

$\downarrow$

Proceed

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[58] Used with permission and adapted to the Canadian context from Martha Burt (1992). Practical methods for counting homeless people: A manual for states and local jurisdictions. Washington, DC: The Urban Institute.

First, I'd like to get some background information.

1. How old were you on your last birthday? _____ years

2. Sex: (DO NOT ASK/ MARK ONE)
_____ 1. Male
_____ 2. Female

3. Which of the following racial or ethnic groups do you belong to?
   (READ LIST/ MARK ONLY ONE)
_____ 1. White
_____ 2. Black
_____ 3. Hispanic
_____ 4. Native Indian, Tribal Affiliation:_____
_____ 5. Southeast Asian
_____ 6. Indo-Pakistani
_____ 7. Mixed
_____ 8. Other (specify):_____

4. Is your mother alive?
_____ 1. Yes   _____ 2. No   _____ 8. Don't know → (GO TO 6)
         ↓   ↓

5. Where does she live? (or) Where was her last residence?
                         (Where did she live before she died?)
_____ 1. Greater Vancouver area
_____ 2. British Columbia (not Vancouver area)
_____ 3. Another province or country (specify) _____

6. Is your father alive?
_____ 1. Yes   _____ 2. No   _____ 8. Don't know → (GO TO 8)
         ↓   ↓

7. Where does he live? (or) Where was his last residence?
                         (Where did he live before he died?)
_____ 1. Greater Vancouver area
_____ 2. British Columbia (not Vancouver area)
_____ 3. Another province or country (specify) _____

8. What is your current marital status?
_____ 1. Never married (single)
_____ 2. Separated
_____ 3. Married
_____ 4. Common law
_____ 5. Divorced
_____ 6. Widowed

9. In what city did you last attend school?
    ____ 1. Vancouver
    ____ 2. Burnaby
    ____ 3. Other Greater Vancouver area
    ____ 4. British Columbia (not Greater Vancouver area)
    ____ 5. Another province or country (specify) _____
    ____ 6 Never attended school → (GO TO 11)

10. What was the highest grade in school or year in college you completed?
(Circle Number)
\00 01 02 03 04 05 06 07 08 09 10 11/ 12 \13 14 15 16 17+/
                    ↓

> (If respondent didn't graduate from high school)
> 10a. Did you pass a high school equivalency test (GED)?
>   ____ 1. Yes   ____ 2. No

11. Which of the following services have you used in the last month?
(MARK YES OR NO TO ALL QUESTIONS)

Yes	No	
1. ____	2. ____	a. Food Vouchers
1. ____	2. ____	b. Free or almost free clothing shelves
1. ____	2. ____	c. Drop-in centers
1. ____	2. ____	d. Food banks.
1. ____	2. ____	e. Meal programs
1. ____	2. ____	f. Hospital emergency room
1. ____	2. ____	g. Free medical clinic - which one?_____
1. ____	2. ____	h. Free dental clinic - which one? _____

12. Is <u>tonight the first night</u> you have ever stayed in a shelter?

        ____ 1. Yes → (GO TO 13)   ____ 2. No

                                                       ↓

12a. How many nights in a row, including tonight, have you stayed in <u>this</u> shelter?

                              _____ nights

12b. During the past month have you slept in shelters: (READ ALL - <u>CHECK ONE</u>)

        ____ 1. Every night or most every night

        ____ 2. At least 3 nights per week

        ____ 3. 1 or 2 nights a week <u>or</u>

        ____ 4 Less often than that?

12c. Have you ever slept in a shelter outside the downtown Vancouver area?

        ____ 1. Yes (specify: _____)   ____ 2. No

12d. Have you ever tried to find shelter in a hospital, jail or detox center?

        ____ 1. Yes   ____ 2. No

12e. Thinking back to <u>last</u> year at this time, were you staying in any shelters then?

        ____ 1. Yes   ____ 2. No

           ↓   ↓

12f. Were you staying in shelters   12g. What about before that?
     in cities other than   Did you ever stay in shelters
     Vancouver   <u>more</u> than 12 months ago?

     ____ 1. Yes   ____ 2. No   ____ 1. Yes   ____ 2. No

---

13. When you are not in a shelter do you ever stay with: (MARK YES OR NO TO ALL QUESTIONS)

Yes	No	
1. ____	2. ____	a. Friends?
1. ____	2. ____	b. Relatives?
1. ____	2. ____	c. In hallways?
1. ____	2. ____	d. Outside—out of doors?
1. ____	2. ____	e. In vacant buildings <u>or</u> vacant apartments?
1. ____	2. ____	f. In a room, apartment or house of your own or that you share with someone else?
1. ____	2. ____	g. Other (specify) _____

14. Where was the last place you stayed before coming to this shelter?
(DON'T READ LIST—CHECK ONE ONLY)
_____ 1. With friends
_____ 2. With relatives
_____ 3. In a hallway
_____ 4. On the streets
_____ 5. Vacant building or apartment
_____ 6. Outside—out of doors
_____ 7. Room, apartment or house of your own or that you share with someone else?
_____ 8. Hotel
_____ 9. Jail
_____10. Detox facility
_____11. Hospital
_____ 12. A shelter (which one) _____
_____ 13. Treatment facility/ transitional housing
_____ 14. Other (specify): _____

15. Could you tell me briefly, why you are staying in a shelter tonight? _____

_____

_____

_____

16. Have you ever lived in a:
IF YES, ASK: Did you ever live in a (type of facility)

	16a		16b As a child?		16c As an adult?		16d Within the last 2 years	
	Yes	No	Yes	No	Yes	No	Yes	No
a. Foster Home?	1	2	1	2	1	2	1	2
b. Drug Treatment Facility?	1	2	1	2	1	2	1	2
c. Residential Treatment Center?	1	2	1	2	1	2	1	2
d. Detention Center or Corrections Facility?	1	2	1	2	1	2	1	2
e. Residence for Handicapped People?	1	2	1	2	1	2	1	2
f. Mental Health Facility or Hospital?	1	2	1	2	1	2	1	2

17. How long have you lived in the Greater Vancouver area?
(DON'T READ CATEGORIES)

_____ 1. Less than one year →

_____ 2. 1 to 2 years →   →

_____ 3. 3 to 5 years

_____ 4. 6 to 10 years

_____ 5. 11 to 20 years

_____ 6. 21 or more years

17a. Where did you live before coming to Vancouver?
(LIST MOST RECENT PLACE)

_____

17b. Had you ever lived in Vancouver before that?

_____ 1. Yes   _____ 2. No

17c. What was the main reason you came to Vancouver?
(DON'T READ LIST—CHECK ONLY ONE)

_____ 1. Looking for work

_____ 2. Relocate for new job

_____ 3. Be with family/friends

_____ 4. Returning home

_____ 5. For shelter

_____ 6. To get welfare

_____ 7. Alcohol treatment

_____ 8. Attend school

_____ 9. Flee abuse

_____ 10. No reason

_____ 11. Other(specify) _____

17d. Were you able to obtain regular housing when you first moved here or did you have to stay in a shelter?

_____ 1. Regular housing

_____ 2. Shelter

_____ 3. Some other arrangement (specify

_____

_____

18. How long have you been without a place to live not including emergency shelter?
(DON'T READ CATEGORIES)

_____ 1. Less than a month

_____ 2. 1 to 3 months

_____ 3. 4 to 6 months

_____ 4. 7 to 12 months

_____ 5. More than a year

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19. How long do you expect that you will be without your own housing?
    _____ 1. Less than one month
    _____ 2. 1 to 3 months
    _____ 3. 4 to 6 months
    _____ 4. 7 to 12 months
    _____ 5. More than one year

20. Are there members of your immediate family (other than those with you here) who would be living with you if you had your own place?
    _____ 1. Yes   _____ 2. No   _____ 8. Don't know

21. Right now, how much rent would you be able to pay each month for your own place to live? (DON'T READ LIST — CHECK ONLY ONE)
    _____ $0
    _____ $1 - $100
    _____ $101 - $ 200
    _____ $201 - $300
    _____ $301 - $400
    _____ $401 - $500
    _____ more than $500
    _____ don't know

22. How many bedrooms would you need?
    1   2   3   4   5

23. Where was the last place you owned or rented?
    (DON'T READ CATEGORIES)
    _____ 1. Vancouver (SPECIFY NEIGHBORHOOD) _____
    _____ 2. Burnaby
    _____ 3. Other Greater Vancouver area
    _____ 4. British Columbia (not Greater Vancouver area)
    _____ 5. Other province or country (specify) _____
    _____ 6. Have never owned or rented housing → (GO TO 30)

24. Did you own or rent that housing?
    _____ 1. Own
    _____ 2. Rent
    _____ 3. Other (specify) _____

25. How much did you pay per month to live in that housing including rent and utilities?
    (DON'T READ LIST — CHECK ONE ONLY)
    ____ less than $100
    ____ $101 - $ 200
    ____ $201 - $300
    ____ $301 - $400
    ____ $401 - $500
    ____ More than $500
    ____ Don't Know
    ____ Not Applicable (never owned/rented)

26. How long did you live in that housing?
    (DON'T READ CATEGORIES)
    ____ 1. Less that 1 month
    ____ 2. 1 to 3 months
    ____ 3. 4 to 6 months
    ____ 4. 7 to 12 months
    ____ 5. More than 1 year

27. Why did you leave that housing? Do any of the following apply to you?
    (READ LIST - Check all that apply)
    ____ 1. Change in ability to pay
    ____ 2. Rise in rent
    ____ 3. Marital/relationship problems
    ____ 4. Evicted
    ____ 5. Foreclosed mortgage
    ____ 6. Other (specify) _____

28. Were you without housing before that?
    ____ 1. Yes   ____ 2. No

29. Before coming to this shelter did you try to get into another shelter?
    ____ 1. Yes   ____ 2. No (GO TO 30)
         ↓

    | 29a. Why didn't you stay in that shelter? (DON'T READ LIST — CHECK ONE) |
    | ____ Full/No room |
    | ____ Poor conditions |
    | ____ Limit on number of days you can stay |
    | ____ No money to pay |
    | ____ Wasn't abused this time |
    | ____ Kicked out |
    | ____ No families/no children allowed |
    | ____ Other (specify) _____ |

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30. If you couldn't have stayed here tonight, where would you have stayed?
    (CHECK ONE ONLY — DON'T READ LIST).
    ____ 1. Another shelter
    ____ 2.. With friends or relatives
    ____ 3. In a hallway
    ____ 4. Outside - out of doors
    ____ 5. In a vacant building or apartment
    ____ 6. In a rented room
    ____ 7. Other (specify) _____
    ____ 8. Don't know

31. Do you have any children under 18?
    ____ 1. Yes   ____ 2. No (GO TO 32)
            ↓

31a. How many children under 18 do you have? _____
            ↓

Could you tell me the age and sex of each child? IF MORE THAN (5) TAKE
YOUNGEST (5)

		Child #1	Child #2	Child # 3	Child #4	Child #5
31b.	Age	0 Under 1 yr __ __ years 7 Refused 8 Don't know 9 NA	0 Under 1 yr __ __ years 7 Refused 8 Don't know 9 NA	0 Under 1 yr __ __ years 7 Refused 8 Don't know 9 NA	0 Under 1 yr __ __ years 7 Refused 8 Don't know 9 NA	0 Under 1 yr __ __ years 7 Refused 8 Don't know 9 NA
31c.	Sex	1 Male 2 Female 7 Refused 8 Don't know 9 NA	1 Male 2 Female 7 Refused 8 Don't know 9 NA	1 Male 2 Female 7 Refused 8 Don't know 9 NA	1 Male 2 Female 7 Refused 8 Don't know 9 NA	1 Male 2 Female 7 Refused 8 Don't know 9 NA

32. Have you ever gone to school to learn a particular type of job? [Does not include on-
    the-job training]
    ____ 1. Yes   ____ 2. No (GO TO 33)
            ↓

    32a. What type of job training have you received? _____
    _____
    _____
    32b. Did you complete the training?
            ____ 1. Yes ____ 2. No
    32c. Did you ever have a job that used that kind of training?
            ____ 1. Yes ____ 2. No

33. Do you now have a steady job that has lasted for at least 3 months?

_____ 1. Yes _____ 2. No (GO TO 33c)

↓

33a. How many hours do you work per week? _____ hours

33b. What is your current job? (PROBE: Job title, most important duties) ____

_____

_____

↓

(NOW GO TO 34)

33c. How long has it been since you last held a steady job? (One that lasted for at least 3 months)

_____ 1. - less than 6 months

_____ 2. - 6 to 12 months

_____ 3. - 1 to 2 years

_____ 4. - 3 to 5 years

_____ 5. - More than 4 years

_____ 6. Never held a steady job → GO TO 33f

_____ 7. Never worked for pay → GO TO 33f

33d. What was your last job? (PROBE: Job title, most important duties) _____

_____

33e. Why did you leave your last job?

_____ 1. Quit

_____ 2. Was fired

_____ 3. Laid off

_____ 4. Job ended

_____ 5. Plant closed

_____ 6. Childcare problems/expense

_____ 7. Pregnancy

_____ 8. Other (specify)_____

33f. When was the last time you looked for work? (DON'T READ CATEGORIES UNLESS THERE IS NO RESPONSE)

_____ 1.   1 to 7 days ago (a week)

_____ 2.   8 to 30 days ago (a month)

_____ 3.   31 to 90 days ago (1 to 3 months)

_____ 4.   91 to 180 days ago (3 to 6 months)

_____ 5.   More than 6 months ago

_____ 6.   Not interested in finding employment

33g. What do you feel are the biggest barriers to your getting a job? (ENCOURAGE RESPONDENT TO GIVE 3 REASONS)

1. _____

2. _____

3. _____

34. Have you received any money from any of these sources in the last month? (READ EACH ITEM AND CHECK YES OR NO FOR EACH)

Yes	No		
1. ___	2. ___	a.	Blood or Plasma Center
1. ___	2. ___	b.	General Income Assistance (IA)
1. ___	2. ___	c.	Unemployable IA (GAIN)
1. ___	2. ___	d.	Handicapped Pension Income Allowance (HPIA)
1. ___	2. ___	e.	Old Age Pension
1. ___	2. ___	f.	Veteran's pension
1. ___	2. ___	g.	Other pensions
1. ___	2. ___	h.	Steady employment
1. ___	2. ___	i.	Day labour — if yes, how many days last month? ___
1. ___	2. ___	j.	Trusteeship
1. ___	2. ___	k.	Private Disability Insurance
1. ___	2. ___	l.	Unemployment Insurance
1. ___	2. ___	m.	Volunteer Incentive/Special Employment Program
1. ___	2. ___	n.	Spouse
1. ___	2. ___	o.	Parents
1. ___	2. ___	p.	Other relatives or friends (includes boyfriends or girlfriends)
1. ___	2. ___	q.	Sale of personal belongings
1. ___	2. ___	r.	Asking for money on the streets
1. ___	2. ___	s.	Underground activities _____
1. ___	2. ___	t.	Other _____

35. What was your total income last month from all sources?

$ _____

36. Have you been cut off from any of these programs in the last year? (READ EACH ITEM AND CHECK YES OR NO FOR EACH)

Yes	No		
1. ___	2. ___	a.	General Welfare (If Yes, Why?) _____
1. ___	2. ___	b.	Unemployable IA (GAIN)
1. ___	2. ___	c.	Handicapped Pension Income Allowance (HPIA)
1. ___	2. ___	d.	Food vouchers (If Yes, Why?) _____
1. ___	2. ___	e.	Unemployment Insurance
1. ___	2. ___	f.	Meal Programs (If Yes, Why?) _____
1. ___	2. ___	g.	Other (specify) _____

37. Do you feel that you need assistance in applying or reapplying for any services?

___ 1. Yes   ___ 2. No

38. Do you consider yourself to be dependent on any kind of substance?

_____ 1. Yes _____ 2. No _____ 8. Don't know

↓

> 38a. With what substance do you consider yourself to have the most problem? (LET THEM RESPOND)
> _____ 1. Alcohol
> _____ 2. Other (specify) _____
> _____ 3. Combination including alcohol

39. Have you ever been admitted to a detox center?

_____ 1. Yes _____ 2. No (GO TO 40)

↓

> 39a. How many times have you been in a detox center?
> _____ times.
> 39b. Have you been in a detox center in the last six months?
> _____ 1. Yes _____ 2. No

40. Have you ever been diagnosed as chemically dependent?

_____ 1. Yes _____ 2. No

41. Have you ever been treated in an <u>outpatient</u> alcohol or drug treatment program?

_____ 1. Yes _____ 2. No (GO TO 42)

↓

> 41a. How many times have you been in an outpatient alcohol or drug treatment program?
> _____ times

42. Do you have any chronic health problems? (Problems that don't go away, that you have had for awhile)

_____ 1. Yes _____ 2. No (GO TO 43)

↓

> 42a. What kind of problems do you have? Please describe _____
> _____
> _____
> _____
>
> 42b. Are you receiving medical care for any of these problems?
> _____ 1. Yes _____ 2. No
>
> 42c. Do you need medical care that you have not been able to obtain?
> _____ 1. Yes _____ 2. No

43. Are you taking medications for any physical (not mental) health problems?

    ____ 1. Yes   ____ 2. No

43a Should you be taking any medication that you're not taking?
____ 1. Yes   ____ 2. No

44. Do you now need dental treatment?

    ____ 1. Yes   ____ 2. No (GO TO 45)

44a. What dental treatment do you need?
(DON'T READ LIST—CHECK ALL THAT APPLY)
____ fillings
____ dentures
____ check-up/cleaning
____ extraction
____ gum disease
____ other_____
44b. Have you tried to get this treatment?
____ 1. Yes   ____ 2. No

45. Have you needed to see a doctor in the last six months?

    ____ 1. Yes   ____ 2. No (GO TO 46)

46. Is there anything that stops you from seeing a doctor or getting health care if you need it?

    ____ 1. Yes   ____ 2. No (GO TO 47)

    46a. What would that be: _____

_____

_____

_____

47. Are you currently on medical financial assistance?

    ____ 1. Yes   ____ 2. No

48. Did you receive any care in an emergency room in the last six months?

    ____ 1. Yes   ____ 2. No (GO TO 49)

48a. Which hospital was that? _____
48b. Were you admitted to the hospital?
____ 1. Yes   ____ 2. No

49. Have you ever quit a job because of nervousness, depression or mental health problems?

    ____ 1. Yes   ____ 2. No

50. Are you currently taking any medications for a mental health problem?

    ____ 1. Yes   ____ 2. No

51. Have you ever seen a counselor or physician for emotional or mental health problems

    ____ 1. Yes   ____ 2. No (GO TO 52)

      ↓

> 51a. Do you currently see a counselor or physician for emotional or mental health problems?
>
>   ____ 1. Yes   ____ 1. No

52. Do you feel that you <u>now</u> have an emotional or mental health problem?

    ____ 1. Yes   ____ 2. No

53. Have you ever been diagnosed by a professional as having a mental health problem?

    ____ 1. Yes   ____ 2. No

54. Were you ever physically mistreated as a child or youth?

    ____ 1. Yes   ____ 2. No

55. Were you ever sexually mistreated as a child or youth?

    ____ 1. Yes   ____ 2. No

56. Do you feel that you could benefit by seeing a counselor, community worker, social worker or outreach worker for any reason?

    ____ 1. Yes   ____ 2. No

57. Do you want to have permanent housing in this city?

    ____ 1. Yes   ____ 2. No

58. Are you registered to vote?

    ____ 1. Yes   ____ 2. No

59. Have you voted in a public election in the past two years?

    ____ 1. Yes   ____ 2. No

60. How long has it been since you have had contact with any of your family or relatives?
    _____ 1. Less than one month
    _____ 2. More than one month but less than one year
    _____ 3. One year or more
    _____ 8. Don't know
    _____ 9. Not applicable, no family

61. Do you have 3 close friends with whom you have regular contact?
    _____ 1. Yes   _____ 2. No

62. Who are your main sources of emotional and social support at this time?_____
    _____
    _____

    Is there someone you can turn to for comfort? _____
    _____
    _____

63. Have you ever been assaulted?
    _____ 1. Yes   _____ 2. No (Go To 66)
              ↓

    | How many times? _____ |
              ↓

    Were you assaulted by a:
        _____ 1. live-in partner
        _____ 2. friend
        _____ 3. acquaintance
        _____ 4. stranger
        _____ 5. other (specify)_____

64. In the last year have you been assaulted?
    _____ 1. Yes   _____ 2. No (GO TO 66)
              ↓

    | How many times? _____ |
              ↓

    Were you assaulted by a:
        _____ 1. live-in partner
        _____ 2. friend
        _____ 3. acquaintance
        _____ 4. stranger
        _____ 5. other (specify)_____

65. In the last 30 days have you been assaulted?

    ____ 1. Yes   ____ 2. No

            ↓

How many times? _____

            ↓

Were you assaulted by a:
    ____ 1. live-in partner
    ____ 2. friend
    ____ 3. acquaintance
    ____ 4. stranger
    ____ 5. other (specify)_____

66. In the last 30 days have you had anything stolen or taken without your consent?

    ____ 1. Yes   ____ 2. No

            ↓

How many times? _____

67. In the last year have you had anything stolen or taken without your consent?

    ____ 1. Yes   ____ 2. No

            ↓

How many times? _____

(ASK IF IT IS OK TO TURN ON TAPE RECORDER, IF NOT TAKE HAND WRITTEN NOTES)

68. Do you have anything to add—any questions we failed to cover?
69. Why did you come to this shelter?
70. What does this shelter do for you?
71. What do you see as the most important need that this shelter provides?
72. What do you see as the most important need that this shelter does not provide?
73. If you were not living here, and you wanted to come here, what would you do when this shelter is closed for visiting?
74. What does the term "client" mean to you?
75. How do you feel about emergency shelters?
76. How could this shelter help you better?
77. How does Triage differ from other shelters?
78. If you were in the old Triage how does it compare to the new Triage?
79. What is one thing that Triage does not do that you think it very much should do?
80. What does this shelter have to do with housing people?
81. What does having a home mean to you?
82. What is the difference between staying in a shelter and living in a home?
83. What does homelessness mean to you?
84. What does welfare mean to you?
85. What does welfare have to do with homelessness?
86. What does discrimination mean to you?
87. What does social justice or fairness mean to you?
88. How does social justice relate to homelessness?
89. How does social justice relate to this shelter?
90. What does security mean to you?
91. What does safety mean to you?
92. How do safety and security relate to this shelter?
93. What does care mean to you?
94. What does control mean to you?
95. How do care and control relate to the organization of this shelter?
96. What does power mean to you?
97. How does this shelter lead to your own self-empowerment?
98. What do you think of the file system that is made up when you move into this shelter?
99. What do you see happening to yourself in the future regarding homelessness?
100. What do you see happening in the future concerning homeless persons as a whole?
101. As a community what can we do about homelessness?
102. What do you think about the prospects for people on welfare in the coming years?
103. Is there anything you want to say about your current situation or what led up to it?
104. Do you have any questions for me?
105. How do you feel about this interview?

<u>Interviewer Comments</u>:

106. Respondent appeared to: CHECK ALL THAT APPLY)
    _____ 1. Be reliable
    _____ 2. Provide unreliable or inconsistent answers
    _____ 3. Other (specify) _____

_____
_____
_____

Additional Comments:

APPENDIX B

Triage Referral Form

Bed #_____   File # _____

Client's name:_____ Triage Worker:_____
Time Referred:_____ Time Client Must Report to Triage by:_____
Clients not using their bed on the first night will by checked out at 8:00 am
Date:_____ Referred by:_____
Birthdate:_____ Sin #:_____ Medical #:_____
Unit #: _____ Start:_____ Expire:_____

REASON FOR REFERRAL

Reason: ALCOHOL:_____DRUGS:_____PSYCH:_____OTHER:_____
Treatment Centers:_____
Detox:_____
Where client was living prior to Triage:_____

MEDICAL INFORMATION

Mental Health Team:_____ Medications:_____
_____
Psych. History:_____
Medical History or Problems: _____
_____
Family History:_____

MINISTRY OF SOCIAL SERVICES INFORMATION

Regular FAW's Name & Office # _____
Telephone # _____ Income: IA___GAIN___OAP___HPIA___CPP___
Administered: Yes ___ No ___ Administered by: _____

AUTHORIZATION

Authorizing FAW's Name & Worker # _____
Authorizing FAW's Office # _____ Telephone # _____
Extension from: _____ To: _____

Area of residence for the past 12 months

Vancouver:___ Burnaby:___ Richmond:___ Fraser Valley (including New
Westminster):___ Okanagan/Kootenays:___ North Shore/Sunshine Coast:___ Northern
BC:___ Vancouver Island:___ Out of Province:___

Triage Intake Form

Bed#_____   File #_____

Client's name:_____ Referred by: _____

Date:_____ Time of arrival:_____ Intake worker:_____

Reason for referral: _____

Birthdate: _____ Sin # _____ Gender: Male ___ Female ___

Medical Information

Medical # _____ Unit # _____ Expire date: _____

Family Doctor:_____ Office Phone #_____

Specialist:_____ Mental Health Team:_____

Mental Health Worker:_____ MHT Phone # _____

Psychiatrist:_____ Psychiatrist Phone # _____

Have you ever been in Riverview?   Yes:____ No:____ Date:_____

Have you been in hospital in the last 6 months?   Yes:_____ No:_____

If yes which hospital? Name: _____Date: _____

Reason: _____

Are you on any medications?   Yes___ No___   If yes list medications:

Medication	**Dosage**	**Administration Times**
1)		
2)		
3)		
4)		
5)		

(1) Are you diabetic?   Yes____ No_____

(2) Do you have a problem with seizures of any type?   Yes____ No____

(3) If so what type of seizures?_____

(4) Do you have any allergies?_____

Financial Information

Current FAW:_____ Office #_____ Phone #_____

FAW worker #_____ Is your money administered?   Yes:___ No:___

Administered by:_____ Phone #_____

What is your source of income?   IA___ Gain___ OAP___ HPIA___ CPP___

Criminal Information

1) Do you have any outstanding charges? Yes___ No___

2) If yes what charges?_____

3) Do you have a court date?   Yes _____ No _____ Date: _____ Time:_____

4) Have you used other emergency shelters?   Yes:_____ No:_____

5) If yes which ones?_____

Triage House Rules

Welcome to Triage. We are staffed 24 hours a day and will try to connect you with any resources you may need with your current situation. We expect your full cooperation and assistance in clarifying your situation so we may assist in planning an appropriate direction for your future. We would like you to feel comfortable and at home while you are with us. There are, however, some rules necessary to ensure things operate smoothly in a communal-living arrangement.

1. **All medications must be handed in to staff while staying at Triage.** Any and all prescriptions filled while at Triage **must** be turned in to staff for dispensation. No medications are to be left with family or friends; they must be handed in to staff.
2. **No alcohol or non-prescription drugs are permitted in the building. Please turn in any drug paraphernalia to staff upon arrival at Triage.** You will be checked out if drugs or drug paraphernalia is found on your person or in your room. You will not be allowed into the building under the influence of drugs and/or alcohol.
3. **Physical violence will not be tolerated.** Any act of violence will result in immediate check out. Any and all weapons must be turned in on intake.
4. **Smoking is permitted in designated areas only.** If you are caught smoking in your room, you will asked to find other accommodations.
5. **Staff reserves the right to search personal belongings if deemed necessary** to ensure no drugs, alcohol or weapons are in the building. This will only be requested if there is strong suspicion of the presence of any of the above items. You have the right to refuse the request for a search and must be present during the search.
6. **Triage is not responsible for your personal belongings while you are here**; we are not set up for secure storage. Belongings left by you after checking out will be held in storage for a period of 2 weeks only. After that time, they will be put into general circulation.
7. **Monies received from the Ministry must be turned in for safekeeping.** While at Triage, you **may** be entitled to a **maximum of $82 if funds are available** to you from the Ministry. The balance will be released to you upon check out.
8. **A bath or shower must be taken upon admission** and every second day thereafter.
9. **Wake up is at 8:00am** and you must be out of your room by 9:00am. **Meals are at set times only**, unless prior arrangements are made with staff. Meal times are posted throughout the facility. **You are to be in the building by 11:30pm**. If planning to be away or late, it is your responsibility to inform staff. If you do not use your bed for two nights, you will be checked out. As well, anyone not using their bed on the first night of their stay will be checked out. **Daily visiting hours** are: 1:00pm to 2:45pm and 7:00pm to 9:00pm. Staff has the right to cancel visiting hours.

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