

Seeking Inclusion in the 'Land of Broken Toys': Negotiating Mental Health Managerialism Among Homeless Men and Women

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Abstract

Mental health, homelessness, addiction, and criminalization are the usual suspects of exclusion. The connection between these factors are often taken for granted, with positivistic accounts of causality making up the bulk of the literature. Using an institutional ethnography framework, this study draws attention to how individuals make sense of their exclusion. In particular, in this research I examine how homeless men and women ‘do’ their mental health status. Exploring themes of responsabilization, exclusion, identity, performativity, hope, and resistance, this research highlights the ways in which homeless individuals use the mental health system and the mental illness identity to contextualize their circumstances and to demonstrate their redeemability.

Stemming from thirty-eight interviews with homeless men and women, participant observation, as well as a focus group with professionals and para-professionals I consider how mental illness identities are negotiated and performed among homeless men and women. Specifically, I am interested in how homeless individuals engage with mental health managerialism, given their vulnerable status. I contend that while some individuals resist mental illness discourses to varying degrees, a number of homeless individuals adopt the role of mental health consumer so as to align with the broader consumer society. In so doing, many homeless men and women seek to position themselves as included among the excluded and thus privy to the sense of hope, empowerment, and privileges that follow.

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List of Acronyms

AA/NA	Alcoholics Anonymous / Narcotics Anonymous
ACT	Assertive community treatment teams
ADD	Attention deficit disorder
ADHD	Attention deficit hyperactivity disorder
CAMH	Centre for Addiction and Mental Health
CBT	Cognitive behavioural therapy
CMHA	Canadian Mental Health Association
CTO	Community treatment order
<i>DSM</i>	<i>Diagnostic and Statistical Manual</i>
OCD	Obsessive-compulsive disorder
OCDC	Ottawa Carleton Detention Centre
ODSP	Ontario Disability Support Program
OW	Ontario Works
PTSD	Post-traumatic stress disorder
ROH	Royal Ottawa Hospital
WRAP	Wellness recovery action plan

Table of Contents

Abstract	ii
Acknowledgements	iii
List of Acronyms	iv
Chapter 1- Introduction: Managing the homeless through mental health	1
Research Question	5
Dissertation organization	6
Chapter 2 – Literature Review: Situating Mental Health Managerialism in the Homelessness Context	10
Introduction.....	10
Homelessness.....	11
A short history of homelessness	15
Understanding homelessness: Individualization and socio-political paradigms	19
Mental health	28
The making of the medical model	29
The Mad movement: Resisting psy.....	37
Uncomfortable bedfellows: Homelessness and mental illness	40
Addiction and mental illness.....	43
The ‘not-quite’ medicalization of addiction	44
Treating addiction	50
The intersection of addiction and mental illness.....	53
Criminalizing the vulnerable.....	56
Criminalizing mental illness	56
Criminalizing homelessness.....	59
Transcarceration.....	62
Conclusion	66
Chapter 3 - Theoretical Framework: Managing the Excluded Identity Through Technologies of the Self	68
Introduction.....	68
Governing Through Freedom	69
Governmentality	69
Ideologies of government	71
Governing ourselves: Technologies of the self.....	75
Obligated to be free.....	80
To be disciplined until free	83

Identity: Finding the self in a socially constructed world.....	88
The reflexive self	88
Performing the self.....	92
Excluding the homeless/mentally ill identities	96
Naming and framing exclusion.....	97
Forming a gradient: Breaking down the inclusion/exclusion dichotomy	98
Social junk and social dynamite	104
Inclusionary practices amongst the excluded	107
Inclusion.....	108
The exclusion through inclusion paradox	110
Including the social junk?	113
Resistance within the margins	117
Conclusion	121
Chapter 4 – Methodology: Managing the Field	123
Introduction.....	123
Epistemological engagement	124
Methodology	127
Operationalization.....	131
Homelessness	131
Distress.....	132
Professionals and para-professionals	133
Research method.....	134
Entering the field.....	134
Participant observation.....	140
Interviews.....	142
Focus group.....	151
Analysis.....	154
Transcription	155
Critical discourse analysis.....	155
Ethical reflections	158
Methodological rigour	160
Limitations	162
Reflexivity.....	163
Conclusion	166

Chapter 5 –Managing in Place: The Shelter as a Neo-Liberal Total Institution	168
Introduction.....	168
Framing the issue: Theorizing the shelter as a neo-liberal total institution	170
Locating discipline in a post-disciplinary system	174
The ‘freedom’ to leave and the need to stay: Managing shelter space	179
The permeable institution	180
The voluntary inmate	183
Controlling time and space in emergency shelters	190
‘It’s true hell’’: The emergency shelter as a prison.....	193
Getting too comfortable	195
The bubble boys: Staff as producers of the total institution	199
‘We’re not the enemy’’: Frontline staff as police	201
Conclusion	206
Chapter 6 – Identity Management: Performing the Homeless, Mentally Ill and Addict Identities.....	208
Introduction.....	208
The marginalized identity: Shame and ‘Otherness’	209
The shamed poor.....	209
Separate from community	215
Situating the homeless/mentally ill/addict identities	222
The homeless identity	222
Resisting the homeless identity.....	226
Framing the mentally ill identity.....	227
The mentally ill and the addict – one in the same?.....	230
Managing the mentally ill and homeless identity performance	233
The limits of identity performance	234
Goffman in practice: Impression management and distancing.....	237
Creating a ‘second skin’	241
Conclusion	243
Chapter 7 – Taking the Blame: Responsibilization Strategies to Manage Mental Illness and Addiction.....	245
Introduction.....	245
‘The island of broken toys’: Medicalizing distress.....	246
The biological imperative	247
Resisting the biological model.....	251

Finding the ‘true’ self.....	254
Responsibilization: Fixing the flaw	258
The Maté effect	260
No Excuses: Taking responsibility for the mentally ill and addict identities	266
Becoming empowered through responsibilization.....	273
Conclusion	277
Chapter 8 – The Homeless Mental Health Consumer: Managing Exclusion through Redeemability	279
Introduction.....	279
Rags where riches are required: Poverty and homelessness in consumer society	280
The flawed consumer	283
Tracing the client in the prison and mental hospital	284
Aiming for inclusion	287
Becoming a better person: Performing the homeless mental health consumer role	288
Diagnosis as entrée into mental health consumption	290
Hope at the bottom of a pill bottle	293
Redeemable but never redeemed: The reality of the homeless mental health consumer	297
“Just like prostitutes”: Critically assessing the mental health consumer role.....	298
The voiceless consumer	302
Inclusion among the excluded	306
The hopeless.....	313
Giving up	315
Beyond “bat shit bananas”: Expanding the psy-complex to manage the irredeemable.....	317
Criminalizing the irredeemable.....	319
Conclusion	321
Chapter 9 – Conclusion: Beyond managing the homeless	324
Theoretical contributions	326
Practical contributions	329
Insights from the research.....	333
Reconsidering the relationship between addiction and mental illness subjectivities	334
Final remarks	337
References	339
Appendix A: Research and Ethics Board (REB) Approval Letter	389
Appendix B: Shelter Flyer.....	391
Appendix C: Consent Form for Interviews	392

Appendix D: Consent Form for Focus Group.....	394
Appendix E: Interview Guide	396
Appendix F: Focus Group Interview Guide.....	398
Appendix G: Participant Attributes.....	399

Chapter 1- Introduction: Managing the homeless through mental health

Scholars have long considered homelessness, addiction and mental illness to be intimately linked; in addition to criminalization these ‘usual suspects’ of marginalization and exclusion are well known. In the last thirty years a plethora of research documenting the interaction of these three phenomena has seemingly rendered the conversation moot (Etter, Birzer & Fields 2008; Fischer et al. 2008; Greenberg & Rosenheck 2008; Lamb, Weinberger & Gross 2004; Lurigio 2000). It appears that all that is left to consider is the proverbial chicken or the egg scenario in order to assess the causes of homelessness, distress and involvement in the criminal justice system (Johnson & Chamberlain 2011; Sullivan, Burnam & Koegel 2000). Despite decades of research, however, there has been little systematic change to improve the lives of Canada’s most vulnerable populations (not for the lack of trying on the part of many charities, non-governmental organizations, and activists). On the contrary, the number of individuals experiencing homeless or who are precariously housed had reached epidemic proportions. Approximately 235,000 Canadians experience homelessness in a given year, 13,000 to 33,000 of whom are chronically or episodically homeless.¹ As government investment in affordable housing waned throughout the 1980s and 90s the number of households experiencing extreme housing affordability problems surged. Currently one in five Canadian households spends more than fifty percent of their income on rent (Gaetz, Gulliver & Richter 2014). The prevalence of Aboriginal peoples in the homeless community is noteworthy, especially as First Nations, Métis and Inuit peoples are likewise disproportionately represented in the criminal justice system (Patrick 2014).

¹ Chronic homelessness refers to those who have experienced homelessness for more than six months; episodic homelessness are those who transition in and out of homelessness regularly (Kuhn & Culhane 1998)

Similarly, the tough on crime agenda has gained traction in the federal and provincial political spheres, propelling the use of jails and detention centres in lieu of conditional or suspended sentences. The remand rate in Canada has tripled over the last thirty years so that by 2005 there were more people detained in provincial jails awaiting trial than those who were convicted and sentenced (Deshman & Myers 2014). Legislative changes that make it difficult to secure bail, along with restrictive and onerous bail conditions leave many people ‘set up to fail’ and many end up detained for administrative rather than criminal breaches (JHSO 2013; Hannah-Moffat & Maurutto 2012; McLellan 2010; Webster, Doob & Myers 2009). The transformation of remand detention, the controversy regarding double credit for time served pre-trial detention (*R. v. Summers* 2014) and mandatory minimum sentences (*R. v. Nur* 2015), and the increased penalties for a number of crimes under the *Safe Streets and Communities Act* (2012) create the conditions whereby the federal prisoner population has grown almost eighteen percent since 2005, with significant increases among Aboriginal and Black prisoners, along with a sixty-six percent increase in the number of women prisoners. On any given day over fifteen thousand prisoners are incarcerated in a federal institution in Canada, 850 of whom are in segregation (OCI 2014). The increased use of incarceration comes at the same time Canada’s crime rate hit a four-decade low in 2013.

Meanwhile, the rates of individuals diagnosed with a mental illness among both the homeless and prison population continues to rise. Canada’s jails and prisons are referred to as ‘the new asylum’ (MHCC 2012) or the ‘dumping ground’ for marginalized groups for which we have no other available social service supports (Allen 2000; Etter, Birzer & Fields 2008). Likewise, there is a general consensus among scholars that the deinstitutionalization of mental

hospitals beginning in the 1960s² had at least some role to play in the increased number of homeless men and women experiencing distress (Davis 2006; Steadman & Morrissey 1987) who are often criminalized. Those experiencing distress continue to be marginalized and vilified, despite their likely status as victim rather than perpetrator (Elbogen & Johnson 2009).

The mad movement, the activist-oriented successor of the anti-psychiatry movement of the 1960s and 70s (Burstow 2005), problematizes the marginalization of individuals experiencing distress, in particular methods of social control that seek to govern their bodies through psychopharmaceuticals, involuntary incapacitation, or electro-convulsive therapy, among other techniques. The mad movement challenges the medicalized conception of mental illness and seek alternative understandings to distress and its treatment, advocating for peer-support services (Diamond 2013; Rissmiller & Rissmiller 2006; Stroman 2003). Made up of psychiatric survivors/consumers, those in the mad movement often use personal narratives to reclaim knowledge production away from psy-experts and towards those with lived experience of mental health intervention.

The mad movement advocates for individuals experiencing distress, resists discrimination and works to empower the mad community (such as Mad Pride days that take place annually in cities around the world, most notably Toronto). Still, the mad movement has remained largely silent on how mental health is used as a governing strategy in the homeless community. With a few exceptions (Schneider 2010; Snow et al. 1986; Voronka et al. 2014) there is little critical research that examines how mental illness is used, negotiated, and made sense of among the homeless population. This is the gap that I will begin to fill with this research project.

² In their historical analysis of Quebec at the turn of the twentieth-century, Thifault and Perreault (2012) found that deinstitutionalization practices began as early as 1909, disrupting the notion that the 1960s deinstitutionalization movement was new.

At the beginning of my doctoral work I immersed myself in the anti-psychiatry and mad movement literatures. Authors such as Burstow (2004, 2005), Laing (1960, 1967, 1971), McLean (1995, 2000), Sedgwick (1982), Shimrat (1997), and Szasz (1974, 1989) inspired me to think critically about how the mental health system seeks to exclude those who do not meet dominant conceptions of normality. As I was reading mad activists' seminal works I began volunteering at two of Ottawa's homeless shelters. Walking through the hallway of one of the shelters one day I came across a poster that listed several criteria to evaluate a resident's well-being. The poster claimed that if residents are having trouble sleeping, are angry or sad, or lack motivation they may suffer with depression and should seek an assessment from the psychiatric doctor and nurses who frequent the shelters. I was shocked at the medicalized understanding of distress as completely devoid of the social context of life in a homeless shelter. What I perceived to be rational reactions to difficult and oftentimes degrading circumstances are often pathologized in the homeless community.

Interestingly, the coercive governing strategies that are the focus of the mad movement's protests, such as community treatment orders (CTOs),³ are not as prominent in the homeless community as one might suspect. Of course some homeless residents are involuntarily incapacitated (see chapter five) and subject to CTOs but I noticed that by and large mental health interventions are based on encouraging residents to seek out their own care rather than imposing treatment. This more complex and nuanced understanding of mental health managerialism⁴ led

³ Community treatment orders compel individuals to comply with a medication regime in order to be discharged from a mental hospital (Davis 2006; O'Reilly 2004).

⁴ By mental health managerialism I am referring to the multifarious forms of governance that are directly and indirectly related to the mental health system and exist as a way to manage those deemed abnormal. This includes, but is not limited to: mental illness diagnoses; psychotropic medication; in and out patient addiction treatment; case management; group therapy; provisions for basic care (encouraging/forcing hygienic practices); and involuntary hospitalization).

me to ask questions about how mental health care is negotiated and reconciled among homeless men and women, what are its aims and why use mental health treatment in lieu of other forms of social control.

Research Question

In this project, I am interested in uncovering how homeless men and women negotiate their mental health identity and the techniques of governance that intersect the mental health system and community services. I consider how homeless individuals are governed through their freedom (Rose 1999) to take up mental health discourses as a way to mitigate their exclusion from the wider social body. In order to work through these ideas I asked the following question:

How are homeless men and women governed through mental health managerialism and how do they respond to these strategies? Specifically, how do homeless individuals negotiate strategies of governing based on their freedom/autonomy, especially as an otherwise excluded group?

To pursue this question I asked several subsidiary questions:

- 1) How is mental health/illness defined and understood by homeless men and women?
- 2) In what way does their excluded status impact the negotiation of their identity as mentally ill and the governing strategies they are subsequently subject to?
- 3) What significance do responsabilization techniques have on their perception of norms and their ability to resist the normal/abnormal binary?
- 4) What role do institutions within the homeless community, in particular emergency shelters, play in reinforcing homeless individuals as 'Others'?

Using an institutional ethnography framework (Campbell 1998; Smith 1987) I sought to answer these questions by hearing from individuals who live in the homeless community. I used the personal narratives of those who experience homelessness and mental health intervention to foreground my analysis. I learned from homeless men and women through participant observation and qualitative interviews, along with contextualizing the homeless sheltering

industry (Lyon-Callo 2000, 2004) through a focus group with professionals and para-professionals.

Through these methods I explore how homeless individuals engage in choice-making regarding their mental health care within the constraints of living a life of poverty and marginalization. Using a theoretical toolbox made up of critical conceptualizations of autonomy, responsibility, individualization, empowerment, exclusion, performativity, resistance, and redeemability I construct an analysis of how adopting the mentally ill identity impacts homeless men and women's position as redeemable and thus worthy of services or hopelessly irredeemable in the eyes of professionals and para-professionals as well as in their own sense of self. Of particular interest in this study are the way autonomy, empowerment, encouragement, and coercion come to form a tangled web where the notion of 'choice' is problematized.

Dissertation organization

In order to adequately assess the nature of mental health managerialism among homeless men and women I provide a detailed description of the literature and conventions upon which I built this project and, using the lived experiences of homeless individuals as an anchor, construct an analysis that weaves together the theoretical and conceptual framework I used to make sense of the data. In chapter two I situate this project within the vast literature on homelessness, mental illness and criminalization. A gap exists in critically assessing the convergence of homelessness, mental illness, addiction, and criminalization, in particular resisting individualized and medicalized explanations of marginality as the dominant discourses. Instead, I call for a more nuanced study of how excluded individuals are governed and come to participate in their own governance.

In chapter three I detail the theoretical concepts used to grapple with the governing strategies employed among the homeless population. Here I consider how freedom is used as a technology of governance in the late modern⁵ world and how these tactics co-exist with some more traditional disciplinary techniques, especially among groups designated as ‘Others’. Relatedly, I probe the literature on identity and performativity. Through a comparison of Butler (1990) and Goffman (1959), I assess how personal autonomy takes shape within a paradigm that is critical of an ontological reality devoid of context. Moreover, I examine the literature on exclusion and consider how people interact with that status. Using Spitzer’s (1975) social junk and social dynamite approach as a frame of reference, I consider exclusion as existing along a continuum and suggest that redeemability, or to be included among the excluded, is a useful framework to think about how and why inclusionary strategies are implemented and taken up by otherwise marginalized people.

Chapter four provides a detailed description of the methodology deployed in this research project. Building upon a standpoint epistemology and through the lens of institutional ethnography I document the ways in which I entered the field, collected stories and analyzed the data. In addition to chronicling how the participant observation, semi-structured interviews, and focus group took shape, I also aim to situate myself within the research by engaging in a reflexive analysis and considering the ethical implications of conducting this kind of project.

In chapter five, I begin to provide my analytic findings. Interacting with both theory and data I engage in a fruitful discussion of what mental health managerialism looks like from the perspective of homeless men and women and seek to understand why certain governing schemes

⁵ Although the terms post-modern and late modern are often used interchangeably (Forman 1997), I use the term late modern in the same way Bauman (2001a) frames ‘liquid modernity’ to emphasize the era of individualism, diversity, and anxiety as a continuation of, rather than break from, modernity.

are used on some individuals and not others. Chapter five sets the scene for the remaining chapters. Here, I provide details on homeless individuals' daily lives and study the ways in which the emergency shelter acts as a neo-liberal total institution. By this, I mean that shelter residents are subject to many of the same forms of isolation, deculturation, degradation, and strict rules of traditional total institutions, but notably, are thought to enter and stay in the institution voluntarily through their own sense of freedom. The shelter acts as a form of poverty management whereby marginalized individuals are regulated through their own self-governance unless they fail to adequately self-surveil and are then subject to disciplinary tactics.

Chapter six investigates identity construction and management. Individuals make sense of their homeless, mentally ill and/or addict statuses in complex ways, underscoring the heterogeneity of those who make up the homeless community. Moreover, I study how identity performance and stigma management are exercised as a means to distinguish oneself from other members of the excluded group. Through these forms of identity negotiation I parse out the ways research participants experience exclusion and how many manage their identity so as to present themselves as redeemable.

In chapter seven I explore the social construction of mental illness in greater detail by assessing how respondents understand the medicalized approach to distress. A paradox exists where by and large homeless men and women adopt the biological determinism central to the medical model conception of distress, but conversely, responsibilize themselves for their circumstances. The individualization of social precariousness is so strongly felt that many describe those who use mental illness and/or addiction to explain their marginality as making excuses and failing to live up to the responsibilities of self-governance.

In the final analytic chapter I argue that through the negotiations and tensions described in the previous three chapters many homeless individuals model themselves as homeless mental health consumers. To be a consumer is tantamount to good citizenship in late modern society and so some homeless men and women demonstrate their willingness to self-regulate by consuming publicly funded mental health interventions. Although mental health resources are couched in the rhetoric of hope, in reality adopting the mental health consumer role implies an acceptance of the pathologization and individualization of social problems thus cementing their status as permanently *redeemable* but never *redeemed* and accepted by the included circuit. Meanwhile, some homeless individuals are identified as irredeemable and thus as hopeless.

Finally, in chapter nine I offer some concluding remarks. I work through some of the themes and theoretical questions identified throughout this project that could not be fully developed here and offer considerations for future research.

Chapter 2 – Literature Review: Situating Mental Health Managerialism in the Homelessness Context

Introduction

Research on mental illness, homelessness, and their intersection is not new. A quick Google search yields an abundance of scholarship pertaining to the state of homelessness, ways to solve homelessness (in particular the Housing First model), and the characteristics of homeless populations, typically emphasizing the common connection between mental illness and addiction. Suspiciously absent from much of the literature on homelessness is a critical engagement with the discourses used to conceptualize homelessness. That homelessness is a social construction (Hacking 1991) with a long and complex history that takes a unique form in the contemporary landscape is largely ignored in the literature. More than this, critical analyses of the pathologization of homelessness and the constitution of homeless people as inherently abnormal are limited, and the literature that does exist is often dated.

In this chapter I situate this research project within the vast scholarship on homelessness and mental illness. I am contributing to what I argue is a grossly undervalued aspect of the literature – namely a critical assessment of conceptions of homelessness, mental illness, addiction, and their foregrounding within discourses that privilege the medical model and the individualization of distress and marginality. I provide a detailed and intersectional review of the literature on homelessness and mental health and illness as well as their connection to addiction and criminalization. By highlighting the often understated connection between the homeless sheltering industry (Lyon-Callo 2004), the recovery industry (Travis 2009) and the mental health and criminal justice systems, I call for a more nuanced and messy (O’Malley, Weir & Shearing 1997) analysis of the social control of marginalized people.

Homelessness

In this section I will assess the history of homelessness research as well as highlight its contemporary configuration. I do so by exploring the myriad of studies related to homelessness, both quantitative assessments of the homelessness crisis as well as theoretical conceptions such as shelterization.

By the numbers

A large portion of the research on homelessness consists of attempts to quantify and document the extent of the crisis. Given the methodological challenges with measuring this kind of social phenomenon (Busch-Geertsema 2010; Frankish et al. 2005)⁶ the available statistics are inconsistent and not especially reliable. In fact, the United Nations has scolded the Canadian government for its lack of data on homelessness (Echenberg & Jensen 2008) stemming in part from Canada's dubious reputation as the only G8 country that does not have a national housing strategy (MacKinnon 2012). Still, the statistics that are available give us a sense of the scope of the homelessness problem in Canada.

At the national level homelessness continues to grow; there was a surge in homelessness during the 1980s and there are continued effects stemming from the 2008 recession. The number of Canadians who experience homelessness annually varies between 150,000 – 300,000 people (Aubry et al. 2013; Echenberg & Jensen 2008) and 35,000 people are homeless in Canada on any given night (Gaetz, Gulliver & Richter 2014). The heterogeneity of the homeless population is evidenced in the data. Women account for between twenty-five and thirty percent of the homeless population, one percent self-identify as transgender, while the majority of homeless

⁶ Frankish et al. (2005) find that there are four major challenges with obtaining a clear scope on homelessness in Canada: inconsistent definitions of what constitutes homelessness; the challenge of identifying homeless people; the transient nature of homelessness; difficulty communicating with homeless people; and a dearth of interest/participation by local agencies.

people are men. Twenty percent of the homeless are youth (Gaetz et al. 2013). Family homelessness, the majority of which are headed by women (Stainbrook & Hornik 2006), make up four percent of the homeless population, but account for fourteen percent of the total bed nights in shelters (Gaetz et al. 2013).

Most 'point in time counts' use shelter stays to track the homeless population. We must keep in mind that for every four people staying in a shelter there is one person sleeping rough, meaning to sleep outside, which further expands the extent of the homelessness problem (Gaetz et al. 2013). As of June 2008 there were 1,128 shelters in Canada holding approximately 25,000 beds (Echenberg & Jensen 2008). The average length of stay in a shelter is fifty days. Eighty-eight to ninety-four percent of individuals will only experience homelessness once (Aubry et al. 2013). This statistic points to a common misperception about homelessness. The vast majority of those who use emergency shelters are transitionally homeless. This means that they are homeless for a short period of time often due to a crisis such as a job loss or house fire, stay in a shelter for less than one month, and are able to become housed with little use of homelessness resources. Those who are chronically homeless have longer shelter stays (more than six months) and are more likely to identify as having mental health and/or substance abuse problems (Culhane & Metraux 2008; Kuhn & Culhane 1998). Although the chronically homeless make up only two to four percent of the homeless population (Aubry et al. 2013; Gaetz et al. 2013) they use a disproportionate number of services. Aubry et al.'s (2013) study of homelessness in Toronto, Ottawa, and Guelph found that although only twelve percent of their sample could be categorized as chronically homeless, they used half of the shelter beds during the study period.

As I explore below, the recent push for a Housing First⁷ paradigm stems from an interest in reallocating resources to the chronically homeless.

The chronically homeless are often the focus of research, including this project where sixty-six percent of participants would be characterized as chronically or episodically homeless.⁸ The hidden homeless have only recently come to the attention of homelessness scholars. Hidden homelessness refers to precarious and temporary living situations, such as those who sleep in a car, couch surf, or live in a motel (Harter et al. 2005). Some statistics suggest that for every one person who is living in absolute homelessness there are four who are among the hidden homeless (Echenberg & Jensen 2008). The problem is especially acute in Aboriginal communities where there is a lack of housing on reserves and the dearth of affordable housing in urban centers disproportionately affects Aboriginal peoples (Distasio, Sylvestre & Mulligan 2005). When accounting for individuals who are experiencing extreme housing insecurity, the extent of the homelessness crisis becomes dire. Over one million Canadians were homeless or among the hidden homeless between 2008-2013 (Gaetz, Gulliver & Richter 2014). According to another survey, one in nine Canadians experienced homelessness or severely precarious housing in one year (Salvation Army 2010).

The extent of hidden homelessness is apparent when we consider how social services are used amongst the housed population. Food bank use has risen exponentially, with a ninety-one percent increase between 1989 and 2006 (Gaetz 2010), and the problem is worsening. When the

⁷ Housing First is based on five key principles: immediate access to permanent housing with no readiness requirements (i.e. sobriety, medication compliance); consumer choice and self-determination; recovery oriented (individual well-being which may include harm reduction); client-driven supports; and social and community integration (Gaetz 2013).

⁸ Episodic homelessness refers to those individuals who transition in and out of homelessness several times over three or four years. Sometimes these shifts in/out of homelessness occur because the individual moves into a jail/prison or hospital (Kuhn & Culhane 1998).

economic recession hit in 2008, many who were relatively homeless (those at imminent risk of becoming homeless due to poverty, unsafe and unhygienic living conditions (Echenberg & Jensen 2008)) were no longer able to make ends meet, and the demand for homeless services increased twenty-six percent (Salvation Army 2010).

Homelessness in Ottawa

Like many cities in Canada, Ottawa is experiencing a homelessness and housing crisis. In 2013 6,705 different individuals used a shelter bed in Ottawa (ATEH 2013). Like the national statistics, Ottawa has a relatively small number of chronically and episodically homeless (they make up approximately thirteen percent of Ottawa's homeless community) but account for over half of the shelter beds used (Aubry et al. 2013). The average length of stay in an Ottawa shelter is seventy-three days (ATEH 2013). The chronically homeless remain in shelters or on the street for approximately 3.7 years. Of these chronically homeless, seventy-five percent are male, twenty-five percent are female, and one percent identify as transgender (ATEH 2015). Gender is an important component to the homelessness experience and according to Aubry et al. (2013) is the single most defining characteristic to finding and maintaining housing.⁹

We must also consider race and indigeneity in our analysis of homelessness in Ottawa. First Nations, Métis and Inuit peoples make up 2.1 percent of Ottawa's population (Statistics Canada 2011), but account for approximately thirty percent of the homeless community (ATEH 2015; Gaetz, Gulliver & Richter 2014), a relatively high percentage compared to eighteen percent in Calgary, eleven percent in Vancouver, and five percent in Toronto (Hwang 2001). In a recent survey of Ottawa's chronically homeless, of those who identified as Aboriginal eighty-

⁹ In the longitudinal analysis of housing trajectories Aubry et al. (2013) found that single women and women led families were almost twice as likely to find housing as single men.

nine percent reported suffering with a mental health condition and eighty-four percent reported having a substance use problem (ATEH 2015).¹⁰ In this same report, twenty-two percent of all individuals surveyed were in jail or prison within the last six months and thirty-four percent were dealing with some sort of legal situation (ATEH 2015). Given the disproportionate rate of Aboriginal peoples caught in the criminal justice system (OCI 2012), it is very likely that many of those respondents were Aboriginal. These statistics provide us with a glimpse of the complexity of the homelessness crisis and shape our understanding of the social phenomenon in particular ways (Hacking 1991); they show the undeniability of the claim that more Canadians than ever are finding themselves in the zone of vulnerability and disaffiliated (Castel 2003), with the City of Ottawa being no exception.

A short history of homelessness

Homelessness has been politically managed in one way or another for centuries. As Castel (2003) explains, during feudalism communities were responsible for taking care of those who could not work through acts of charity. As populations grew and people became more mobile poverty became a political problem that was thought to require unique forms of regulation. In the sixteenth century there was a shift from thinking of the poor as simply lazy to characterizing them as potentially dangerous (Castel 2003; Snow & Anderson 1993). The English poor laws were developed to manage the poor through local parishes who distributed relief to those identified as vagrants and beggars (Beier 2004). The crux of the legislation was to socially control those who did not own land by requiring able-bodied workers to work in low-wage employment and fill the labour shortage brought on by the Black Death (Paradis 2014;

¹⁰ Unfortunately and problematically, this survey does not provide statistics on the overall number of homeless individuals who identify as suffering with mental health and substance use issues and only provides the data for Aboriginal peoples and youth.

Snow & Anderson 1993).¹¹ During the nineteenth century industrial revolution the poor laws were revamped to address the migration of people to urban centres. Institutionalization was introduced as a technique of social control by confining the poor to workhouses where they were compelled to perform the most menial and dangerous tasks (Lees 1998) that other workers refused to do.

It was also at this time that English and French settlers were colonializing North America. As Paradis (2014) explains, homelessness and colonization are intimately linked. European settlers brought the colonial concept of ‘owning’ land and subsequently having the power to exclude people from owning land with them to Turtle Island¹². Moreover, legislation such as the *Indian Act* (185 (1876)) prohibited many Aboriginal peoples from owning land, for example Aboriginal women who married non-status or non-Aboriginal men lost their Indian status (McIvor 1994). The oppression of Aboriginal peoples during colonization is mirrored today in the disproportionate rate of Aboriginal men and women experiencing homelessness:

Such state, church, and market projects utilized to sort out, punish, contain, and control surplus, colonized, racialized, and deviant populations find their contemporary descendants in laws and policies mandating discriminatory and excessive policing, criminalization, and incarceration of people facing homelessness (Paradis 2014: 55).

The connection between colonization, criminalization, the cultural genocide of Aboriginal traditions (McLachlin 2015; TRC 2015), the continued struggle for self-determination in Aboriginal communities and homelessness should be analyzed throughout homelessness research (Patrick 2014). The development of this body of literature in the last decade is promising especially as Aboriginal people themselves take a leadership role in conducting research (Baskin 2007; Culhane 2003; Walker & Barcham 2010).

¹¹ The Black Death was one of the most devastating pandemics in human history, killing at least one third of the European population from 1347-1350 (Ziegler 1969).

¹² Turtle Island is the original name for North America as per the Anishinaabek people.

Little research existed on homelessness at the beginning of the twentieth century. In the 1920s and 1930s the Chicago School's social ecology model focused on 'zones of transition' where the poor and immigrant populations would concentrate and unsurprisingly, where sociologists studied deviance and criminal activity (Taylor, Walton & Young 1973); however, this research did not study homelessness as a unique social phenomenon. In the 1950s and 1960s homelessness research concentrated on 'skid row' (Attkisson 1970; Bahr 1970; Bittner 1967; Wallace 1965) and the challenge of substance abuse among 'skid row alcoholics' (Bahr 1967; Myerson & Mayer 1966; Olin 1966; Rooney 1961). Both bodies of literature demonstrate the history and longevity in biological explanations of deviancy and the pathologization of poverty that I explore below.

Homelessness research as we understand it today exploded in the 1980s. As the welfare system was battered with criticism from all sides of the political spectrum and neo-liberal ideologies began to take hold (Cohen 1985; Garland 2001) the contemporary homelessness problem was made (Hacking 1991). Across the Western world governments cut social spending dramatically and privatized social services while expanding the criminal justice system (Allen 2000; Layton 2000). Specific to homelessness, in 1993 the federal government withdrew its once robust post-World War II investments in affordable housing, transferring the responsibility to provinces (Gaetz 2010; Gaetz, Gulliver & Richter 2014). As Gaetz (2010: 22) notes, this shift "...leav[es] Canada as virtually the only major developed nation without a fully funded national commitment to housing". The steep decline in affordable housing, other neo-liberal economic policies that favoured tax cuts, 'small government', and privatization, the widening income gap between the wealthy and the poor, as well as the 1990s recession and high unemployment rate

(Gower 1996) are among the conditions that led to the dramatic rise in the homeless population (Gaetz 2010; Lyon-Callo 2004).

Because of these factors the demographics of the homeless population changed. No longer were the single men on skid row understood to be demonstrative of the homeless community. Youth, women, and families became part of the homelessness landscape (Allen 2000; Gaetz 2010; Meanwell 2012; Snow & Anderson 1993). With these changes came a newfound interest in homelessness by social scientists looking to document the transformation of marginality. It is likely because of the politicization of homelessness at this time (Allen 2000) as well as the relatively short history of contemporary homelessness that the vast majority of the research was published in the 1990s and was primarily concerned with documenting who is homeless and the trajectories in and out of homelessness (Snow & Anderson 1993). As I explore below, there are some sophisticated, nuanced, and critical analyses of homelessness but they occupy a small corner of the scholarship. Much of the homelessness literature continues to seek to count, diagnose, and individualize the homelessness phenomenon. This is likely because, given its thirty-five year history as a modern topic of study, homelessness research is still in its infancy (Gaetz, personal communication). Homelessness research is not a discipline in the same way as psychology, sociology or criminology. Indeed, homelessness experts come from a variety of disciplines – geography, social work, sociology, gender studies, psychology, population health, education, and criminology among them. It is essential then that as the body of literature develops it does so with a critical and socially contextualized understanding of homelessness, one that I hope to contribute to with this research.

Understanding homelessness: Individualization and socio-political paradigms

How homelessness is framed dictates the social reaction to it. From England's poor laws to the modern emphasis on temporary emergency services, the response to homelessness is based predominantly on an individualized understanding of the pathways to homelessness (Aubry, Klodawsky & Coulombe 2012; Mackenzie & Chamberlain 2003). To date, the focus has been on managing the crisis more than prevention or helping people permanently move out of homelessness (Gaetz 2010). This response comes from the discourses that homelessness is individually caused. Whether from an unwillingness to work, addiction, mental illness, or disability, the rhetoric on homelessness emphasizes individual explanations for people's housing precariousness (Allen 2000; Snow & Anderson 1993). Generally, the public perception that homelessness and deviancy or disability are inherently linked comes from the media's portrayal of homeless men and women as helpless victims of vice or illness who need to be controlled for their own good and for the welfare of the social body (Hodgetts, Cullen, & Radley 2006; Schneider, Chamberlain, & Hodgetts 2010). Allen (2000) notes that privileging individualized explanations of homelessness aims to de-politicize what are inherently socio-political concerns.

The individualization of homelessness continues to pervade the research, in particular the focus on deviancy, mental illness, and addiction (Anderson & Rayens 2004; Caton et al. 2005; Clarke et al. 2000; Copeland et al. 2009; Eyrich-Garg et al. 2008; Greenberg & Rosenhack 2008; McNaughton 2008; Orwin, Scott & Arieira 2005). Although many scholars acknowledge the impact of structural barriers on homelessness, modes of intervention continue to privilege individual risk factors. Through this research, marginalized people are portrayed as disordered, dangerous, and innately different than the housed community (O'Grady, Gaetz & Buccieri

2011). Nowhere is the individualization of homelessness more apparent than in the body of research that seeks to identify and explain a homeless sub-culture.

Shelterization

Shelterization borrows from psy-discourses to describe patterns of behaviour that come from long-term exposure to homelessness 'culture'. Shelterization is explained in this way:

...patterns of behavior that are adaptive primarily for a shelter-dependent life and become coterminous with the experience of homelessness itself. 'Shelterization' is in a sense the 1980s parallel to the 'institutionalization' of earlier days, when long stays in mental hospitals contributed to symptoms and behaviors that were mistaken for the mental illness itself (Gounis & Susser 1990: 241).

Shelterization, as a concept, focuses on the passivity and dependence of individuals who become embedded in shelter life. Scholars who embrace the concept take at face value that there is a deviant homelessness culture that weak-willed individuals succumb to and that fosters chronic homelessness (Allen 2000; Dordick 1997; Feldman 2004). The description of shelterization is in keeping with Sykes (1958) conception of deprivation and the 'pains of imprisonment'. For Sykes, prisoners modify their behaviours to cope with the multiple tangible and intangible losses they face upon incarceration. Most notably, the deprivation model is used to explain why self-identified heterosexuals engage in homosexual acts while in prison, the argument being that homosexual behaviour is a coping mechanism on account of gender segregation and as such is part of the prison culture; this model fails to understand sexual identity as fluid and complex (Blackburn et al. 2011; Eigenberg 1992).

Likewise, the shelterization literature points to homeless men and women's withdrawal, apathy, and dependency as an adaptation to the social environment (Gounis 1992; Grunberg & Eagle 1990; Ranaginshe 2013). In this way shelterization refers to the 'pains of homelessness'. However, as Gounis (1992: 690) notes, this deprivation model individualizes feelings of

exclusion rather than focusing on how institutional arrangements create the conditions of dependency: “Instead, the emphasis has been on interpreting shelter malaise as a self-inflicted condition. The causal hierarchy is usually inverted and the responsibility in engendering these phenomena is shifted from the institution to the inmates”. For example, DeOllos’ (1997) study of homeless families analyses the limited role fathers play in caring for their children while homeless. While shelterization studies would characterize the lack of responsibility a part of the ‘lazy’ homeless culture, DeOllos astutely notes that men are not allowed to stay in the family shelters she studied, and the men’s shelter requires its residents to actively job search during the day, leaving few opportunities for fathers to spend time with their children. In this way, the concept of shelterization is not especially useful as it frames dependency as a moral fault rather than considering how the physical environment, for example its insecurity and lack of privacy, creates the conditions for ‘deviant’ behaviours such as residents carrying a weapon (Huey 2012), or ‘public’ intoxication. Shelterization literature and other individualizing discourses portray the homeless as “a highly crippled, dysfunctional population” (Snow, Anderson & Koegel 1994: 462), an interpretation that continues to inform shelter policy.

Because the shelterization literature emphasises individual inadequacy, it is no surprise that the discourse pathologizes structural barriers as mental illness. Marcus (2003) criticizes Grunberg and Eagle (1990), who coined the term shelterization, as perpetuating the stereotype of homeless men and women as deviant. The authors offer solutions to ‘shelter subculture’, such as programs that build self-esteem, fostering pro-social relationships, and psychiatric care. These solutions reflect Cruikshank’s (1999) analysis of empowerment programs that, as I explore in chapter three, emphasize individual responsabilization to the detriment of structural and environmental impediments. Marcus (2003) critiques this interpretation of homelessness,

suggesting that it is the lack of privacy built into the shelter's architecture, rather than deviancy or mental illness that explains 'inappropriate' behaviour. He argues that behaviours that would ordinarily take place in the privacy of one's home – lounging around, alcohol and drug use, urinating in the shower, and sexual activity, to name a few – are necessarily performed within the purview of staff and other homeless individuals. Marcus explains:

The shelter was, in fact, a giant room that was somewhere between a subway car and a private bedroom in a locked apartment. The idea that a space is either public or private misses the fact that the level of deviance and the social power of the actor determine the amount of privacy and secrecy necessary to avoid notice and trouble (Marcus 2003: 139).

Marcus suggests that rather than homeless individuals being deviant, we would all be considered abnormal if frontline staff had cameras in our private bedrooms, or if researchers made notes on our actions in our home. Marcus (2003) offers that there is no 'homeless culture' but rather, that the shelter acts as a snapshot of our own culture. In this way, Marcus harkens back to the 'importation model' that supplements the deprivation model to explain the pains of imprisonment (Sykes 1958). The importation model contends that prisoners' behaviours are not an adaptation of a prison culture, but are previously existing attitudes and ideologies that prisoners bring into the prison (Blackburn et al. 2011; Eigenberg 1992; Irwin & Cressey 1962). Although Marcus' (2003) analysis questions the individualization of homelessness, I seek to push his conclusions about the behaviour of shelter residents further to question how the shelter environment, as a social, historical, and cultural artifact, impacts an individual's ability to negotiate their identity, behaviours, sense of place, and the systems that make up the shelter, including the mental health system (see chapter five).

Situating homelessness in the social world

Despite the proliferation of individualized understandings of homelessness, the last two decades have witnessed an increased acknowledgment of its social and structural causes. Housing unaffordability, unemployment, limited access to social services, deindustrialization, a minimum wage that does not keep up with the cost of living, discrimination based on race/ethnicity (in particular Aboriginal peoples), gender (Baskin 2007; Leach 2010; Patrick 2014; Sider 2005), and reduced benefits (especially pensions) are among the myriad of social, political, and cultural conditions that allow the homelessness crisis to continue (Allen 2000; Gaetz, Gulliver, & Richter 2014; Lyon-Callo 2004; Paradis 2014). Beginning with Snow and Anderson's (1993) seminal ethnography on street life in Austin, Texas, homelessness scholars have begun to take an interest in homeless men and women as diverse, interesting, and thoughtful people rather than simply objects to be counted. These authors cautioned against a body of research built strictly from surveys looking to describe who is homeless:

We argue that this portrait of the homeless as drunk, stoned, crazy, and sick is partly distorted and flawed. It is distorted in the sense that a makeup mirror distorts the face of its user by highlighting and magnifying only the blemishes or imperfections, and it is flawed in the sense that the picture or image is in part an artifact of the questions asked and the procedures used to pursue those questions. In other words, given researchers' preoccupation with the problems the homeless presumably have, namely, personal disabilities or pathologies, and the procedures used to track this preoccupation, namely, the cross-sectional survey consisting of face-to-face structured interviews conducted anywhere from 15 to 90 minutes, it is not surprising that the homeless are generally portrayed as being riddled with various 'conspicuous dysfunctions' (Snow, Anderson, & Koegel 1994: 462-463)

In the decades that followed, emerging scholars took up Snow, Anderson and Koegel's (1994: 470) call for "...a more balanced, contextualized, and adaptive picture of the homeless..." by nuancing homelessness and privileging the voices of those with lived experience (Blasi 1990). For example, Allen (2000: 20) writes: "Homelessness does not so much reflect a flawed

individual as it does a flawed system”. Paradis (2014: 53) claims: “Women’s homelessness in Canada is no accident. Like incarceration and militarism, it is a central feature of the neo-liberal security state. Ultimately, it is a project of disenfranchisement: one to exclude from liberal citizenship those who cannot or will not participate in the market”. Lyon-Callo (2004: 16) contends: “...neo-liberal and medicalized thinking set the conceptual boundaries for the ‘realistic’ or ‘reasonable’ ways of responding to homelessness, but these dominant ways of knowing and being are challenged in a variety of ways”. It is among this scholarship that I build this research so as to question assumptions about deviancy and illness and where otherwise ‘abnormal’ rationalities and behaviours are contextualized in order to reconsider the normal/abnormal binary.

Critically-oriented homelessness research reimagines the homeless identity by highlighting the heterogeneity of the population. For example, until recently women’s homelessness was largely ignored (Aubry et al. 2013; Klodawsky 2006; Paradis 2014). When women’s poverty was discussed, it was often in relation to the highly derogatory and racialized ‘welfare queen’ (Chunn & Gavigan 2004; Gustafson 2009; Little 2001; Mosher 2006). The current research on women’s homelessness points to the staggering rates of physical and sexual abuse experienced by women primarily before but also while homeless (Paradis & Stermac 2001; Paradis et al. 2009). Studies that explore women’s hidden homelessness (Paradis et al. 2009; Passaro 1996), their health disparities (Benoit, Carroll & Chaudhry 2003; Bungay 2013), victimization (DeWard & Moe 2010; Paradis & Stermac 2001) and motherhood in the homeless community (Barrow & Laborde 2008; Connolly 2000; Paradis 2014) are all examples of critical research that debunks the homogenized homeless subjectivity, contextualizes the lives and

experiences of homeless women, and provides evidence for more meaningful and practical forms of support to help individuals prevent or escape homelessness.

As noted above, Aboriginal peoples are disproportionately represented in the homeless community. Almost half of homeless women in Canada identify as Aboriginal (Klodawsky 2009). First Nations, Métis and Inuit peoples are more likely to become homeless, are less likely to use supports and services while homeless, and remain homeless longer than other homeless people (Leach 2010). Recent critical scholarship on Aboriginal homelessness brings to light the ongoing racism Aboriginal people experience in terms of accessing affordable housing and seeking well paid, meaningful employment (Gaetz, Gulliver & Richter 2014). Most importantly, the long-term effects of colonization, cultural genocide, residential schools, discriminatory government policies, and other forms of state sanctioned trauma contextualize Aboriginal homelessness (Leach 2010; Menzies 2009; Paradis 2014; Patrick 2014; Sider 2005). Importantly, there has been an increase in the number of studies that privilege the voices of Aboriginal homeless people and work within the OCAP¹³ principles to ensure that Aboriginal people have ownership and determination over the research process (Fillmore, Dell & Kilty 2014; Stewart et al. 2013).

Homelessness scholarship has begun to consider the resiliency, determination, and skills that homeless men and women possess, in contrast to previous research that depicted the homeless as passive victims or risky subjects (Meanwell 2012). Literature on resiliency looks to the skills and strengths that individuals have to make meaningful choices in constrained environments (Kidd & Davidson 2007; Williams et al. 2001). However, studies on strength and

¹³ The First Nations Principles of OCAP (ownership, control, access, and possession) sets out the mandate and protocol for external researchers to conduct projects in conjunction with First Nations peoples. To learn more, visit: <http://fnigc.ca/ocap.html>

resiliency are almost exclusively concerned with homeless youth (Bender et al. 2007; Dell, Dell & Hopkins 2005; Prescott et al. 2008; Roebuck 2013). It is unfortunate that focusing on people's strengths, abilities, and skills is seemingly restricted to youth. The contention that children and youth have unlimited potential and that, with the right intervention, all young people can have bright futures and become 'good' citizens is politically salient rhetoric that I have explored elsewhere (Dej 2011b). That research is beginning to acknowledge that homeless men and women do find meaning and actively participate in their lives and exert autonomy in unlikely places is promising (Snow & Anderson 1993; Snow, Anderson & Koegel 1994; Meanwell 2012).

I take inspiration from this body of work and seek to contribute to the literature that recognizes how homeless men and women negotiate and manage their lives and identities in contrast to the objectification of homeless people in some research. Boydell, Goering and Morrell-Bellai (2000: 35), for example, study how homeless men and women shape and make sense of their past, present and future identities and depict homelessness as a process of becoming rather than an event. The authors assess the ways homeless individuals build their identity within and through the constraints of homeless living: "Instead of the customary conception of the self as passive and dependent on reflective appraisals, the self is viewed as active and rooted in emotion." Conceptualizing how homeless individuals make sense of their lives given their marginalization and the unequal power dynamics between the homeless and the housed is a relatively new conceptual framework in this field of research.

Similarly, Harter et al. (2005) consider the politics of invisibility among the homeless and how homeless people engage in a variety of strategies to reinforce or resist the opacity of their lives. In their assessment of stigma management, the authors reveal the challenges some youth face in working with and through identifying as homeless:

Participants are faced with a double bind: To access many of the services they need, they must take on the burden of stigma. Meanwhile, youth might embrace stigma symbols and inadvertently reproduce the distance between themselves and service providers, as well as domiciled youth (Harter et al. 2005: 315).

Using survival strategies, coping mechanisms and ‘street smarts’ the young people in this study attempt to reclaim the homeless identity, or at least shield themselves when possible from the overt stigmatization they experience daily. Privileging the voices, events, and knowledges of the homeless at the micro level is an essential component of this research project as it provides a nuanced account of how people make themselves up in everyday life (Hacking 2004), which is imperative when seeking to understand something as personal and intimate as experiencing homelessness.

Just as homelessness is a lived experience, it exists because of particular historical, social, and political constructs. Another recent critical body of work on homelessness explores the structural arrangements that allow homelessness to exist as a social phenomenon. I have already discussed some of the practical, systematic causes of homelessness. Scholars such as Feldman (2004) and Lyon-Callo (2000, 2004) provide detailed analyses of the social conditions that perpetuate the exclusion of the homeless. Feldman (2004) argues that because homeless individuals are not regarded as citizens, interventions to alleviate homelessness may further entrench their exclusion. For example, redistributive programs that seek to increase the affordable housing stock may have the unintended consequence of creating ghettos and thus reinforcing the spatial and social division between the wealthy and the poor. Feldman, and others (Evans 2011; Foop 2002), argue that homeless shelters and support services may provide short-term assistance but ultimately reproduce the homeless individual as a risky and vulnerable subject in need of care and control.

Lyon-Callo's (2004) study of the homeless sheltering industry assesses the neo-liberal governance strategies that individualize and pathologize homeless individuals despite the benevolent intentions of shelter staff: "One effect of conceptualizing social problems through a lens of diseased bodies is often a neglect of systemic inequality. Consideration of the material and historical conditions that might contribute to the production of problems is silenced or marginalized by a focus on individual traits and habits" (Lyon-Callo 2004: 51). Lyon-Callo's research provides a foundation upon which to build this research project. Like his study, I am looking to uncover how systematic responses to distress impact how men and women experience homelessness. I am adding to the work (Flint 2009; Foop 2002; Lyon-Callo 2004; Mosley 2012) that critically assesses how contemporary systematic responses to marginality reinforce dominant, individualized understandings of homelessness and the included/excluded binary (Young 1999). In order to contribute to this body of work, I enlist the framework provided by Boydell, Goering and Morrell-Bellai (2000), Harter et al. (2005) and others to analyze how individuals make sense of the governing structures imposed on them on account of their homeless status. By combining the narratives of individuals experiencing homelessness with an analysis of how different institutional systems frame these experiences, I add nuance and depth to the critical homelessness literature. As I explore in the next section, this research fills a particular gap in the literature by critically examining mental illness amongst the homeless.

Mental health

In order to assess how mental health is used in the homeless community as a tool of individualization and pathologization, it is imperative that we assess the development of the medical model, its relationship with normalization, and the counter-narratives that resist the medicalization of problems in living (Szasz 1974).

The making of the medical model

“...you see psychiatry becoming something infinitely more general and dangerous than the power that controls and corrects madness; it is becoming power over the abnormal, the power to define, control, and correct what is abnormal” (Foucault 2006: 221).

Contemporary psychiatry developed in the nineteenth century as a response to the Great Confinement (Castel 2003; Foucault 1988)¹⁴, using a scientific orientation for conceptualizing madness. Cockerham (2003; Everett 1994) suggests that the medicalization of psychiatry was spearheaded by physicians such as Tuke and Pinel who sought humane and benevolent approaches to treating the mentally ill. Foucault (1988), however, is critical of this claim suggesting that Tuke and Pinel’s ‘scientific’ techniques enforced a particular conceptualization of morality. Tuke was primarily responsible for the creation of the asylum while Pinel developed moral treatment, including the removal of physical restraints, in the asylum. While Cockerham (2003) writes of retreats and the end of physical abuse in asylums, Foucault paints an altogether different picture of nineteenth century madness. Foucault (1988: 259) writes: “In one and the same movement, the asylum becomes, in Pinel’s hands, an instrument of moral uniformity and of social denunciation”. Foucault (1977) claims that psychiatrists (the new experts of human behaviour) use techniques of individualization and responsabilization to govern those thought to be lacking moral order.

Foucault (1988: 270) credits Tuke and Pinel with the integration of the physician into the field of psychiatry, transforming the asylum into a space for the production of medicalized knowledges: “If the medical profession is required, it is as a juridical and moral guarantee, not in the name of science”. As mental health gained traction as a scientific field of inquiry by adopting

¹⁴ The Great Confinement refers to the popularity of using specialized institutions to incapacitate individuals designated mentally ill, the unemployed, prisoners, and the poor. In England these establishments were known as ‘houses of correction’.

an increasingly positivist approach, Pinel's moral treatment fell into disrepute¹⁵ leaving the medical framework as the primary means for understanding distress. Not only did psychiatry become recognized as a branch of medicine (Rogers & Pilgrim 2005) but according to Foucault (1988: 275) the 'medicine of the mind' assumed greater power to govern people's lives and an autonomous place in the institution of medicine.

The success of the medical model is due in large part to its connection to scientific empiricism and its reliance on pathologization as a tool to dominate knowledge production about those experiencing mental distress. Psychiatry has built a strong relationship with medicine, relying on the body as a site for scientific discovery and intervention (see Foucault 1976).¹⁶ Using the medical model, distress is regarded as an illness that derives from a virus, biochemical disorder, or a genetic predisposition (Tew 2005), all of which are seemingly value-neutral and objective causes of mental illness.

Using the illness framework as a guide, the medical model allows for a "single technical-psychiatric view" (Goffman 1961: 351) of a problem, ignoring the social circumstances that give rise to distress. This is not to say that those who prescribe to the medical model do not make reference to external causes, but environmental factors are often understood as triggers to an already existing biochemical condition. In order to maintain a connection with physical

¹⁵ Cockerham (2003) suggests the demise of moral treatment occurred for several reasons: there were no standard guidelines for treatment; it was regarded as forcing conformity; the methods were criticized as a tax burden for those seen as undeserving of assistance; the common belief that mental illness could not be cured; and mental illness began to be viewed within the disease framework.

¹⁶ The debate between the Cartesian dualism of body and mind, physical and mental illness is beyond the scope of this project. In short, authors such as Sedgwick (1982) critique Laing, Goffman and Szasz for being critical of mental health but prescribing to the values of physical medicine. Wakefield (1992) in turn critiques Sedgwick for taking a pure value approach to understanding disorder. For examples on how the mind and body experience distress in tandem see Shantz and Frigon (2010)

medicine, the psy-disciplines¹⁷ are obliged to seek out a biological connection between the body and mental distress. The answer continues to be treating the body for mental distress, despite the lack of physical evidence to support this strategy (Cockerham 2003). The search for a biological connection is most evident in the continued struggle to find a neurological and/or genetic explanation for schizophrenia (Gilmore 2010; Harrison 2015; Oh & Petronis 2008). The dominance of the medical model does not reside in its infallible relationship with physical health but rather with its minimization of social factors as contributing to mental distress (Rogers & Pilgrim 2005). The psy-sciences are more apt to consider environmental factors as contributing to the etiology of mental illness, but continue to ignore social explanations with reference to prognosis and treatment.

The latest literature on mental illness maintains its adherence to the medical model. Studies continue to emerge from medical schools and psychiatry departments that reaffirm the pathologization of mental illness. From genetics (Bigos et al. 2010; McClellan & King 2010; Uher & McGuffin 2007) to neurology (Goodkind et al. 2015; Lindenmayer et al. 2008), the cornerstone of research on mental distress remains grounded in biological explanations. From this perspective it is no wonder that treatments for mental illness are rooted in the medical model, with psychotropic medication as the primary means of intervention.

Before the 1950s, electroconvulsive therapy (ECT) was commonly used to treat depression, schizophrenia and mania and is still used in some cases today despite doubts about its effectiveness (Feliu et al. 2008; Kimball 2007; MacQueen et al. 2007). Over the last decade ECT has begun to be touted as an innovative treatment for individuals suffering with

¹⁷ By psy I am referring to psychology, psychiatry and other disciplines related to these areas, but recognize a hierarchy in the psy disciplines amongst those most closely associated with the medical model, namely psychiatry.

methamphetamine-induced psychosis (Chao, Chen & Chen 2012; Grelotti, Kanayama & Pope 2010).

Since the introduction of chlorpromazine in the 1950s to reduce hallucinations in individuals diagnosed with schizophrenia (Cockerham 2003) psychopharmacology has dominated the medical treatment of distress, often as the exclusive form of therapy and has bourgeoned the development of 'Big Pharma'.¹⁸ Ideologically, the over-reliance on psychopharmaceuticals has led to the social control of individuals who do not comply with medication regimes, reasserting the belief in bio-determinism and in the misrepresentation of medication as a cure rather than a tool to manage symptoms (Cockerham 2003; Rogers & Pilgrim 2005). Losing housing or using the criminal justice system (when treatment compliance is listed in parole/probation orders) is effective at increasing medication compliance (Monahan et al. 2005; Redlich et al. 2006; Skeem & Louden 2006). More commonly, different assertive community treatment (ACT) teams (made up of psychiatrists, nurses, social workers and peer supports) are used to monitor compliance (Kilty & DeVellis 2010), especially in the homeless population (Aubry et al. 2006; CPHI 2009).¹⁹ Moreover, the prevalence of psychotropic medication amongst both the homeless (Dixon et al. 1997; Morse et al. 2006) and prison populations (Kilty 2012a; Maidment 2006; Pollack 2005) speaks to its widespread use on marginalized people.

¹⁸ Big Pharma refers to large pharmaceutical companies who yield a great deal of economic and political power primarily through direct-to-consumer advertising and economic incentives for physicians to prescribe brands of pharmaceuticals.

¹⁹ For a critical analysis of ACT teams, see Shimrat (2013).

Recently, the most controversial technique used to ensure treatment compliance is a CTO.²⁰ CTOs are legal provisions that allow individuals who would otherwise be institutionalized in a mental hospital to live in the community under certain conditions, most notably complying with medication (Davis 2006; O'Reilly 2004). CTOs bring to the fore the debate between 'benevolent coercion' and autonomy (Chaimowitz 2004) by mandating treatment compliance with the threat of police apprehension and hospitalization (Campbell et al. 2006). Although CTOs are said to be voluntary, one must question whether choosing between a CTO and involuntary hospitalization is a decision made free of coercion (Fabris 2006). Proponents of CTOs tout its effectiveness at reducing hospitalizations, invoking greater access to mental health resources, and reducing victimization (Gibbs et al. 2006; O'Reilly 2004); conversely, the coercive nature of CTOs is equated with 'chemical incarceration/ institutionalization' and a 'chemobotomy' (Fabris 2006). All of these interventions privilege a pathologized understanding of distress and vulnerability.

The medical model also informs organizational rhetoric and policy. For example, many of the provincial mental health acts refer to "...diagnosis and treatment of persons with a mental disorder and the rehabilitation of patients..." (B.C. *Mental Health Act* 2007: 2) and provide psychiatric facilities with varying degrees of power to involuntarily hospitalize (or institutionalize) individuals for the purpose of medical treatment, known as 'forming'.²¹ At the same time, the medical model is reflected in the mandate and programming offered by

²⁰ Community treatment orders, mandatory outpatient treatment, and involuntary outpatient treatment take various forms in the provinces and territories but through a cursory glance can all be understood as compulsory community treatment laws (Gray & O'Reilly 2005).

²¹ The *Ontario Mental Health Act* describes the criteria for an involuntary admission to a mental hospital via an Application for Psychiatric Assessment, commonly known as a form 1. The form sets out the criteria for involuntary hospitalization; namely, if a physician is of the opinion that an individual has a mental disorder and is likely to cause serious harm to herself or another person. While a physician must personally examine the individual and make the application she can rely on others' reports, in this case usually shelter staff.

organizations such as the Canadian Mental Health Association, the Schizophrenia Society of Canada, and the Mood Disorders Society of Canada. For example, a number of government and non-governmental organizations pay lip service to the impact of social factors on mental illness but conclude that the biological approach is at the heart of the issue:

Research suggests that mental illnesses are the result of a complex interaction of genetic, biological, personality and environmental factors; however, the brain is the final common pathway for the control of behaviour, cognition, mood and anxiety. At this time, the links between specific brain dysfunction and specific mental illnesses are not fully understood (Health Canada 2002: 22).

One of the priorities of this research project is to complicate the notion of a strictly medicalized definition of mental illness. Although it is not my intention to refute any connection between biology and mental distress, I engage with and privilege alternative conceptions of mental distress and account for how individuals make sense of what it means to be diagnosed with a mental illness. This position is especially important when we consider the literature on treatment and the dearth of knowledge related to alternative ‘therapies’ (such as peer-support offered by the mad movement) in social science scholarship.

The knowledge produced through the medical model is so effective at governing people that it has not changed substantively since the nineteenth century. For example, age, sadness, and excitability continue to be pathologized as dementia, melancholia/depression, and mania/bipolar disorder, respectively. Alternatives to the medical model, such as psychoanalysis and social psychiatry, have acted as momentary glitches to the dominance of the biological approach (Rogers & Pilgrim 2005). Moreover, Tew (2005) finds that even with the introduction of modern treatment strategies (for example, psychotropic medication) recovery rates for mental illnesses such as schizophrenia have not changed for at least fifty years. The medical model retains its dominance notwithstanding this failure because psychiatry does not feign an ability to cure

mental distress. Unlike physiological medicine, psy-experts claim only to manage symptoms (Rogers & Pilgrim 2005; Russell 1995). Tew (2005) recognizes this ‘management’ as a technology of power used to govern individuals for a lifetime. The failings exhibited by psychiatry through the medical model have not diminished its power because, as Bean (2008: 8) describes: “Its acceptance has also been assisted by the law of repetition: if assertions are made with sufficient regularity, and by people of high status, eventually they will become accepted”. Psychiatry’s use of the medical model has not only survived over time but has flourished and expanded the discipline²², not because it is a necessarily useful paradigm, but because of its coupling with the power of medical discourses to enforce dominant conceptions of normality.

Psy experts

The psy-sciences unite to create the psy-complex, a collection of discourses, language, identifiers, and pathologies that permeate almost every aspect of our lives and provide the words and tools for individuals to understand who they are and how act upon themselves (Ingleby 1985; Rose 1998). Expertise is defined as a group of trained persons who claim special knowledge and whose authority allows them to identify our needs and speak on our behalf in the name of scientific neutrality and efficacy (Rose 1996, 1998, 1999). While Rose focuses on how psy discourses are used to encourage us to take up our own improvement, Castel (1988) sees expertise as a delegation of power where experts are able to make unilateral decisions about other people, depriving them of their autonomy. We must keep in mind that the psy-complex takes many forms; the disciplines’ ability to shift from encouragement to coercion is deeply problematic and a significant theme in this research project.

²² The ‘net-widening’ (Castel 1981; Cohen 1985) of psychiatry is part of the larger medicalization of society (Conrad 2007).

Certainly, psy-experts play a significant role in naming and framing abnormalities and pathologies. Szasz (1974) coined the term ‘problems in living’ to describe the personal difficulties that are erroneously taken up by the psy-disciplines. He adds that mental illness is in fact an individual’s “...struggle with the problem of *how* he should live” [emphasis in original] (Szasz 1989: 16). Using the medical model as leverage, psy-experts claim to have the wisdom and medical know-how to improve others’ lives in a number of ways: “Old problems are reconfigured and new ones discovered, when life is rendered intelligible in terms of the languages and judgements of the ‘psy’ disciplines” (Miller & Rose 2008: 143). The psy-complex proliferates the landscape of human nature as it pathologizes a variety of aspects of daily life (Caplan 1995; Conrad 2007), thereby demanding that all active citizens guard against their potential abnormality through techniques of responsabilization.

Key to the psy-disciplines’ success is its subtlety and ‘generosity’ (Rose 1998) in lending terminology, discourses, judgements, and practices to experts in other fields. As diverse groups of experts embrace and implement psy-discourses, psy’s normalization might make it easy to lose sight of its dominance. Psy is weaved into interactions with not only doctors, but also any number of front-line workers such as social workers, teachers, counsellors and other para-professionals. Castel (1988) uses the term ‘third specialist’ to describe someone who combines and makes sense of the directives of the doctor and the administrator in the application of practices and programs on an individual, and who thus harnesses the power of these experts:

Professionals, who have become extremely numerous, continue to work in institutions that have exploded the theoretical codes, which themselves have become more subtle; technologies that have been diversified continue to meet populations whose numbers have increased and whose characteristics have become more subtly defined. These constitute many innovations. Yet they do not invalidate the hypothesis that the same apparatus of domination was able, during the course of its modernization, to renew its prestigious nature, to tighten its grip and multiply its powers (Castel 1988: 7).

As psy-discourses are employed by an infinite number of professionals and para-professionals, a strong allegiance between psy and control agencies develops. Psy-rhetoric is shared between police, social workers, counsellors, nurses and others who work together to form a tighter network of surveillance and control (Rose 1998, 1999). It is this collection of agents and institutions that allows for the state to limit direct intervention and to govern at a distance. The psy-disciplines' insidious and 'seductive' nature (Rose 1988) make it exceptionally difficult to build a counter-narrative and resist its normalizing discourses.

The Mad movement: Resisting psy

The mad movement offers a radical understanding of the psy-disciplines and the nature of distress. Here I explore the major tenants of the mad movement and how it can be a useful framework to think through mental health intervention in the homeless community.

Definitions and tenants

The mad movement encompasses a number of ideologies and advocacy goals related to the rights of individuals involved in the mental health system. The movement is largely influenced by the anti-psychiatry movement of the 1960s and 70s (Burstow 2005), led by scholars like Szasz (1989) Cooper (1967) and Laing (1960, 1967, 1971) who examined mental illness as a social construction and questioned the value-laden judgments behind the medical diagnosis (Sedgwick 1982). Survivors/consumers began to protest the mental health system in the 1970s (Tomes 2006) and organized collectively in the 1980s throughout North America and Europe (Rogers & Pilgrim 2005). Distinct from the anti-psychiatrists, the mad movement reaches beyond solely an intellectual debate (Dain 1989; Rogers & Pilgrim 2005) and is committed to direct action, including protests against laws allowing involuntary commitment, ECT, and forced treatment, especially CTOs (Beresford 2005; Stroman 2003). Later, the movement began running

community-based mental health services such as outreach programs and crisis intervention services (Diamond 2013; Rissmiller & Rissmiller 2006; Stroman 2003). The mad movement takes up the challenge presented by the failure of deinstitutionalization to establish resources in the community and help people experiencing mental or emotional distress.

Although an imperfect categorization, the mad movement can be loosely divided between survivors and consumers. Chamberlin (1990) finds that the differences in terminology reflect various priorities amongst factions of the group. The most significant division, and arguably the greatest source of tension in the movement, is between the ex-patients/survivors who reject the medical model (sometimes including taking psychotropic medication) and focus on user-controlled alternatives. Consumers/clients/patients find fault with, but generally accept, the medical model and seek to reform the system to better include consumers in mental health decision making (Burstow 2004, 2013; Diamond 2013; McLean 2000).²³ Although these differences may cause tension between some activists, the mad movement has a number of common goals, including: a quest for self-determination (Chamberlin 1990; Cook & Jonikas 2002); empowerment afforded to those suffering with distress in terms of respecting decision making capacity and gaining self-esteem (Cohen 2005; McLean 1995, 2000); privileging the narratives of those who have encountered psychiatry (Crossley & Crossley 2001; Maidment 2007); and focusing on recovery as a holistic response to negotiating symptoms rather than necessarily eliminating them (Cook & Jonikas 2002; Tew 2005).²⁴ With these goals in mind the

²³ There is much disagreement about the meaning of the term consumer as it denotes a sense of choice in a private system, which is not an accurate representation of the public mental health system (McLean 1995; Rogers & Pilgrim 2005).

²⁴ Some argue that term recovery has been co-opted by the mental health system (Burstow 2013). For example, the Schizophrenia Society of Canada uses the idea of recovery as paramount to their treatment programs, which relies heavily on medication compliance (see Martin 2009).

mad movement adopts strategies such as receiving social support, participating in social activism, and having good physical health, among others, to execute self-determination.

The mad movement in practice

The lessons provided by the mad movement are essential to orienting this project. Mad scholars critically engage with the mental health system and problematize the social construction of the mentally ill identity as strictly pathological. The philosophy of resistance advanced by the mad movement acts as a foundation for this research. By questioning who is involved in the mental health system (disproportionately women, the poor, racial minorities) (Chunn & Menzies 1990; Shirmat 1997; Tew 2005) and the potentially coercive techniques of governance employed by the system (heavy reliance on psychotropic medication, CTOs, ACT teams, etc.), the movement opens up a theoretical and practical space to challenge the mental health system.

To date, the majority of research on the mad movement comes from psychiatric consumers/survivors and integrates personal experience with a broader consideration of the issues facing the community (Chamberlin 1990; Fabris 2006; Shirmat 1997). Still, there remain several gaps in the literature that I hope to fill with this project. Challenging the mental health system is vital because to date there is very little support outside the mad movement for individuals who have experienced mental health intervention to achieve autonomy. There is a lack of support for someone looking for alternatives to medicalized forms of treatment; in fact many are even hostile to the idea (Quart 2009; Whiting 2009).²⁵

Some research is available regarding resources/programs for individuals who have experienced mental health intervention from their perspective, such as their relationship with

²⁵ Fear of the mentally ill was epitomized in the recent changes to the not-criminally responsible legislation where, despite a lack of evidence of its efficacy, a new 'high-risk accused' category was created and discharge decisions emphasize public safety over the rights of the accused (Dej 2015).

service providers (Barreira et al. 2008; Rogers, Pilgrim & Lacey 1993) and what influences program retention (Padgett et al. 2008). Cohen (2005) conducted research on the meaning of recovery and Rogers et al. (1997) present a scale to measure empowerment created by members of the mad community. Likewise, Schneider (2010) uses participatory action to investigate how those diagnosed with schizophrenia communicate with medical professionals and the challenges involved with achieving and maintaining stable housing (including compliance with medication).

Studies such as these make up a small but influential body of literature from which this project is inspired. Above all, the primary purpose of most of these research projects is to describe the current state of the mental health system and to give members of the mad community a platform upon which to share their narratives. Indeed, I too hope to privilege the stories of those labelled mentally ill; however, I would like to go beyond questions about satisfaction with specific programs to unearth the impact of the mentally ill identity on an individual's interaction and negotiation with the psy-complex. Although this literature sometimes speaks to issues of gender and class (much less to race), there is little research on how these and other characteristics alter the way we make sense of the world, how identity is managed, and the complicated negotiation process that takes place when an individual accesses mental health services. Another significant gap in the literature comes from the mad community and their supporters to make a space for homeless men and women who have experienced mental health intervention.

Uncomfortable bedfellows: Homelessness and mental illness

There is little relationship between the mad movement and homelessness research. Although discussions of resistance and autonomy in the mad community are vital, it is clear that

the majority of people labelled mentally ill, including the homeless, do not identify as a part of, or may never have heard of the mad movement (Castel 1981; Chamberlin 1990):

The organized ex-patients of the 1970s constituted a conglomeration of groups and individuals. The major spokespeople were largely white, middle-class, well-educated – the very class from which psychiatry traditionally drew its staunchest support. Lower-class activists, more anarchistic and anti-capitalist in outlook than their middle-class colleagues, saw themselves as an underclass, cut off from society, an exploited minority having more in common with the poor, blacks, Chicanos, feminists, prisoners, and homosexuals than with the white middle-classes (Dain 1989).

Homelessness is under researched by the mad community with only Schneider (2010) and Voronka et al. (2014) including some homeless individuals in their exploration of mental health governance strategies. One of the purposes of this project is to bridge the gap between research stemming from the ideology of the mad movement and the work on homelessness.

Besides the mad movement, there is an immense body of literature on homelessness and mental illness, given the disproportionate rate of mental illness diagnoses in this population (Christensen 2009; Davis 2006; Drury 2003). Estimates suggest that one third of homeless individuals suffer with mental illness (based on the medical model framework of understanding distress) although rates range from ten to almost seventy percent (Allen 2000; CPHI 2009). The vast majority of this research comes from the psy-disciplines and is made up largely of survey research on the epidemiology of mental illness (Henry et al. 2010; Insel 2008) and the evaluation of services (Barreira et al. 2008; Farrell et al. 2005; Padgett et al. 2008). Some of the research acknowledges the stress and trauma individuals face on account of their homeless status and how this distress may contribute to the duration of their homelessness (Paradis & Stermac 2001; CPHI 2009). Recent work in this field concentrates on achieving housing with supports for individuals diagnosed with mental illness, both with and without requiring treatment compliance (Goering et al. 2014; Sylvestre et al. 2007; White 2009). The Mental Health Commission of

Canada's *At Home/Chez Soi*²⁶ project propelled the Housing First model into the mainstream of Canada's housing policy. The Housing First model is built on the premise that individuals should receive immediate access to housing of their choosing with supports (usually ACT teams) without having to meet housing readiness requirements. Housing First recognizes that in order for people to work through trauma, mental illness, and/or substance abuse, it is imperative that they feel safe and secure in a stable home (Gaetz, Gulliver & Richter 2014; Goering et al. 2014).

There is some critical research on the connection between mental illness and homelessness. Bresson (2003) uses Foucault's (1988) analysis of the rise of madness to reconsider the social construction of mental illness amongst the homeless as a method of social control. Bresson (2003: 312) argues that it is politically beneficial to equate mental illness and homelessness in order to responsabilize individuals for being 'fragile' and 'vulnerable' with little consideration of the impact of the socio-political environment. Similarly, Snow et al. (1986; 1993) suggest that the very nature of homelessness and common adaptive responses to homelessness (inappropriate dress/appearance; depression; agitation; unresponsiveness, etc.) are pathologized. Like critics of shelterization (Gounis 1992), some scholars argue that the 'abnormal' behaviour of homeless individuals is a rational response to their exclusion rather than a symptom of pathology. Although the authors acknowledge the mental distress that some homeless men and women face, they find:

²⁶ *At Home/Chez Soi* followed 2,000 homeless and precariously housed individuals with mental health/addiction problems for two years in five Canadian cities – Vancouver, Winnipeg, Toronto, Montreal and Moncton. Half of the participants received housing and support while the other half used the usual services and treatments offered in their respective communities. At the study's completion sixty-two percent of the Housing First group maintained housing at all times compared with thirty-one of the participants who used standard community supports (Goering et al. 2014). The popularity of the Housing First model has led the federal and some provincial governments to reallocate funding to programs that support Housing First, to the detriment of drop-in centres and some homeless shelters (Pearson 2015a, b). There is also critical literature on Housing First, such as the modest success in housing individuals with serious and persistent substance abuse problems and the rapid adoption of the model without careful attention to model fidelity (Kertesz et al. 2009; Waegemakers Schiff & Rook 2012).

...it is demeaning and unfair to the majority of the homeless to focus so much public attention on the presumed relationship between mental illness, deinstitutionalization, and homelessness. To do so not only wrongfully identifies the major problems confronting the bulk of the homeless, it also deflects attention from the more pervasive structural causes of homelessness, such as unemployment, inadequate income for unskilled and semi-skilled workers, and the decline in the availability of low-cost housing (Snow et al. 1986: 422).

Almost twenty years later, Lyon-Callo echoes Snow et al.'s claims:

Additionally, with the medicalization of social problems, it becomes common sense to understand the coping strategies of homeless people as symptoms and evidence of mental illness. Through such a medicalized understanding, homeless people are understood as passive victims of biological disorders rather than situated agents (Lyon-Callo 2004: 53).

Questioning the assumptions that make up the discourses on homelessness and mental illness is vital to this project. While scholars have made some headway in this field, further research must be conducted on how the relationship between homelessness and mental illness is constructed, reinforced, and contested by homeless individuals who have experienced mental health intervention, a gap this project begins to fill. In the next section I explore another gap in the literature, specifically the conflation of mental illness and addiction in the homeless community.

Addiction and mental illness

Given that anywhere from fifty to seventy-five percent of the homeless population identify as struggling with substance abuse (Edens et al. 2011; Orwin, Scott & Arieira 2005), it is no wonder that addiction is often referenced in relation to mental distress in the homeless community. While mental illness and addiction are often talked about concurrently in the scientific and social work literature there is little scholarship that explores the connection between the two from a theoretical perspective. This gap in the literature is problematic given that many participants in this research project spoke about mental illness and addiction as one and the same. In order to better assess how mental illness is conceptualized and negotiated in the

homeless community we must tease out the history of addiction as a medicalized entity and its relationship with mental health.

The 'not-quite' medicalization of addiction

Unlike the psy-disciplines that found their footing in the medical model in the nineteenth century (Cockerham 2002; Everett 1994; Rogers & Pilgrim 2005) addiction was never medicalized in the same way. Instead, addiction has remained at the intersection of psy, clinical medicine, religious doctrine moral regulation, and the law (Valverde 1998). Conrad and Schneider (1992) refer to addiction as framed within a 'quasi-clinical' and 'contested' medical model and Valverde describes alcoholism as a 'mixed medical-moral' entity. Interestingly, the medicalization of addiction varies in different geographical locations. For example, in Britain addiction largely falls under the purview of the medical model. There, physicians are responsible for the care and treatment of addicts, which include supplying prescription opiates, such as heroin maintenance, as a form of harm reduction (McCusker & Davies 1996). This position stems from an historical focus on addiction as sickness; although Britain created the *Dangerous Drug Act* (1920) which criminalized the illegal possession of opiates, in 1926 the Rolleston Committee clarified that it was acceptable to maintain an addict on their drug if she could not function healthily without it. This decision cemented addiction in Britain as 'medical property' and largely out of the purview of the criminal justice system (Berridge & Griffith 1981). The 1980s saw the influence of the American model moving Britain towards a crime and punishment agenda to deal with the drug scare, this time concerning heroin, cocaine, and marijuana, but the criminalization of addiction did not take hold and addiction management remains primarily medical based and without the moral undertones found elsewhere (Berridge & Griffith 1981;

Conrad & Schneider 1992; Shiner 2003). Certainly in Europe, addiction has long been associated with mental illness more so than deviancy.

The history of the medicalization of addiction in the United States is a far more sordid tale. Beginning in the 1870s alcohol and drug consumption began to be constituted as a social problem. As in Canada, the problematization of opium smoking in particular came from an interest in the racialized oppression of Chinese immigrants who used opiates regularly (Comack 1985; Conrad & Schneider 1992; Morgan 1981; Mosher 1998; Musto 1999).²⁷ Canada's 1908 *Opium Act* and revised 1911 *Opium and Drug Act* (the first anti-narcotics legislation in Western nations) along with the US federal *Harrison Anti-Narcotic Act* (1914) were lobbied for by moral reformers and were predicated on anti-Chinese sentiment:

This hostility [to Chinese immigrants], although it was manifest prior to the concern about opium and had deeper roots, nevertheless made credible sinister stereotypes of Chinese depravity including opium use. The identification of opium smoking with the Chinese meant, in turn, that punitive legislation gratified the prevailing sinophobia. (Giffen, Endicott & Lambert 1991: 53)

The early nineteenth century saw a huge influx of Chinese immigrants to both the US and Canada largely to fill labour shortages in the mining and railroad industries. As these jobs waned there were labour disputes, specifically the preferential treatment given to Chinese workers because they were paid less at all skill levels than white workers. This, along with fears that young white girls were being lured into opium dens, which were considered places of crime and prostitution propelled the criminalization of opiate use in the US and Canada (Giffen, Endicott & Lambert 1991; Morgan 1981; Musto 1999).

²⁷ Musto (1999: 65) notes that other drugs were likewise racialized and associated with 'alien subgroups': Cocaine raised the specter of the wild Negro, opium the devious Chinese, morphine the tramps in the slums; it was fear that use of all these drugs was spreading into the 'higher classes'".

Like opium's association with the Chinese, cocaine was racialized as problematic among Black users in the United States in the early twentieth century. The subsequent criminalization of drugs was used as a means of maintaining white privilege through the racial oppression of Black Americans:²⁸

The fear of cocainized black coincided with the peak of lynchings, legal segregation, and voting laws all designed to remove political and social power from him. Fear of cocaine might have contributed to the dread that the black would rise above 'his place', as well as reflecting the extent to which cocaine may have released defiance and retribution (Musto 1973: 7).

The irony of associating cocaine with Black people is that, at least by the late nineteenth century, few Black Americans used drugs on account of poverty and a lack of access to medical care where drugs could be prescribed (Morgan 1981). Still, the myth that the Black community consumed cocaine and subsequently committed sexual assault and murder (Musto 1973) was politically salient enough to pursue criminalization, especially in the South where the racial tensions that spurred the American Civil War (1861-1865) remained high.

In the United States in particular, the representation of addiction as evil rather than sickness as depicted in England, led to widespread prosecution of those who used illicit substances. Whereas in Britain physicians and legislatures realized that most addicts became dependent on opium because of its over-prescription by doctors to cure any number of maladies (Berridge & Griffith 1981), politicians and lobbyists in the US used the temperance movement to further the prohibition of narcotics through criminal sanctions. Indeed, in 1928 one third of American prisoners were prosecuted on state or federal narcotics laws (Musto 1999). Similarly, Emily Murphy, Canada's first female magistrate, referred to addicts as dangerous and violent

²⁸ We must not forget Canada's contemporary oppression of Black men and women, in particular in the criminal justice system where Black people make up more than nine percent of those under the purview of federal corrections while they represent less than three percent of the Canadian population. They are also one of the fastest growing sub-populations in federal corrections (OCI 2013).

and supported the notion that narcotics held pharmacological properties that produced criminality. Convictions under the *Opium and Drug Act* soared from 342 in 1912 to 1,375 in 1915. In 1922 sixty percent of all prisoners convicted of narcotics offences were Chinese (Giffen, Endicott & Lambert 1991).

Beginning as early as the eighteenth century, some physicians were interested in exploring the physiological dimensions of addiction, contending that some individuals had a biological flaw that rendered them vulnerable to addiction. Here we find another example of the racialization of addiction, where researchers asserted that individuals of Chinese descent were ‘weak willed’ or had a ‘low moral constitution’ and were thus more susceptible to addiction (Conrad & Schneider 1992; Morgan 1981; Valverde 1998). Still the search for the ‘addict gene’ continues (Klee et al. 2012; Li & Burmeister 2009). While it is the paradox of addiction as a sickness but the addict as responsible²⁹ that frames Canada’s historical and contemporary response to illicit drug use as a hybrid between Britain’s regulative approach and The US’ punitive logic, in the United States the very nature of addiction was criminalized. Overcrowded prisons filled with detoxing individuals following the *Harrison Act* led bureaucrats to create two ‘narcotics farms’ in Lexington, Kentucky (1929) and Fort Worth, Texas (1938). Although presented as treatment facilities, the farms were used to incarcerate and punish addicts: “These farms had been exactly what the wardens envisioned in the mid-1920s – additional prison space for convicted addicts” (Musto 1999: 206). Although later turned into addiction hospitals in the 1960s the criminalization of addiction in the United States has remained the primary method of intervention for over one hundred years.

²⁹ I revisit this paradox as it relates to the mental illness identity in chapter seven.

In the 1950s addictions research was reoriented with the development of Alcoholics Anonymous (AA) and later Narcotics Anonymous (NA). AA is premised upon a disease model of addiction, in particular the allergy concept. Known as the Silkworth/Wilson model of alcoholism, the allergy model posits that some individuals are allergic to alcohol in the same way that people are allergic to peanuts or shellfish. The model proposes that the allergic reaction to alcohol is the loss of control over one's drinking habits.³⁰ As I explore below, although AA uses the disease model it challenges medical and psy experts' role in treating addiction and focuses on spirituality based treatments (Conrad & Schneider 1992; Valverde 1998). At the same time, the 1950s saw the American Medical Association declare alcoholism a disease (drug addiction was not declared a disease until 1987) (Roy & Miller 2010). Alcoholism was reported in the first edition of the *Diagnostic and Statistical Manuals* (DSM) and both alcoholism and substance use disorders were expanded and clarified in the third edition of the *DSM-III*, published in 1980.

Beginning in the 1960s addiction research took a notably psycho-social turn. As with other decentralizing movements at the time, including deinstitutionalization (Cohen 1985), critics of the disease model, such as Howard Becker (1997) and Jock Young (1971), called into question the social construction of deviance and the socio-cultural influences on how behaviours are framed (Campbell 2012; Conrad & Schneider 1992; Valverde 1998). Specifically:

They held that an understanding of both the drinker or drug user and the cultural definitions surrounding such use is essential to clarify the origins and nature of addiction. Repeated drug taking is not the automatic consequence of the drug's pharmacological properties but rather a complex process wherein the individual learns to use the drug under particular circumstances (Conrad & Schneider 1992: 95).

³⁰ Some people are allergic to alcohol in the traditional sense of the term. Alcohol flush reaction refers to immediate symptoms after ingesting alcohol, such as blotches or hives on the face, neck and back, and sometimes respiratory issues (Milingou et al. 2004). This kind of allergy to alcohol is quite distinct from AA's assertion that an inability to control one's inhibitions is as an allergic reaction.

The critical questions about what it means to consume certain substances and how they interact with the body changed the nature of addiction research. The Salvation Army published information on alcohol consumption that portrayed drinking as a means of coping with poverty, domestic violence, unemployment etc., suggesting "...that there is nothing pathological about drinking. Drinking heavily is simply an aspect of live in a fallen world" (Valverde 1998: 89). Indeed, a failed attempt to pass Part II of the *Narcotic Control Act* (1961) would have mandated compulsory treatment for criminal addicts in an attempt to marry the medicalized and punitive response to addiction (Giffen, Endicott & Lambert 1991). Positioning addiction discourses as culturally contingent expanded the research beyond a disease/deviant binary and has the potential to reshape drug policy. Unfortunately, the United States remains steadfast in their war on drugs (Wood et al. 2009) and the use of the criminal justice system as the primary mode of governing addiction.

The most recent transformation of the addiction framework is the resurgence of the disease model. Physicians have a renewed interest in managing addiction and recent legislation in the United States that expanded insurance coverage to include addiction treatment acts as a catalyst to further include doctors in the active care of addiction (Roy & Miller 2010, 2012). The American Board of Addiction Medicine created certifications in 2009 and accredited residency programs for doctors in 2011 (Smith 2011). Still, Roy and Miller (2010) argue that addiction is not regarded as a chronic illness and until it is, the medicalization of addiction remains incomplete. The continued use of the criminal justice system rather than the health care system as the primary institution to manage addiction reinforces the moral undertones of addiction discourse. Medical professionals play a very limited role in addiction treatment, which reinforces the constitution of addiction more as a moral disorder rather than a mental illness.

Treating addiction

While mental illness is primarily treated with psychopharmaceuticals, treating addiction has rested largely with non-medical experts such as counsellors and case managers. Much of the expertise regarding addiction treatment comes from AA where although they use the disease model of addiction, they reject medicalized forms of intervention and treatment, often including pharmaceuticals that are commonly used to treat mental illness (Roy & Miller 2012). For proponents of AA, the problem of addiction lies in the individual's ability to self-govern rather than a physiological response to substances; therefore, treating addiction must center on the soul:

Although organized around alcoholism as a disease, the gaze of AA is first and foremost an ethical one. It observes and judges, but what is being observed, judged, and transformed is one's own spiritual progress, not the body of medicine or the mind of psy sciences... The ultimate goal of AA is not the already ambitious one of helping people stop drinking; it is the even more ambitious one of helping people achieve inner peace... Sobriety is thus more than the absence of drinking: it is a difficult-to-define but nevertheless positively existing state (Valverde 2006: 303).

In keeping with the themes that will be explored in this project, the thrust of addiction treatment rests on self-help group therapy that responsabilizes individuals and emphasizes self-governance. Until recently medical intervention was restricted primarily to detoxification clinics (Conrad & Schneider 1992; Roy & Miller 2010). Scholars argue that the lack of interest by the medical establishment to treat addiction stems from the continued moral underpinnings of addiction discourses and the perpetuation of addiction as not quite a 'real' disease. Conrad and Schneider (1992: 98) argue that the medical community's failure to embrace addiction leaves its acknowledgement as a disease by the AMA and in the *DSM* to be "more symbolic than substantive". This trend, however, seems to be changing.

Methadone maintenance has acted as the mainstay of pharmacological intervention into addiction since the 1960s. Methadone maintenance treatment consists of individuals ingesting

(usually) a liquid dose of methadone under the supervision of a doctor, nurse, or pharmacist in order to offset withdrawal from opiates (Joseph, Stancliff & Langrod 2000). Methadone was once touted as the ‘technocratic magic bullet’ (Bourgois 2000) to cure addiction and the social deviance that comes with the criminalization of substance use because of its relatively long half-life.³¹ Unfortunately, methadone’s curative properties were not realized. Instead, methadone is found to be even more addictive than opiates and the effects of withdrawal are more severe. The medical researchers who discovered methadone as a treatment method for opiate addiction envisioned a treatment plan where patients would be weaned off methadone progressively over the course of approximately ten days (Conrad & Schneider 1992). Now, many individuals suffering with addiction remain on methadone maintenance for years (Bourgois 2000). The difference between methadone and heroin lies in the labels these drugs are given and the forms of regulation that follow, the former being characterized as a pharmaceutical while the latter is criminalized (Bourgois 2000; Conrad & Schneider 1992; Moore 2007). Critics of methadone maintenance describe it as ‘chemical parole’ (Conrad & Schneider 1992) because it requires individuals to visit the methadone clinic daily and report to a physician or counsellor there. Bourgois’ (2000) study of methadone clinics paints a devastating picture where people’s lives are controlled by methadone. It is difficult to maintain employment when clinic hours overlap with work hours; clinics are often located in run-down urban areas where those looking to become sober are made to return to street-life daily; and constant dosage changes wreak havoc on an individual’s body and state of mind. As Bourgois describes:

...it only takes a few minutes inside (or outside) a methadone clinic to realize that what the scientific biomedical treatment community refers to as ‘effective methadone dosage’

³¹ A drug’s half-life refers to the period of time that the amount of drug in the body is reduced by half. Methadone’s half-life is twenty-four to thirty-six hours in contrast to morphine’s half-life of two to three hours and heroin’s half-life of two to three minutes.

level has little to do with technocratic pharmacological logics and much more to do with naked power relations. Dosage is determined by a struggle over pleasure, pain, and compliant social control (Bourgois 2000: 182).

Although methadone maintenance treatment fails to live up to the hopes of the medical community it remains a fixture in treating addiction. While research on heroin maintenance programs yields promising results in terms of harm reduction and the individual's ability to participate meaningfully in their life and community, the continued representation of heroin as innately 'bad' or 'evil' in the United States restricts its use. In Canada, the North American Opiate Medication Initiative (NAOMI) introduced a pilot study on heroin assisted treatment in Montreal and Vancouver in 2006. Despite its controversy (Fischer et al. 2007; Kahan, Srivastava & Shen 2006) the project provided promising results with regards to treatment retention rates and the reduction in illicit drug use and other illegal activity (Oviedo-Joekes et al. 2009). In the same vein, the success of Vancouver's Insite, Canada's first supervised injection site, to remain open despite legal challenges (Small 2007, 2012) shows promise that Canada is moving towards a more harm-reduction based drug policy, although much political and social resistance remains (in the form of NIMBYism)³² with respect to expanding consumption sites to other major Canadian cities and the Conservative federal government continues to push its tough on crime agenda that denounces the benefits of harm reduction (Hathaway & Tousaw 2008; Moore & Donohue 2008).³³

Beyond methadone or heroin maintenance, there is an interest in finding pharmaceuticals to treat addiction beyond merely coping with withdrawal symptoms. For example, Naltrexone

³² NIMBY is short for 'not in my backyard' to refer to those who oppose a development (often those seeking to support vulnerable populations) because of its proximity to their home.

³³ We must be careful not to romanticize alternatives to the criminalization of drug use. While their intentions are benevolent, heroin maintenance programs and safe injection sites act as forms of responsabilization and social control within a public health model (Bourgois 2000; Fischer et al. 2004).

blocks the effects of opiates from activating neurological receptor sites and Disulfiram has been used for sixty years to produce extreme side effects such as nausea and severe vomiting, chest pain, and light-headedness when someone consumes alcohol to deter substance consumption (Anton et al. 2003; Suh et al. 2006). Most descriptions of these pharmacological treatments reiterate that it should be combined with talk therapy, in particular cognitive behavioural therapy. This stands in contrast to the standard approach to mental health treatment in the homeless community, which consists almost exclusively of pharmacological intervention.

The intersection of addiction and mental illness

The connection between addiction and mental health is unclear. Substance use disorder is listed in the *DSM-V* but given that addiction has never been fully medicalized, there is a tension in the literature in describing addiction as a mental illness. Despite the psy-sciences' success at medicalizing mental illness, addiction scholars shied away from associating addiction with mental illness and attempted to gain legitimacy through physical health. Indeed, in the development of addiction discourse, eighteenth century physicians attempted to distinguish addiction from the 'pure' mental illnesses by focusing on its physiological dimensions (Conrad & Schneider 1992). Proponents of AA continued with this theme, rejecting compulsive drinking as a mental health problem and instead characterizing it as a problem of will-power (Valverde 1998). Addiction is also differentiated from mental illness because it is regarded as something that an individual does to herself. Even among those who believe that addiction is biologically derived, the initial consumption of substances is regarded as a voluntary choice. The moral repudiation of addiction is centered on the notion that individuals bring addiction upon themselves (Conrad & Schneider 1992) unlike mental illness that is generally regarded as biologically determined.

Despite these differences, addiction and mental illness share common traits. For example, both are tangential to the traditional disease framework because they are assessed primarily through self-report and ‘abnormal’ social behaviour rather than physical observation or measurement (such as a blood test, body scan, etc.) (Kerwin 2012). In this way, mental illness and addiction are both regarded as somewhat suspect and less legitimate than other physical ailments. It is the incivility of addiction and mental illness – namely, the breaking of social mores – that binds the two in a unique way. While both issues are more or less medicalized, their relationship with normalization and self-regulation lead those who are identified as mentally ill or as addicts to be governed through a variety of institutions, including in the homeless sector and the criminal justice system.

Finally, Bourgois (2010) highlights that whether explained through the mental illness or addiction paradigm, distress is distress. Describing heroin addiction, Bourgois (2010: 239) writes: “Their suffering is eminently visible. They endure the chronic pain and anxiety of hunger, exposure, infectious disease, and social ostracism because of their inability to control their chronic consumption of heroin and other psychoactive drugs”. Bourgois’ description of homeless drug addicts can be translated to the experiences facing homeless men and women identified as mentally ill. The marginalization, loneliness, despair, and hopelessness facing those experiencing mental or emotional distress and the use of piecemeal and quasi-medical resources to manage them is found among those who identify as suffering with mental health problems, addictions, or both.

The divide between mental illness and addiction appears to be waning. A paradigm shift (Kuhn 1970) has taken place over the last two decades where studies on concurrent disorders or

dual diagnosis³⁴ have found overlapping causes of mental illness and addiction, be they biological or environmental explanations. In fact, much of the scientific literature suggests that substance use may ‘lead to’ or exacerbate psychiatric symptoms or that individuals use illicit substances to manage or cope with psychiatric symptoms (Crawford, Crome & Clancy 2003).

Given this paradigm shift, mental illness and addiction treatment has moved away from a ‘treatment first model’ where only once substance abuse was effectively treated would practitioners consider other mental health issues (or vice versa), to studies in ‘integrated treatment’ where the same program addresses mental health and addiction simultaneously (Crawford, Crome & Clancy 2003; Kuehn 2010). Despite the literature on concurrent disorders declaring the benefits of combined treatment, it is clear that the divide remains. Kuehn’s (2010) research revealed that only twelve percent of individuals dually diagnosed receive integrated care. At the same time, I argue that for those living in the homeless community, mental health and addiction are intimately linked. I suspect that the two are conflated because of the types of treatment that are typically offered in the homeless community. As I explore throughout the dissertation, because mental health treatment consists almost exclusively of psychotropic medication, those experiencing distress turn to the addiction group therapy for advice on coping strategies and support. This is not surprising given that many of the out-patient addiction treatment programs commonly speak about post-traumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), depression, and bi-polar disorder. Therefore, while not everyone identified as suffering from both mental illness and addiction receive concurrent disorder treatment they are regarded as part and parcel to one another among many front-line

³⁴ Some scholarship is critical of this term because it assumes that there are only two diagnoses involved – a single addiction and a single mental disorder (Crawford, Crome & Clancy 2003). As observed in other literature (Beswick et al. 2001) and among research participants in this project, individuals often use a variety of substances (although they may not be addicted to each substance they use) and are given a litany of diagnoses.

workers, counsellors and individuals in distress. Although the bodies of work on addiction and mental illness remain related but ultimately distinct areas of research and expertise, on the ground and among those on the margins they are framed as interconnected. This subject is virtually absent in the literature and requires a great deal more study to clearly articulate how individuals make sense of mental illness and addiction discourses in day to day interactions, specifically when options are limited on account of an inability to access privately funded treatment. This research serves as a platform to begin this conversation.

In the next section I consider how the vulnerability of being homeless and in distress is criminalized as a means of social control.

Criminalizing the vulnerable

In this section I examine how mental illness, homelessness and criminalization are connected and create a complex web or net (Cohen 1985) through which to surveil and manage those individuals deemed unable or unwilling to maintain social norms. Moreover, using the literature on transcarceration, in particular the concepts of the punitive city (Cohen 1979) and the shadow carceral state (Beckett & Murakawa 2012) I suggest that we can think about the criminalization process beyond the prison walls.

Criminalizing mental illness

Part of the critical research on homelessness, mental illness and addiction is the implicit connection to the criminal justice system. As part of the broader decentralization movement that included decarceration and delegalization (Cohen 1985; Lowman, Menzies & Palys 1987) the deinstitutionalization of mental hospitals between the 1960s and 1990s called for treatment to take place in the community. Community alternatives were considered more humane and cost-effective than the hospital (Davis 2006; Maidment 2006; Stroman 2003). However, community

alternatives were not adequately implemented and this lack of care led to the disproportionate representation of individuals diagnosed with a mental illness in the prison system (Etter, Birzer & Fields 2008; Lamb & Weinberger 2005; Steadman & Morrisey 1987). The connection between mental illness and the criminal justice system is not new. In 1939 Penrose equated the relationship between the mental health and criminal justice systems with the ‘balloon effect’ – that is, when you push one part of the balloon in, the other part will bulge out (Lamb et al. 2004; Torrey et al. 1992). The criminal justice system is coined as the institution of last resort or the dumping ground for those in distress. In fact, mental illness is criminalized in such a way that people who have not committed a crime (Torrey et al. 1992)³⁵ or who commit minor infractions (such as trespassing, traffic violations, disorderly conduct, etc.) end up in the system (Arrigo 2002; Etter, Birzer & Fields 2008). As Zinger (2012: 25) explains: “...addressing the criminalization and warehousing in penitentiaries of those who suffer from mental illness is not simply a public health issue, it’s a human rights issue”. Estimates are that between twelve and thirty percent of Canadian federal prisoners meet the criteria for a mental illness (Brink, Doherty & Boer 2001; Fazel & Danesh 2002; Martin et al. 2012), although we must think critically about how mental illness is defined and assessed within such an oppressive and harmful institution.

Poor treatment of mental health in Canadian jails and prisons has received considerable attention over the last few years, particularly in the wake of Ashley Smith’s tragic death at the hands of the Correctional Services of Canada (Kilty 2014; Sapers 2008). In fact, the dearth of mental health supports in jails and prisons is widely acknowledged (Bewley & Morgan 2011; Ruddell 2006). In particular, feminist criminologists spoke of the lack of meaningful care in jails

³⁵ Torrey et al. (1992) uses the example of individuals in distress spending the night in a jail cell when psychiatric hospital beds are full or police cannot/will not wait in an emergency room, a practice that continues today (Steadman et al. 2000). To respond to this issue, some police and mental health professionals have collaborated to form crisis intervention teams (Compton et al. 2008; Teller et al. 2006).

and prisons (Kendall 2000; Kilty 2008, 2012a; Maidment 2006; Pollack 2005, 2006, 2009) and the transformation of mental health needs into risks (Hannah-Moffat 2005; Kilty 2006). Moore and Hannah-Moffat (2005) point to the punitiveness of therapeutic initiatives in prison and Carlen and Tombs (2006) refer to the symbiotic relationship between therapy and prison as a ‘therapeutic rhetoric’ that presents the prison as a place for correcting the causes of crimes and facilitating rehabilitation, while downplaying the prison as an essentially coercive and exclusionary carceral space.

Critiques of the number of individuals identified as mentally ill in the criminal justice system and the lack of care for those in distress has led both provincial and the federal government to create mental health strategies that seek to provide more screening, staff training, suicide and self-injury prevention and assessment, as well as developing community supports for a continuum of care (FPT 2011). Ontario Corrections, for example, promised to overhaul its mental health system, including looking into creating a secure treatment centre for women, following a Human Rights Tribunal settlement between the Ministry of Community Safety and Correctional Services and Christina Jahn. Jahn spent 210 days in solitary confinement at the Ottawa Carleton Detention Centre (OCDC) because of her erratic behaviour, subsequently missing surgery and chemotherapy for her advanced breast cancer (Gurney 2013). While promises are being made at the federal and provincial levels to improve mental health care in jails and prisons, to date there is little improvement (Dempsey 2015; Service 2010; Zinger 2012). It is also problematic that many individuals only receive mental health care once they enter the criminal justice system.

What is striking in the widespread literature on the criminalization of the mentally ill is the symbiotic relationship between the criminal justice and mental health systems. For example,

Etter, Birzer and Field (2008) suggest that the increased rights against coercive treatment awarded to the mad community is responsible for the rise in the number of individuals labelled mentally ill in prison. Others suggest that an even stronger working relationship between the two systems will benefit individuals diagnosed with a mental illness, for example, encouraging a close relationship between those administering treatment in the community and criminal justice personnel (Lamb et al. 2004; Lamb & Weinberger 2005; Lurigio 2000, 2001). There is little research that explores how issues of governance related to organizations responsible for the criminalized, the homeless, and the mentally ill impact self-identity – a gap this research will begin to fill.

Criminalizing homelessness

Homelessness reinforces the relationship between mental illness and the criminal justice system. Research demonstrates that individuals who have experienced homelessness and who are diagnosed with a mental illness are between seven and eleven times more likely to be incarcerated than housed individuals (Greenberg & Rosenhack 2008; McNeil et al. 2005). Just as shelters are used as a stopgap to the homelessness crisis, the criminal justice system is another facet of this emergency response (Gaetz 2010). Scholars identify some of the ways that the homeless are criminalized, including: enacting laws to restrict homeless people's movements; discriminatory enforcement of existing laws; manipulating the environment to restrict homeless people's movements³⁶; increased surveillance by police; increased incarceration; and discharging people from jail, prison or hospital into homelessness (O'Grady, Gaetz & Buccieri 2011).

³⁶ Last year an apartment complex and several department stores in England installed 'anti-homeless' spikes to deter homeless people from sitting or sleeping on the ledge (Andreou 2015). The same tactic was used outside a music store in Montreal (Carpenter 2014). In each situation there was widespread backlash on social media and the mayors of the cities condemned the strategy as inhumane (Logan 2014). Calgary's more covert spikes or 'pyramids' received less media attention (Logan 2014).

Numerous research studies show that individuals living in poverty do not commit more crime than wealthy people, but are unfairly targeted by law enforcement. As Allen (2000: 127) contends: “As the system criminalizes those in poverty, it fails to criminalize the activities of governments and business that permit such suffering”. Homeless men and women are much more likely to be fined for ‘disturbing’ or ‘nuisance’ behaviour such as public intoxication, loitering, spitting, or urinating in public (Allen 2000; Bernier et al. 2011; O’Grady, Gaetz & Buccieri 2011; Mosher 2002; Snow, Baker & Anderson 1989; Sylvestre 2010b). A 1998 study of homeless adults in Toronto found that seventy-three percent of the sample had at least one arrest; half of the men and twelve percent of women in the sample had spent time in jail, but almost all of these sentences were less than six months (Novac et al. 2009), suggesting that homeless individuals are incarcerated for minor offences. Additionally, research shows that homeless black and Aboriginal youth are subject to greater surveillance and ticketing for minor offences such as loitering than are white youth (O’Grady, Gaetz & Buccieri 2011).

Homeless men and women are targeted by the criminal justice system with specific ‘anti-homelessness’ legislation. For example, the *Safe Streets Act* (1999) was passed in Ontario as a response to public complaints regarding aggressive panhandling and ‘squeegee kids’ (Hermer & Mosher 2002). From 2000 to 2010 the number of tickets issued for panhandling or ‘soliciting a captive audience’ (in effect being in a public space such as a bus terminal) in Toronto increased 2,147 percent, despite a moderate decrease in the number of individuals who panhandled and squeegeed. In Toronto in 2010 alone, 15,324 tickets were issued (O’Grady, Gaetz & Buccieri 2011). In Montreal, a neighbourhood police system sought to crack down on incivilities such as panhandling, squeegeeing, and sleeping in public. Between 1995 and 2004 there was a 500 percent increase in statements of offences to homeless people in Montreal (Bernier et al. 2011;

Sylvestre 2010a). There is a sad irony in issuing fines to individuals who are panhandling in order to meet their basic needs and unsurprisingly, it is common for homeless individuals to spend time in jail for a failure to pay the fines.

The zealous use of law enforcement and the criminal justice system in the homeless community is a result of housed individuals feeling uncomfortable with the mere presence of homeless individuals. Sylvestre's (2010a, 2010b) study of policing amongst Montreal's homeless found that this trend is in keeping with the broken-window theory (Wilson & Kelling 1982) that visual disorder spurs deviant behaviour, despite substantial evidence to the contrary (Harcourt 2001; Hinkle & Weisburd 2008). Protecting public and semi-public space is prioritized over the well-being of marginalized people and the criminal justice system is used as a tool to manage those who are undesirable (Paradis 2014; Metraux & Culhane 2006). Police are expected to take action to eliminate disorder and incivility. As Sylvestre contends:

The police use the criminal law to control the homeless with which they have to deal on a daily basis, perhaps due to a lack of a better alternative. It ultimately boils down to a question of administering a recurring problem. It may well be that it is not homelessness that bothers them, but rather the fact that some situations remain unresolved (Sylvestre 2010b: 452).

Homeless individuals are regarded as always already risky and are thus taken up by the criminal justice system at an alarming rate.

Not only are homeless individuals more likely to be ticketed and arrested for minor infractions, but they are significantly more likely to be detained because they cannot make bail. The number of individuals under remand has increased dramatically in Canada since the 1990s (Deshman & Myers 2014; Gaetz & O'Grady 2009). Homeless individuals and those identified as mentally ill are more likely to end up in remand because they are denied bail, cannot afford it, or do not make their court appearance (Baldry, Dowse & Clarence 2012; Bernier et al. 2011; Novac

et al. 2009). They are also more likely to plead guilty to an offence than those with a fixed address (Novac et al. 2009). In Deshman and Myers (2014) aptly titled report, homeless men and women who encounter the criminal justice system are ‘set up to fail’.

Emergency shelters are inherently linked with the criminalization of homelessness. In some cases shelters act as temporary spaces between periods of incarceration: “The shelter then, contains those on their way back in or out of the community” (Allen 2000: 62). One Toronto study showed that in one year more than 800 shelter admissions came from individuals discharged from jail or prison. Moreover, those who enter the shelter system from a correctional facility tend to be homeless longer than other shelter residents (Novac et al. 2009; see also Metraux & Culhane 2006). Both the homeless sheltering industry (Lyon-Callo 2004) and the criminal justice system act as a ‘dumping ground’ (Allen 2000) for society’s underclass (Rose 1999; Young 1999). In this project I complicate the normative understandings of punishment and carceral control by considering how ‘free’ and open spaces such as the homeless community exist within a model of social control that governs at a distance.

Transcarceration

“We may say that the prisons are ghettos with walls, while ghettos are prisons without walls” (Bauman 2001: 121).

The frequency with which individuals move between the criminal justice system, mental health system and the homeless community is well documented (Arrigo 2001; Greenberg & Rosenhack 2008; Metraux & Culhane 2004, 2006; Novac et al. 2009; Steadman & Morrissey 1987; Thifault et al. 2012). Moreover, research shows that many homeless individuals spent time in Children’s Aid Services during their youth (ATEH 2015; Paradis 2014; Snow & Anderson 1993). This phenomenon can be understood through the transcarceration framework.

Transcarceration refers to the ways individuals are managed through a system of “cross-institutional arrangements” (Lowman, Menzies & Palys 1987: 9) in order to control those who cannot or will not self-govern (Bauman 1988; Rose 1999). Although emergency shelters are not intimately tied with the criminal justice system in the same way as diversion programs (Myers & Goddard 2013) or halfway houses (Kilty & DeVellis 2010) they are a crucial element in the social control of those at risk of entering the criminal justice system and act as a holding place for individuals who cycle in and out of the correctional system. Using the transcarceration framework to consider the relationship between the mental health system, criminal justice system and homelessness industry (Lyon-Callo 2004) allows us to highlight the polysemy of governing apparatuses that are situated within the ‘public’, rather than considering only those tactics used in closed institutions. Transcarceration demonstrates the ‘net-widening’ (Cohen 1985) effect of various methods of social control.

The neo-liberal emphasis on self-governance supports the notion of looking for sites of control beyond the prison or asylum walls. Rose (1998) suggests that the proliferation of psy-discourses beyond the mental hospital and into the home, the school and the boardroom, for example, renders intelligible a whole host of sites that act upon and govern us through our freedom.³⁷ Technologies of control are no longer limited to physically coercive spaces but can instead be implemented in a whole host of what Rose (1999: 31) terms ‘governable zones’. For example, after school programs for at-risk youth target particular young people (often racialized young men living in low-income neighbourhoods (Shann 2001)) and transform the homework club or basketball practice into a setting that encourages appropriate social behaviour, the

³⁷ I explore the concept of governing through freedom and empowerment in great detail in theoretical framework chapter.

development of pro-social peers, and maximizes school performance. All of these markers of program success are based on psy-discourses that focus on the individualization of deviance. The use of psy-rhetoric to legitimize technologies of governance is so deeply entrenched that one study referred to the frequency that after school activities are delivered as ‘program dosage’ (Durlack, Weissberg & Pachan 2010). In this way, almost any site can be imbued with governing schemes in order to ‘govern through community’ (Rose 1999: 176).

The role of the community in acting as a site of governance was reinforced through the deinstitutionalization of mental hospitals (Bastien & Perreault 2012; Sealy & Whitehead 2004). The community became the new site for governance so that, “the inhumanity of the asylum has simply been replaced by the negligence of the community” (Rogers & Pilgrim 2005: 198; see, Lowman, Menzies & Palys 1987). Instead, the community becomes responsible for increased disciplinary governance, described by Cohen (1979) as ‘community control’. Beckett and Murakawa’s (2012) notion of the ‘shadow carceral state’ allows us to think through the homeless community as existing along a continuum of punitiveness in conjunction with the mental health and criminal justice systems. They define the shadow carceral state as follows:

We use the phrases ‘shadow carceral state’ and ‘shadow penal state’ interchangeably to mean government policies, legal doctrine, and institutions with the power to impose sanctions that either mimic the coercive practices widely considered to be of punishment (e.g. incarceration, whether under the moniker of administrative detention or immigrant detention) or impose significant hardship and carry with them social and political opprobrium (Beckett and Murakawa 2012: 239).

This ‘submerged’ form of punishment opens up multiple sites for analysis and not simply those officially deemed carceral by the state (Shantz, Kilty & Frigon 2009). Wacquant (2009) refers to the discreet surveillance and management of the poor as ‘social panopticism’ where sites such as the unemployment office, social services, and indeed homeless shelters are conceptualized as

captured within the expansion of the penal system. Whether called ‘seeping saturation’ (Kilty & DeVellis 2010), ‘the punitive city’ (Cohen 1979), or the ‘carceral archipelago’ (Foucault 1977), the social control of those deemed dangerous or risky (Castel 1991) is not limited to the prison and mental hospital.

One of the goals of this project is to shed light on the complex connection that the homeless community and the shelter system in particular shares with disciplinary systems. In this way, I expand on DeVerteuil’s (2006) notion that shelters and homeless services are a form of poverty management that seek to hide the homeless from the broader social body. He contends:

By the early 1990s, an institutionally based backlash emerged—a new poverty management. Simply put, the increasing presence of homeless individuals in prime urban areas generated calls to physically remove them, part of an effort to reduce homeless visibility through entrenched community opposition, anti-vagrancy laws, and, critically, re-institutionalization and circulation. Within this conceptual framework, I can therefore speculate that shelters are embedded within a larger institutional context that encourages the expedient removal and institutionalization of visibly homeless people from prime urban locations. Shelters are contradictory and nuanced institutions that contain/conceal/manage the homeless while also providing basic subsistence needs and hopefully some prevention (DeVerteuil 2006: 119).

DeVerteuil’s analysis of the homeless community as a site of conflicting ideologies and complex social and personal arrangements is useful to this project. However, I disagree with his contention that because the homeless sheltering industry is made up of piecemeal and uncoordinated programs and resources from state funded, charitable, and for-profit organizations and because the focus is on managerialism, that it “...avoids outright punitive responses...” (DeVerteuil 2006: 119). Through the transcarceration framework I orient non-carceral settings as containing potentially punitive elements in conjunction with useful and helpful resources.

Conclusion

In this chapter I explored a number of topics relevant to this research. First, I delved into the abundance of literature on homelessness, profiling its proliferation in Canada and Ottawa specifically as well as providing a short history on how homelessness emerged as a socio-political problem beginning in the 1980s and reaching epidemic proportions to this day. I described the vast literature that individualizes homelessness as a problem to be confronted through personal change rather than broader systematic reformulations. The shelterization literature epitomizes the individualization of homelessness by describing a sub-culture that breeds laziness and dependency. This literature fails to consider the lack of employment and housing options available to those living on the margins and the systemic oppression and racism facing many of those without a home. In the last two decades more critical accounts of homelessness have emerged that question the long-standing assumptions about the causes of homelessness and the need to ‘fix’ those who require assistance. In this project I build upon this literature to consider how mental health managerialism in the homeless community works to individualize and reinforce the exclusion felt by many homeless men and women.

This chapter also assesses different ways of knowing mental illness, from its emergence within the medical model and the creation of psy-experts to the resistance offered by the mad movement. This project is inspired by the mad movement and seeks to fill a void in the critical mental health scholarship by assessing how resistance to the medical model plays out in the homeless community. I argue that given their marginalization and vulnerability the principles of the mad movement are much more difficult to apply in the homeless community and indeed, as I describe throughout this project, in many instances participants embrace rather than reject the mental health system.

Equally contentious in the literature is the medicalization of addiction and its connection to mental illness. The history of addiction discourses has a different trajectory than mental health. Addiction is not medicalized to the same extent as mental illness, especially in the US, because of its conceptualization as morally reprehensible voluntary behaviour. Although Britain adopted a medical framework for addiction, Canadian drug policy is a hybrid between the punitive and medicalized responses. Despite their distinction in the literature, mental illness and addiction are both forms of significant distress and are often conflated by those experiencing said distress and among counsellors and case managers. Likewise, both are frequently subject to intervention from the criminal justice system.

The criminalization of mental illness and homelessness occurs in the name of public safety and protecting private and semi-private spaces. Materially, criminalization further marginalizes already vulnerable populations by positioning them as both risky and at risk (Castel 1991; Hannah-Moffat 2005). In this project I use transcarceration to think through how the homeless community exists as part of a 'shadow carceral state' (Beckett & Murakawa 2012) and 'punitive city' (Cohen 1979) that further excludes and manages the underclass (Rose 1999; Young 1999), particularly those in mental or emotional distress.

These various bodies of literature act as a foundation for this research project, providing a platform to think critically about homelessness and mental illness. At the same time, I have noted several gaps that I intend to fill, in particular a critical assessment of homelessness, bringing the principles of the mad movement into homelessness research, addressing the conflation of mental illness and addiction, and analyzing the homeless sheltering industry as existing within the broader prison industrial complex.

Chapter 3 - Theoretical Framework: Managing the Excluded Identity Through Technologies of the Self

Introduction

Studying mental health managerialism among homeless men and women from a critical criminological framework requires engaging with multiple theoretical concepts to flesh out the convergence of a variety of institutions, discourses, interventions, and personal interactions that come to affect and make up the homeless and mentally ill subjects. In this chapter, I borrow largely from Rose's (1996, 1998, 1999) conceptualization of governing through freedom to think through what mental health managerialism looks like in the homeless community. I then assess how identity theory allows us to consider how the micro-politics of the self reinforce or resist normalization discourses that are pivotal to social control. When combined with the study of exclusion, this theoretical toolkit allows me to uncover how minute, seemingly innocuous practices, discourses, and inter-personal relations can be understood as part of a broader governance regime that pathologizes, criminalizes, and excludes particular segments of the population.

I begin this chapter with an analysis of how marginalized people are managed through governing paradigms, namely welfarism and neo-liberalism. I proceed to assess freedom as a governing scheme, especially as it relates to empowerment and self-help. The obligations that come with this freedom are paramount to its efficiency and credibility. I will consider how disciplinary strategies co-exist with tactics of freedom to manage those who cannot or will not manage themselves. In the next section, I turn to the literature on identity to make sense of governance at the interactional level. I work through the sometimes incongruent literature on

reflexivity, autonomy, and selfhood. This analysis provides the key concepts through which to understand performativity in a late modern world. The final section of this chapter uses the literature on exclusion to consider how men and women who are homeless and often designated mentally ill are qualified as lesser people, or ‘anti-citizens’ (Rose 1999). I explore the ways individuals interact with and perform their excluded status. I argue that the current literature does not clearly articulate the varied degrees of exclusion that homeless/those deemed mentally ill experience. Spitzer’s (1975) social junk and social dynamite provide the foundation through which to re-interpret inclusionary practices amongst some of the most marginal people in Canadian society. Finally, I highlight how resistance permeates all of these governing trends, recognizing and privileging the lived experiences of those who are thought to lack freedom, autonomy, and who are otherwise excluded.

Governing Through Freedom

Whereas hardness of heart on the part of the rich stirs the unfortunate to revolt, generosity shown towards them is the political basis for their subjugation.
(Castel 1988: 111).

Governmentality

In this project I seek to uncover how mental health practices are used as tools of governance. In order to do so, I must first consider governing trends in the twenty-first century, particularly the use of freedom, empowerment, and norms. These and other technologies can be understood through governmentality. The oft cited definition of governmentality is the ‘conduct of conduct’ (Foucault 1991), which refers to a system of thought about how government is practiced – that is, who can govern, what governing looks like, and who or what is being governed (Gordon 1991). Governmentality is concerned with the different ways actors and techniques problematize our lives by addressing our conduct and how this impacts our understanding of the self (Dean 1996). Studies of government do not study specific institutions

or structures, but rather consider regimes of truth (Garland 1990; Rose 1999) that make up the discourses, strategies, programs, or tactics used to shape the way we act upon ourselves (Burchell 1993; Rose 1999). Foucault (1991: 87) and his successors study the heterogeneous ways we come to act upon ourselves (Rose 1998) and others (Garland 2001) to produce a ‘ritualization of conduct’ through acceptable norms and lifestyles. The term ‘lifestyle’ is used in critical scholarship to refer to cultural preferences, habits and sometimes subcultures (McQuail 2002). Lifestyles “...are also sensibilities which become imbued with ethical, moral and aesthetic significance” (Taylor 2002: 481). Importantly, lifestyle is closely tied to consumer practices and choices (Taylor 2002).

The art of government (Foucault 1991; Nettleton 1997) translates approved values into a set of desires, judgements, and ways of being across a range of spaces, populations, and experts. It is this translation, rather than a direct imposition of norms, that constitutes government ‘at a distance’ (Miller & Rose 2008; Rose 1996). Foucault articulates what it means to govern populations and individuals:

One governs things. But what does this mean? I do not think this is a matter of opposing things to men [sic], but rather of showing that what government has to do with is not territory but rather a sort of complex composed of men and things. The things with which in this sense government is to be concerned are in fact men, but men in their relations, their links, their imbrication with those other things which are wealth, resources, means of subsistence, the territory with its specific qualities, climate, irrigation, fertility, etc.; men in their relations to that other kind of things, customs, habits, ways of acting and thinking, etc.; lastly, men in their relation to that other kind of things, accidents and misfortunes such as famine, epidemics, death, etc. (Foucault 1991: 93)

As Foucault describes, technologies of government consider how people engage with those around them so as to shape how they govern themselves, the family, the community, and the state. The objective of this type of governing is to persuade individuals to adopt socially

acceptable norms so that they will police themselves and others in order to ensure their civility,³⁸ happiness, economic and physical security, and physical and mental health (Nettleton 1997).

Governmentality studies focus on relations of power, because as Foucault (1980a: 98) notes: "...individuals are the vehicles of power, not its point of application". Power can be exercised over others by public actors in the traditional sense (Burchell 1993) but governmentality scholars are also keenly aware of the role individual subjects play in developing and maintaining power relations (Cruikshank 1999; Nettleton 1997) whereby individuals embrace a variety of technologies that shape their morals, behaviours, and interactions with others. The notion of the 'active citizen' (Rose 1998) and the subject's complicity in and embrace of governing techniques are integral to understanding mental health managerialism in the homeless community. As I will demonstrate in this project, mental health in the homeless community is rarely administrated through coercive measures such as CTOs or involuntary hospitalization; rather, it is predominantly accessed through self-governing mechanisms.

Ideologies of government

Different ideologies of government shift the emphasis on how individuals are subjectified. The welfare state is a political rationality in which there is a redistribution of wealth towards those who are socially disadvantaged with the state acting as a 'safety net' (Rice, Goodin & Parpo 2006). As some aspects of life come to be defined as social problems warranting government intervention (Garland 2001) the state expands its role and minimizes private enterprise (Lipsky & Smith 1989). Following the nineteenth century's use of confinement

³⁸ Civility in this context means to conduct oneself in a manner that avoids embarrassment and condemnation from others. Civility has developed into cultural rituals concerned with etiquette, decorum, politeness and comportment to dictate how to interact with others in an appropriate fashion and to therefore be accepted by others (Ranasinghe 2011). Prudentialism is associated with civility; both demand asserting dominant social values (Kemshall 2002) but prudentialism adds concern for our future civility and the need to mitigate our risks so as to maintain our status as good citizens (Rose 1999).

(Castel 1988; Foucault 1977; Rothman 2002) and the early twentieth century's focus on degeneracy and eugenics (Bastien & Perreault 2012; Rose 2007), Young (1999) frames the welfare practices of the mid-twentieth century as representative of an inclusive society. For most Western nations, the post-World War II era was a time of optimism and economic affluence that allowed for an inclusive political rhetoric and facilitated increased public spending at various levels of state intervention (such as schools, hospitals, child care, and economic security) (Garland 2001). Because the welfare state and penal welfarism employed the principles of a fuller version of social citizenship, deviancy and poverty were understood as being forced upon and internalized by marginalized populations (Cloward & Ohlin 1960; Sutherland & Cressey 1966). Poverty in particular was defined as a 'social inefficiency' because those without money could not participate in the consumption (Bauman 1988) vital to capitalist interpretations of civility. The state and its experts acted as agents of care, treatment and control with the aim of civilizing those who had adopted anti-social values.

The project of civilizing the population did not eliminate the individualization and pathologization of deviancy, nor did it succeed in discarding modes of classification (such as the mentally ill person, the delinquent youth, or the dangerous offender) that would allow for increased inclusion. In fact, Cohen (1985: 127) disagrees with Young's (1999) assertion that the welfare state made an inclusive society, arguing that there was a continued emphasis on correcting individual defect during this era. The practices of diagnosing and attempting to cure weakness amounted to the 'control of communities' rather than community control. Rose (1988; 2000) takes an even firmer position, suggesting that because the welfare state rejects pluralism and invokes a singular, standardized, and middle class notion of normality, those who are governed by the state fall into an exclusion/dependence trap. Either the person living in poverty

is a rational, calculable actor who strategically chooses to live on social assistance rather than work (Herd, Mitchell, & Lightman 2005; Katz 2013), or she³⁹ is a victim of dependence and is incapable of being a productive citizen. This dichotomy between the manipulative abuser of charity and the helpless victim plays out in conceptualizing the homeless individual.

The rise of neo-liberalism⁴⁰ was a response to the welfare state's reliance on state actors, experts, and institutions to intervene in any number of problems in living (Szasz 1989). As the lack of political accountability for experts (particularly psy experts) was challenged and Martinson's (1974) supposed claim that 'nothing works' resonated with an overall pessimism in the penal system, neo-liberal ideologies became increasingly appealing to those in positions of power and the public alike. Neo-liberalism creates a distance between government intervention and social actors (Miller & Rose 2008). Governance under a neo-liberal framework means to shape how non-political entities engage with targeted populations and deliver services in lieu of that done through direct state involvement. The role of government is balanced with the autonomization (Burchell 1993) of the individual. Because neo-liberal schematics tend to work outside of formal control mechanisms where possible (Miller & Rose 2008), the art of neo-liberal governing is made up of heterogeneous and fragmented groups, institutions, and practices that target different populations in an effort to create and maintain 'civil society' (Rose 1999).

The ideals of the welfare state have not disappeared as a result of the ascendancy of neo-liberalism, and despite the dramatic shift in policy and rhetoric certain deposits of power (Cohen

³⁹ In this dissertation, I typically use the pronoun 'she' to disrupt the common masculinization of gender neutrality that uses 'he'.

⁴⁰ I use the term neo-liberalism because it is most widely used in academic scholarship and is efficient to get at the myriad of destructuring movements that took place in the 1970s and 1980s (Cohen 1985) as well as the focus on fiscal responsibility, assessment, and efficiency (Feeley & Simon 1992, Garland 1997). I recognize, however, that neo-liberalism is traditionally associated with the purely economic rationale of minimal government intervention in the marketplace and that other words are used to describe the wider social phenomenon, such as advanced liberalism (Miller & Rose 1994; Rose 1996) and high modernity (Giddens 1991).

1985) remain embedded in governing practices. For example, the literature on penal welfarism demonstrates the continued role of correctionalism in the criminal justice system, especially in Canada where therapeutic jurisprudence and programming remain (Carlen & Tombs 2006; Meyer & O'Malley 2005; Moore & Hannah-Moffat 2005) although many argue they are now used as tools of risk management (Hannah-Moffat 2005; O'Malley 2009). The ideal of building up the capacities of individuals in the welfare state are likewise found in the neo-liberal era. The distinction lies in the neo-liberal view of the state's limited role to achieve these ends. Moreover, the connection between individual successes acting as catalysts to social change and increased social equality is less obvious in a neo-liberal framework (Rose 1999). Similarly, expert discourses remain powerful after the demise of the welfare state but most (privileged) individuals seek out the expert advice they desire rather than the state providing the expertise they deem suitable (Miller & Rose 2008).

Because the state distances itself from formal governing where possible (Rose 1996) greater autonomy and responsibility is downloaded to individuals. Individuals, families, and communities are expected to actively participate in an appropriate lifestyle (Petersen et al. 2010), manage any number of risks related to employment, finances, or health, to name a few (O'Malley 1996), and take on issues that were once thought to be the sole responsibility of the state, such as crime prevention (O'Malley 1992) policing (Johnston & Shearing 2003) and corrections (Garland 2001; Phelps 2013). From an ideological standpoint, the state's role fundamentally transforms as we shift from a welfarist to a neo-liberal regime: "The powers of the state thus had to be directed to empowering the entrepreneurial subject of choice in their quest for self-realization" (Rose 1999: 142). The individualization of social problems is a key pillar and critique of neo-liberalism. As Rose (2000) argues, solidarity and universalism are no

longer valued as these qualities are thought to be a waste of individual resources and create dependency. The irony of the neo-liberal logic is privileging the capitalist free-market, entrepreneurial spirit, and achieving social cohesion through individualized projects of the self, while at the same time encouraging, and indeed depending upon, non-state actors such as charities, not-for-profit organizations, and private enterprises to take on the needs of those who “refused the project of individual freedom” (Rose 1999: 135), seemingly out of a broader sense of morality and unity. The facet of the neo-liberal agenda most relevant to this study is the reorganization of social systems to reflect an increased focus on the individual and the freedom and responsibility we have to be productive, healthy, and safe.

Governing ourselves: Technologies of the self

In order to achieve these desired goals in a neo-liberal era, Rose (1998, 1999) contends that individuals and populations are governed through their own capacity to regulate their bodies and souls. In essence, we are governed through our autonomous decision making. Autonomy is likened to an ability to govern oneself without external constraint, domination or coercion (Burchell 1991; Reindal 1999). Rose (1999: 84) equates autonomy with freedom: “Freedom is seen as autonomy, the capacity to realize one’s desires in one’s secular life, to fulfil one’s potential through one’s own endeavours, to determine the course of one’s own existence through acts of choice”. This definition of freedom is counterintuitive to the lay notion of freedom as a complete lack of restrictions or restraint. Instead, the notion of freedom is transformed to mean the capacity for self-control (Valverde 1998) and realizing one’s desires through self-regulation.

The revised definition of freedom in the neo-liberal era transforms but does not eliminate power dynamics. Here we are referring to positive freedom (Berlin 1969) whereby freedom is

regarded as the presence of control and self-mastery.⁴¹ A Foucaultian analysis situates power beyond violence or coercion, but more pervasively in its ability to encourage people to choose to act in prescribed ways. Power is an “...endless and open strategic game” (Gordon 1991: 5). The concept of freedom is laden with power dynamics that we exercise both upon ourselves and on others. Rose (1999) is clear that the awareness that we are governed through our freedom does not mean that freedom is an insidious governing strategy. We need to consider how we have come to define and use our freedom to govern. This does not mean that freedom is not ‘real’ but that the notion of freedom is historically, culturally and socially constituted and is given meaning through the techniques and practices we attach to it. In the neo-liberal era, this means using freedom to master oneself.

The freedom to self-govern means that one must develop technologies of the self in order to assess, work on, and control oneself. Freedom does not simply remove constraints in a passive sense; it requires us to act (Dumm 1996). While we expect an individual to utilize appropriate tools and strategies (for example seeking counselling or taking medication for problems in living) in the end it is the individual’s free will and ability to manage desire that shapes her life (Valverde 1998). Just because we have the freedom to govern ourselves does not mean that we do so *well* (Cruikshank 1999). Individuals must develop a relationship with the self in order to gain authority over their desires, impulses, behaviours, and cognitive patterns. Technologies of the self build that relationship and allow the individual to engage with, care for, and master her ontological self (Rose 1998). Neo-liberal citizens are also expected to become ‘enterprising selves’, which encompasses the necessary goals to be autonomous and personally fulfilled and

⁴¹ Berlin’s (1969) seminal essays on liberty distinguish positive freedom described here with negative freedom that refers to the absence of obstacles or interference from others from behaving autonomously.

the methods through which we can achieve these goals, namely taking on the responsibility to judge and act upon ourselves in order to facilitate improvement. To be self-enterprising is to be an active participant in our own governance.

In order to choose among the myriad of self-betterment regimes that are conducive to neo-liberal consumerist citizenship⁴² (e.g., fitness camps, meditation retreats, or clean eating) we must objectify the self so that we can adequately assess, evaluate, discipline and judge sites for self-improvement (Cruikshank 1999; Foucault 1977). We become ‘objects of help’ (Cruikshank 1999) so that the self becomes a project we can modify, monitor and continuously improve upon (Rimke 2000). Key to this objectification is self-surveillance, which is the attention we pay to our own behaviour when facing perceived observation by others (Vaz & Bruno 2003). As Foucault (1977) notes, when an individual feels always already visible she is more likely to engage in persistent and enduring self-surveillance. Rose (1999) equates intense self-scrutiny as part and parcel with governing through freedom. The more we judge ourselves, the less we rely on state actors to classify and judge us (Cruikshank 1999).

Paradoxically, the self becomes both an object and a subject: “...The self becomes an object of knowledge *and* a subject/object of governance, not simply under the gaze of an expert acting at a distance but, most importantly, under the ever-present gaze of one’s self” (Rimke 2000: 68). The self is assessed and subjected to various projects. Subjectification entails the way people problematize and act upon themselves. Rose (1998; see Butler 1990) argues that we subjectify ourselves through established, rationalized understandings of humanity, sociality, and performativity such as femininity, masculinity, modesty, virtue, pleasure, among others. Concepts such as these render ourselves easily knowable and allow us to compare, evaluate and

⁴² See chapter eight for a detailed analysis on consumerism.

improve ourselves based on established norms (Foucault 1977; Rose 1998; Turkel 1990). Rose (1998) argues that people constrain themselves, not through repression and domination but through subjectivity. Subjectification works to maximize individual happiness which is directly linked with civility. Rose's work does not address the implicit coercion and constraint that comes with subjecting yourself to narrow social definitions of happiness and normality. A powerful example is the literature on individuals trying to fit within a heteronormative definition of sexuality (Eguchi 2009; Wright 2006). I suggest that we must consider the adoption of often gendered, classist, racialized, and heteronormative norms as an insidious form of coercion in which we are all complicit. The coercive nature of subjectification is most obvious among those who are unlikely to be able to achieve these norms but nevertheless feel compelled to try to produce them (Bauman 1988).

Many individuals are encouraged to strive for normative lifestyle goals through empowerment strategies. Empowerment is a vital concept to understanding government through freedom because it captures the notion that happiness, success, health, and vitality are achieved through individualized thought processes and practices. As with subjectivity, Cruikshank observes that turning attention to self-discovery and self-management does not disavow power dynamics from the tactics of governing:

The will to empower may be well intentioned, but it is a strategy for constituting and regulating the political subjectivities of the 'empowered'. Whether inspired by the market or by the promise of self-government and autonomy, the object of empowerment is to act upon another's interests and desires in order to conduct their actions toward an appropriate end; thus 'empowerment' is itself a power relationship and one deserving of careful scrutiny (Cruikshank 1999: 68-69).

Cruikshank finds that empowerment strategies are part of a broader political rationality that persuades people to seek out socially acceptable goals and to look to themselves to realize these

ambitions. Empowerment strategies use concepts like poor self-esteem to individualize social issues as problems that are to be worked on by reinvigorating one's desire for normality (Cruikshank 1999). Hannah-Moffat's (2000a, 2000b) research on the use of empowerment strategies in Canadian women's prisons exemplifies how empowerment is used to influence particular types of self-governance. Correctional Services Canada (CSC) appropriates the term 'empowerment' from feminist vocabularies that meant to highlight structural inequality and patriarchy and instead aligns it with penal policy that is individualizing and emphasizes low self-esteem and irresponsibility among women (Dell, Fillmore, & Kilty 2009). Empowerment strategies directed towards women in prison target the prisoner as a rational decision maker who can make virtuous choices if she wants to be a contributing member of society:

An emphasis on strategies such as empowerment, however, suggests a greater reliance on self-governing, making links between the aspirations of individual prisoners and those of government, and contributes to the formation of prudent subjects prepared to take responsibility for their actions (Hannah-Moffat 2000b: 31).

These programs and practices do little to account for structural impediments to a 'responsible lifestyle' such as poverty, sexism, racism, addiction, or single parenthood (Kendall 2000). For example, if a woman is unable to secure a job after receiving workplace training she is regarded as having a personal failure (Hannah-Moffat 2000b) rather than acknowledging the strained labour market, lack of affordable child care, and stigma from having a criminal record.

Ironically, the same institution that calls for women prisoners to take ownership of their lives simultaneously removes any semblance of choice that women have so that their schedule, dress, food, and therapeutic interventions are decided for them (Bosworth 2007; Kilty 2012a; Pollack 2009). Hannah-Moffat (2000a) argues that there are few attempts for women to make meaningful choices within a total institution (Goffman 1961) where the power differentials between staff and

prisoners are so divisive. While women's correctional policy may call for women to reformulate their lives through their own free will (Hannah-Moffat 2000a, 2000b; Maidment 2006; Pollack 2009), the reality of achieving this kind of transformation when their social environment is not improved is little more than rhetoric.

Rimke (2000) discusses the empowerment practices used in self-help discourse that simultaneously promises a happier, more fulfilling life while never being satisfied with one's current state and always looking at ways to modify the self. Rimke (2000: 62) observes that the self-help model is built on the 'principle of individuality' which, "... assume[s] the social world to be the sum aggregation of atomize, autonomous and self-governing individual persons". Self-help gained prominence in the neo-liberal era because it advances the discourse that social accord can be achieved through self-government, rather than the kind of community solidarity advocated for in the welfare state. In her genealogy of governing alcohol, Valverde (1998) connects empowerment strategies and self-help movements specifically with governing through freedom. She argues that individual freedom acts as the ultimate late modern value and is likewise the vehicle we use to work on ourselves. The technologies of the self discussed thus far amount not only to the freedom to govern our own person, but rather the responsibility to do so.

Obligated to be free

Rose's analysis of governing through freedom has at its forefront notions of obligation and responsibility to govern ourselves appropriately:

Through the transformation of all these institutional presuppositions, modern individuals are not merely 'free to choose' but *obliged to be free*, to understand and enact their lives in terms of choice. They must interpret their past and dream their future as outcomes of choices made or choices still to make. Their choices are, in their turn, seen as realizations of the attributes of the choosing person – expressions of personality – and reflect back upon the person who has made them [emphasis in original] (Rose 1999: 87).

While Rose contends that the concept of freedom is not a sham per se, it does come with rules and norms on how to properly govern the self. Certainly, we are free to make day to day decisions but we must participate in ‘practices of liberty’ (Burchell 1993; Dean 1996) by conducting ourselves rationally. Autonomy is redefined as the personal capacity to accept responsibility. As we will see in chapter seven, a common discourse among individuals who participate in self-help programs is to assume complete personal blame for their social circumstances, to see personal power as the central tenant to escaping homelessness, and reference to past victimization or social inequality as an unhealthy avoidance strategy. It is because of the connection between freedom and responsibility that Bauman (1988) calls freedom a mixed blessing – the freedom to choose who you want to be but the responsibility to choose correctly.

The responsibility bared upon those who are free comes from a perception that the sum of how individuals conduct themselves equals the level of a civility in a given society. Individual responsibility is thought to lead to collective responsibility (Rose 1999). When social goals become personal goals social deviancy can be curbed through the adoption of technologies of the self. It is our responsibility as active citizens to properly govern ourselves so that, in true neo-liberal discourse, we can limit our reliance on the state (Cruikshank 1993, 1999). It is this coalescence of the private and the public that partially explains the hostility towards those on social assistance and the individualization and criminalization of poverty (Chunn & Gavigan 2004; Mosher 2002). The paradox lies in the notion that as we become increasingly solitary and isolated (Putnam 2000) it is this individualization that is meant to build social harmony.

The convergence of freedom and responsibility sheds new light on the underbelly of freedom. As Cruikshank (1999) iterates, freedom itself holds no essential moral value; it is how

freedom is used to govern that delineates its interpretation as good or bad. Castel and Huey offer prime examples of how the responsibilities that come with freedom are problematic. Castel (2003) situates the freedom to labour in its historical context. One of the tenets of the Enlightenment was a shift from mercantilism (involving intense governmental regulation and restrictions on who could work) to the ‘right to labour’. But this freedom to labour also came with severe penalties for vagrancy and a transformation of the economy that required men (and often women) to work on contract for their sustenance. The freedom to work, as Castel argues, is quickly revealed as an obligation to work in a narrow conceptualization of the term.

Huey (2012) offers a contemporary example of the double-edge sword that comes with the obligation of freedom. Huey analyzes victimization among homeless men and women in Canada and abroad. She finds that given the level of distrust between police and homeless communities and the high rate of victimization (Maniglio 2009), most homeless individuals devise their own strategies for self-protection. Often these practices involve threats, violence, and other criminalized activities. Huey points out the irony that these men and women embrace neo-liberal discourses by not relying on the state for their protection; rather, they accept responsibility for their own safety. Contrary to Bauman (1988), it is the lack of resources (to be able to lock a door, live in a safe home, have an alarm system) that leave homeless individuals with no choice but to take on the individualized responsibilities of freedom. To further the irony, oftentimes these tactics lead to arrest and punishment. It is clear that failure to live up to the obligations of freedom, and to do so in a socially unacceptable way, leads to a loss of that freedom (Kemshall 2002). This is especially the case, as Cruikshank (1999) argues, for those empowerment projects and calls for self-responsibilization that occur in populations that have

few resources to live up to normative ideals. In this case, the distinction between freedom and coercion becomes increasingly blurred.

To be disciplined until free

Thus far, our survey of the literature on government has focused on the neo-liberal prioritization of governing through freedom; however, it is imperative that we consider other forms of regulating conduct. Simply because a political economy favours one form of regulation does not mean that others are abandoned. In this way positive and negative freedom do not necessarily exist separately from one another; rather, factors that are external to the subject (constraints such as probation conditions or incarceration) interact with an individual's internal sense of freedom (Berlin 1969). Given my focus on homeless men and women who engage with the mental health system, an analysis of how practices of freedom co-exist with disciplinary strategies is essential. Foucault (1977: 138) defined discipline in this way: "In short, [discipline] dissociates power from the body; on the one hand, it turns it into an 'aptitude', a 'capacity', which it seeks to increase; on the other hand, it reverses the course of the energy, the power that might result from it, and turns it into a relation of strict subjection". In his seminal study, *Discipline & Punish*, Foucault chronicles the transformation from punishing the body to punishing the soul using disciplinary strategies to create 'docile bodies'. Although his genealogy focuses on the prison, Foucault (1977) is quick to point out that discipline is not restricted to a single institution; we are disciplined through a myriad of regulations, informal controls, practices, and objectives. Discipline happens in and through a number of institutions: the school, the mental hospital, the factory, and the family are but a few key sites. Sylvestre (2010a: 807) articulates how homeless bodies are rendered docile through anti-poverty legislation: "In that sense, being noisy, lying down in the street, begging, or soliciting drivers can not only be seen as

a loosening of one's posture and moral standards, but also poses a threat to a specific social order that is seen as worth preserving". For marginalized people in particular, disciplinary forces are omnipresent. Of equal importance is that people internalize the disciplinary values endorsed by these institutions and disseminate them in the community. As Rimke (2000: 68) notes "...when we teach ourselves and our children discipline, we are teaching them and ourselves how to suffer and also how to grow". Learning to endure short term pain, for example detoxing and recovery, places an individual in a position to later regulate themselves permanently, such as through abstinence to narcotics. An individual who is able to discipline herself is working at self-regulation – a hallmark of governing through freedom.

Discipline is one of three logics of government identified by Foucault. Sovereignty, discipline and government create a complex form of power that targets specific populations differently. While government and the administrative state is currently the preferred method of governance, each system of authority has its role (Foucault 1991). One form of government does not exist independently from the other; rather, they exist in conjunction with each other to foster more widespread social control. Single techniques of governance can simultaneously engage in disciplinary and self-governing elements. Werth (2012; Moore 2007a) cites the parole system as one that demonstrates the dynamism of power relations, as parole can be equally responsabilizing and de-responsibilizing. Whereas parolees are told that they are now 'free' and must make their own decisions, they are under constant surveillance through urine tests, electronic monitoring, and check-ins with parole officers. Rose (1999) finds that disciplinary practices are more commonplace among a few targeted populations, specifically children, the poor, and those deemed mentally ill. Those who cannot adequately govern themselves through their freedom (largely because they do not have the resources to do so, as per Bauman (1988)) are disciplined

until such time as they are capable of self-governance (Foucault 1977). We must also keep in mind that evaluations of who is able to self-govern fall along classist (Castel 1988; Esmonde 2002); racial (Jiwani 2001); and gendered lines (Chan, Chunn & Menzies 2005; Frigon 2012).

While many scholars point to the combination of disciplinary tactics and technologies of the self (Kemshall 2002; Valverde 1998), Bauman (1988) emphasizes that where there is coercion there is a loss of freedom. While he agrees that some members of society are encouraged to and are able to exhibit self-control, those who are controlled by others lose their freedom entirely. Bauman (1988: 15) states: “The permanence and the ubiquity of control will not merely deprive the inmates of their freedom: if effective, it will render the inmates *incapable* of being free, of choosing and guiding their own action, of structuring and administering their own life” [emphasis in original]. This contention parallels analyses of ‘prisonization’ that identifies the prisoner subculture as one based on the prisoner as inferior to law-abiding citizens, and taking a passive role in their own lives (Paterline & Petersen 1999). For Bauman, the free/unfree dichotomy is exemplified in how society treats those on social assistance, where he suggests that the strict rules and lack of discretion on the part of recipients renders them passive and socially useless. From Bauman’s perspective there is no space for governing through freedom within these disciplinary strategies; disciplinary strategies create objects, not subjects. This argument, although in keeping with Foucault’s notion of objectification (Hacking 2004), does not capture the nuance found in *Discipline & Punish* (1977; see also Dumm 1996). Whereas prisoners, asylum patients, students, and factory workers are meticulously observed, normalized, and evaluated they are also taught to self-surveil and to take up the role of self-discipline. The link between discipline and freedom cannot be so easily broken.

Although Bauman creates what I argue is too stark a contrast between disciplinary strategies and governing through freedom, his work underscores how discipline shapes late modern governing in ways governing through freedom cannot. This revelation is important because in the era of choice, autonomy, and consumerism, disciplinary tactics are often invisible and less likely to be attached to formal, state based sanctions. Moreover, many people are complacent about these practices as they become implicit in their own discipline, for example people's willingness to submit to community policing (Fischer & Poland 1998; see also Cruikshank 1993). Techniques once used in penology are now applied covertly throughout the social body (Cohen 1985; Cruikshank 1999), such as the use of CCTVs to act as a form of constant surveillance (Norris & McCahill 2006). While neo-liberal ideology and actuarial justice stress cost-effective, efficient management by targeting specific populations through risk assessment (Feeley & Simon 1992; Silver & Miller 2002), every area of the social world is offered their own unique method of social control leading to piecemeal but totalizing governance (Valverde & Mopas 2004).

The concept of complete discipline is embodied in Bentham's panopticon. The panopticon is a 'laboratory of power' whereby surveillance is constant and invisible, maintaining the ideal conditions to create the disciplined object (Foucault 1977: 204). Bauman (1988) asserts that disciplinary objects exercise no freedom whatsoever. While they may have a choice over whether or not to submit to authorities the institutions are set up in such a way that the minimal incentives to behave and the potential sanctions that come with disobeying leave little room for autonomy. Additionally, whether an individual believes in the value of the disciplinary ideals is irrelevant; simply behaving as a docile body is satisfactory for this form of governance. Others

disagree (McDermott 1999; Rose 1999) finding that internalizing institutional discourses is the most effective form of social control and is tantamount to a successful disciplinary structure:

Discipline, as I have suggested in other places in this book, was not a means of producing terrorized slaves without privacy, but self-managing citizens capable of conducting themselves in freedom, shaping their newly acquired 'private lives' according to norms of civility, and judging their conduct accordingly (Rose 1999: 242).

Rose's description of the symbiotic relationship between disciplinary practices and governing through freedom corresponds to the complex, ad-hoc and messy actualities (O'Malley, Weir, & Shearing 1997) that exist in practice. Still, Bauman offers a vital perspective on disciplinary technologies where we must think critically about the environmental parameters within which adopting governing practices takes place.

Marginalized individuals are most likely to be subject to disciplinary strategies because they do not have the resources to engage in normalized, consumer-based practices. The objectives of self-actualization and improvement are the same among 'active citizens' and marginalized individuals but the avenue through which to achieve these aims differs (Rose 1998). Even in a governing scheme designed around freedom, the state uses the law to legitimate sanction-based disciplinary strategies on the poor (Castel 1988). Later in this chapter I consider the role of inclusive goals amongst otherwise excluded populations. For now it is important to underline the use of disciplinary tactics on marginalized populations. Active citizenship is predicated on an individual's freedom and ability to purchase expertise and goods from whomever they wish. For those who do not have the means to make these purchases disciplinary regimes impose authority figures (e.g., social worker, counsellor, probation officer – among others) and programs upon them. They are culturally pathologized and considered personally weak, and so require the kind of paternalistic authority figure characterized by disciplinary

structures (e.g., parent, clergyman, manager, or correctional officer) (Foucault 1977; Rose 1996, 1999). Many groups, including the homeless and those labelled mentally ill, are restricted from the ‘regime of choice’ regarding which sorts of programs and experts they want to engage with or avoid. In the section that follows I consider how normalization discourses further subjugate marginalized people, and the role psy experts play in promoting narrow conceptualizations of normality.

Identity: Finding the self in a socially constructed world

Foucaultian studies of government investigate how regimes, institutions and discourses are produced, their manifest and latent purposes, and how they transform the ways we move, act, and think. By examining identity, we can consider the social practices that take place within these places and spaces. The two perspectives complement rather than act in opposition to each other (Hacking 2004). We must take note of how we have come to understand the notion of selfhood and what role technologies of freedom have in shaping our identity.

The reflexive self

Definitions of identity vary but there is consensus that underlying one’s identity is an individual’s unique biography upon which social facts become intertwined (Goffman 1963; Rose 1998). Personal identity is made up by the conceptualization of the self as in some way unique. Our individuality has to be, in some respect, differentiated from others. From this perspective we shape our biography. Our personal identity is closely bound to our social identity – that is, how we present ourselves to others and the behavioural expectations the social world bestows on us based on our personal characteristics. We are also constantly trying to ascertain how others think of us, based on our presentation of self (Goffman 1959, 1963).

Our materiality situates our identity. Our freedom to identify as we like is limited by external constraints such as racism, classism, and sexism among other oppressions, and internalized constraints that come from the adoption of our social identity, which is based on how others view us (Bauman 1988). For example, a child living in poverty is unlikely to become an astronaut in part because she does not have the financial resources to obtain the necessary education, but also because she is unlikely to have such an ambition because nobody suggested to her that she may pursue such a life course and because she does not have female astronauts from her neighbourhood to model herself after. She is unlikely to imagine herself as an astronaut so she will not become an astronaut. Feldman (2004) offers the example of the homeless individual who begins to embody the stereotypes of the disturbing, lazy and/or mentally ill beggar because she internalizes and self-identifies with the social identity prescribed to her from her interactions with other individuals and institutions. The way identity changes based on perceptions of our identity by others parallels Lemert's (1969) concept of secondary deviance, whereby deviance is understood as the outcome of being so labelled.

Likewise, our identity situates our reality and the thoughts, actions, and beliefs that make us up (Rose 1998). Identities are fluid, negotiable, and evolving depending on changes in discourse, how society interacts with certain identities, and how self-identity is interpreted. Scholars struggle to ascertain in what ways identity is shaped by determinism and where our freedom to self-identify lies. Hacking (2004) suggests that identity is forged as we grow and gain experience. He privileges the choices we make *despite* our deterministic features as conducive to constructing our identity. In Hacking's (1991, 1999) work on 'making up people' he builds on Lemert's theory to frame the looping effect:

But also about the ways in which those who are classified, and who are altered by being so classified, also change in ways that causes systems of classification to be modified in turn. I call this the looping effect of classifying human beings. Classifying changes people, but the changed people cause classifications themselves to be redrawn (Hacking 2004: 279).

The complexity of the looping effect is exemplified in the proliferation of psy-terminology in everyday vocabulary that provides people with a new way to think about themselves as anxious, depressed, or paranoid (among other terms); in other words, as mentally ill. As we will see in chapter six, one does not have to spend time in a mental hospital or be on psychotropic medication to identify as part of the mental health system and to use psy language. The looping effect allows us to consider how an individual's identity might change by adopting the term 'depressed', but also how the category of 'depression' itself takes on new symptoms because different people identify as depressed (Conrad 2007).

Scholars suggest that situating the self within identity is demonstrably more difficult in the late modern era. "Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is *the self as reflexively understood by the person in terms of her or his biography*" [emphasis in original] (Giddens 1991: 53). In light of their mutability, identities become 'reflexive projects of the self'. In many respects, the decisions we make, our consideration of expert and lay knowledges, and our presentation of self deliberately informs our identity. Self-identity is not simply the result of life events, but requires us to continually create, shape, and maintain our identity through reflexivity. In effect, we are what we make ourselves (Gergen 2000; Giddens 1991; Roseneil & Seymour 1999). Self-identification is more problematic in the late modern era because of a lack of ontological security. Who we are and what that means is no longer a static script (if it ever was so). The myriad of identity choices and the constant need to reaffirm these choices leads to a destabilized self that is made up of a sense

of anxiety and a loss of trust in how we understand the world around us. Gergen (2000) defines these conditions as ‘social saturation’ where the self becomes fragmented because of the sheer number of relationships it must contend with. These divergent interactions and lack of coherency requires increased reflexivity so that we can maintain our self-identity (Giddens 1991), but the more reflexive we are, the more sceptical we become and we lose trust in our basic understanding of who we are, our place in society, and how the social world is made up. In fact, “the fully saturated self becomes no self at all” (Gergen 2000: 7).

The lack of an ‘authentic identity’, of tradition, and of social structure, requires that we continually reconstruct the self. Gergen (2000) suggests that rather than postmodernism offering us multiple identities, its conditions act as a form of nihilism where our identity changes as social conditions change. Here we see the role of psy in navigating our sense of self. Psy offers assistance not only as a way to build back some of the trust lost in a neo-liberal society that privileges individualism and competition, but it also acts as an ideal form of reflexivity so as to re-orient the self within the chaotic and uncertain social world (Giddens 1991). Psy allows us to mitigate some of the risks and anxieties of the late modern world by suggesting that we can know ourselves and thus be better able to predict our life course and maximize our opportunities (Miller & Rose 1994). Psy promises to provide a fixed and holistic sense of self in an environment that is divided and contextualized (Rose 1998). Given this perspective, we can assess how identity is shaped through technologies of freedom so as to encourage individuals to take up obligations to themselves and their community that will in turn frame their sense of self (Dean 1996). To be a law-abiding citizen, a good parent, and a productive employee requires a reformulation of the personal and social identities that align with the normative expectations that are drawn from nationhood, parenthood, and the work environment. Rose (1998: 3) situates

identity within the framework of technologies of the self as: "...ideals concerning our existence as individuals inhabited by an inner psychology that animates and explains our conduct and strives for self-realization, self-esteem, and self-fulfillment in everyday life". Freedom's role in our ability to shape our identity to these ideals or to resist normative discourses is contemplated in the literature on social and cultural identity.

Performing the self

The notion of performativity is valuable in this research project in order to consider how homeless men and women 'do' their mental health status in the same vein as feminist scholars refer to 'doing' gender. To 'do' gender means to invoke "... a complex of socially guided perceptual, interactional, and micro-political activities that cast particular pursuits as expressions of masculine and feminine 'natures'" (West & Zimmerman 1987: 126). 'Doing' gender implies that normative conceptions of gender are constantly being assessed in our social relationships and activities in such a way that we are always acting out our gender. Although we must be cognizant of the differences between an omnipresent status such as gender or race and a mental health status that is not necessarily visible, I argue that West and Fenstermaker's (1995) study of difference opens up the notion of 'doing' to a broader conceptualization. West and Fenstermaker study class as an overlapping identity construct in relation to gender and race. They argue that while class lacks the biological imperative and scientific nature of gendered and racialized discourses, poverty is often associated with laziness and a lack of ambition, and is therefore essentialized and reduced to the internal personality qualities of the person. Just as with poverty, mental health is certainly ascribed to individual character. While arguably more contentious than

normative conceptions of gender and race,⁴³ mental health status has a long history of being situated within biological discourses (Foucault 1988; Wakefield 1992). If an analysis of ‘doing mental health’ is to be justified, we must consider the nature of performativity as it relates to the self. We will use Goffman and Butler as exemplars of the social and cultural perspectives, respectively.

In *The Presentation of Self in Everyday Life*, Goffman (1959) outlines the ‘dramaturgical approach’. He describes a performance as the following:

A ‘performance’ may be defined as all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants. Taking a particular participant and his performance as a basic point of reference, we may refer to those who contribute the other performances as the audience, observers, or co-participants. The pre-established pattern of action which is unfolded during a performance and which may be called a ‘part’ or ‘routine’ (Goffman 1959: 15-16).

A performance falls somewhere along the continuum between sincere and cynical. Not all performers believe that they truly inhabit the role they are playing whereas some are so immersed in their role that they do not realize it is a performance at all. The question is, in what way is the performance a veil for the true self? Goffman writes that we are not our performance. In describing the stereotypical props to display femininity, such as make-up (which he refers to as a ‘disguise’), Goffman (1959: 58) reminds the reader that the body she puts forward is not *herself*: “she is, like the picture or the statue, or the actor on the stage, an agent through whom is suggested someone not there[;] that is, the character she represents, but is not”. Goffman argues that the way we use our body, language, gestures, etc. is part of an elaborate theatrical display, where our social identity can be equated with a disembodied object such as a statue. This analysis suggests individuals have detailed control over their presentation of self.

⁴³ The important critical work on trans and intersex bodies provide valuable insights into the fluidity of seemingly static concepts such as sex and gender (Holmes 2008; Monro 2005). Moreover, research on the variability of racial identity suggests that race is negotiated at the individual and relational levels (Harris & Sim 2002).

Butler would disagree with Goffman's explanation of identity presentation. Although she describes a parallel notion of performativity, especially gender as a performance rather than some innate essence, she does not consider these roles as a ruse that conceals a 'true' self:

Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means. That the gendered body is performative suggests that it has no ontological status apart from the various acts which constitute its reality. That also suggests that if that reality is fabricated as an interior essence, that very interiority is an effect and function of a decidedly public and social discourse, the public regulation of fantasy through the surface politics of the body, the gender border control that differentiates inner from outer, and so institutes the 'integrity' of the subject [emphasis in original] (Butler 1990: 136).

Butler argues that there is no pre-existing identity that is formed outside of the social and cultural context. What Goffman would term personal identity, Butler (1990, 1993) describes as constituted from the repetition ('cyclicity') of ritualized forms of language and behaviour, known as 'iterability'. Iterability leads to 'sedimentation': the continued reproduction of ways of being that overtime produce an identity configuration that appears natural or 'true'. For example, over the course of time women have acted as the primary caregiver to children, creating a sense that motherhood is intrinsic to womanhood, despite evidence to the contrary (Douglas & Michaels 2004; McQuillan et al. 2008). Butler (1990) suggests that conceptions of self are a social temporality and that socially established norms constitute identity rather than an individual's autonomous decision making. That being said, because these performances are temporal there is room to contest, negotiate, and transform identities.

The incongruence between Goffman and Butler's description of performativity has received a number of critiques. While Rose (1998) suggests that Butler places too much emphasis on linguistic accounts of identity, the bulk of the critique is directed at Goffman's portrayal of role-playing. Hacking (2004) reiterates the ideas found in Butler, suggesting that

Goffman misrepresents the dramaturgical approach by implying that the roles conceal a 'true' identity underneath. Hacking argues that the roles we embody become aspects of our person. Similarly, West and Zimmerman (1987: 129) find that Goffman's description of gender roles fails to account for gender as a master status.⁴⁴ Moreover, they find it more useful to refer to gender as a 'product of social doings' rather than a role. While these critiques are insightful, I argue that they simplify Goffman's argument and in doing so misrepresent his conceptualization of performance.

Goffman does describe performances as a role and singles out gender as an example of such a role; however, he nuances his claims by reflecting on the layers of identity construction that take place within a performance. For example, he describes young women who present themselves as less intelligent than their admirers in order to appease the male ego. Later in his work, Goffman (1959) suggests that while we condemn these women for playing the role of passive, dependent, innocent, and virginal subjects, we fail to see that their role as middle-class, American, young, and female are likewise performances. To ignore these other facets of identity is to misread the complexity of cultural configurations of the self. Similarly, critics point out that Goffman's description of roles alludes to the presence of a 'true' self, which is aptly critiqued as static. Certainly Goffman's comparison between performances and statuses would support such an assertion. However, later in his analysis, Goffman reorients the self:

The self, then, as a performed character, is not an organic thing that has a specific location, whose fundamental fate is to be born, to mature, and to die; it is a dramatic effect arising diffusely from a scene that is presented, and the characteristic issue, the crucial concern, is whether it will be credited or discredited (Goffman 1959: 252-253).

⁴⁴ A master status is a trait that overrides other identity statuses (Becker 1963). For example, the prisoner status often trumps the parent, friend, and employee status.

This passage offers a more complete perspective on the self that articulates the nature of performance with the constitution of identity as socially temporal, in alignment with Butler. By working through these two frameworks for performativity we find common ground in their description of identity as being flexible, situated within the specificity of time and space, built from pre-existing norms, and contingent upon how others perceive the performance. This conceptualization of performativity allows us to consider how identity can be asserted, negotiated, or resisted. Performativity is a useful theoretical tool through which to analyze how and why individuals govern themselves through freedom. From a Goffmanian perspective we can situate how people use some technologies of the self and reject others as a tool for their performance as mentally ill, mentally well, or somewhere in between. Relatedly, Butler's notion of sedimentation highlights the historical, cultural and social conditions that mediate the homeless men and women's negotiation of the mental health identity. Poverty has a substantial impact in shaping, and more specifically limiting, a mental health identity based on a lack of social and financial resources, a point that this research examines in depth.

Excluding the homeless/mentally ill identities

To be excluded means to be separate, unwanted, and unworthy. Concepts such as isolation, classification, and stigmatization point to the relation between exclusion and identity (Cohen 1985). Those who are excluded are generally understood as a homogenous group – that despite differences in race, ethnicity, age, gender, sexuality, ability, history, and sometimes class, they are intrinsically linked through their exclusion. The excluded are indeed united in their rejection by political, economic, and cultural systems (Feldman 2004) and by the institutions and experts who act upon them (Rose 1999).

The constitution of homelessness as an excluded category is particular to the late modern, neo-liberal regime (Feldman 2004). Concepts like marginalization are substituted for ‘social exclusion’, a term Young (1999) suggests places more of the blame on the excluded individual for not properly integrating into mainstream society. Particularly intriguing in Young’s (1999) analysis is his conceptualization of ‘the dialectics of exclusion’. Young characterizes the contemporary excluded person as one who is complicit in her own exclusion in much the same way as individuals engage in their own governance. Individuals feel trapped in their sometimes perilous existence and internalize the rejection they face by people in positions of authority, actors in the criminal justice system, and the citizenry at large. In assuming the role of an excluded person, they too come to exclude others in similarly marginal positions, thus creating further divides. Moreover, they often police themselves so as to avoid matriculating through the private and public spaces designated for the included citizenry. As scholars note, public spaces are increasingly being denied to the homeless (Hermer & Mosher 2002; Ranasinghe & Valverde 2006; Ranasinghe 2011). The homeless may refrain from visiting shopping malls (technically a hybrid public/private space), busy urban streets, or parks to avoid visible rejection, thus preemptively excluding themselves from these public spaces.

Naming and framing exclusion

Exclusion is dichotomized in relation to inclusion. Although many authors call for a continuum of exclusion, it proves difficult to escape the inclusion/exclusion binary and adequately develop a middle ground. I argue that falling back on static conceptions of being either included or excluded does not adequately capture the material experiences of many marginalized people who find themselves included and excluded in a variety of ways. I am especially reluctant to equate homeless individuals as occupying a singularly excluded existence

as they are already commonly stereotyped under a number of unrealistic dichotomies (Feldman 2004) such as sane/insane, rational/irrational, good/bad, or productive/unproductive, among other binaries. These classifications are adopted by powerful institutions and actors, such as the criminal justice system (Yankah 2003), and further exclude already marginal populations.

Forming a gradient: Breaking down the inclusion/exclusion dichotomy

Castel (2003) best describes the gradation of inclusion to exclusion. Beginning with an historical analysis of the vagabond, he charts inclusive and exclusive strategies from the *ancien régime* to the late modern Western world using ‘zones of social integration’. These are: the zones of integration, vulnerability, assistance, and disaffiliation. Castel (2003) emphasizes the growing category of ‘mass vulnerability’ or ‘semi-excluded’ that describes modern day labour relations built on insecure and uncertain access to work (usually short contracts), a lack of insurance, and the disproportionate rise in the cost of living. Castel does not elaborate on the modern formulation of the zone of assistance, but it can be extrapolated from the historical notion of ‘handicapology’, where a select group of people are understood to be unable to work due the perceived handicaps associated with age, disability, or insanity, among other possible oppressions. This group of ‘handicaps’ can be likened to the modern day ‘deserving poor’ who, like Christie’s (1986) ideal victim, warrant support only if they meet the appropriate standards of victimhood (Herd, Mitchell & Lightman 2005; Sylvestre 2013).

Castel’s (2003) description of the disaffiliated is vital to my analysis of the excluded. Historically, the vagabond was the most reviled of the socially marginalized because while he⁴⁵ had the ability to work he chose not to or worked only infrequently. Vagabonds, otherwise known as beggars, *misérables*, and the dangerous class, were characterized as manipulative,

⁴⁵ Because vagabonds were predominantly men (although many women who worked in the sex trade were considered vagrants) (Woodbridge 2001), for this discussion I use the term he.

deceitful, and lazy. These same descriptors are often unfairly used to describe prisoners (Crewe 2009) and social assistance or welfare recipients (Chunn & Gavigan 2004). Vagabonds were subject to harsh punishments such as banishment, imprisonment, execution, and sometimes forced labour. According to Castel (2003) vagrancy laws were a means to govern, oversee, and control certain populations, to administer charity in particular proscribed ways, and were thought to act as a deterrent, especially for the vulnerable who may be 'tempted' into living off the avails of others. The vagabond character was stripped of social contextualization such as a lack of training and apprenticeships and stable or permanent work and instead was completely responsabilized for his indigency.

Castel (2003) argues that the modern day vagabond, the disaffiliated, live and operate within the zone of exclusion. Disaffiliation entails a rupture of 'primary integration', most notably work, the family, and communal belonging. Castel (2003: 79) also refers to them as the residual population, those who have no place in the labour power and who are subsequently dislocated and 'on the fringe'. Certainly homeless individuals, including those who have been taken up by the mental health system, can be described as part of the zone of disaffiliation. Most do not work or work sporadically in unskilled labour earning minimum wage or less. Castel (2003) referred to the homeless community as a 'fourth world' whereby those who do not adequately participate in the capitalist social structure are segregated both spatially and socially. Similarly, Ruddick (1996; 2002) refers to the homeless as a 'surplus population' where, unlike Castel's residual population, the homeless are unwanted and unneeded. She compares the plight of the homeless to that of slaves who are likewise disenfranchised but deemed useful whereas

homeless are not.⁴⁶ Young (1999) agrees, citing a post-Fordist Western society where cheap, unskilled labour is no longer relevant to the overall production of wealth.

Homeless individuals certainly fit into the zone of disaffiliation but the category does not adequately capture the lived reality of human relations. Despite their exclusion, evidence of inclusive ties remains. For example, many homeless men and women have significant and meaningful relationships to parents, siblings, and sometimes children, despite living precariously. Although exploitative labour practices are common place among marginal communities (Valenzuela Jr. 2003), there are likewise many who work in stable, albeit low paying jobs, for example in grocery stores, construction, bowling alleys, and restaurants, but remain homeless for a variety of reasons. Castel (2003: 393) later reorients his conception of the ‘fourth world’ by explaining: “Similarly, it might be argued that what I have called ‘disaffiliation’ may be shown as not necessarily equivalent to a complete lack of social bonds, but only with the absence of belonging in structures that carry a social meaning”. Here I find the greatest potential in Castel’s zones of integration. Not only does exclusion exist along a continuum, but it also co-exists with inclusive elements that complicate the presentation of exclusion as a static and homogenous way of being. Castel’s ruminations offer a starting point to think about where exclusionary strategies exist and the nature of the exclusion and its relationship with different institutional and social structures and discourses. We must also keep in mind how exclusionary strategies used by some of the most powerful institutions (e.g., the health care, social welfare, and criminal justice systems, to name a few) can breakdown inclusionary elements and perpetuate subjective experiences of exclusion as well, such as a

⁴⁶ The racial component to comparing slaves and the homeless should not be overlooked. As described in chapter two, the disproportionate representation of First Nations, Métis and Inuit people in Canadian prisons and the absurd incarceration rate of young Black men in the United States remind us of the continued systemic oppression facing racial minorities (Wacquant 2002).

mother being unable to have access to her children in prison and resultant fragmenting of the mother/child relationship (Enos 2001; Maidment 2006; Mignon & Ransford 2012).

To further Castel's argument that disaffiliation means exclusion from socially meaningful sites, we turn to Rose's description of the 'anti-citizen'. Unlike Castel's focus on exclusion existing on a continuum, Rose's description of the 'anti-citizen' exemplifies the construction of the excluded category as the antithesis to those who are included:

...outside the communities of inclusion exists an array of micro-sectors, micro-cultures of non-citizens, failed citizens, anti-citizens, consisting of those who are unable or unwilling to enterprise their lives or manage their own risk, incapable of exercising responsible self-government, attached either to no moral community or to a community of anti-morality (Rose 1999: 259).

Anti-citizens are those who exist "outside the nexus of activity", namely the underclass, the truly disadvantaged, and the criminalized (Rose 2000: 331). This assessment of the anti-citizen's lack of social integration is consistent with Castel's assertion that exclusion literature largely refers to structural exclusion. Rose (1999) describes the underclass as a group of long term welfare recipients, street criminals, alcoholics, drug dealers, single mothers, and deinstitutionalized psychiatric patients. Many members of the homeless community can be described in this way. In fact, Rose (1999: 88) lists the drug user, the criminal and the homeless person specifically as living 'outside of society'. I would add that many of those identified as mentally ill could be included in this marginalized category. Simply being without an address hinders a number of inclusionary activities, such as applying for jobs, spending time with family and friends, and spending leisure time as one wishes to. Homelessness is a process whereby an individual is distanced from positive social experiences and relationships. Feldman (2004) argues that because many homeless individuals cannot participate socially and politically, and others would argue economically (Bauman 1988, 2001; Huey 2012; Rose 1999, 2000), they cannot be considered

citizens. Huey (2012) characterizes the homeless as being ‘lesser citizens’ and notes degrees of inclusion/exclusion but later frames homeless men and women as ‘non-citizens’. Similarly, Young (1999: 20) refers to the same groups of people as the outgroup: “...the social impurities of the late modern world...”. Young’s definition of the outgroup mirrors Rose’s underclass but it takes on a noticeably moral undertone. Rose (1999, 2007; see also Wacquant 2008, 2009) would agree with Young, and suggests that inclusion calls for civility, prudentialism, responsabilization, and impulse control and those who fail to live up to these standards make up the underclass.

As with the conceptualization of disaffiliation, the anti-citizen fails to account for how marginalized individuals make sense of their own subjectivity (Huey notes that some of her interviewees felt they were full citizens) and it does not consider the use of inclusionary strategies amongst the homeless. Instead, we must further nuance exclusionary and inclusionary strategies that will allow us to sift through the responsabilization and empowerment strategies used among the homeless as tools of governance.

Young describes the degrees of inclusion/exclusion with a beach analogy:

The mode of exclusion... does not present itself as an on/off switch of inclusion or exclusion: either you’re inside society or you’re not. Rather it is a sifting process which occurs throughout society, for exclusion is a gradient running from the credit rating of the well-off right down to the degree of dangerousness of the incarcerated. Its currency is risk, its stance is *actuarial* – calculative and appraising. The image of society is not that of a core of insiders and a periphery of outsiders but more that of a beach where people are assigned to a gradient of positions in a littoral fashion. At the top of the beach there are the privileged sipping their cocktails, their place in the sun secured, while at the bottom there are creatures trapped in the sea who can only get out with great effort and even then are unlikely to survive. The beach has its gradient in between but this does not preclude at its extremes sharply segregated worlds, whether of the super-rich or the underclass” [emphasis in original] (Young 1999: 65).

Young’s presentation of a gradient is worthwhile in trying to make sense of exclusion but it falls short of providing a theoretical tool to break down how exclusion is experienced and its relation

to inclusionary goals and practices. There are two fundamental problems with the beach metaphor. First, while the sand on the beach acts as a sort of hierarchy of inclusion/exclusion, it does not explain how the beach works with and/or against the sea and the wealthier party goers at the top. It also assumes a linear process of inclusion/exclusion. Presumably, the wet sand closest to the sea is more excluded than the soft white sand under the umbrellas of the included. The sand does not, therefore, allow us to think through simultaneous practices of inclusion/exclusion existing in a single control strategy or being engaged with by any one individual. Instead, we may be able to think about the tide as representative of the ebbs and flows of exclusion. The party goers are protected from the tide by their deck chairs and umbrellas. They are rarely witness to the changes in the sand as the tide drags some of the sand towards the sea, while at other times allows the sand to dry and regain the consistency of the sand closer to the party-goers. The same patch of sand may not always be completely submerged in the water but is continually at risk of being swallowed by the tide.

Second, Young's 'sharply segregated worlds' of the cocktail sipping people and sea creatures is so extreme it actually removes the human element to the excluded category. Young writes that the sea creatures try to get out but rarely survive. Even if they do survive they will still be sea creatures rather than human beings who might be able to sit on the beach and be near, if not with, the bourgeoisie. Perhaps Young gestures to the notion that those in the excluded category are so heavily stigmatized and marginalized that the dominant class will never view them as anything more than an organism they can throw back in the water or, in an even more dramatic hyperbole, ingest and toss away the bones/shell, or collect for their own private voyeurism. But while this representation is provocative it does not capture the essence of exclusion – that our social institutions and governing schemes are excluding people who are in

many ways like the included group. Our primal needs for food, shelter, clothing, intimacy, and a sense of security are paramount to our individual and communal survival. It is because of the similarity between the included and excluded groups that those on the margins are demonized and scapegoated in an attempt to set moral absolutes to revitalize the notion that the included population is essentially different from the excluded; whether excluding people actually results in stronger feelings of unity among the included is unknown, although I am sceptical that it would do so. In the next section I consider how categories of exclusion can be nuanced in order to make sense of inclusionary practices among the excluded.

Social junk and social dynamite

Castel speaks of a continuum and Young speaks of a gradient, but how this inclusion/exclusion divide or slide is realized is still uncertain. I argue that exclusion – its practices, strategies, material experiences, and consequences – are not homogenous; thinking of exclusion simply as the end point of a continuum does not get us very far by way of understanding how exclusion is experienced. Spitzer (1975) famously distinguished between ‘social junk’ and ‘social dynamite’ based largely on the perceived threat of the groups so designated to the wider public. Social junk is defined as:

On the one hand, there is social junk which, from the point of view of the dominant class, is a costly yet relatively harmless burden to society. The discreditability of social junk resides in the failure, inability or refusal of this group to participate in the roles supportive of capitalist society. Social junk is most likely to come to official attention when informal resources have been exhausted or when the magnitude of the problem becomes significant enough to create a basis for ‘public concern’. Since the threat presented by social junk is passive, growing out of its inability to compete and its withdrawal from the prevailing social order, controls are usually designed to regulate and contain rather than eliminate and suppress the problem. Clear-cut examples of social junk in modern capitalist societies might include the officially administered aged, handicapped, mentally ill and mentally retarded (Spitzer 1975: 645).

Many homeless individuals align with the social junk categorization, in particular the elderly, disabled, and many of those who are taken up by the mental health system. Yet, as others have noted (Donley 2008; Elbogen & Johnson 2009; Lurigio 2000), homelessness and mental illness are each considered volatile and threatening groups and are not nearly as benign as the social junk category suggests. Perhaps the social dynamite category is more fitting:

The essential quality of deviance managed as social dynamite is its potential actively to call into question established relationships, especially relations of production and domination. Generally, therefore, social dynamite tends to be more youthful, alienated and politically volatile than social junk. The control of social dynamite is usually premised on an assumption that the problem is acute in nature, requiring a rapid and focused expenditure of control resources. This is in contrast to the handling of social junk frequently based on a belief that the problem is chronic and best controlled through broad reactive, rather than intensive and selective measures. Correspondingly, social dynamite is normally processed through the legal system with its capacity for active intervention, while social junk is frequently (but not always) administered by the agencies and agents of the therapeutic and welfare state (Spitzer 1975: 645-646).

The social dynamite category is more closely connected with the disciplinary tools commonly used on the homeless and mentally ill, in particular the heavy reliance on the criminal justice system as a technique of exclusion. However, social dynamite refers to an acute state of risk more so than chronic exclusion. Spitzer (1975) suggests that a population can be dealt with alternatively or simultaneously as social junk and social dynamite. The combination of the two varieties is in keeping with the myriad of social control strategies used on the homeless and those identified as mentally ill; however, Spitzer does not explain how the two identities co-exist. The coalescence of disciplinary schemes and techniques of the self is pivotal to understanding how homeless individuals negotiate the mental health system and make sense of their status as homeless and often the comorbid categorization as mentally ill. We turn to Rose's classification of exclusionary types to sift through how the differing practices for social junk and social dynamite populations may be combined.

Rose (2000) describes at length the various control strategies used on anti-citizens, namely those related to actuarial justice. It is clear that the homeless and/or mentally ill fit with Rose's definition of the anti-citizen. Elsewhere Rose (1999; see also Goffman 1961) uses the homeless and the mentally ill as examples of the most stigmatized and marginalized people. Rose goes on to distinguish between control strategies used on individuals who are considered 'redeemable' and those considered 'impossible'. He defines the irredeemable or 'monstrous' individuals as the anti-social, the predator, and the paedophile (Garland 2001). Hannah-Moffat (2000a, 2000b) refers to Garland's (2001) conceptualization of the 'criminology of the other' when she suggests that some women prisoners are deemed 'unempowerable', among them, those deemed to be mentally ill. To decry the result of being designated unempowerable, Desjarlais (1997) uses the term 'unsalvageable' to describe resistant women in prison. Similarly, Rose (2000: 334) describes these individuals as 'impossibles': "individuals whose very make up as human beings appears somehow faulty or incomplete, and whose very nature thus seems to place them permanently beyond the limits of civility and its demands on subjectivity". Control strategies for this population follow an actuarial risk management logic that is focused on containing future harm (Rose 2002).

Most of my research participants would not be identified as the heinous criminals Garland and Rose describe although many of them were subject to risk management techniques such as incarceration in jails, prisons, and mental hospitals at some point in their lives. The majority of people who cycle in and out of prison and homeless shelters are not under continuous state surveillance⁴⁷ and are not likely considered high risk. Referencing the criminal justice

⁴⁷ We must be cognizant of other forms of 'surveillance at a distance' that homeless men and women may be subject to, such as the type of therapeutic surveillance found in drug treatment courts described by Moore (2011).

system as the ultimate tool of exclusion, Rose (2000: 336) refers to a 'semi-permanent quasi-criminal population' that is more in keeping with the people who shared their story with me. If they are only 'semi-permanent' they are not likely the 'monsters' to which Garland is referring. The redeemable are those anti-citizens who need to take responsibility for their behaviours and become self-reliant. Rose (2000: 335) references responsabilization strategies and empowerment techniques discussed in the previous section to account for a continued effort to moralize the excluded with the expressed aim "...that the excluded citizen is to be reattached to a virtuous community". Rose's work on sub-dividing the excluded population into the impossible and redeemable camps is helpful because it nuances how exclusionary practices play out and makes sense of competing actuarial and welfare based strategies that co-exist as part of the broader schemes for governing marginalized people (Goddard 2012). Rose's analysis provides a space to further examine how inclusionary and exclusionary practices are maintained simultaneously among the excluded and to question the goals of these inclusive practices if many of the participants straddle the line between the redeemable and the impossibly excluded.

Inclusionary practices amongst the excluded

Rose (2000) remarks that inclusive strategies necessarily create oppositional excluding strategies. This makes sense when we think about, for example, the criteria one must meet to become a Canadian citizen, which necessarily means that some individuals will not meet this threshold and are subsequently excluded. For example, those who cannot 'adequately' speak English or French, memorize Canadian political history, or are deemed a security risk will be excluded from citizenship. However, it is misleading to think of an inclusive technique as creating an intrinsically opposing exclusive technique as some kind of yin and yang. In some ways Rose maintains the inclusion/exclusion binary by equating the included circuit with

practices that act to optimize one's self in the name of order and civility (for example, employment retraining programs) and the exclusionary circuit with more traditional disciplinary practices (such as prison) where freedom is couched in power dynamics that constrain choices and self-determination. Reinforcing certain techniques as either inclusive or exclusive runs counter to Rose's (1999) own call for governmentality studies to demonstrate the messiness and complexity of modern modes of government. Although the homeless community is an excluded group, we still find space for inclusionary governance. I argue that not only can inclusionary strategies actually lead to further exclusion, as witnessed for example in Canada's drug treatment courts (Moore & Hirai 2014), but exclusionary strategies can create mini-sites of inclusion when marginalized groups come together and form a unique sense of community: "These communities thus tend to function as self-regulating and homeostatic systems, which recover their equilibrium by marshalling their own resources" (Castel 2003: 12). The hybridity of inclusionary goals and exclusionary practices is witnessed through mental health managerialism. We must consider the ways in which inclusionary goals are promoted amongst excluded groups and why homeless and/or mentally ill individuals might adopt or reject the ideals that inclusionary strategies offer.

Inclusion

Perhaps not surprisingly given criminology's focus on the marginal (Young 2002), clear definitions of inclusion are not easily found in the literature. Just as the normal is defined through the abnormal (Frigon 1996), definitions of exclusion abound and we must assume that inclusion is the opposite of the exclusionary category. In doing so, true inclusion inhabits three locales: economic, political and social. As developed in further detail in chapter eight, to be able to participate in society as a consumer is paramount to contemporary citizenship. Feldman (2004) calls for a broader definition of political inclusion that is not restricted to enfranchisement

but also entails having one's rights protected and enforced. Inclusion suggests that a person is a member of and can participate meaningfully in a community (Horsell 2006). Cohen (1985) equates inclusion with assimilation, normalization, accommodation and incorporation. This definition fits well with Rose's (1999) work on the obligations of freedom and draws attention to inclusionary practices as problematic because they seek to condition individuals into restrictive norms rather than being inclusive of diverse values and lifestyles.

The ideal of inclusion as being part of the communal fold is based on the rules of civility. To be included one must exhibit self-restraint: "In these circuits of inclusion, the calculated modulation of conduct according to principles of optimization of benign impulses and minimization of malign impulses is dispersed across the time and space of ordinary life" (Rose 2000: 325). Valverde (1998) works through the notion of impulse control when she considers the role of proper habit formation and will power among those who consume alcohol in ways that do not align with social expectations. Inclusion, therefore, is heavily associated with normalization. Those who cannot or will not adhere to these norms are subsequently excluded.

The literature demonstrates that despite their exclusion, those individuals who are deemed social junk/redeemable as opposed to social dynamite/impossible/irredeemable are held to the inclusive ideals, despite the unlikelihood that they will ever become included. Rose (2000) argues that exclusion is a subjective condition rather than a permanent state of being because some individuals can realign with the community by adopting the appropriate morality. I have already highlighted Cruikshank's (1999) work on empowerment strategies and their call for oppressed people to gain self-esteem and become self-aware. Rose (2000) identifies these techniques of empowerment such as gaining life planning skills, furthering education and employment opportunities, and fostering independence as a reconstruction of their will so that

they can be reinserted into their communities of family, work, and consumptive life. These strategies, although built upon the obligations of freedom, are part of more expansive and heterogeneous control strategies. For the excluded population, in order to become included they must submit to various authority figures and expert discourse.

The exclusion through inclusion paradox

Scholars argue that when excluded individuals engage in inclusive strategies, paradoxically they are often further excluded (Feldman 2004; Moore & Hirai 2014; Rose 2000; Young 1999). Indeed, “what a strange world this is of inclusion and exclusion: a *bulimia nervosa* of the social system where at one point the outside world touches and shapes the underclass, whilst at another point it rejects and expels it [emphasis in original] (Young 1999: 87-88).⁴⁸ The irony lies in the excluded group buying into the included group’s norms without the means to live up to the standards because of their exclusion, typically by way of economic and knowledge resources and social ties, which further entrenches their marginalized status. As Rose (2000) points out, simply because someone takes on the project of self-responsibilization does not mean they will be successful at dislocating themselves from regimes of dependency such as institutionalization and social assistance. Moreover, their willingness to take up responsabilization programming forces them to identify as excluded in the first place. Not only this, but embracing these technologies creates the appearance that they agree with the premise of these programs – namely the individualization and depoliticization of their exclusion. These policies of insertion (Castel 2003) target groups in need by distinguishing the redeemable from the impossible, where attempts to integrate the former have ultimately failed. This failure comes

⁴⁸ The bulimic society is one where people are engulfed in cultural norms, which are played out through consumer practices. The inclusive norms take in, ingest (cannibalize), and shape the underclass, who are thereafter ejected (Young 1999).

from secondary socialization where both Castel and Rose find that such programs permanently attach individuals to the excluded circuit and in turn make their status as redeemable or 'being inserted' a permanent fixture rather than a transitive state.

The homeless shelter and the programs often linked to the homeless community offer a salient example of this further exclusion through adopting inclusive ideologies. While authors such as Allen (2000) suggest that homeless shelters act as a barrier to inclusion, others postulate that making use of the homeless shelter and its programs actively encourages exclusion by 'Othering' a target population. Feldman (2004) uses Foucault's notion of 'dividing practices' to argue that homeless shelters do not act as a transition for excluded people to become included; rather, shelters constitute a divide between the normal and the deviant and as such act to broaden the distance between the included circuit and the redeemable excluded. Through the programs and supports it offers, the homeless shelter reproduces stereotypical images of the homeless individual as helpless, pathologized, deviant (Lyon-Callo 2000) and ultimately uninsertable.

Borrowing from Young's (1999) concept of the bulimic society, Moore and Hirai (2014) explore this exclusion through inclusion paradox by detailing the characters that make up Canadian drug treatment courts. The authors describe the different ways responsabilization messages are taken up by drug treatment court participants (what Young refers to as cannibalism), arguing that regardless of whether or not they adopt the strategies, they remain excluded. The outcast who rejects responsabilization strategies, the performer who acts out the moralizing techniques but dismisses others, and the true believer who is fully committed to the governing techniques all continue to be 'Othered' (Moore & Hirai 2014; see also Werth 2012). From their analysis, the authors find that responsabilization is not simply a form of governance that creates subjectivities:

It is, rather, a more complex arrangement of hierarchal and self-governance in which some individuals actively perform but ultimately, at least in regards to the hyper-marginalized who populate the criminal justice system (CJS), are mostly ingested only to be later expelled by society (Moore & Hirai 2014: 6).

Moore and Hirai conclude that under the current social and political framework the exclusion faced by the most marginalized people seems virtually inescapable. Part of the explanation for their continued exclusion is, as we have noted earlier, the latent goal of creating obedient, normalized, and disciplined subjects through an empowering/self-governing framework. Another important factor is the role of the 'Other' as an identifier that is reinforced by the subject and society at large. For many, exclusion is a permanent state of sociality that they attempt to negotiate by claiming stake in their identity as redeemable, rather than a temporary state of being to navigate through.

Young (1999) suggests that despite the permanent state of exclusion experienced by most of those identified as social junk, the ideals of inclusion remain largely intact in places like the ghetto. Using Young (1999) to further Moore and Hirai's claims, the bulimic actions of social systems do not resign the ejected from aspiring to inclusion. Young finds that the culture of inclusion (i.e., beauty norms derived from the media and consumptive practices) ingests the excluded, so much so that the creation of an underground culture is built on inclusive ideals of individualization, competitiveness and meritocracy. Young (1999) argues that because many marginalized individuals internalize these values, they account for their exclusion as a failure on their part rather than due to systemic and structural barriers. As suggested above, those who fail to live up to the ideals of freedom see it as a personal rather than systematic failure. This is in keeping with Young's assessment that exclusion is not strictly a top-down form of domination, but rather that the excluded participate in their own exclusion. If these inclusive strategies do not

truly include people and many of the excluded continue to adopt these values, we need to think through why that might be.

Including the social junk?

It is essential that we qualify how inclusive practices work among excluded individuals. The homeless and/or mentally ill identified as ‘lesser citizens’ or ‘anti-citizens’ do not have the plethora of lifestyle options that qualify as part of neo-liberal self-governance. The monthly gym pass, self-help books, detoxifying cleanses, and yoga retreats are beyond the grasp of most individuals in the zone of vulnerability, let alone among those who are on the periphery of society. Having the freedom to choose the nature, quality, and quantity of self-betterment programs is tantamount to the modern mode of governance, so inclusive strategies are disseminated differently among those who have less freedom. For those who belong to the excluded circuit, their engagement with inclusionary programming has less to do with personal reflection, and more to do with what experts and para-professionals deem useful, personal and economic resources, program availability, and eligibility. Sometimes these governing schemes are coerced, such as mandated addiction treatment as part of probation/parole conditions (Klag, O’Callaghan, and Creed 2005); oftentimes they are voluntary but strongly encouraged.

For Bauman (1988) freedom comes from being able to act on your own will, rather than the will of others. Constraining choice and eliminating opportunities reflect the exclusionary circuit in which these inclusionary practices exist. Despite the incongruence between programming that is built from an inclusionary perspective and the lack of freedom in implementing them among the excluded, the goal remains the same: “Subjects are to do the work on themselves, not in the name of conformity, but to make them free” (Rose 1999: 268). We need to make sense of why excluded people embrace inclusionary tactics when it is readily

apparent that there is no space for their actual inclusion. I offer two possibilities why marginalized individuals might voluntarily participate in self-help programs, education and work placement opportunities, and goal oriented leisure activities (such as running or cooking groups) that are often organized by not for profit organizations. I suggest that the, albeit intangible, notion of hope and the desire to be the ‘included among the excluded’ act in tandem with other potential factors to explain why many excluded individuals buy into the unsubstantiated promises of the inclusive circuit.

Rose (2007: 135) defines hope as part of the broader risk management project that seeks to manipulate the present in order to achieve a desirable future: “In a world imbued with a drive to master the future and still clinging to an ambivalent belief in progress, hope draws our gaze to a horizon upon which things are imagined that we expect with desire, or desire with expectation”. Rose suggests that we need to think about hope beyond a subjective feeling and consider its role in affecting our choices and behaviours. While homeless shelters are thought of as spaces of hopelessness (Huey 2012; Huff 2008), inclusive strategies invite excluded people to reframe their futures by changing their thoughts and behaviours today. This hope, however unfulfilling it may be long term, provides individuals who face unyielding barriers, oppression, and hostility to formulate a sense of progress and of action to create purpose in their lives: “Hope, here, is not mere wishing and anticipating – it postulates a certain achievable and desirable future, which requires action in the present for its realization” (Rose 2007: 148). Hope acts as a catalyst for individuals to make sense of and see potential in their future. This is realized through ambitions to complete school, find well-paid and meaningful work, and to achieve the emotional stability to reconnect with family. Unfortunately, the resources required to successfully complete high school or post-secondary education, the dearth of well-paying stable

jobs, and complex and potentially volatile family dynamics undermine the prospects offered through inclusive discourses.

Rose and Novas (2005) describe a 'political economy of hope' that occurs when individuals actively participate in awareness campaigns, fundraising, and finding treatments/cures for their illness. Working through hope suggests that individuals are expected to be active players in their own well-being rather than passive recipients of wellness. The term also highlights the economic role hope plays in producing wealth for the health/wellness/lifestyle sectors. Rose and Novas (2005) illustrate both of these meanings of the political economy of hope with the example of a support group found on Prozac.com. The discourses on the website suggest that depression is manageable⁴⁹ so long as a patient takes up her own personal recovery narrative that includes psychopharmaceuticals. Experts and para-professionals have a vested interest in maintaining the political economy of hope so that their programs remain full, state funding is renewed, and members of the excluded community are docile. Fostering a sense of hope maintains a steady stream of interested people in various programs and initiatives without the state and their partners having to demonstrate increased inclusion. It is the same neo-liberal logic that calls for increasing punitiveness while the state acknowledges that it cannot eliminate crime (Garland 2001; Loader 2009). Program administrators encourage participants to gain a sense of hope so that they voluntarily participate in self-responsibilization and disciplinary techniques without having to provide them with the rights and privileges that are thought to come with adopting these ideologies, namely financial independence, happiness, and security. It

⁴⁹ It should be noted that, especially with reference to mental health rather than physical health, the discourse has turned into managing rather than curing illness. This comes in part from the recognition that the most common treatments for mental illnesses, namely psychopharmaceuticals, target symptoms rather than treat the cause of the illness. In many cases the cause is unknown, but there is also a financial benefit for pharmaceutical companies to retain a customer for life (Moynihan, Heath & Henry 2002).

cultivates a climate where the excluded are expected to act out inclusive discourses without being included in a material way.

We should not assume, though, that the homeless and/or mentally ill are simply being duped into a false sense of hope. Beyond the dreams of a meritocracy that Young (1999) describes in the American ghetto, there are also strategic and practical reasons why the excluded might take up inclusive discourses. I argue that participating in inclusionary programs is a tool to become and remain included within the excluded circuit. If, as I have detailed, the exclusionary category can be sub-divided into the social junk/redeemable and the social dynamite/irredeemable category, it stands that many marginalized people will seek out ways to be identified as social junk. To be designated redeemable is to be thought of as worthwhile, which comes with certain privileges. Whether the excluded adopt the inclusive rhetoric earnestly or are performing their role as social junk (Goffman 1961; Moore & Hirai 2014) is unclear. As Moore (2007a; see also Kilty 2012a) articulates in her analysis of resistance in drug treatment courts, some participants perform the addict identity and follow the rules of the program in order to keep favour with the court so that they might be discharged. As we will explore in the chapters that follow there are high stakes involved that significantly influence the quality of life in the homeless community – factors such as the best rooms, access to restricted spaces, opportunities for leisure activities such as outings or liberal access to television and movies, and more autonomy and privacy. All of these resources come from being singled out as worthy and can only be maintained if the redeemable submit to the rules and basic responsabilization strategies set out by the resource providers.

The threat of not becoming or sustaining the social junk/redeemable status is to fall into the social dynamite/irredeemable scope. As we recall, social dynamite are especially risky

individuals who are not ‘deserving’ of inclusive programs but are simply managed to minimize risk, often through incapacitation (Spitzer 1975; Rose 1998, 2002; Castel 1991). Many homeless and/or mentally ill participate in inclusionary practices to avoid being given up on which would make them even more vulnerable to incarceration in a jail, prison, or mental hospital. Those who participate in programming are looked upon more favourably by experts and para-professional authorities as fulfilling their role as marginal but responsabilized subjects. For example, staff may turn a blind eye to someone thought to be redeemable who shows up to the shelter intoxicated, whereas those who are considered social dynamite may be barred from the shelter. Likewise, staff may hesitate to contact police if a fight breaks out if they know they can appeal to the individual’s sense of reason and civility. Those categorized as social dynamite are thought not to have any civility, thus requiring targeted environments such as the prison in order to manage them (Fisher & Poland 1998). While the redeemable are not immune to the criminal justice system’s pervasive reach as it acts as a key site of social exclusion (Wacquant 2000), it is but one form of discipline, whereas for the social dynamite, the criminal justice system is often the primary strategy of governance.

Resistance within the margins

Marginalized individuals exist in a sphere of highly contested power dynamics. To be excluded requires the intersection of multiple sites of governance, including both disciplinary and self-responsibilization strategies. Foucault (1980a) tells us that power relations are everywhere and that power can indeed come from below. If we recognize the malleability of power relations we can carve out a space where acts of resistance exist among the excluded. Sure enough, the establishment of ‘non-conventional communities’ (Rose 1999: 195) such as that of the homeless and psychiatric survivor communities may be acts of resistance by developing their

own sets of values, lifestyles, and relationships (although Young would argue it is still built on the inclusive citizenry's principles). Resistance theory adds a further analytic layer to consider how mental health managerialism is used, negotiated, and rejected among homeless individuals.

Resistance is defined as "...opposition to a particular regime for the conduct of one's conduct..." (Rose 1998: 35). Because resistance is a form of power relations (Bosworth & Carrabine 2001), Bauman suggests that resistance exists in combination with acceptance. He argues that "...most of the time they are present together, blending uneasily in one's relations to power as they do in one's attitude toward freedom" (Bauman 1999: 53). Concepts such as contestation and transgression are related to resistance theory. Contestation refers to the smaller, more insidious forms of resistance that may not exact systematic change but work to shift power dynamics (Bosworth & Carrabine 2001; Rose 1999). The term transgression is used to signify a continuum of resistance. Given the messy realities of resistance (Bosworth & Carrabine 2001), transgression allows us to break down dichotomies (Pickett 1996) such as sane/insane, good/bad, normal/abnormal, housed/homeless, and instead witness identity production as it takes shape. Transgression research seeks to acknowledge the experience of all people, not only those who subscribe to strict binaries and in doing so engages in critical reflection on exclusion:

The various rules, limits, and norms history has placed upon us, which are often seen as natural, are the sources of exclusion, marginalization, and the resulting solidification of identity for those who 'confine their neighbours'. Through transgression it is possible to undermine these limits, although new ones will always arise (Pickett 1996: 450).

As I alluded to above, resistance takes many forms. Scholars note a gap in the research where resistance is often equated with issues of class alone, or when accounting for 'heroic opposition' and rarely classifies small, individual markers as resistance that can be equally

effective (Bosworth & Carrabine 2001; O'Malley 2001).⁵⁰ O'Malley extends a description of resistance as it relates to subjugated knowledge that highlights the possibility for small sites of resistance amongst the excluded:

It [resistance] is to interrogate rationalities for their hidden voices, ambiguities and contradictions. And it is, perhaps even more significantly, to move beyond rationalities and look for the disruptive and the different that may be inchoate, operating within or alongside – as well as in opposition to – the more visible rationalities. These are formed and sustained by minorities, the colonised and the outcast, and less visibly but equally importantly by all manner of people who carve out for themselves a space for self-government that is not programmatically articulated with more prominent and ascendant political rationalities (O'Malley 2001: 26).

Foucault (1980a) makes clear in his discussion of resistance that there are a plurality of resistances, all of which have their place in the realm of relational power. Often, it is more detailed and conspicuous modes of resistance that have the effect of breaking apart specific knowledge sets and recasting discourse with new knowledge frames. Rose (1999) adds that what he terms modest, pragmatic and tentative forms of resistance often take place in 'cramped spaces', such as excluded identities, and so these minor engagements are the only realistic spaces through which to resist. Many of Bosworth and Carrabine's (2001) examples of resistance in prison, such as filing a complaint against poor mental health care and deriding a hair stylist, exhibit these kinds of small acts within an environment built upon structures of domination. Castel (1988) concurs, noting that the 'twists and turns' that otherwise powerless people exert onto the rules of an institution demonstrate an inordinate amount of strength among those thought to be weak.

Despite the potential power shifts that may come from these acts of contestation, we must be careful not to be swept up in the romanticism of resistance scholarship. As Munn and

⁵⁰ There is some, predominantly feminist, research filling this gap, such as Frigon and Jenny's (2009) study of the female body and dance in prison as a site of resistance; Kilty's (2008) work on self-harm amongst former women prisoners; and Moore's (2007a) research on participants in Canada's drug treatment courts.

Bruckert (2010) note, it is theoretically and methodologically challenging to illuminate which practices account for resistance without overestimating all acts that differ from the norm as resistance as well as underestimating actions such as non-engagement. Similarly, Bosworth and Carrabine (2001) explore the challenges of representing acquiescence, non-compliance, and violence as resistance. They work through this tension by considering how one's identity and subjectivity impacts an individual's capacity for and techniques of resistance. Situating resistance within broader themes of inequality provides greater context through which to assess it. O'Malley, Weir and Shearing (1997) suggest that resistance often occurs between 'serious statements' and 'everyday discourses' and a research project that focuses on one or the other misses much of the complexity around contestation. Rose (1998) contends that in the neo-liberal era where individuals are governed through diffuse sites of power, it is much more difficult to identify and gauge acts of resistance. He argues that the myriad of identities that are made possible in a late modern world and the heterogeneity of lifestyles and knowledges to guide ways of being creates the conditions where refuting one framework may not be an act of resistance, but simply a matter of choosing a different set of discourses. Rose reminds us that labelling an action as resistance is making a judgement claim and we must be cognizant of how dominant discourses shape these assessments. Pollack's (2005) work illuminates some of the challenges that come with assessing resistance related to mental health. She finds that many of the narratives the participants provided her regarding mental health care in prison accepted the mentally ill identity and noted a form of appreciation for the institutional recognition of their distress, yet simultaneously resisted much of the expert psy-discourse offered in prison. Resistance literature asks us to consider how issues of identity and exclusion, in combination with various governing

strategies adopted by or imposed on individuals, characterizes our negotiations with the self, with others, and with institutions.

Conclusion

In this chapter I outlined three theoretical frameworks that guide this research project: governing through freedom, identity construction, and processes of exclusion. The literature on technologies of the self, empowerment, and the obligations that come from these neo-liberal strategies exemplify how we are rendered subjects through acts of self- and other-surveillance, risk management strategies, and the production of ‘appropriate’ lifestyles. Those who do not abide by the expectations of governing through freedom are subject to disciplinary strategies with the aim of creating responsabilized citizens.

Implicit in neo-liberal tools of governance that rely on self-actualization is an awareness of what constitutes the self. Our understanding of personal biography and selfhood has transformed significantly in the late modern world where identities are shaped by increased anxiety and insecurity. The doubts that emerge from living in a world built on scepticism and mistrust cause us to engage in a reflexive project of the self wherein identity is socially, culturally, and temporally situated. The autonomy to choose our identities and to perform identity self-consciously is contested in the literature. I argue that the continuity of these theoretical arguments lies in the complexity of understanding the self as a social product that is performed through everyday interactions. The situatedness of identity is apparent when we consider the structural and institutional imposition of marginalized identities.

Finally, I considered how framing the marginalized identity as the ‘Other’ reinterprets social problems as ‘problems of the excluded’ (Rose 1999). Exclusion is thus a mode of governance that exists in opposition, yet parallel to, technologies of the self. I argue that

inclusion/exclusion is an insufficient binary through which to analyze populations at the margins. Exclusion theory on its own does not account for the proliferation of the ideals of inclusion within governing strategies. In this chapter I considered why technologies such as empowerment and self-responsibilization are used on otherwise excluded groups and why some excluded individuals adopt these strategies. The excluded category can be nuanced by considering those who are identified as 'redeemable' and 'irredeemable'. The redeemable subject is one who is more likely to participate in technologies of the self, despite the unlikeliness that engaging in these strategies will lead to inclusion, based partially on the political economy of hope. Still, the redeemable status brings with it some benefits, namely fewer coercive and overtly hostile disciplinary techniques. However, not all marginalized people adopt inclusive discourses. Scholars (Bosworth & Carrabine 2001; Castel 1988; Munn & Bruckert 2010; Pollack 2005) note that small acts of resistance can and do take place and that these signs of transgression offer a space where the excluded identity can be negotiated.

Having built my theoretical toolbox using concepts and terms from the literature on governing through freedom, identity, and exclusion I move to analyze how homeless men and women 'do' their mental health status within the structural, cultural, and temporal confines of the homeless community in the twenty-first century. These theoretical constructs allow me to privilege the subjugated knowledge (Foucault 1980b) of this particular excluded group and make sense of the dynamics of mental health managerialism amongst the homeless and their negotiations with the mental health and homeless identities and the related discursive and institutional structures. Before turning to the substantive analysis, the next chapter outlines the methodological framework used to structure this project and the specific methods used collect and analyse qualitative experiential data.

Chapter 4 – Methodology: Managing the Field

Introduction

Conducting critical social research that problematizes normative assumptions about governance strategies, modes of exclusion, and systematic oppression based on gender, race, ethnicity, sexuality, class or ability has long been a staple in the sociological and criminological fields. Although, it continues to be discredited by some who seek objectivity and measurable validity found in more traditional, positivist research (Kilty, Felices-Luna & Fabian 2014). Qualitative and inductive critical research that privileges the voices and experiences of participants rather than proposing a supposedly ‘neutral’ analysis by an ‘expert’ researcher is rooted in a commitment to social justice and allows for a situated understanding of a social phenomenon such as homelessness and distress. Despite its many benefits, critical qualitative research projects face many epistemological, ethical, and practical challenges. The ways people shape and locate their narratives holds the potential to disrupt the notion of a universal and static ‘Truth’ and it is by asking questions and hearing from those on the ground that we can begin to make sense of how our individual and collective sense of the social world emerges.

In order to answer the research questions set out in chapter one I used a qualitative research design that allowed me to theorize on the nature of mental health managerialism in the homeless community through the narratives of those with lived experience. In this chapter I present the epistemological and methodological underpinnings of this research project and describe the research process in detail. I explain the methodological design of the research as well as the coding and analysis processes used to make sense of the data. I conclude by reflecting on the limitations of conducting a finite research project and on my own position in the research. Despite years of planning, research, and training the execution of this research project was

inevitably messy, challenging, and emotional; at the same time, it provided a platform to hear the stories of those whose voices are so often subjugated and acts as a springboard to advance social justice campaigns in the future. On a more personal level, this research project has transformed my perspective on compassion, strength, and resiliency and has shown me the common ground upon which we all stand and from which we can promote greater dignity and respect for vulnerable citizens.

Epistemological engagement

I rely on standpoint theory to contextualize knowledge as socially situated (Harding 1991) and refute the notion of research as a search for an empirical and knowable truth. Although a variety of definitions of standpoint theory abound, particularly as it relates to standpoint feminism, here I use standpoint theory to characterize ways of knowing as: "...human activity, or 'material life', not only structures but sets limits on human understanding: what we do shapes and constrains what we can know" (Harding 1991: 120). If knowledge is mediated by the researcher's positionality, the subjects being investigated, and the broader social and cultural structures that inform our ways of being and knowing, we must recognize the multiplicity of perspectives that come to shape how we 'know what we know': "Rather than 'leveling' the world with a singular, objectivizing narrative voice, it preserves and recovers the polysemy of multiple positions, interests, and agencies in the settings it analyzes" (Macbeth 2001: 39).⁵¹ Framing knowledge as incomplete, multifarious, and positional leads to competing theories on the usefulness of searching for epistemological objectivity (Corbin & Strauss 2008; Haraway 1988; Harding 2004; Pels 2000); however, it is clear that a standpoint theory of knowledge production seeks to fill the gap between individual experiences and the structures that produce

⁵¹ Here Macbeth (2001) is referring to positional reflexivity, which is used in standpoint theory, textual deconstruction and critical theory, among others.

the dominant discourses that shape how we understand the world around us (Harding 1991, 2004).

Paramount to standpoint theories is that knowledge is situated (Haraway 1988). Unlike the search for objectivity or even relativism, standpoint theories build their foundation on ‘partial knowledges’: “The alternative to relativism is partial, locatable, critical knowledges sustaining the possibility of webs of connections called solidarity in politics and shared conversations in epistemology” (Haraway 1988: 584; see also Pels 2000). Haraway (1988: 590) goes on to describe standpoint epistemology as: “the joining of partial views and halting voices into a collective subject position”. Because all knowledge production is made from a specific ‘lens’ and consumed through individualized forms of ‘vision’ (Haraway 1988) critical social research is poised to find the spaces of convergence and dissonance between various ways of knowing. In this way, standpoint epistemology is especially useful when studying marginalized groups because research that is premised on the subjugated knowledge of the oppressed reveals unique accounts of the social order that are ignored by conventional discourses (Chunn & Menzies 2014; Harding 2004; hooks 2000). When we study a setting through the perspective that all knowledge is socially situated (both dominant and subjugated knowledges) we are privy to how knowledge is made, reproduced, and the power dynamics that embolden some knowledges while dismissing others.

Standpoint theories’ emphasis on partial and situated knowledge complements the social constructionist paradigm. Social constructionism argues that knowledge is mediated by social, cultural and temporal conditions:

Social constructionist arguments, by and large, begin from a number of explicit or implicit propositions concerning knowledge. Knowledge is ‘underdetermined’ by experience, so that the world must be understood in terms that are the product of culture.

Hence these understandings are dependent not on the nature of reality or the empirical validity of the propositions, but on social processes (Rose 1998: 49)

Kerwin (2012) agrees, citing seminal scholars such as Butler, Haraway, and Latour as theorists who argue that there is no way to separate knowledge production from culture and politics. The goal of social constructionism is to deconstruct discourses so as to reveal the power relations that produce them (Rose 1998). Standpoint theories and social constructionism are both critically oriented and, mirrored in the discussion on institutional ethnography below, are suited to social justice research that seek to shed light on power imbalances and the oppression of marginalized groups. By rebuking dominant ways of knowing, standpoint theories open up a space to question the ontological reality of disciplinary truisms.

Of special consideration for this research project is privileging the knowledge of those who have experienced distress. The ontological reality of mental illness in particular is worth questioning. The anti-psychiatrists of the 1960s and the contemporary mad movement question the foundation of mental illness within the medical model (Burstow & Weitz 1988; Laing 1960, 1967; Shimrat 1997; Szasz 1974). The anti-psychiatry movement asks us to place the ‘symptoms’ associated with mental illness in the context of the individual being diagnosed. Each person has her own perspective on her world and her own unique form of truth (Laing 1960; Laing & Esterson 1964). Anti-psychiatry and later the mad movement’s position reflects a postmodern emphasis on recognizing how people interact with their environment and the multiple truths that are contextually and materially dependent (Gergen 2000; Roberts 2000). Psy knowledge and the mad subject are both social constructions; critical scholarship seeks to unpack these constructs by highlighting their social, cultural and temporal contingencies and by making a space for alternative discourses. Re-framing mental illness as a classification tool rather than a

discoverable entity is consistent with labelling theory, where concepts such as criminality are deconstructed in order to refute the notion that an act or someone is inherently criminal (Becker 1963; Klein 1986; Link et al. 1989; Ussher 1991).

Problematizing the epistemology of mental illness in this research project allowed me to engage critically with how mental illness is governed. In doing so, however, I am sensitive to the distress facing many people in the homeless community. Ussher (1991) notes that while it is important to be critical of society's role in creating sadness, anger, and crises, deconstructing the discourse must be accomplished without denying people's pain. By using the stories of those with lived experience to anchor this research, I undertook to critically analyze the nature of mental health managerialism in the homeless community while paying deference to the often traumatic and vulnerable narratives of the research participants.

Methodology

In keeping with a focus on the lived experiences of homeless men and women and their interactions with mental health managerialism, I endeavoured to conduct an institutional ethnography. Institutional ethnography maintains the critical epistemological position described above by situating social phenomena in complex social relations rather than as natural ways of being (Smith 1987) and uses 'experience as a method' (Smith 1997). Institutional ethnographic research seeks to: "...understand and describe the connection among these sites of experience and social organization" (Campbell 1998: 62). Everyday experiences are problematized and given meaning within the social, cultural and temporal landscape (Macbeth 2001). Here institution refers not only to specific social structures but also to the intersection of multiple ruling apparatuses: "The notion of ethnography is introduced to commit us to an exploration, description, and analysis of such a complex of relations, not conceived in the abstract but from

the entry point of some particular person or persons whose everyday world of working is organized thereby” (Smith 1987: 160). In this research project the institutionalization of homeless men and women in shelters, mental hospitals and jails/prisons is investigated in addition to the broader social, political and spatial arrangements that mediate individuals’ experiences of poverty, distress and exclusion.

Institutional ethnography is grounded within everyday experiences. It centers sociological inquiry on the variety of experiences instrumental to knowledge production, ‘work’⁵² processes, and social practices (Campbell 1998; DeVault 2006; Kaler & Beres 2010; Liebling 2001; Smith 1987, 1992). In this way, institutional ethnography uses people’s everyday lives as a point of interpretive entry to make sense of the ruling relations that make up our institutional arrangements (Campbell 1998; Smith 1987). For example, in this research project many participants spoke at length about the kinds of activities that take place in drug treatment programming, attempts at finding employment, and disagreements with shelter residents. These stories serve as a gateway to explore modes of governance, identity construction, responsabilization discourses, and forms of exclusion, among other themes. The narratives ground the analysis and are enlightening not only as a glimpse into the lives of Ottawa’s homeless men and women, but also because they allow us to investigate social relations in practice: “Though women are indeed the expert practitioners of their everyday worlds, the notion of the everyday world as problematic assumes that disclosure of the extralocal determinations of our experience does not lie within the scope of everyday practices” (Smith 1987: 160-161). An individual’s worldview is situated within her particular experiences and institutional

⁵² Smith’s (1987: 166-167) notion of ‘work’ is expansive and is used to “...engage with the ways in which people are actually involved in the production of their everyday world, examined with respect to how that world is organized by and sustains the institutional process”.

ethnography, as a method of inquiry, provides the framework through which to extrapolate meaning from these ‘actual’⁵³ events.

Founding sociological inquiry on personal experience is in keeping with a symbolic interactionist paradigm. Symbolic interactionism studies how people make meaning of their lives based on social interaction. Meaning-making is a social, cultural, and political process rooted in connections between people and between people and institutions (Becker 1963; Blumer 1969, 1980). For example, Becker’s (1963) *Outsiders* investigates the labels used to define deviancy as a product of ambiguous rule creation and subjective enforcement by dominant groups (moral entrepreneurs).

Although borrowing from both a social constructionist and symbolic interactionist approach may appear contradictory the two orientations can complement one another and provide a rich schema for analysis. Referring to Foucault’s social constructionist leanings and Goffman’s symbolic interactionist approach Hacking writes:

There is something missing in those [Foucaultian] approaches – an understanding of how the forms of discourse become part of the lives of ordinary people, or even how they become institutionalized and made part of the structure of institutions at work. Of course there is something absolutely missing in Goffman too: an understanding of how the institutions he described came into being, what their formative structures are (Hacking 2004: 278)

Likewise, in his study on drug treatment in the United States Bourgois (2000: 188) finds that a social constructionist paradigm is inadequate on its own to fully explain methadone clinics as a social arrangement and can “lead to [analytic] paralysis”. Bourgois uses a symbolic interactionist lens to make his critical insights on the structural forces at play ‘concretely relevant’. In this way,

⁵³ Smith (1992: 92) uses the term ‘actual’ purposefully to account for the continued emergence of sociological knowledge from the experiences of living (both the subject and researcher’s experiences): “I want the term *actual* to be always directing us back to the ‘outside [of] the text’ in which living goes on and in which the text is being read” [emphasis in original].

using institutional ethnography as a mode of inquiry bridges constructivist and symbolic interactionist paradigms to allow for the epistemological questions on the nature of homelessness and mental illness and their governance to be formed in and through an investigation of the day-to-day lives of the research participants.

Many researchers who engage in institutional ethnography as a method develop a ‘deep sympathy’ (Becker 1967) for their participants and it is common for these projects to be politically oriented. Indeed, institutional ethnographers are often compelled to ‘take a side’ (Becker 1967) and expose how relations of ruling affect marginalized groups.⁵⁴ Although modest in her goals for institutional ethnography, Campbell suggests that the nature of the research is implicitly connected to social justice:

The relations of ruling do not disappear by learning about them, however, nor can they be shaken off by individuals, themselves. They are every-present in our lives, like the water that fish swim in. Knowing more about how our lives are tangled in ruling relations can help to reduce the frustration we feel about living and working in societies such as ours where things seem to get decided behind our backs, or at least outside of our control. (Campbell 1998: 70)

Campbell’s goals concentrate on how research may impact the lives of her participants. Others find that institutional ethnographic research is often rooted in political activism and thus must be committed to asserting particular values so as to resist injustice and develop a more equitable political landscape (Becker 1967; Liebling 2001). Dorothy Smith (1992) is less certain of the ‘transformative’ potential of institutional ethnography but calls for a reflection on the ways in which social relations and organizational structures shape our lives. In the analysis that follows it is clear that my allegiance lies with the homeless, although I have to be careful not to impose a

⁵⁴ Liebling (2001) questions why Becker and other institutional ethnographers cannot be sympathetic and thoughtful to multiple ‘sides’; in her work she aims to sympathize with both prisoners and prison staff and management. She chooses to study both sides in order to better appreciate and be sensitive to the material reality of prison life.

romanticized version of sympathy (Liebling 2001). As I explore below, the best way to connect with individuals experiencing homelessness is through participant observation and interviews.

Operationalization

Before entering into a discussion on the methods employed in this research project, I must clarify how some terms were used in the participant recruitment and data analysis.

Homelessness

It is widely acknowledged that homelessness is a difficult concept to define. Chamberlain and MacKenzie (1992) remind us that homelessness is a socially constructed concept and our perception of what qualifies as a minimum community standard of living is based on our historical, cultural and social context. Although the terminology varies, the homelessness literature acknowledges that definitions of homeless fall along a spectrum. As described in chapter two, absolute or literal homelessness are situations where a person is living on the streets, in cars, shelters, abandoned buildings and other places ‘unfit for habitation’ (Echenberg & Jensen 2008; Eyrich-Garg et al. 2008; Harter et al. 2005). Relative or marginal homelessness consists of individuals participating in transitional living programs, temporarily living with relatives, couch surfing, and living in boarding houses. Finally, there are those who are at risk of homelessness or inadequately housed, defined as those in permanent living situations but who spend more than fifty percent of their family income on housing and/or those who live in an environment filled with noise, pollution, infestation, and minimal privacy (CIHI 2007; Chamberlain & MacKenzie 1992; Gaetz, Gulliver & Richter 2014; Neale 1997).

Noting the practical limitation of accessing hidden homelessness (Chamberlain & MacKenzie 1992), this project defines homelessness as absolute and relative homelessness to allow participation from individuals who reside in semi-independent community housing but

who identify as members of the homeless community and continue to rely on supports from the homelessness sector, such as food, clothing, employment and other intervention programming, and social interaction. In order to address episodic homelessness (Kuhn & Culhane 1998; Santiago et al. 1988) individuals who were absolutely or relatively homeless in the three months leading up to the interview were eligible to participate. It is important to have a broad definition of homelessness given that one of the guiding research questions is how a relative lack of resources impacts one's ability to negotiate and/or resist mental health managerialism or if it is through 'compliance' that individuals gain access to more supports and resources such as semi-independent living.

Distress

Susser et al. (1990) found that many studies rely on psychiatric treatment history to operationalize mental illness. This measure is insufficient because it ignores self-determination as to whether or not the distress experienced is the result of a psychotic disorder and because prior institutionalization does not necessarily indicate current mental distress (Snow & Anderson 1993; Snow et al. 1986). Moreover, I argue that one result of the psychiatric deinstitutionalization movement of the 1960s and 70s is that mental health intervention does not always take the form of hospitalization. With reference to the homeless, we must consider the outreach psychiatric doctors and nurses who make weekly rounds to shelters and community health centers as playing an important role in expanding intervention beyond the hospital setting. While limiting the research to those with specific types of diagnoses is plausible, as Kilty (2008, 2012) found, many individuals do not know their diagnosis or why they are prescribed psychotropic medication.

In light of this information and my interest in the negotiation of the mental illness identity, I made no specific participation requirements based on specific types of mental health intervention. Instead, I look to those who have experienced the mental health system in some capacity to relate their understanding of mental health managerialism. Moreover, I was interested in speaking to homeless individuals who did not identify as interacting with the mental health system about their experiences with living among those formally labelled mentally ill. In retrospect this was a worthwhile decision because a number of respondents who had no direct contact with the mental health system and who otherwise would not have been eligible to participate identified as suffering with mental illness, which opened up a level of analysis regarding self-assessment and mental health responsabilization that may not have presented itself had I limited the inclusion criteria.

Instead of referring to mental illness I use the term ‘distress’, as used by some authors (Susser et al. 1990) and mad activists (Tew 2005) to recognize the difficult physical and emotional situations people find themselves in while de-privileging medicalized discourses. As Ussher (1991, 2010) argues, when using a social constructionist framework we must be cognizant not to reject, dismiss or romanticize the distressed experiences or misery that people face on a daily basis. Using the term distress allows me to place lived experience at the centre of the research without making assumptions as to the nature or cause of the pain.

Professionals and para-professionals

Homeless men and women experience different forms of intervention from support staff. The role of professionals and para-professionals can be conceived broadly as practitioners (Davis 2006) or as community mental health workers. This wider interpretation is important given the ‘role blurring’ that occurs in the field of mental health (Robin & Wagenfeld 1977) where

frontline staff are sometimes called upon to provide counselling and support workers have to become rule enforcers (Cohen 1985). There is, however, a notable difference between professionals and para-professionals. Professionals are those individuals with the education and qualifications to act with authority on an individual (Robing & Wagenfeld 1977). Cohen (1985: 162) defines para-professionals or semi-professionals as groups who “...are dependent employees of public bureaucracies and, despite their pretension or aspirations, have little power in determining major policy decisions”. Para-professionals are those who work with the homeless population on the frontline and organize and run the support programs. While in many cases para-professionals must defer or report to professionals, the distinction is not always clear. Demonstrating the connection to but distinction between both groups allows us to consider the complex power dynamics and multiple forms of intervention taking place in the homeless community.

Research method

In this section I provide detailed information on the methods used to conduct this research, including participant observation, interviews, and a focus group. In order to ethically and effectively engage with these methods, I first discuss how I entered the field and built relationships with members of the homeless community built on transparency and trust.

Entering the field

Before beginning the PhD program I had some experience with people suffering distress (friends/family) but little interaction with people living in the homeless community other than informal encounters. I was, and in many ways continue to be, an outsider (Adler & Adler 1987;

Bridges 2001; Kaler & Beres 2010: 32).⁵⁵ In order to gain entrée into the field and to get my bearings on the state of homelessness and mental health I began volunteering in the homeless community. In order to gain ‘epistemological clarity’ Bridges (2001) contends that outsiders must become immersed in the community; have empathy that spawns appropriate inquiry; and hear the stories of the population in an open, honest and responsible way. In order to fulfill these obligations, I began volunteering in shelter one, a large men’s shelter, in June 2010 and in the women’s section of shelter two in November 2010. I also volunteered in a soup kitchen run out of a local church once a month in November 2010. In the year before I collected data via semi-structured interviews I volunteered approximately twelve to eighteen hours a week in the two shelters and soup kitchen. I took on a number of roles including serving meals in all three locations, working in the computer lab, participating in evening socials, activity nights (bingo) and simply spending time in the common areas of the shelter. The activity nights were especially fruitful for meeting new people as both housed and homeless men and women participated. I also attended special events such as Christmas parties, carnival days, and music nights. I was often seen around the halls of these organizations four days a week.

It took a long time to gain respect and to build trust and rapport in the homeless community, as there is a great deal of turnover among volunteers. Because I told many of the individuals I was a student (I was clear from the beginning that in the future I was hoping to do research at these shelters so as to enter the relationships transparently) and because I am often mistaken to be younger than I am, many of the people I met assumed I was volunteering for school community service hours and would leave once I had reached the set number of hours.

⁵⁵ An ‘outsider’ is a researcher who does not belong to the community she is studying. There are opportunities and challenges to being an insider or an outsider that are explored elsewhere (Adler & Adler 1987; Bruckert 2014; Sherif 2001).

Alternatively, many of the volunteers I have met over the years are in the process of applying to various police units and only volunteer during the active recruitment phase. I was able to distinguish myself from these volunteers primarily by remaining in the field for longer than a few months, but also because I believe it was apparent that I was genuinely interested in getting to know them and I had candid conversations with people about the nature of volunteering and the paternalistic attitude some volunteers project in their attempt to ‘do good’ (Doerr 2015).⁵⁶ I spent a great deal of time getting to know people in the homeless community. Most of my encounters were casual, chatting about sports, the weather, and current events. Some interactions were especially meaningful: I played crossword every Friday for two years with Seamus; William tried to teach me how to paint; Jasmyn hung out with me while I did dishes to talk about her struggles with religion and with men. The more time I spent ‘bearing witness’ to the lives of the people around me (Caron 2014) and simply being in the community, the deeper my resolve for social justice with respect to homelessness became.

Over time many individuals got to know me by name and reputation. My reputation followed me in shelter one because my father was the chaplain at the time and I was jokingly referred to as ‘the chaplain’s daughter’. Kaler and Beres (2010) suggest using personal contacts and networks as gatekeepers to gain access to a field. Using my father as a gatekeeper was likely advantageous in securing permission from the shelters to conduct research given the research fatigue facing many homelessness organizations so that fewer researchers are gaining access to marginalized populations (Clark 2008). But I proceeded with caution. When I began

⁵⁶ For example, one volunteer I worked with serving breakfast on Monday mornings was appalled that not everyone said good morning and thank you when they received their meal. To counter-act this habit, she would loudly say ‘you’re welcome’ to those who did not say thank you. I eventually pulled her aside and spoke to her about the expectations of volunteer work and the degrading and dehumanizing system that many homeless people face. I also suggested that many individuals in the line at Starbucks likely don’t say thank you on a Monday morning but aren’t berated for their omission. After a few months she was hired onto a police force in rural Ontario and left the shelter.

volunteering I requested that my father not inform shelter residents that I was his daughter to avoid any potential conflict future research participants may have in believing that participating in my research project would build an alliance with the chaplain (Singer & Bossarte 2006). However, as anyone who has spent time in an institutionalized setting knows there are no secrets and within weeks people were asking me if the chaplain was my father. Over time I began to carve out an identity distinct from his in shelter one and more easily in shelter two. The revelation that I was the chaplain's daughter occurred so early in my volunteering that it was 'old news' by the time I was ready to recruit interview participants a year later. Still, my father was careful not to mention my project to any of the residents and I used every available opportunity prior to and during recruitment to reassert that the Chaplain's office was not connected in any way to the research and that there was no institutional advantage for participating.

I also had to manage the dynamics that come from performing the volunteer and researcher role simultaneously. Although volunteers have little authority in the shelters, there are power differentials inherent with providing service and being served. This was a difficult balance. I avoided tasks involving rule enforcing, perhaps to the detriment of my assigned volunteer job. For example, in the computer lab I assisted individuals with conducting web searches, finding information online, and writing resumes. I was also tasked with enforcing the thirty-minute time limit. If there was no one waiting for a computer I did not intervene. When there was someone waiting, I would appeal to those in the room to see if anyone was done with the computer and only had to 'enforce' the rule on a couple of occasions. Similarly, as a volunteer in shelter one I attended boundary training which detailed strict ethical guidelines. Some of these rules were antithetical to building rapport and breaking down some of the power imbalance between me and the residents (Dickson-Swift et al. 2007). Rules included not

accepting gifts from residents, no touching of any kind, not providing any personal information about myself, and not having online contact with any residents. In order to manage these boundaries I deployed the tactic that I too was subject to the arbitrary rules of shelter management. When an individual would ask me to ‘friend’ them on Facebook I told them that the shelter has rules against this and if I accepted their request I would not be allowed to volunteer anymore. In these instances I tried to align myself with residents more so than shelter management by demonstrating the power differential between staff and I.

On several occasions, however, I resisted the guidelines, in part to build the rapport I know is essential to conducting meaningful fieldwork and also because of my personal desire to connect with the people I was spending so much time with. Indeed, despite the no touch rule I have hugged many residents upon news that they have found a home, become engaged, lost someone close to them, or are moving to another city. I continue to accept gifts from residents, such as a can of pop, a candy, and even more meaningfully, art and poems people have made for me. While I acknowledge that some individuals may conflate gift giving with seeking preferential treatment or wanting the favour to be returned, I am also deeply aware that among those with few possessions, the act of gift giving is incredibly moving and reorients the power dynamics to one where they are the giver and I the grateful recipient.

By the time I began recruitment I had transitioned from a ‘peripheral member researcher’ to an ‘active member researcher’ (Adler & Adler 1987). I am still an outsider, but gained the status of ‘acceptable incompetent’ (Lofland et al. 2006) where the terms and references that I do not know are generally forgiven and people are willing to teach me rather than dismiss me as an ignorant stranger. Indeed, my felt acceptance in the community came from G., a quiet spoken

man with whom I had always been friendly but had not had long interactions with. He caught me by surprise when he brought me a poem he wrote and framed:

A Golden Heart

Arriving the blues and manic of Monday
An angel came on down to our land
Good morning to us all did she say
Bringing smiles with French toast in her hand.

But as Thursday rolled by on its way
She took the strongest of all stand
Shouting let the balls fall as they may
It's bingo night where prizes are so grand.

Now Friday to resume her good deed
As a librarian she kindly took a pause
For to listen much more than to read
From a heart who believes in its cause.⁵⁷

Adopting the feminist position that the personal is political, G's poem is an example of how many people in the homeless community came to view me as an ally. My personal connectedness to the homeless community provides me with the confidence and motivation to respectfully conduct research as an outsider. Fillmore, Dell and Kilty (2014) discuss the importance of building reciprocity, respect and recognition when conducting research alongside Aboriginal participants. Their research with Aboriginal women emphasizes the value of multiple voices and building and implementing a research design that understands and values interconnectedness. By 'researching with respect' I was able build a relationship with G. and others in the homeless community that fostered my commitment to conducting critical, social justice oriented research.

⁵⁷ This poem is reprinted with G.'s approval.

Participant observation

I received ethics approval from the Research Ethics Board of the University of Ottawa in April 2011 in concordance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (CIHR, NSERC & SSHRC 2010) and permission from shelters one and two and the soup kitchen to conduct research in May 2011. Posters went up at both shelters on the same day, looking to recruit interview participants as well as inform individuals that I would be conducting participant observation.⁵⁸ Regarding note taking, the poster read: “Erin Dej, a volunteer here, is doing research for her PhD thesis. This means she may write down non-identifying information about what she sees and hears. If you do not want to be part of the observation, please inform Erin”. No one requested to be omitted from the research.

I took field notes after each volunteer shift from June to December 2011, accounting for approximately 296 hours of participant observation. Participant observation was an important component to the research because I was able to make sense of the homeless community broadly through an analysis of multiple, ongoing, local experiences (Campbell 1998). I acted as both a participant and observer by engaging in a variety of volunteer duties while observing the space, and conversations and exchanges that took place around me (Bailey 2007). Balancing the two roles is optimal (Kirby, Greaves & Reid 2006) and although my priority was to observe, I was active in my interactions with participants, both for the sake of the research and as a component of praxis.⁵⁹

My participant observation took the form of unstructured observations so as to take note of any intriguing or relevant issues as they came up (Bailey 2007; Palys 1997). This flexibility

⁵⁸ See the poster in the appendix B.

⁵⁹ Praxis comes from feminist activist research that seeks to “...break up the social silences to make spaces for fracturing the very ideologies that justify power inequities...” (Hollingsworth 1997: 494) and exists along with positionality and politics as a basic feminist principle (Kilty 2014).

allowed the field and participants to shape the narrative of my field notes. I noted the physical characteristics, behaviours, body language, verbal behaviours, and actions of both staff and homeless individuals I encountered (Wolfinger 2002). I took field notes directly after each volunteering session so as to take the most precise account of my observations (Kirby, Greaves & Reid 2006; Oberhuber & Krzyzanowski 2008). On several occasions I was able to take discreet notes while in the field. In the computer lab I sat at a computer for the duration of shift. When possible I would make notes to myself in an email to refer to after leaving the field. Other times I was able to jot down key words in the library notebook or on my cell phone in order to retain as much information as possible. In this way unstructured field notes acted as a method of data collection and also a form of record keeping and reflexivity on the research process (Palys 1997).

Field notes were a rich source of data and were a way to reflect on my position within the data as I often included my own thoughts, emotions and concerns within the notes (Hannem 2014; Jewkes 2011). For example, one evening after serving supper Jasmyn came to speak to me, very upset, talking about her past victimization and claiming that every few weeks she is abducted by aliens who probe her sexually. My field notes describe the situation and my emotional response:

This was one of the things I had been so scared of before I started volunteering. I thought there were going to be lots of super crazy people running around in hysterics. Now, the sort of ultimate 'crazy' declaration has happened – being abducted by aliens – and it doesn't scare me. It surprises me a bit, but I was not uncomfortable listening to her and didn't need to quiet my judgement (except I suppose, not believing the facts). What I see as more important here is not whether or not she was abducted, but what that means for her and how she feels. How scary it must be to not feel safe anywhere. At one moment when she was crying she said she just didn't want them to come back anymore. I can understand that. I can understand her story more than I thought I would have ever been able to. Because I don't think Jasmyn is crazy. I think she's working through things the best way she knows how (December 2011).

The notes from one of my interactions with Jasmyn provides an accurate retelling of the events that took place that evening which is important to data collection; additionally, it calibrates my focus and reminds me of my position at the time of the field work and how my interpretation of the situation impacted the notes I took.

It was important that participant observation take place before, during and after the other forms of data collection as the field notes acted as a form of triangulation with which to assess, complicate and nuance findings (DeWard & Moe 2010). Field notes provided me with helpful information to create my interview guide, remark on emerging themes, and make sense of the data that arose during the individual and focus group interviews (Oberhuber & Krzyzanowski 2008). Conducting participant observation allowed me to witness how the agencies and the actors involved in mental health managerialism, and social control generally, engage with homeless individuals. It also provided insider knowledge with regard to how the shelters function, the routines and rules that homeless men and women experience, and how relationships are formed and maintained between homeless individuals and between the homeless and staff.

Interviews

Interviews were an essential method given my interest in personal accounts of identity construction, autonomy and resistance. Interviews provide a space for research participants to share their story and communicate meaning through narrative (Chase 2003) and they allow researchers to make sense of the impact of broader social structures on lived experience. As per Doucet and Mauthner (2008: 335; see also Caron 2014): “The research interview can be a site for the construction of one’s ‘moral’ identity as well as a potential avenue for resistance and healing when topics are of a sensitive nature”. While the interviews were not counselling sessions, they offered a unique space to think deeply about the actions the participants take and why.

Interviews, while somewhat unnatural in their formulation, establish human-to-human relations so that the researcher can understand the perspective of the interviewee rather than passively explain a phenomenon through rigid survey questions (Fontana & Frey 2000).

As aforementioned, recruitment flyers were posted in shelters one and two on the same day. Within hours of hanging posters at shelter one I was inundated with phone calls, so much so that I had to call shelter two to ask them to delay hanging the poster.⁶⁰ Because of the time gap between the interviews conducted in shelter one and those done in shelter two I interviewed all of the male participants before the female participants. This was not intentional as I met a number of women I would later interview through shelter one and I interviewed people who were not residing at either shelter. Because there was such an overwhelming response to the call for participants, likely influenced in part by the financial remuneration⁶¹ I provided, I was unable to recruit from the soup kitchen.

Interview Sample

I conducted forty-four interviews in June and July 2011, thirty-eight of which are used in this dissertation. Four interviews were omitted on account of their brevity (lasting less than ten minutes) and lack of any kind of substantive response. I was unable to transcribe two interviews because they occurred outside in extremely windy conditions and the tape recorder was unable to pick up the voices (in one of these interviews the participant was only comfortable walking in the

⁶⁰ I could only schedule so many interviews in a day and scheduling interviews too far in advance was not ideal for participants and would likely have led to missed appointments.

⁶¹ Remuneration is a contentious issue in the methodological literature (Kirby, Greaves & Reid 2006; Guyll, Spoth & Redmond 2003), especially concerning vulnerable populations because of its potentially coercive power (Singer & Bossarte 2006); however, much of the concern over using monetary incentives rather than gift cards comes from a paternalistic attempt to control how research participants spend their money (in particular not condoning drug use) (Ensign 2003). While these are challenging ethical concerns, given that this project is centered on the autonomy of homeless men and women I paid participants twenty-five dollars for their time and expertise and did not inquire as to how they would spend the money.

wind while we talked). These six research participants still received their remuneration. Of the thirty-eight interviews, eleven were conducted with women and twenty-seven with men.

Unfortunately, this means that my research sample falls just shy of the one-third of women who make up the homeless population. The four interviews that were under ten minutes in length all occurred with female participants, which would have achieved a proportionate sample.

Detailed demographic information is provided in the appendix. Summarily, participants ranged in age from twenty-nine to sixty-three with an average of thirty-seven years of age. Seventy-three percent (28) of respondents were white, approximately sixteen percent (6) identified as First Nations, Métis or Inuit (notably five out of six Aboriginal participants were women), and eight percent (3) identified as Black or bi-racial. Seventy-five percent (28) of respondents identified as heterosexual and twenty-four percent (9) identified as gay, lesbian, bisexual or asexual. Not all participants were living in a shelter at the time of the interview, but they had all experienced homelessness or precarious housing at some point, the average length of time being four years. All but six (32) respondents identified as suffering with distress in their lifetime and seventy-three percent (28) were currently taking psychotropic medication or had taken some in the past. Eighty-nine percent (34) identified as having an addiction and eighty-four percent (32) had some negative interaction with police and/or the criminal justice system.

Figure 1a: Race reported by sample

Figure 1b: Sexual orientation reported by sample

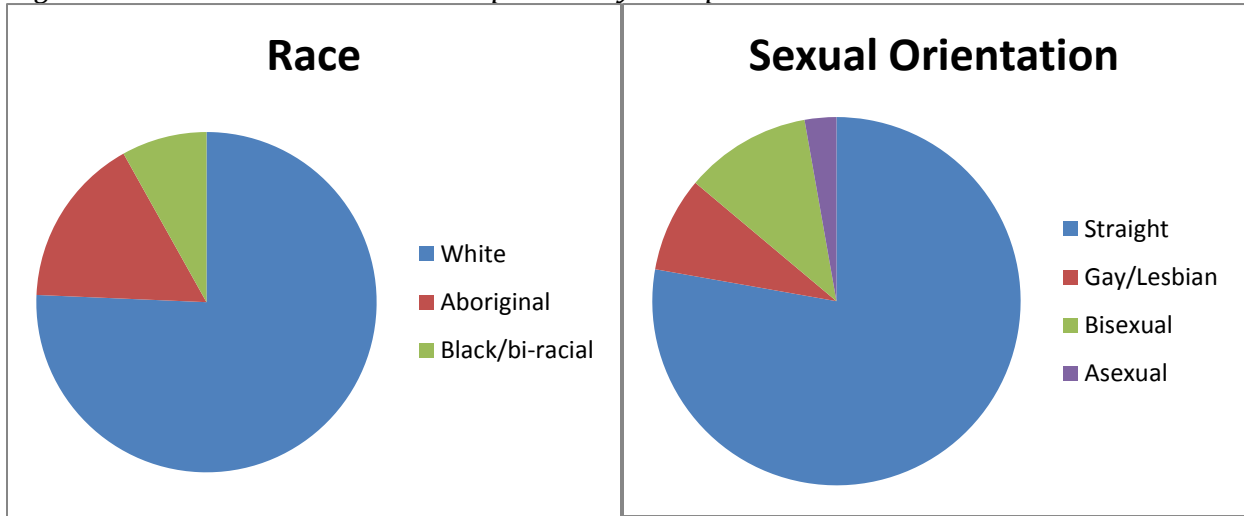


Figure 2: Diagnoses identified by sample

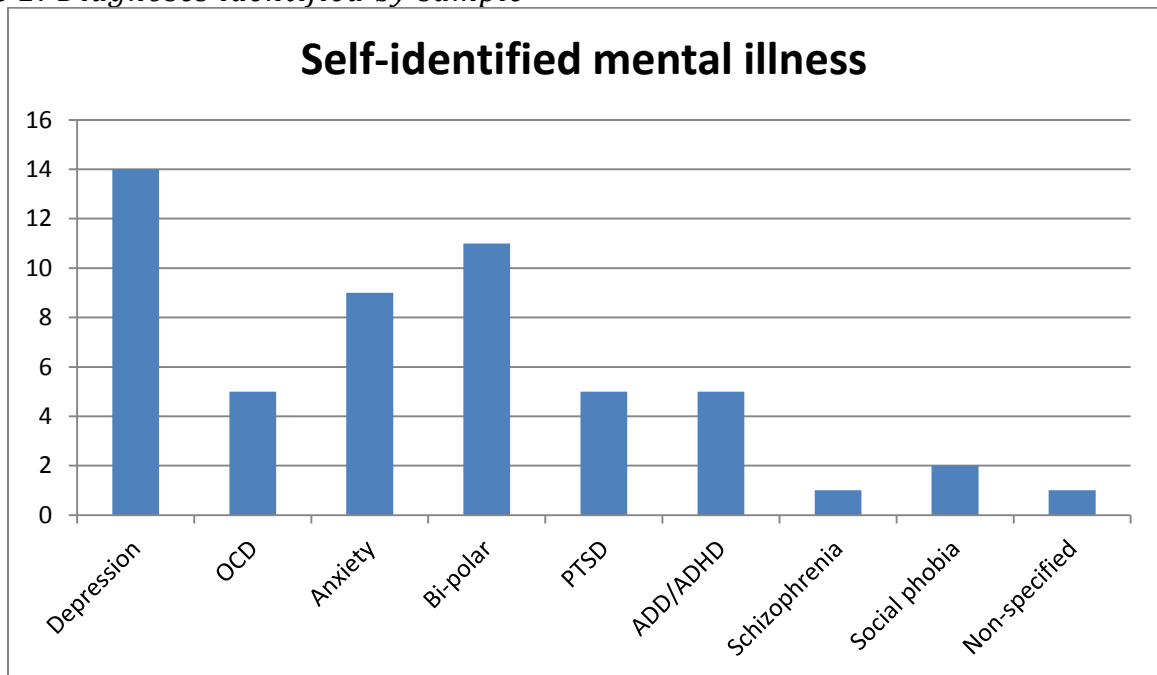
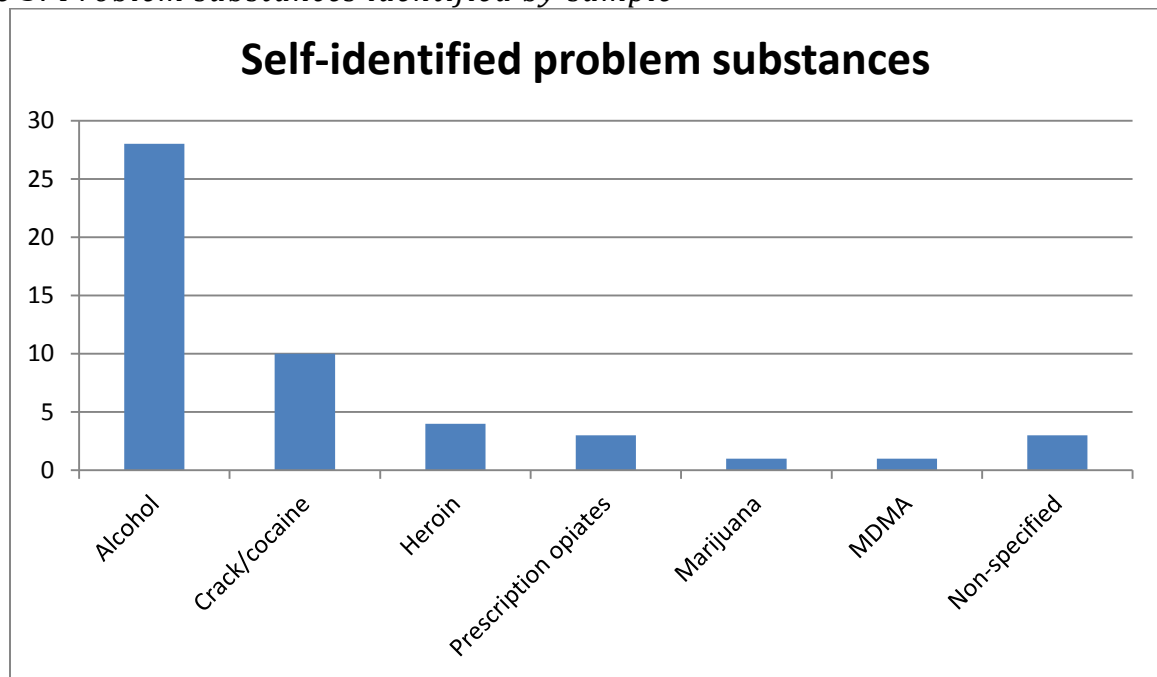


Figure 3: Problem substances identified by sample



The interview process

Interviewees were recruited through the posters I put up in shelters one and two and subsequent snowball sampling (Neuman & Robson 2007). Given how quickly news spread of my research project and the number of respondents who did not reside in the shelters it is clear that snowball sampling was a primary recruitment method. I arranged a time and location to conduct the interview that was convenient and comfortable for each participant (Bailey 2007). Shelter one and two provided me with private spaces to conduct interviews on site. Shelter one gave me keys to privately access a room so that staff would not know who participated in the research, which helped to maintain anonymity. Access to a private space to conduct interviews in shelter two varied depending on availability. On occasion staff members may have seen who entered the office I used but they did not request the names of participants. Some participants

were more comfortable conducting the interview outside in the park, at a coffee shop, or at the University of Ottawa.

Upon arrival at the agreed upon location the interview participant and I chatted informally. I provided drinks and snacks as a gesture of kindness and gratitude and it also acted as a great ice-breaker. Once we were seated each participant was given an envelope containing an information sheet about the research study, a copy of the informed consent form, a list of numbers to call in case of distress, and the twenty-five dollar remuneration. The informed consent form described the purpose and procedure of the research, and provided a guideline to the potential risks, among other items (Neuman & Robson 2007). I explained the consent form and focused on four key aspects: interviewees were not obliged to answer any questions they did not want to; they could ask to turn off the tape recorder at any time; they had the power to end the interview at any time; and the compensation was not contingent upon the length or quality of their answers. I also explained that I would protect anonymity and confidentiality by using a pseudonym of their choosing that would not be connected to their name on the consent form and by anonymizing any self-identifying information. I was clear that staff and other interviewees would not be informed as to who participated in the research. Once the consent form was signed I sought permission to turn on the digital recorder and I began each interview by asking the participant to “tell me about yourself”.

Interviews lasted between twenty-five minutes and two hours, with an average length of forty-five minutes. The interview guide was semi-structured and focused on: health and mental well-being; use of the mental health system, including taking/refusing psychotropic medication and programming; how their status as homeless impacts their mental health; and their thoughts on treatment. The interview concluded with demographic questions, which allowed the interview

to end on a lighter note.⁶² Semi-structured yet open-ended, these intensive interviews allowed me to gather information about the participant's subjective experiences of mental health managerialism (Charmaz 2006; Palys 1997). The interview guide truly acted as a *guide* where broad themes were discussed but the conversation emerged fluidly from the interests and comfort level of the participant. Lindow (2001) notes the importance of semi-structured interviews in survivor research because it allows participants to use their own voice and maintain an order that is natural to them, in an otherwise unnatural setting.

Unfortunately, the shortest and least thorough interviews occurred with some of the women I spoke with. In some ways this is surprising given that the interviews were unintentionally temporally divided by gender and I had conducted twenty-eight interviews with homeless men before beginning the interviews with women. I was much more comfortable with my role as interviewer and with the interview guide when I began to interview women. The lack of substantive responses from many women was disappointing given that some feminists argue that women's gendered experiences can transcend race, class, ability, and sexuality⁶³ and that "women talk and listen in order to understand each other" (DeVault 1990: 103). It is not clear precisely why I had so much difficulty soliciting the narratives of homeless women. Like the interviews with men, I had established long-standing relationships (over a year) with some of the women participants, although some were strangers. Although I had built empathetic relationships with many of the women it seemed to make little difference in terms of the types of responses I received; put simply, the women were much less candid overall than the men.

⁶² See the full interview guide in the appendix E.

⁶³ Of course third-wave feminism is built on the premise that there is no single unifying voice for women and that assuming there is further silences already oppressed and marginalized women (Hill Collins 2000; hooks 2000; Kilty 2014; Moore 2008).

I developed three theories to help explain the discrepancy between the interviews with men and women. First, perhaps because I had conducted so many interviews with men before women, I might have unconsciously built an interview format and persona that reflected a masculine perspective in terms of the way I asked questions, probed, and built rapport. It would be very disappointing if this were the case given that the gender divide in the interviewing process was accidental. Second, some scholars argue that “gender is not enough” (Riessman 1987) and that class and racial⁶⁴ divides cannot be surmounted by common experiences of womanhood. Although interviews with male respondents also fell along class and racial lines, there is some research that explicates the complicated gender dynamics that exist between men interviewees and women interviewers, where men may feel more comfortable speaking candidly and emotionally to women than to other men (Arendell 1997; Williams & Heikes 1993). Arendell (1997) explains: “Most commonly, however, I was the token nurturing, caretaking woman, carefully listening to and prompting their stories and encouraging the expression of feelings. I listened attentively, occasionally nodding my head in a supportive gesture, doing the ‘work women do’ in conversations with men”. In this sense, perhaps discordant genders provided me with an advantage with male interviewees.

Finally, some researchers in the field of homelessness as well as front-line workers I have spoken with on this subject suggest that homeless women’s reluctance to speak with me is a defence mechanism that they have developed in order to survive in a deeply traumatizing and vulnerable atmosphere. Homeless women are more likely to experience sexual violence than homeless men and are often subject to physical violence (Wenzel, Leake & Gelberg 2001). Other

⁶⁴ It is important to keep in mind that five out of the six Aboriginal research participants were women meaning almost half of the female respondents (5/11) were racialized minorities.

research shows that women are less likely to become absolutely homeless and are among the ‘invisible homeless’ (Bukowski & Buetow 2011; Klodawsky 2006) because they tend to have stronger support networks than men and if they have children in their care are able to access housing resources more quickly (Evans & Forsyth 2004; Passaro 1996). This would imply that the chronically homeless women who participated in this research are among the most impoverished, traumatized, and marginalized in the homeless community. This might explain their distrust of others given their experiences of violence, exclusion and isolation (Padgett et al. 2006). Likely, it is a combination of factors that led to the poor interview outcomes with the women participants. Above all, I am disappointed with myself for not having adequately navigated the complicated terrain of homeless women’s lives and not being able to sufficiently act as an empathetic witness to their “discomfort, pain and brokenness” (Caron 2014: 150) but also to the ways they engaged in resistant practices. I wish I could have been a better researcher and listener for Christine, Mia, Courtney, Karla, Matilda, Wanda, Louise, Katie, Toby, Sheela and Mary.

The lack of overall depth in the interviews conducted with women is a limitation of this research; however, this project was never intended to be a comparative gender analysis of how men and women experience mental health treatment in the homeless community. Instead, I analyzed themes that were observed and/or relayed to me by both men and women. Of course how individuals experience everything from institutionalization to mental health treatment is mediated by gender politics and I address some of these narratives in the following chapters. Still, many similarities are found in how homeless individuals negotiate mental health resources and these issues are the focus of this analysis.

Once the interview was completed I turned off the digital recorder and spoke with the participant for some time afterwards. I checked in with each respondent to see how they felt and if they needed to speak to someone. Most participants, especially those with experience in the criminal justice system, are used to telling their story (Maruna & Ramsden 2004) and a number of people relayed how enjoyable they found the process. Unsurprisingly, several interviewees found it difficult to talk about sensitive information. In these cases, I reminded respondents that they did not have to answer any questions they were not comfortable with. I also spent extra time after the interview to debrief and often to simply talk of easier, happier things. I offered all of the participants a copy of their transcript should they like to review or simply have a copy of it; only one interviewee accepted this offer and I sent him the transcript via email.

Focus group

Finally, I conducted a focus group with professionals and para-professionals that work in the homelessness industry. Focus groups are: "...unstructured group interviews in which the group leader actively encourages discussion among participants who have personal or professional experience with the topic being studied" (Peek & Fothergill 2009: 31). The focus group was conducted with key informants in order to gain information on how mental health is managed in shelters and in the community, the types of diagnoses and medication prescribed to homeless men and women, and a breakdown of mental health services. Focus groups "...throw light on the *normative understandings* that groups draw upon to reach their collective judgments..." [emphasis in original] (Bloor et al. 2001: 4). In this way, I used the focus group as a way to supplement and provide context to the narratives provided by homeless men and women and not to test the truth claims made in the interviews (Kitzinger 1994; Lofland et al. 2006).

Given the potentially sensitive nature of the topic and to enhance the discussion, I chose to conduct a small focus group with five key informants who meet regularly to discuss the mental health status of specific homeless men and women (Bloor et al. 2001; Peek & Fothergill 2009). Participants in the focus group represented a variety of organizations in the homeless community and ranged from front-line workers to case managers and shelter management. The focus group was one hour in length (the length of their meeting). I provided coffee but the focus group members did not receive remuneration. Before the focus group began each participant received an envelope with a copy of the informed consent form and an information letter regarding the research project. Anonymity could not be guaranteed for focus group participants, not only because these participants knew one another, but also because there are a limited number of staff members that work in the field of community mental health in Ottawa so it is possible that their identity can be deduced by others working in this community. In order to minimize detection, I use pseudonyms and refer to their professional position in general terms (i.e. shelter management). It is not foreseeable that any harm would come from their identification for participating in this research project.

Once everyone signed the consent forms I turned on the digital recorder. My role as facilitator was to solicit information from key informants by encouraging interaction between focus group members (Fontana & Frey 2000; Kitzinger 1994). On several occasions one member in particular attempted to dominate the conversation so I used probing questions specific to other participants in order to foster discussion and to solicit different voices (Peek & Fothergill 2009). Having focus group members interact with one another opens up a new dimension of understanding by highlighting where different professionals and para-professionals agree and where opinions differ. Because focus group members were speaking in their professional

capacity rather than sharing personal information, they were unlikely to feel restrained or inhibited in sharing information (Kitzinger 1994). In fact, questions such as ‘what are some long-term solutions to appropriate mental health care’ solicited divergent responses, where one member suggested re-opening a mental health emergency room while another member disagreed, arguing that that long-term recovery-oriented programs are necessary.

The focus group took place after I had conducted sixteen interviews, allowing for an early opportunity to situate what I had gleaned so far in a broader context. It allowed me to start making sense of emerging themes as well as receive clarification on terms, protocols and resources that I did not understand. For example, one focus group member provided detailed information on some of the ways an individual can access a mental health support worker, which contextualized information I had gleaned from interviewees regarding their relationship with support workers.

Although it was not part of the original research design, I did conduct one interview with a professional after I finished the interviews with homeless men and women. A public health nurse, Kathy, called me on behalf of one of the interviewees who wanted clarification regarding the consent form and she expressed interest in being interviewed too. I took this opportunity to ask for further clarification on issues such as how different organizations that serve the homeless interact; how medication is prescribed to homeless individuals; and how public health care providers make sense of concurrent disorders. This was a ‘member checking’ interview (Fontana & Frey 2000), not in the sense of ensuring the validity of interviewee claims, but as a way to receive feedback on some of the lingering questions that remained after the interviews were completed. For example, one of the themes that emerged from the interview data was the lack of felt stigma expressed by the interviewees, despite the emphasis on stigma in homelessness

literature (Boydell, Goering & Morrell-Bellai 2000; Harter et al. 2005), so I asked Kathy how she thought stigma is expressed in the homeless community. Questions such as this allowed me to begin unpacking complex personal experiences by situating them within larger systematic structures that perpetuate the exclusion of homeless individuals.

Analysis

I continued to collect data until I reached theoretical saturation. Rather than a set number of interviews or hours of participant observation, a project achieves theoretical saturation “...when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of your core theoretical categories” (Charmaz 2006: 113). In trying to determine when I reached theoretical saturation it was helpful to reread the regular field notes I kept in my research journal, especially the entries I made after conducting each interview. On several occasions I noted that I might be reaching saturation because I was not finding any new themes in the data. Although total saturation is seemingly impossible (Corbin & Strauss 2008) there came a point in the research where the depth and breadth of my understanding of the issues was clear and I was ready to tell a story about what I had seen and heard (Kaler & Beres 2010). At this point I ‘left the field’ in that I completed interviews in July and field work in December 2011, but as recommended by others (Kaler & Beres 2010; Rossman & Rallis 2012; Wagle & Cantaffa 2008) I continued to volunteer in shelter two for eight months after concluding the interviews and I continue to volunteer one night a week at shelter one. My commitment to the homeless community has transformed the ‘field’ into a site where I am passionate about offering my time, energy and skills (Dej 2011a).

Transcription

Most of the field notes were typed in a Word document and those that were originally recorded on my phone or written by hand were typed at a later date. Interviews were transcribed verbatim, which includes documenting pauses, inflections, interruptions and false starts in order to provide a close examination of the narrative (Lapadat 2000). It is useful when the researcher transcribes the interviews because it allows for a greater familiarity with the data and foregrounds the analytic process (McLellan, MacQueen & Neidig 2003). Moreover, transcription is not neutral, as transcriptionists interpret audio recordings and make decisions about what is recorded and what is left out (DeVault 1990; Lapadat 2000). For this reason I transcribed almost all of the interviews. Due to the challenge of completing the transcriptions through a difficult pregnancy, I did hire a transcriptionist to complete three interviews. She signed a confidentiality agreement regarding what she heard in the interviews and provided me with the only digital copies of the transcription. I gave her a template to follow and upon completion, I listened to the interviews again while reviewing the transcripts in order to member check and to make minor changes.

Critical discourse analysis

In order to maintain the epistemological principles of standpoint theory I conducted a critical discourse analysis that allowed me to situate individual narratives within broader systematic and institutional power relations. Critical discourse analysis challenges the reproduction of dominant ways of knowing by closely examining texts:

Discursive events (e.g., interviews, conversations, newspaper articles) are analysed linguistically as texts, as instances of discourse practice, and as instances of social practice. By “discourse practice” I mean the practices of producing, distributing, and consuming texts. The aim is to map these different types or dimensions of analysis onto one another: to reach explanatory understanding of how particular sorts of text are

connected with particular forms of social practice, and how the connections are mediated by the nature of the discourse practice. (Fairclough 1992: 269)

Critical discourse analysis uses texts (including individual narratives) to analyze ideological formation, as it exists within dominant social structures. Critical discourse analysis distinguishes itself from other practices, such as content analysis, by making explicit the power dynamics at play in the texts (Fairclough 1985; van Dijk 1993).

According to van Dijk (1993: 258-259) the goal of critical discourse analysis is to explain “...and critique the ways dominant discourse (indirectly) influence such socially shared knowledge, attitudes and ideologies, namely through their role in the manufacture of concrete models”.⁶⁵ By challenging dominant discourses, a critical discourse analysis can disrupt hegemonic social norms by locating their power through ‘micro’ or ‘local’ sites of production (Fairclough 1985). In order to accomplish these goals, the researcher must code and analyze her data within a framework that brings to the fore the interconnectedness between everyday discourses and macro structures.

In order to find and make sense of the local sites of power production I engaged in a rigorous coding process that compared the data, labelled the data with specific codes, and allowed me to move from coding to producing analytic categories (Charmaz 2006; Kaler & Beres 2010). In order to efficiently ‘mine the data’ (Corbin & Strauss 2008) I used *QDA Miner* software to manage my data and codes. I built a preliminary codebook based primarily on memos I wrote during the transcription process, as well as from themes I gleaned from my theoretical framework and review of the literature (Ryan & Bernard 2000). I began the coding

⁶⁵ Although van Dijk (1993) suggests that the best way to challenge dominant discourses is by analyzing texts produced by the elite, I lean instead towards the standpoint theories’ premise that inequality and injustice can be explored from the bottom-up (Haraway 1988; Harding 2004; Smith 1987; Corbin & Strauss 2008; Chunn & Menzies 2014).

process by conducting open coding, otherwise known as *in vivo* coding, which involves reading each transcript ‘vertically’ several times in order to generate codes that originate from the data itself (Charmaz 2006; Corbin & Strauss 2008; Ryan & Bernard 2000). I developed a codebook with a description of each code to ensure greater consistency as I coded the texts and I revised the codebook as time passed to either refine or eliminate coding overlap for certain passages of text. I proceeded to read the transcripts horizontally (across participants) to make connections across different cases (Bailey 2007; Charmaz 2006).

In the second coding phase I performed axial coding, which involved making connections between codes so that some codes were broken up into several more specific codes and others were merged. As codes were developed and refined I revisited the transcripts so that several rounds of axial coding took place. Through this process I was able to begin connecting themes to the broader theoretical constructs I was using as sensitizing concepts (Peek & Fothergill 2009). In its final form, I had 143 codes that fell within twenty-five themes.

After coding I sifted through the data to find support for a potential explanation and ranges of variation that I needed to account for analytically.⁶⁶ For example, as I will describe in chapter six, participants had divergent opinions on the homeless identity. Using a critical discourse analysis, I connected the texts to each other and to wider social practices in order to make sense of shifting narratives about what constitutes a home. The potential explanations for the emergent themes were refined until all cases were accounted for (Bailey 2007). Analyzing research participants’ discursive practices allowed me to form a comprehensive explanation of

⁶⁶ The notion of a ‘range of variation’ in the data is a response to Glaser and Strauss’ (1967) ‘negative case’. Being cognizant of a multiplicity of narratives and meanings in the data is one of the changes adopted in constructionist grounded theory (Clarke 2005).

the complex power relations that underscore mental health managerialism among homeless men and women (Jäger 2001).

Ethical reflections

Ethics in practice is complex. I have already described some ethical quagmires, such as the controversy surrounding remuneration and how I navigated the ethical boundaries imposed by my position as volunteer. Where possible, I set clear ethical boundaries during the research process. For example, before interview participants signed the informed consent form I made it clear that if they suggested that they may hurt themselves or someone else that I was ethically obliged to break confidentiality. Luckily this did not occur.

I struggled ethically with the potential psychological stress that can come from participating in a research project. Discussing sensitive topics often causes anxiety or psychological discomfort (Neuman & Robson 2007). This is why I set parameters in place to relieve anxiety, such as a location of their choice to conduct the interview, the possibility of stopping the interview at any time, and providing the list of available resources for crisis intervention. I was not only concerned with the potential psychological harm that might come from participation, but also the potential harm of interpreting their stories for my own purposes (Dickson-Swift et al. 2007).

The potential for exploitation was at the forefront of my mind throughout the data collection period. For example, in referencing other work he's done with researchers or community organizations, J.J. made it clear he did not want to be taken advantage of:

...And he said to me, 'J.J., can I use that plan for other clients?' I said, 'you go right ahead sir.' A lot of people who use the system, I say, if I ever read this in, uh, one of your medical...uh...what do they call them? Journal. People...yourself included...to help people, once you get your...your degree and whatnot, I want it in my name. Cause the

old J.J. would have said, ‘yeah, use...take it from me, and take all the credit’. Now, I have no problem sharing, but I want some credit. That’s the new J.J talking.

J.J. is calling for community-based and participatory action research (CBPAR) that conducts research with, rather than on, vulnerable groups (Bellot, Sylvestre & St-Jacques 2014; Cahill 2007; Conrad & Sinner 2015; Fillmore, Dell & Kilty 2014; Paradis & Mosher 2012). This is a project design I aspire to embrace for future research projects. While some may see the lack of a CBPAR approach as a limitation of this dissertation, it is important to note that my standpoint epistemological position, lengthy immersion in the field, and attention to different relations of ruling have helped to counter the risk of exploitation.

When the topic of the research process came up with some interviewees none claimed that they felt taken advantage of. Of course they may have said this to avoid hurting my feelings and in an effort to say the ‘right’ thing, but I was left with the overall impression that the research participants did not feel exploited. In fact, on a number of occasions, respondents cautioned that it was participants who could take advantage of me:

Like, um, I can’t tell you how much, you know, non-information I was planning on sharing with you when I first got here and I thought, well you know, I’ll just play it as it goes. I’ve been through some of these before, um, I been actually, ashamedly, admittedly, they, they, they, go around once in a while and they’ll put up notices saying they want to interview, like, same sort of thing for, you know, crackheads and stuff like that. Well I can’t tell you how many times I was a crackhead (Otto).

In this way the interview process can act as a form of resistance (Weiner-Levy & Giveon 2011) where the research participant exercises power in the interview process. Indeed, after I turned off the recorder several respondents revealed that they had thought about undermining the interview once they received the twenty-five dollar remuneration but that once we began talking they felt comfortable opening up to me. I took this as a positive sign that participants did not feel exploited. Moreover, I became astutely aware of the fluidity of power dynamics; perhaps the four

interviewees who responded abruptly to questions for less than ten minutes did so as an act of resistance against the research process as a site of exploitation.

Methodological rigour

Good quality qualitative social science research must be evaluated for its rigour; however, its evaluative criteria differs significantly from the natural sciences. Traditional markers of scientific rigour used for positivist research studies include: reliability (consistent results when measuring a phenomenon using the same research design); validity (accurately measuring what you intend to measure); and generalizability (extending the research findings to other populations) (Kraska & Neuman 2011; Palys 1997). These evaluative criteria emphasize research as objective and the researcher's position as a 'dispassionate' observer (Palys 1997; Shenton 2004). This assertion is problematic as no evidence is neutral: "It is rather a question of who has the power to control the definition of evidence, who defines the kinds of materials that count as evidence, who determines what methods best produce the best forms of evidence, whose criteria and standards are used to evaluate quality evidence?" (Denzin 2009: 143). Rather than try to fit qualitative research into positivist and/or quantitative evaluative schema many researchers encourage the discipline to build its own conceptualization of quality research that emphasizes credibility, transferability, and transparency.

Credibility in qualitative research refers to the truthfulness of the research project and the authenticity of the data and analysis. As Kraska and Neuman (2011: 127) describe: "Qualitative researchers are less concerned with matching an abstract construct to empirical data and more concerned with giving a candid and accurate portrayal and interpretation of social life that is true to the experiences of people being studied". Shenton (2004) provides several factors to gauge a project's credibility. First, he suggests that researchers use established methods to collect and

analyze data. Although this criterion potentially discourages researchers from using innovative methodological tools, as a new scholar I thought it best that I ‘stand on the shoulders of giants’ and use pre-established devices. Interactive methods (i.e., participant observation, interviews, focus groups) have a long and reputable history in qualitative research, as does critical discourse analysis, the method I used to analyze the data. Second, Shenton notes that researchers should have prolonged interaction in the field so as to establish a relationship of trust with participants. In this chapter I have highlighted the long-standing relationship I have built with members of the homeless community and how I entered the field a year before collecting data. Third, random sampling is purported as the best method of recruiting participants as it heightens transferability and provides a more accurate representation of the sample. As I described above, opening up my research criteria to include all homeless adults regardless of their mental health status proved to be a rich source of data and is a tactic Shenton (2004) would argue encourages honesty amongst participants. As Otto comments, he has lied about being a crack user in order to receive remuneration for other research studies. Other than being over the age of eighteen and their length of time in the homeless community (broadly defined) there were no restrictions that would compel respondents in this research project to lie. Moreover, although staff at shelter two offered to speak directly to some of the residents they identified as suffering with mental illness in order to encourage them to participate, I politely rejected in order to ensure the research sample was not made up of staff-picked respondents.

Transferability is the qualitative researcher’s answer to generalizability. Qualitative research uses relatively small sample sizes and findings are situated within a specific context (the ‘ethnographic present’ as Shenton (2004) professes), built from mutual meaning-making of the researcher and participants; therefore, there is no assumption that the findings from one research

project should mirror similar research in different locations and/or with different populations. Instead, qualitative researchers are encouraged to provide a detailed description of the field, the ways data were collected, and the analysis process so that the reader can make her own judgement as to whether the research may fit her population of interest (Shenton 2004). In this chapter I provided a detailed account of the research process, the interview sample and the analysis methods so as to make the research design clear. Moreover, in the appendix I provide the interview guides for the interviews and focus group.

Relatedly, qualitative research strives to be trustworthy and transparent (which increases transferability). Like transferability, transparency calls for researchers to be explicit about the logic of their inquiry (Denzin 2009) so that readers are clear as to the practical, ethical, and political nature of the research. Moreover, to be transparent means to identify the data that supports the analysis. Given my epistemological standpoint position it was essential that I build the analysis from participant stories. In the coming chapters I use the research participants' narratives to situate my analytical and theoretical arguments. Where possible I use more than one interviewee's story to demonstrate the prominence of a particular theme.

Limitations

There are several limitations to this research. First of all, the research participants in this project were all adults (18 years old and above), thus eliminating important work on youth, mental illness and homelessness. The age restriction is necessary because the context of youth homelessness is unique. Although some work has been done on this subject (Gaetz 2004; O'Grady & Gaetz 2004; O'Grady, Gaetz & Buccieri 2011) research on mental health managerialism amongst youth is an important area of inquiry for future research.

My methods create a specific limitation in that only those individuals who access services were likely to see the flyer⁶⁷ and participate in the research. By accessing a community resource, be it the food bank, clothing donations, support programs or a shelter, homeless individuals engage in some form of managerialism by working with these services in some capacity, however minimal. Susser, Conover and Struening (1990) caution against restricting sampling to shelters as it limits the type of respondents. I sought to rectify this problem by recruiting from other locales such as the church-based soup kitchen but due to the overwhelming response to the call for participants at the shelters I did not have the financial resources or time to recruit from this site.

Finally, also due to a lack of time and resources, I was unable to solicit interviews with other key players involved in mental health managerialism, including professionals, paraprofessionals, police officers, and the public beyond the one focus group. While a study that includes all of these actors is ideal, I chose to focus on the homeless men and women whose voices are too often absent in research.

Reflexivity

I must grapple with my own conceptual baggage (Kirby, Greaves & Reid 2006) and be reflexive of why I conducted this project. First, I hope that what I am doing is helpful. In the feminist tradition of engaging positionality, politics and praxis in research (Kilty 2014) I envision this project extending beyond academia to provide practical knowledge to those who work with and who experience homelessness and distress. The questions I am asking are also important from a scholarly perspective and they supplement the experiential research produced by the mad movement with the voices of people who are similarly marginalized (Cohen 2005). It

⁶⁷ Using a poster as a recruitment tool also assumes literacy among the respondents; however, the use of snowball sampling in this project aided to counter this limitation in this respect.

also has the potential to help homeless individuals labelled mentally ill by making service providers aware of alternative conceptions of mental illness and how to help those suffering with distress outside the mechanisms of the medical model, such as through active and supportive listening and establishing peer support networks.

I endeavour to be reflexive about the project and my place within it. I take on a positional reflexivity approach, which “takes up the analysts’ (uncertain) position and positioning in the world he or she studies and is often expressed with a vigilance for unseen, privileged, or, worse, exploitative relationships between analyst and the world” (Macbeth 2001: 38). In doing so, I must place myself within my research and be accountable for how my own lived reality impacts the data I collect and how I make sense of the data (Kilty 2014). Acknowledging my own place is especially important because some members of the mad movement call for the exclusion of non-users from conducting this kind of research.

I have never been homeless. I have always been aware that in a difficult financial position I have a network of people ready to support me if I fall. It is this network and the hope that comes with it that separates me from the homeless individuals I encounter at a fundamental level. Likewise, I am not a psychiatric survivor/consumer. I have not been institutionalized nor have I been subject to chemical incarceration. Instead, I am a white woman from a middle-class background. Lindow (2001) would argue that I should not have done this research because I do not have the lived experience to claim expertise on the subject; however, I do not claim expertise. While I agree that researchers who have intimate knowledge of a field have a unique insider’s perspective, research from an ‘outsider’ and an ally such as myself can also be valuable because I may perceive a different but equally valuable dynamic in the field (Bailey 2007). A researcher who is a member of the population may be able to gain the trust of her participants

through their shared experiences, but building trust and rapport is also possible for outsiders. Referring to researchers who are unfamiliar with the field, Bailey (2007: 18) recounts: “If during interviews we can close the social distance, however briefly, we might have a better chance of understanding each other”. I tried to close the social distance by volunteering and becoming known in the community for over a year before recruiting participants for interviews. By that time participants were aware who I was and I had made friendly connections with many of them.

Positional reflexivity requires that I dig deeper than this, however. It calls upon researchers to use a confessional voice because “fieldwork involves placing our physical, embodied selves among the lives, selves and bodies of others” (Coffey 1999: 131), without falling into narcissism (Pels 2000). I do have family and friends who have experienced the mental health system, including diagnoses and treatments for depression, anxiety, and schizophrenia. During the course of this research one of my close friends began to suffer with severe delusions for the first time in her late-twenties, to such a degree that she became a risk to herself. Her partner, understandably distraught, came to me (among others) seeking advice. In my attempt to console him I found myself suggesting that if she would agree to take psychotropic medication it would be ok. I was immediately ashamed of myself. Everything I had read from the mad movement, all of the critical research I had engaged in seemed to go out the window when one of my friends was identified as ‘seriously mentally ill’. I felt like a hypocrite (Wagle & Cantaffa 2008), and indeed I was. At the time all I could think about was making sure my friend was safe and trying to find the words to provide solace to her partner who was scared he had forever lost the person he knew. In this case my friend was open to taking psychotropic

medication; however, I do not know what my advice would have been had she refused.⁶⁸ This experience opened my eyes to the nature of my deeply ingrained biases and the need to continually reflect on the assumptions I make about mental illness, distress, and treatment. It also brought to the fore the sometimes debilitating nature of distress, how fragile the basic building blocks of our everyday lives can be, and how easily everything we know can be lost, especially for those without a strong support network.

Recently, I personally began to encounter the power of the medical model, psy-discourses, and big pharma. Like many graduate students (Myers et al. 2012) my general practitioner has encouraged me on several occasions to accept a prescription for anti-anxiety medication, and has become more vocal on the subject in the last six months. I have resisted so far but certainly feel the pressure to use psychotropic medication as a means to ‘get through the PhD’ as my doctor iterated. I recognize that this experience pales in comparison to the kinds of mental health interventions experienced by many of the research participants; however, experiencing the pressure and authority of psy-discourse first hand has given me a glimpse and a reference point into how more extreme experiences might feel and how they come to shape personal views about identity, and power and agency in mental health care.

Conclusion

This research project was thoughtfully and methodically developed within a standpoint theory framework that emphasized the everyday lived experiences of homeless men and women. Using institutional ethnography as a methodological tool I was able to examine individual narratives and how they are situated within dominant structural arrangements.

⁶⁸ I am pleased to report that my friend recovered fully from her distress and no longer takes psychotropic medication.

Using best practices offered in the qualitative methods literature, I designed a methodology that allowed me to generate data that would not only answer my research questions regarding homelessness and mental health managerialism, but importantly that would allow me to anchor the findings within the complicated and diverse narratives of the homeless men and women I encountered. Through participant observation, semi-structured in-depth interviews, and a focus group with professionals and para-professionals I was able to make sense of how mental health is experienced in the homeless community.

Despite the planning and attention to detail the research process was challenging and imperfect. There were occasions where I had to make practical and ethically ambiguous decisions on the spot. I remained guided by my desire to bear witness to the stories of Ottawa's homeless community and my commitment to move beyond research to praxis and thus towards social justice for those who are most marginalized.

In the chapters that follow I present the interpretive findings of this research. Grounded in the voices of my participants, I explicate how mental health resources are used along with other methods of social control (in particular those that emphasize individualization and responsabilization) to govern the always-already excluded homeless community.

Chapter 5 –Managing in Place: The Shelter as a Neo-Liberal Total Institution

Introduction

The homeless community, and specifically emergency shelters, are sites of paradox. Participants described the shelter as chaotic but boring; used for self-protection, but inherently insecure; spaces completely devoid of privacy but where people felt most lonely; and a place to access resources and care but in an environment that breeds physical and mental distress. Living on the margins reinforces physical, psychological, and social exclusion. It is important to think about how the shelter acts as a form of institutionalization within the community that fortifies the homeless as an excluded group.

Not all of the research participants were living in a shelter at the time of the interview (8/38 participants lived in community or subsidized housing), but all but one had previous experience living in an emergency shelter.⁶⁹ Thus, even for the handful of participants who do not live in one of Ottawa's emergency shelters, the growth and transformation of the 'homeless sheltering industry' (Lyon-Callo 2000, 2004) beyond simply housing and feeding the poor into a hub of social supports and resources (such as containing food pantries, clothing rooms, and physical and mental health care) situates the shelter as an essential component to the survival of those who are vulnerably housed and is part of a network of institutions that manage the poor.

In chapter two I discussed the role of the community as a site of governance and punitiveness. Transcarceration allows us to think about the broadening scope of the prison industrial complex, not only between closed institutions such as the jail, prison, and mental hospital, but also to those community organizations that are directly related to such disciplinary

⁶⁹ The one participant who had not lived in the shelter, Max, used Ottawa shelters' services (such as receiving his meals, participating in activities, and attending the shelter's out-patient addiction treatment). Since conducting the interview, Max lost his housing and spent a short time in a shelter.

tactics, which Cohen (1979: 346) describes as, “thinning the mesh and widening the net”.

Transcarceration allows us to consider the polysemy of governing apparatuses that are situated within the ‘public’ rather than limiting carceral techniques to closed institutions. In this way I expand on Goffman’s (1961) notion of the total institution and assert that shelters act as neo-liberal total institutions, where the socio-political climate fosters the institutionalization of the poor and where the disciplinary tactics of the shelter reach beyond its walls.

Likewise in chapter two, I explored the literature on shelterization. Shelterization refers to the acceptance of shelter practices by homeless individuals and their immersion in shelter life, which is thought to generate passivity and dependency (Gounis 1992; Gounis & Susser 1990). True to the individualization of problems in living that defines the traditional total institution (Lyon-Callo 2000), shelterization can only occur if emergency shelters act as highly controlled disciplinary spaces. Shelterization reorients an individual’s reaction to an uncomfortable, insecure, and often hostile environment as signs of laziness, mental illness, and criminality.

In this chapter I consider the role emergency shelters play in ‘poverty management’. Poverty management refers to a host of state and charitable techniques that are meant to regulate “disruptive populations” (DeVerteuil, May & von Mahs 2009: 652). This includes, but is not limited to, techniques related to mental health interventions. By framing the shelter as a neo-liberal disciplinary space, I am teasing out the ways the shelter reflects the institutionalization found in the prison and mental hospital (Foucault 1976, 1977, 1988), yet acts through freedom. Situating the shelter as a site for strict social control allows us to bear witness to the extent of the homeless person’s exclusion. I explore the limited debate on shelters as total or near total institutions and argue that emergency shelters fit Goffman’s parameters in that their structure, policies, and spatial arrangements seek to create docile subjects (Goffman, 1961; Foucault 1977)

but in a decidedly neo-liberal way by orienting shelter life as a freely chosen enterprise. The paradox of the shelter as a neo-liberal total institution is that the choice to live there is framed as either a positive step towards empowerment and self-discipline or, true to the shelterization literature, as resignation to the hopelessness and permanence of their excluded status.

In order to qualify emergency shelters as neo-liberal total institutions I compare them with three key characteristics of a total institution and make note of the shelter's uniquely late modern positioning. First, I work through the spatial arrangements of the shelter as reinforcing the exclusion of those living on the margins. Second, I consider how shelters exert minute and totalizing control over the lives of its residents. Finally, I address how the demarcation of power between staff and homeless men and women can create a tense and insecure environment but also acts as one of the few sources of care and attention in what can otherwise be a lonely and isolating atmosphere. Conceptualizing the emergency shelter as a neo-liberal total institution underscores how homeless men and women are managed through their freedom (Rose 1999) and how individuals negotiate these techniques of control.

Framing the issue: Theorizing the shelter as a neo-liberal total institution

Goffman (1961: xiii) defines the total institution as: "...a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life".

Goffman's *Asylums* (1961) looks at the characteristics of total institutions, namely the prison, the mental hospital, the military base, religious orders, and concentration camps and finds similarities in the ways they act as physical and social barriers to the social body. These institutions are totalizing in nature. An individual sleeps, eats, engages in leisure activities, and works (arguably working on the self (Cruikshank 1999; Hannah-Moffat 2000a; Pollack 2006;

Rose 1999)) in the same space and under the gaze of the same authorities. An individual goes about these often tightly scheduled and highly routinized activities with the same people doing the same thing. Finally, these activities and routines serve the particular mandate of the institution. It is clear that in the prison, for example, prisoners are spatially limited to their cell, common room, or other quartered off areas of the prison. They are constantly surrounded by others who were likewise found guilty of violating the law and interact with this group in every aspect of their life: they share meals together, work together, and sleep in close proximity.⁷⁰ The mandate of the prison is first and foremost to be a security driven institution of confinement (Rhodes 2004). Making the same comparison between Goffman's assessment of total institutions and emergency shelters is less clear, but as I will explore in the next section, research participants were quick to note the similarities between the shelter and prison. Moreover, Goffman (1961) articulates that spaces such as the prison, mental hospital and military base act as ideal types (similar to Foucault's (1977) description of disciplinary regimes) providing the opportunity to expand beyond the examples provided in Goffman's study and explore how the total institution paradigm is realigned in the twenty-first century.

While traditional total institutions have a continued presence as a mode of governance and punishment (Castel 2003), social theorists invite us to think more broadly about the punitive city (Cohen 1979) and the shadow carceral state (Beckett & Murakawa 2012).⁷¹ As described in chapter two, more open and voluntary institutions are independent from, but related to, the

⁷⁰ The exception to a highly scheduled routine amongst other prisoners is if the prisoner is placed in segregation where the absence of activity, social interaction, and communication is precisely part of the punishment (Kilty 2006; Martel 2006).

⁷¹ The punitive city is the "proliferation and elaboration" of systems of control into the community (Cohen 1979: 358). The shadow carceral state refers to: "...government policies, legal doctrine, and institutions with the power to impose sanctions that either mimic the coercive practices widely considered to be of punishment... or impose significant hardship and carry with them social and political opprobrium (Beckett & Murakawa 2012: 239).

criminal justice system in that they deploy disciplinary tactics to manage risky individuals and populations in the community. Indeed, this mode of governance situates a variety of spaces, such as the home, the school, or the workplace as governable zones. The actuarial regime, popularized in the late modern era for its efficiency, targeted governance (Valverde & Mopas 2004), and cost-effectiveness (Feeley & Simon 1992) seeks to manage people in place: "...the control of conduct was now immanent to all the places in which deviation could occur, inscribed into the dynamics of the practices into which human beings are connected" (Rose 1999: 234). By considering different types of spaces as sites of discipline we can situate the emergency shelter as part of the 'net' designed to monitor and manage risky individuals (Cohen 1979, 1985).

If Goffman's portrayal of total institutions is more a guide than a static list of qualities, there is room to consider the homeless shelter as a kind of total institution. A small number of scholars have done just this. Despite the homeless shelter as a (usually) non-mandated⁷² community-based and relatively accessible space⁷³, some argue that the shelter's very purpose is the institutionalization, security, and control of the poor (DeVerteuil, May, & von Mahs 2009). Stark, in keeping with the transcarceration framework (Lowman, Menzies & Palys 1987), argues that the homeless shelter seeks to reassert the experience of institutionalization felt by those coming from the prison and/or the mental hospital. Because emergency shelters house individuals targeted as risky and/or dangerous (Castel 1991; Fischer et al. 2008; Metraux & Culhane 2006) it is not surprising that the primary mandate of the shelter, like the prison, is

⁷² In some cases individuals will be forced to reside in a particular homeless shelter as their place of residence if they are awaiting trial (Gaetz & O'Grady 2009). Ottawa shelters do not receive monetary compensation for these individuals other than the regular funding from the city for the number of beds filled.

⁷³ The two shelters where I conducted my participant-observation had varying levels of accessibility. Shelter one's main lobby, lounge, and offices are open to the public while shelter two's designated outdoor space, located beside the shelter's parking lot, is open during business hours as are its main hallways, but access to any rooms, offices, services, or staff is strictly guarded by frontline staff whom you speak with either through an intercom, or between a sheet of glass..

security: "...Goffman's (1961) thesis [is] that the chief aim of institutional culture, in this case the homeless shelter, is to bring about control of its clients, control that must be maintained in spite of the client's welfare" (Stark 1994: 555). Ranasinghe concurs, citing the paradox that exists in the homeless shelter as a site for the welfare and assistance of the city's poor while maintaining a space of heightened security:

It is important to keep in mind that the site in question here is one that is largely, if not primarily, designed to promote social services and welfare in general, and yet, it is one where concerns about security trump all other concerns and logics. Thus, even welfare services, it appears, are governed through the logic of security and expanding the focus of inquiry can shed light on the way the logic of security has become all encompassing (Ranasinghe 2013a: 91).

Ranasinghe's characterization of the homeless shelter as primarily a site of control suggests a totalizing quality. The inclusion of treatment programming, mental and physical health care, and other services within the shelter space act to indoctrinate individuals into the shelter regime and situate the homeless person as a consumer,⁷⁴ choosing which (if any) services they wish to partake in (DeVerteuil, May & von Mahs 2009; Gounis 1992; Lyon-Callo 2004). Moreover, the shelter monitors the movements of its residents, eliminates any sense of privacy, and creates regimented schedules, much like other total institutions (Allen 2000; Feldman 2004; Grunberg & Eagle 1990). It is for this reason that some scholars suggest that homeless shelters are total institutions and the only reason that Goffman did not include them in *Asylums* (1961) was because the essays were written before the homelessness crisis of the 1980s, the vast growth in the homeless population, and the development of the homeless sheltering industry (deWard & Moe 2010; Lyon-Callo 2000, 2004). In the remainder of the chapter I argue that the shelters represent a new form of total institutionalization, one that emphasizes individual autonomy

⁷⁴ The concept of the homeless as consumers will be explored in chapter eight.

irrespective of the social context that limits a marginalized person's alternatives to shelter dependency.

Locating discipline in a post-disciplinary system

Some scholars challenge the notion of the shelter as a total institution because it is captured in a larger network of surveillance and risk management rather than in strict adherence to the panoptic design of the prison and hospital. I contend that differences between classic notions of total institutions do not disqualify shelters as total institutions; rather, it highlights the evolution of institutionalization as a governing strategy in the age of neo-liberalism. Feldman (2004) reinforces other scholars' (Desjarlais 1997; Wacquant 2008) contention that homeless individuals are characterized as wasted lives (Bauman 2004) and that being warehoused in a homeless shelter (Wacquant 2001) does not facilitate the kind of individualization required for the normalizing practices of a disciplinary institution. Feldman (2004: 98) writes: "For one thing, emergency shelters tend not to individualize their clients in any systematic way. Sheltered subjects at the bottom of the hierarchy are warehoused in dormitory spaces with no privacy at all – warehousing that may reflect a form of power in a *postdisciplinary* society" [emphasis in original]. Rose (1999) would agree that the lack of categorization and segmentation in homeless shelters may be described as post-disciplinary because the focus is on changing the policies and structural environment to ensure security and obedience rather than on rehabilitating the soul (Foucault 1977). With a focus on individualization and choice-making, the primary goal of the neo-liberal total institution is not to coerce people into normalizing practices,⁷⁵ but to manage

⁷⁵ The exception to non-coercive strategies are for those who are found 'irredeemable'; that is, those who are hopeless and who require traditional total institutions in the name of 'public safety', for example individuals who face long-term prison sentences and those involuntarily committed to mental hospitals.

them and encourage them to engage in self-discipline or seek out professionals who will foster normalization (Cruikshank 1999).

Despite the individualization and responsabilization of the homeless person in the neo-liberal era, Foucaultian scholars remind us that power dynamics are constantly in flux (Foucault 1980b; Gordon 1991; Rose 1999) and shelters do deploy some traditional disciplinary strategies. The shelters I visited incorporate disciplinary measures into their spatial and organizational layout. Like Ranasinghe's (2013a) findings, the front desks at both shelters house a series of screens from which staff can monitor every corner of the shelter. In shelter one I often observed staff zooming in on individuals outside the main gates when they suspected a drug deal was occurring. Shelter two is designed with a series of locked doors so that your movements are restricted by staff members who must give you permission to move within a particular room or set of hallways. Staff constantly observe individuals in and around the shelter and document any problematic behaviour in the resident's file. As one shelter manager noted with reference to signs of mental distress specifically:

So the front desk will know what, we have a database that we see and front desk will identify that somebody's...uh, unusual or their behaviour's changed, uh, and, and then the whole place is aware of that and then people can observe it, right? And you can see what's happening (Arnold).

Foucault (1977) argued that one of the techniques of normalization that is concomitant with disciplinary institutions is the case file. It is common for those who are most excluded in society to have the largest and most detailed files. The case file, accessible to most shelter staff on institutional computers, acts as a mode of 'digital rule'⁷⁶ where an individual can be observed

⁷⁶ Digital rule is defined as "...a new form of at-a-distance monitoring which becomes possible with the advent of certain electronic technology. This form of monitoring gives rise to a related form of decision-making, based upon prima facie evidence provided by the electronic system that a rule either has been followed or has been violated..." (Jones 2000: 11)

and documented simultaneously by a number of para-professionals who work in the shelters, including case managers and those involved in treatment and counselling, demonstrating the blurred line between security and social welfare exhibited by emergency shelters. Focus group participants described how, using this database, staff are able to “track” individuals with “perceived mental health issues”:

Mental health does come up [during intake meetings] and, uh, sometimes an individual will identify as having mental health issues whether it’s a diagnosis or they’re, that they’re feeling depressed or anxious, or I may... perceive that they have mental health issues and we’re actually starting to...um, track that... If somebody identifies as having that, I... um... will write a, you know in my... in my database that whatever their diagnosis is or if I perceive it, then I will mark that they have... perceived mental health issues. So, whether it’s like, well usually if it’s pretty, if there are some pretty obvious signs of... mental illness... (Julie, intake worker)

There are consequences to this kind of observation and documentation. Both shelters hold weekly mental health meetings where shelter staff and para-professionals from outreach organizations discuss individuals who they identify as suffering with mental illness. Members of the focus group spoke of several potential outcomes from these meetings. Most often, staff will continue to monitor individuals, especially regarding their safety and the security of the shelter. Case managers may also connect an individual with resources outside the shelter, such as a Canadian Mental Health Association (CMHA) worker or the mental health nurse or psychiatrist who visit the shelter. Alternatively, shelters can ‘form’ an individual and detain them involuntarily in a mental hospital (Davis 2006), demonstrating the continued presence of traditional total institutions for those individuals who cannot/will not engage with the “project of individual freedom” (Rose 1999: 135). Kathy, a mental health nurse who routinely visits Ottawa’s shelters, described the reluctance on the part of medical staff working in the homeless community to form someone:

We don't form people very often... The reality is, is our clients go to the hospital and they often get told, they often get sent right back. Um, and we're not like, we like to keep people's rights in place for as long as we can. We're not like a, um... so we don't form often because the hospital doesn't respond, we lose our therapeutic rapport and we're right back at zero with that person so it doesn't really um, make a lot of sense.

The notion that the mental health system does not respond to the needs of the homeless community was echoed by the other focus group members and will be explored further in chapter eight. What is interesting is that Kathy makes clear how rarely professionals who work in the homeless community use the *Mental Health Act* (1990) at the same time as she reinforces the disciplinary power of those working in the shelter. By stating that "we like to keep people's rights in place for as long as we can" Kathy insinuates that professionals and para-professionals are the gatekeepers of homeless individuals' rights and have the power to retract these rights when they deem necessary, translating their role as health care workers into quasi-legal actors (Moore 2007b). Kathy reaffirms the tension between the powers of freedom and disciplinary strategies described in chapter three. Individuals have the right to be free as long as they perform their freedom according to the norm (Bauman 1988; Rose 1998, 1999, 2000). Those identified as suffering with a mental illness are often thought to be less capable of behaving civilly and are subject to disciplinary strategies. Depending on their level of perceived redeemability by professionals and para-professionals, this may take the form of observation or, at its most coercive, involuntary incapacitation.

Feldman's (2004) critique of shelter's as beyond disciplinary tactics is also problematic because he assumes that people are not categorized. As this project reveals, shelter staff do categorize some of its residents, often through the types of programming they participate in and thus how responsible they are. An individual's mental health, addiction status, and general behaviour can put her on the staff's radar, either positively or negatively depending on her

obedience, dangerousness, or motivation to work on the project of the self. However, Feldman is correct in his assertion that in an institution housing hundreds of people a day, many of whom are transient, people are often anonymized. Some prefer this status, as described by Seamus:

I was very, I... standoffish and I didn't really talk to really anyone for a long time and I still swore after three months there, the staff didn't even know who I am or after that, you know, 'cause every time you know, the checking in thing, and it's like yeah, you know, blah blah blah, and a lot of guys it's just, yep, yeah Seamus, good. Gotcha, or Steve or Dave, whatever. But it was like, you got a bed here? [whispers] yeah, I've been here three months. But that's ok, I'm fine with that. I was, I was happy that way. Um, actually one of the guys I do spend time with here, he's like, I don't know how you do it. You're, you're like Teflon, you can do whatever you want. I'm like what are you talking about? No one knows you. I'm the guy with the hat who reads.

Seamus, a forty-two year old white man who was new to the homeless community at the time of the interview, relished his anonymity as it afforded him a semblance of privacy in an otherwise public space. The fact that staff did not know his name is both characteristic of Feldman's assessment that warehousing is an ineffective form of normalization, but is likewise a mortification strategy found in a total institution: "Perhaps the most significant of these possessions is not physical at all, one's full name; whatever one is thereafter called, loss of one's name can be a great curtailment of the self" (Goffman 1961: 18).⁷⁷ For three months Seamus checked in for his meals three times a day and secured his bed every evening using his shelter number rather than his name. In this way, he is not unknown to staff, but his identity is entirely shaped in their eyes through, to borrow from Goffman (1961), his 'moral career of the homeless person' rather than his personal identity outside of the shelter. Of course, Seamus' friend is wrong; Seamus cannot "do whatever [he] want[s]". If staff take notice of Seamus, either because he becomes a security risk or alternatively, he begins using the services offered by the shelter, for

⁷⁷ The importance of one's name in the homeless shelter is discussed again as it pertains to identity in chapter six.

example attending outpatient addiction treatment or requesting access to the work wing,⁷⁸ he will be observed, categorized and subject to normalization processes in keeping with typical total institutions.

Emergency shelters, as neo-liberal total institutions, are more likely to rely on empowerment strategies that encourage self-discipline (Cruikshank 1999) (such as offering workshops on money management and career counselling), but traditional disciplinary strategies exist as well, especially as it relates to observation and surveillance. In this way, the shelter retains its semblance with other total institutions who use similar, although often more sophisticated and coercive, techniques. Shelters act at a distance from these more formalized political entities (Burchell 1993; Miller & Rose 2008), such as the criminal justice system, and use neo-liberal governance techniques to situate the homeless person as a voluntary disciplinary subject. In the next section I explore three key characteristics of a total institution in order to situate the shelter as its neo-liberal counterpart: spatial restriction; minute control over daily activities; and the power differential between the watchers and the watched.

The 'freedom' to leave and the need to stay: Managing shelter space

Emergency shelters are distinguished from traditional total institutions for two reasons. First, their permeability and connection to the wider social body is thought to negate their totalizing effects. Second, the voluntariness of the residents' admission to a shelter and their freedom to leave the shelter system at any time leads some scholars (Marcus 2003; Ranasinghe 2013a) to suggest the shelter is a 'near' but incomplete total institution. I argue instead that these

⁷⁸ The work wing is a set of rooms accessible to people who are employed. Those who occupy these beds are not required to check in at 4pm, as they may still be at work, or if they are working night shifts are allowed to sleep during the day, whereas other residents are not allowed into the rooms until the evenings. Moreover, the work wing has fewer beds per room and is generally thought of as quieter and safer. At the time of the interview Seamus was not employed and so could not access these rooms.

qualities do not disqualify shelters from being categorized as total institutions, but illustrate the transformation of the total institution in light of neo-liberal governing logics.

The permeable institution

Although Goffman (1961: 119) describes “variation” and “degrees” of permeability among total institutions, total institutions bring to mind the high brick walls of the mental hospital, the barbed wire fence of the prison, and the inaccessibility of these spaces to the public. In contrast, most homeless shelters, including those in Ottawa, are located in the downtown core and residents, staff, volunteers, and visitors move in and out of the space throughout the day. As Gounis (1992: 687-688) comments: “Thus, in spite of increased regimentation, shelters remain relatively open institutions, a hybrid between a degraded type of public housing and a new form of institutionalization”. Most shelters, including the two I studied, require residents to leave their quarters during the day, although they are permitted in common areas, such as the lounge, TV room, and dining hall during meal times. Echoing Dordick’s (1997) observations, shelter policies encourage people to leave during the day, such as one shelter’s refusal to turn on the TV until the 6:00pm news.⁷⁹

Not only do shelters encourage people to leave, but a common narrative found among research participants is their desire to escape the shelter whenever possible.

I stay out of here and go to drop ins during the day or am like looking for apartments or looking for programs to get into, to get away from here (Karla)

Well during the day I’m not here. After I eat my breakfast I... go for a walk somewhere and I read a book and then I go to the centre on Bank Street, and go job hunting... To me it’s a base so I try to go there for lunch and come back to the job centre and then I go back at four, I eat, I walk away and when I finish eating I go to my dorm and I’m by myself. Some nice people chat with me but I don’t hang around (Joseph)

⁷⁹ There are rare exceptions to this rule. For example, during the World Cup of Soccer and the Olympics the TV was on during the day. In fact, my first day at the shelter consisted of watching soccer with a man who attempted to teach me what an offside is.

Well I try to stay away from the [shelter] as much as possible, come back for lunch and dinner... it's boring. It's, uh, not good to be bored and so I, I usually do a lot of walking. I try, I walk the canal a lot and stuff, you know (Gerry)

The shelter is the site of ennui, drug pushers, and 'friends' with sinister intentions.⁸⁰ Joseph uses the shelter as a "base" to eat meals and sleep but otherwise finds the space uncondusive to his project of the self, namely securing employment and rebuilding relationships with his family. In this way, interviewees described the shelter in terms of the shelterization culture noted by Grunberg and Eagle (1990), emphasizing laziness and dependency. Karla, Joseph, and Gerry see it as their responsibility to avoid these pitfalls by leaving the space when possible.

For some scholars, the freedom residents have to leave the building and interact with whomever they wish minimizes the disculturation effect of the shelter and its totalizing quality. Most importantly, homeless individuals are able to maintain familial ties that are essential to one's identity (Gounis 1992). Others, however, are critical of this assumption suggesting that while shelters do not physically prohibit individuals from spending time with family and friends, being homeless creates significant impediments to performing the partner, parent, or friend roles (Stark 1994). DeOllos' (1997) study of the shelterization process finds that after approximately six months in the homeless community individuals are likely to withdraw from their families and spend more time with their homeless peers, often out of shame. Although she acknowledges the effects of homelessness on family relationships, she concludes: "...homeless shelters cannot be considered total institutions since it is not possible to closely restrict contact with the outside world. In fact, stated goals of homeless shelters are to provide support to families so they will be

⁸⁰ For example, Gerry recounted the story of his victimization on his first day in an Ottawa homeless shelter, where two men manipulated him into going to an ATM, withdrawing all of his money, and giving it to them. While he later reported the incident to the police, the suspects were never charged. Gerry resided with them in the shelter until he found a bed in another shelter. Likewise, Karla made several references to women in her shelter who prey upon vulnerable women, befriending them and then stealing their possessions.

able to re-enter the domiciled world” (DeOllos 1997: 168). For DeOllos, because homeless individuals are separated but not isolated from their families, shelters do not constitute total institutions. Conversely, I suggest that although isolation is not one of the goals of the homeless shelter, the very nature of the homeless identity as an excluded group and their rejection from the social body creates an isolating effect. Moreover, these scholars fail to appreciate that many individuals become homeless because of family breakdown (Johnson & Chamberlain 2011). The neo-liberal total institution exists within a punitive city (Cohen 1979) whereby the institution itself does not need to erect barriers to the community; the exclusion of the homeless population from included circuits encourages and reinforces their confinement within the homeless community (Beckett and Herbert 2010). Shelter residents may be free to see their family and friends, but often do not given their emotional and felt exclusion.

Mary’s story illustrates the complexity of maintaining her role as partner while homeless: “Yeah, I was on the street for a while with my boyfriend sleeping outside in the wintertime, for nine months... we were together, that was the main thing. We wanted to be together. It was ok. We were never cold... under the bridge we made a home there”. Mary, a fifty-five year old Inuk woman, spent months living outdoors so that she could be with her boyfriend. Ottawa’s shelters are gender segregated so the only way she could live with her boyfriend was if they slept on the street. Eventually Mary entered an intensive substance abuse treatment program run by a shelter and now lives separately from her boyfriend. She struggles to balance her role as partner with her physical well-being: “I’m getting older so I cannot, I cannot be out, I wish to be but I can’t, I tried when I first came back last August, can’t do it anymore. It’s, uh, it’s not like before. ’Cause I had no problem sleeping outdoors with my boyfriend at that time. But now I can’t do it”. She stated that they try to have the odd date night, consisting of dinner at Wendy’s and a “cuddle in

the bushes” but that her ability to spend quality time with him is greatly diminished by her move to a shelter.

Mary’s predicament illustrates how homelessness, distress, and personal and institutional identity are connected. Whereas critics (DeOllos 1997; Gounis 1992; Marcus 2003) argue that shelters are not total institutions because people are free to come and go as they please and interact with whomever they choose, the reality of living in the homeless community is much more complex. Residents who are not engaged in programming (and thus are assumed to not be working on the project of the self) are not encouraged to spend the day in the shelter, nor are they welcome in other public sites, such as parks, shopping malls, or on the sidewalk (Beckett & Herbert 2010: 34; Mosher 2002). While they are free to come and go from the shelter, many of the interviewees spoke of finding refuge in other services geared to the homeless, such as drop in centres, public health clinics, and friendship centres. Others use public spaces more tolerant of homeless people, in particular the public library, to pass the day. Still, the most popular response among research participants was that they simply walk. They are not welcome to stop in any one place for too long, and as failed consumers (Bauman 2001b) they cannot pay for the privilege of accessing spaces like coffee shops and restaurants. They walk in and amongst, but are separate from, the included majority. In this way, the homeless community as embodied through the shelter is less permeable than scholars suggest. There are no high brick walls or barbed wire fences separating ‘us’ from ‘them’ but there are practical, symbolic, and ideological distinctions between the homeless and the housed that redefine total institutions in the neo-liberal era.

The voluntary inmate

The crux of the scholarship on neo-liberal total institutions resides in the notion of freedom. As outlined in chapter three, freedom is defined as autonomy and self-determination

(Rose 1999). For scholars such as Ranasinghe (2013a) and Marcus (2003) the possibility that homeless men and women can refuse to stay in a shelter distinguishes shelters from other total institutions:

This point about the physical barriers to departure is crucial to its definition, where, more so than not, clients or residents are unable to leave of their own volition. This is however, quite different from an emergency shelter, where the clients are free to choose. For this reason, I label emergency shelters as ‘near total institutions’ (Ranasinghe 2013a: 105).

Scholars from a variety of disciplines use the term near total institution to explain spaces where people may enter voluntarily, unlike a prison or mental hospital, and may rightfully leave although most have an intense desire to stay (DeLint 1998; Morgan 1982; Teachman 2011).⁸¹ According to these authors, because homeless men and women can find a bed in another shelter or sleep on the street, emergency shelters do not qualify as total institutions.

There is some critique as to the nature of homeless individuals’ ‘choice’ to stay in a shelter. First, the voluntariness of entry is questionable. Goffman (1961) referred to the degrees of voluntariness that changes the dynamics of the institution itself. While people are not coerced into residing at a shelter,⁸² the lack of affordable housing and the anti-homelessness legislation that criminalizes a homeless person’s use of public space (Hermer & Mosher 2002) encourages the institutionalization of the homeless population. For those research participants who spent time on the street, the cold Canadian winters strongly influenced their decision to enter a shelter, despite fear of victimization:

⁸¹ These scholars assume that all prisoners and mental patients are involuntarily confined. While this is often the case, there are more complex social and structural factors where the prison and the mental hospital may be considered partially voluntary. For example, some homeless individuals prefer staying in detention as a respite from the stress of living on the street, to sober up, or to have a warm place to stay (Christensen 2014). There are also cases where individuals will request a longer prison sentence so that they can access treatment and programs only available in federal prisons (Maidment 2006). Where these total institutions differentiate from the shelter is an individual’s freedom to *leave* on their own volition.

⁸² In a 2010 interview, Toronto Mayor Rob Ford claimed that homeless individuals should be “forced” into shelters on cold nights. His comments received swift criticism from poverty activists (O’Toole 2010).

Greg: I was scared. I didn't know what was there.

Erin: That's it, that's it. Um, so was it, what was it like, like how did you make the decision to go in and what was that like?

Greg: Um, it was fucking cold. All I had was a sleeping bag and a couple of pieces of cardboard just to block the wind. That's not much of a shelter, so I come in... December 15th I got in. So, I remember the day [laughs]. Fuck it was cold. Hands all red and everything. And, uh, I walk up, walk up the stairs... um, I'm like excuse me is there, is there any beds available? Um, she was like, it was five something in the morning. She's like no, uh, you can put your head down on the table and come at seven o'clock.

For Greg, the danger associated with homeless shelters convinced him that sleeping on the streets was a safer alternative, but the winter temperatures left him with no choice but to seek refuge from the cold. Greg told me that he'd heard "crazy things" about the violence in shelters, but that by the time spring arrived he was comfortable there. This supports the notion of the shelterization process, where people become resigned to their life in the shelter and see no viable avenue to escape homelessness (DeOllos 1997). Indeed, at the time of the interview Greg expressed contentment with his life and was not making plans to leave the shelter.

Conversely, others entered the shelter because they experienced victimization on the street. For example, Al recounted being urinated on while he slept on the sidewalk. Mac, a fifty-seven year old white man, described why he entered the shelter system:

Oh, um, I slept under the bridge over here for a year, uh, before the, uh, moving, moving into the uh, boarded up building. Uh, and, uh, one night there was three, uh, Inuits⁸³ who were out having fun and, uh, I was in my sleeping bag, it was winter time and they started kicking me and they broke my sternum in three places.

Mac later found himself in an ill-maintained rooming house, which later caught fire. He managed to escape but one of his close friends died. For Mac, his move to the shelter was not so much an active choice but rather one of last resort after alternatives proved unsafe. Goffman (1961: 118)

⁸³ It is not clear why Mac mentions the race of his attackers but it is worth noting that he specifies only race, and not other identifiers such as gender or age. It is doubtful that he would have mentioned race had they been white (Kilty & Fabian 2010; Smith 2014)

would describe Greg, Al and Mac's entries as semi-voluntary. In keeping with neo-liberal logic that emphasizes personal risk management and the individualization of social problems (Rose 1999) entrance into a homeless shelter is characterized as voluntary but the choices homeless men and women have to make are constrained by their marginalization and lack of resources from a dismantled welfare state (Cohen 1985; Garland 2001).

More than the voluntariness of entry, it is the freedom to leave the shelter at any time that scholars argue distinguishes emergency shelters from total institutions (Marcus 2003; Ranasinghe 2013a). Marcus (2003) claims that those who characterize shelters as total institutions over-emphasize the importance of shelters in the lives of its residents. He argues that because some residents are able to spend nights away from the shelter by couch surfing or renting a motel room, and because people stay in shelters for a short period of time,⁸⁴ shelters do not institutionalize residents. There is a small body of literature that critiques these assumptions. Above all, scholars question the notion of 'freedom' when the choice to leave a shelter is constrained by challenges to meet basic needs such as accessing food, clothing, and finding a warm and safe place to sleep. While shelter residents are not physically confined to the shelter against their will, their freedom to leave is constrained by their marginalization (deWard & Moe 2010). According to the Social Housing Registry of Ottawa (The Registry), there is at least a five year wait list for social housing. In other Ontario communities, the wait time can be up to ten years (ONPHA 2014). It is because of this waiting list that J.J. claims he chose to enter the shelter system to gain priority:

⁸⁴ Marcus does not specify what constitutes a 'short stay', but in Ottawa, the average length of stay in a shelter increases every year. In 2013, the average length of stay was seventy-three days (ATEH 2013). Moreover, Marcus (2003) fails to consider that simply because someone leaves the shelter does not mean she has escaped homelessness. Often, people leave shelters to temporarily stay with a friend, live in unsafe and unhygienic rooming houses, or because they transition to supportive or subsidized housing (Gaetz et al. 2013; Harter et al. 2005; McLoughlin 2013)

Eighteen months and I did my time so I could subsidize and get my health ... Three to five years for subsidized housing 'cause, but, if you're homeless, at the shelter, you're a priority for anybody who's... uh, on the registry which is for uh, uh subsidized housing... which made, uh, [social housing provider] can subsidize you, or co-ops, or everything, or [supportive housing], whoever it is that house people, their priority are people that are homeless.

The Registry (2015) specifies that individuals who live on the street or in an emergency shelter can receive “homeless status” in order to be assigned as a priority case. J.J. spoke at length about his struggles with addiction and mental illness and how this distress led to homelessness but he characterizes his transition to the shelter as a strategic opportunity. I will discuss how some homeless individuals ‘work the system’ in detail in chapter eight. For now, J.J.’s remarks are useful because it indicates the tension with referring to entering or leaving the shelter as voluntary. For J.J. and others in his situation, the ability to leave the shelter is predicated upon an over-burdened social housing system that does not have nearly enough supply⁸⁵ to meet the demand. It is the external pressure to enter and stay in the institution that distinguishes the shelter as a neo-liberal total institution. Other semi-voluntary institutions described by Goffman (1961), such as religious orders and the military, use mortification and deculturation processes to convince subjects to stay. While some of these strategies are used in the shelter, the neo-liberal total institution relies heavily on external factors to influence people’s experiences of voluntariness. The neo-liberal total institution does not coercively isolate its residents in the same vein as traditional total institutions but the surrounding socio-cultural and political landscape compels marginalized populations to enter the shelter on their own volition.

⁸⁵ While the Alliance to End Homelessness Ottawa (2013) reports that 1000 new affordable housing options must be created each year for ten years in order to end chronic homelessness in Ottawa, in 2013 only 185 units were created.

We must also think critically about the assumption that the freedom to leave the shelter is tantamount to escaping homelessness. True to Cohen's description of the punitive city, community interventions are part of a wider network of social control:

We are seeing, then, not just the proliferation of agencies and services, finely calibrated in terms of degree of coerciveness or intrusion or unpleasantness. The uncertainties are more profound than this: voluntary or coercive, formal or informal, locked up or free, guilty or innocent (Cohen 1979: 346)

Many of the alternatives to homelessness were considered by research participants to be more precarious and dangerous than the emergency shelter. Gaston is a fifty-nine year old white man who cycles between subsidized housing and emergency shelters. He described his social housing unit this way: "Lots of crack head[s] there. Lots of coke... Lots of, uh, lots of [makes banging noises] two or three o'clock in the morning and then, that, that kind of building eh. So it's not easy to live there." Gaston found his current home unsafe and not conducive to maintaining his sobriety but resigned himself to this living situation because other subsidized housing complexes share similar traits. For Gaston, there is no alternative to precarious living.

Mac, a fifty-seven year old white man who identifies as an alcoholic and heroin addict, shared his story of living in a rooming house:

Uh, like where I live now, it's, uh, it's just, uh, swamped with drugs... Like, when I say, uh, there's people banging on my door all night long with drugs, uh, they put it on the tenants. It's, it's my fault. You know, if I, you know, they're, they have security there but if I was to complain, it's my fault. You know? Like, if I was opening the door and they come in. Uh, I've been beaten with bats, pipes, and uh, you name it so they can deal out of my place. And, uh, it's... but it's all my fault. You know? It's the same with the police if I call them, you know. Well you opened your door... but, uh... they bang away at it. They just, uh, treat me as if I've... It's hard to stay clean in those buildings I'm trying to get out. I've been on a high priority, uh, uh, waiting list for two years and my life has been threatened, and, I've been on this waiting list for two years. Yeah, I'm at the top of the list, but... there's no such thing as priority or... or caring about me.

The constant threat of home takeovers⁸⁶ Mac describes is common (Butera 2013). As echoed by Huey (2012), marginally housed individuals are at great risk of victimization and negative relationships with police often limit options for a resolution to the takeover. Anecdotally, homeless men and women have told me of people who had a social housing unit but stayed in the shelter because they were not safe in their homes, which were taken over by drug dealers. Mac's narrative also questions the usefulness of a priority wait list, as described by J.J. Mac uses shelter services and feels insecure in his home but does not meet The Registry's definition of homeless and will therefore have to wait years to receive safe and affordable housing.

In this section I argued that the permeability and voluntariness of the shelter does not disqualify it from consideration as a total institution; instead these features account for how institutionalization takes shape in the neo-liberal era. Although many participants spent as little time in the shelter as possible, the space acts as an anchor through which they access essentials of living and in some cases escape the vulnerability and danger of living on the streets or unsafe rooming houses. Although scholars such as Marcus (2003) and Ranasinghe (2013a) suggest that shelters do not qualify as total institutions because individuals voluntarily choose to stay there, I argue that the lack of safe and viable alternatives to the shelter acts as a significant constraint to homeless men and women's freedom to leave. This neo-liberal total institution is reinforced by outside pressures, namely the lack of safe alternatives to shelter living and the possibility of facing death on the streets during winter. Moreover, leaving the shelter does not always mean leaving the homeless community as it is situated within a group of loosely connected institutions that target risky populations in different venues (Beckett & Murakawa 2012; Rose 1999). Rather

⁸⁶ Home takeovers are defined as: "... a situation in which a legitimate tenant or home owner finds themselves unsafe, physically, financially or psychologically, because of the presence of people in their home that they may or may not be able to remove" (Butera 2013: 7)

than rejecting the shelter as a total institution it is useful instead to consider the institutionalization of poverty and hopelessness found in emergency shelters as a manifestation of the total institution in the neo-liberal era. In the next section I explore how the shelter maintains its totalizing quality by acting as a site of control that residents often describe as similar to the prison system.

Controlling time and space in emergency shelters

One of the key characteristics of the total institution is its highly regimented schedule and routine. As Goffman (1961: 10) explains: “But to say that inmates of total institutions have their full day scheduled for them is to say that all their essential needs will have to be planned for”. Foucault (1977: 139) depicts the timetable as a disciplinary tool meant to control activity and create docile bodies, offering that “discipline is a political anatomy of detail”. As described in chapter three, marginalized people are problematized and individualized in such a way that their bodies and souls are positioned as sites of governance (Foucault 1977), rather than looking at how social systems create poverty:

On this view, the very bodies of poor people need to be regulated and reformed, leading to the development of government institutions, trained experts, and professional reformers like social workers, urban planners, teachers, health services, and police to ‘manage’ and ‘regulate’ the lives of ‘the poor’ in the interest of ‘normalizing’ them (Lyon-Callo 2004: 18)

Spaces like the asylum, hospital and the prison engage in an exhaustive regulation of time (Castel 1988; Foucault 1976, 1977, 1988). In a neo-liberal total institution residents’ schedules are not as strictly fixed, but I argue the reduction of services for the poor limits homeless individuals’ activities and acts as external constraints upon their routine, in turn reinforcing the regulative power of the shelter. Given that many residents rely on the shelter for their basic needs

means that the institution maintains totalizing control over when they eat, sleep, watch TV, have a coffee, take a shower, do laundry, and access their bedroom. Indeed, while the daytime is not tightly controlled, the fact that almost every other activity is scheduled limits residents' freedom to plan the day. For example Chico, a fifty-year old white man who has spent years in shelters across Canada, described the difficulty working around the shelter's schedule:

I mean, coming and going, you have to report, have to check in, I mean, you know, sometimes I'm over in Gatineau and I'm like Jesus I gotta go book in. I don't really want to go for supper but I have to come and book in because there's, you know... but that's a good thing because it keeps you in check.

Chico goes on to say that although he would love to live independently there would be no incentive to stop drinking for the evening to ensure he gets back in time to secure a bed. The tight schedule serves as a form of accountability by limiting how far he can be from the shelter and for how long, thereby acting as a method of social control (Rose 1999). In this way, the neo-liberal total institution uses autonomy to encourage, but not coerce residents to self-regulate by imposing administrative requirements throughout the day that restrict their freedom if they choose to stay in the shelter.

The daytime is more closely scheduled for those who participate in the programs offered by the shelters, such as out-patient addiction treatment and case management. Group therapy, individual meetings, and 'homework' such as journal writing, require residents to regulate their day through the schedules set by social agents (Rimke 2000; Rose 1999). Many participants spoke positively about having their day managed, such as Mick, a fifty-three year old white man who was actively seeking support for his substance abuse and mental health problems:

And so all these programs I'm involved with and have busy days so I'll start out with the day program. Then I'll go to a meeting at noon, either, like NA or, like AA. You know and then in the afternoon I, I'll go for a workout, you know I'll go to the gym or something... So I'll grab a nap if I'm tired, and um, then um, in the evening I'll have

some, something like, uh, Men's Project⁸⁷ or I'll have, uh, uh, a workshop at [a counselling service], or, um, I have a sponsor now in AA and, uh, on Tuesday nights we go to the um, church that's behind the ROH⁸⁸ and from six to seven there's a men's meeting.

Mick moved into subsidized housing with a friend a few weeks before the interview but continued to rely heavily on the shelter for its meals and services. He is involved in a number of mental health and addiction programs that create a highly regimented schedule. This kind of schedule is not mandatory, but it is strongly encouraged by the neo-liberal total institution and is valuable in achieving and maintaining the redeemable status. The more individuals take on the project of the self by deferring to professionals and para-professionals, the more active the disciplinary measures imposed on them because they are characterized as worthy of the time and money required to regulate them. Mick goes on to describe the value in such a structured day:

I've realized, like, as soon as I, as soon as I, I'm not good yet with idle time. I still don't know how to relax properly, so that's anxiety still active. I don't know how to enjoy myself properly, so like I'm not, I can't have fun doing things too easily so that's still depression that's keep going, that's in there somewhere. Um... so, uh, if I stay busy with productive, positive... you know, recovery related, self-healing related activities then I will... you know, avoid... idle time. And idle time will get again in my head, and I get... I get depressed again and I get, I get worried, and I get, I start thinking.

Mick identifies as struggling with post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), social phobia and attention-deficit disorder (ADD), as well as addictions to crack and alcohol. Because of this distress, Mick is not confident that he can make what he envisions are healthy and smart decisions. His sense of empowerment comes from allowing others to schedule his time (Cruikshank 1999) and connects his mental well-being with a highly structured routine. In order for him to engage in "productive" and "positive" (read 'normalized') activities, Mick requires the disciplinary techniques offered in the homeless community. DeWard

⁸⁷ The Men's Project offers counselling for men who were childhood victims of sexual or physical abuse. For more information, visit: themensproject.ca.

⁸⁸ The Royal Ottawa Hospital is the city's mental health care centre.

and Moe (2010) argue that the presumption by staff and the homeless alike that those living in a shelter ‘lack judgement’ and are incapable of governing their own lives is synonymous with a total institution, but in the neo-liberal total institution residents are expected to come to terms with their faults on their own and then to seek support to manage their time.

“It’s true hell”: The emergency shelter as a prison

Some research participants, such as Mick, framed shelters positively. Vince, a thirty-six year old white man, claimed that the shelter “helped save my life”, in particular the health care and addiction services offered through the shelters that are more accommodating and flexible than private treatment centres. Others characterized the shelter system in unequivocally negative terms. Both Katie and Karla, who stayed in the same shelter, described it as “pure hell”. They mention being surrounded by drug pushers, people screaming throughout the night, dirty needles in the bathroom, and physical violence. Milan referred to the shelter as “toxic”; Shadow called it “the jungle”; and Lenny claimed the shelter was “ground zero” for the chaos of living in close quarters with people suffering with addiction and facing debilitating distress. Sheela, a forty-eight year old Native woman who underwent significant trauma in her childhood, paints the shelter in similar terms but gains a sense of comfort from the commotion:

And every day is like that, eh, uh, I gotta go back there and deal with that shit again... So and so did this or the staff did that, so, you know it’s like, but then in a way, because I grew up in a place that wasn’t always settled that there was always commotion going on, it kind of felt like home also, in a way. So the banging of the doors kind of felt like, uh, kind of felt in a way comforting, um... but then again, it shouldn’t be like that. It shouldn’t feel comforting [laughs]. You know what I mean? ’Cause you get used to it.

Sheela connects the shelter’s chaotic environment with the instability of her childhood and although she is unhappy in the shelter, it offers a certain level of comfort in its familiarity, even when the familiar is negative and distressing. Gounis (1992) notes that shelters provide the

material conditions of a home although without the same symbolic significance. The representation of home as a place of reprieve, safety, and relaxation did not exist for Sheela in her childhood and so her conception of home lies in the conditions of material necessity, such as food, shelter and clothing. Because she spent considerable time in foster care, Goffman would likely characterize Sheela as institutionalized, as her deculturation from the social body left her feeling more at home in an institution than on her own.

For many of those who spent time in jail and/or prison, the shelter is regarded as a reminder or continuation of their confinement. Lenny, a fifty-seven year old white man who was incarcerated for years, compared the shelter to his time in prison: “It’s very similar. It’s very similar. Oh sure you’re told when to eat, when to lie down, when to go to bed, um, you know you’re... you’re treated, you’re, you’re not asked, you’re not asked what you want, you’re told what to do, or what you need. You’re told what to do”. Lenny pinpoints his lack of personal autonomy as the common denominator between the prison and the shelter. He highlights the paradox of the shelter, where staff attempt to foster independence among the residents, but the nature of the institution requires obedience and conformity: “In other words, the shelter, whose stated purpose is to help residents become independent, actually reinforced dependence on the system through its support of submissive residents” (DeWard & Moe 2010: 123). This same critique is made by critical criminologists, who question whether prisoners can be empowered and gain self-esteem in a place completely devoid of freedom and the most basic independent decision making (Kilty 2012a; Maidment 2006; Pollack 2006). The shelter, as a neo-liberal total institution, differs from the prison in that its residents are positioned as choosing to stay and thus adopting its rules; however, like their traditional counterparts the strict regulation of time and

space often has a demoting or infantilizing effect (Goffman 1961). Those individuals who come to rely on the shelter to meet their needs are problematized as dependent.

Getting too comfortable

In Dear and Wolch's (1987) ground-breaking research on the deinstitutionalization of mental hospitals and its impact on communities they use the term service dependent ghettos to explain the geographic concentration of those using public assistance and resources. As the spread of urban renewal projects and gentrification saw the dismantling of these spaces (Yanos 2007) the concept shifted to describe the group rather than space; the term service dependent populations (Ruddick 1996) individualizes and problematizes the chronically homeless who use the services. Dependency and shelterization are closely linked, where becoming shelterized is resigning oneself to homelessness and to the disciplinary regime established by the shelter system (Gounis & Susser 1990). Just as shelterization holds an acutely negative connotation, so too is dependency a "dirty word" (Bauman 1988: 80). Dependency is pathologized (Rimke 2000; Valverde 1998) as a trait that undermines the neo-liberal principles of self-actualization, entrepreneurship and responsabilization (Rose 1999, 2000) and individualizes structural inequalities, especially those based on race, class and gender (Pollack 2000). Given their institutionalization, the homeless are deemed particularly susceptible to dependency.⁸⁹ This logic fails to consider how, rather than antithetical to late modernity, inter-dependence is a necessary component of a globalized and industrialized world (Reindal 1999; Ruddick 1996). Instead, the shelterization discourses individualize vulnerability and need while ignoring how dependency is built into the shelter system through its social control mechanisms.

⁸⁹ Goffman (1961: 63) typified those who came to regard the institution as a home as "colonizers".

Some interview participants saw a connection between the highly controlled atmosphere of the shelter and the passivity of many of its residents. Milan, a thirty-eight year old white man, considers his transition to the shelter as contributing to his alcoholism and bi-polar symptoms:

One year led to the other, to the other, working in the restaurant, in construction, having a beer, just being like in a fog for many years and eventually I ended up in the street and that was even worse because the street you can, they pay your shelter, they pay your food, all I have to do is drink now, so it was... I don't really.... I know the shelters have a purpose but I feel it's a big enabler for a lot of people... Without the shelters I don't think I would have stayed in the street more than... couple of months, 'cause it's cold in the winter outside. I slept two winters outside and I know how cold it is.

Milan is highly critical of other men in the shelter who he deems to be wasting their time and lacking sufficient motivation to exit the shelter system. Using shelterization discourses (Grunberg & Eagle 1990), Milan regards efforts to make the shelter more hospitable as contributing to the laziness of its residents. He claims that he resists becoming dependent on the shelter by participating in the out-patient treatment programming offered by shelter one, seeing a psychiatrist, and applying to university; however, Milan's mental health care, addiction treatment, support network, and social assistance all come from the shelter system. This suggests that he is fully entrenched in the shelterization process but because the shelter is a neo-liberal total institution that provides voluntary assistance to the project of the self, Milan characterizes his reliance on the shelter as a choice. Foop (2002) argues that by using shelters as the primary method of assisting the homeless, professionals and para-professionals are able to observe and manage risky populations more than if they were independently housed. Funding shelters in lieu of creating affordable housing endorses the "...discourse of personal inadequacy and deficiency as the cause of homelessness" (Foop 2002: 63; see also Culhane & Metraux 2008). Whereas Milan considers his use of shelter resources as a way to avoid becoming passive and dependent,

having spent nine years in the homeless community appears to have deepened his dependency on the system rather than thwarted it. Stark articulates the paradox Milan finds himself in:

If the individual decides to abandon the shelter resident role, then a safe place to stay, food, basic hygiene, and social services are not available to help in the transition out of homelessness. On the other hand, if a homeless person accepts the role as shelter resident and settles into the dependency of shelter life, he or she is likely to remain homeless for a longer period of time. Those who reject the role of shelter resident, as well as those who accept it, are seen as failures - people who are unable to empower themselves and to go forward with their lives (Stark 1994: 561).

Similar to Moore and Hirai's (2014) argument that both those who embrace the rules of drug treatment courts and those who reject them remain excluded, Milan's narrative demonstrates the pitfall of being considered redeemable – while he gains access to resources and privileges, such as scarce one-on-one therapy, he remains institutionalized in the homeless community and thus excluded from the social body.

The research participants who spoke about 'getting comfortable' had a decidedly negative attitude toward dependency. Many borrowed from shelterization discourses to characterize getting comfortable as being detached from their lives and lacking the motivation required for self-regulation (DeOllos 1997). Otto, a forty-three year old white man who had experienced homelessness for six years, described the moment when he realized he was shelterized:

I was kicking my heels, I was, um, I was getting comfortable living in a six man dorm with a bunch of snorers and smelly feet and people coming in all cracked up in the middle of the night, you know, it was normal life for me. You know, waking up on Christmas day to find a, you know, somehow the front desk staff had managed to sneak a, a, like as a, a, they give this little, I'm going to say like stocking kind of thing... But, uh, I mean, the last year I was here, we got a little pack of cigarettes, you know, Native cigarettes that they'd obviously confiscated from some poor fucker, and decided to hand them to us. But you know, it's really nice, but to, to, to, to have Christmas be sort of, dissolved down to, you know, whatever you can take from a bunch of strangers and stuff like that, it kind of makes you, you know, think hmm.... My life's really changed and uh, not just the physical aspects, the mental aspects. Like, you know, fifteen, twenty years

ago I would have thought my God, what a pathetic Christmas that is, you know, like that, that's so horrible and most people today would think, my God that's, that's sad. That's so sad. That somebody would like, you know, wake up and look forward to that little stocking that they get from the homeless shelter. But, like it's all a matter of perspective. So that's when I decided I gotta get out of here, one way or another I'm not dying in a shelter, so, I gotta get out and if I fail at least I would fail sort of living on my own.

This excerpt from Otto's story illustrates his felt exclusion from the mainstream social body.

Comparing the depressing state of Christmas morning in a shelter and gifts coming from "whatever you can take from a bunch of strangers" to previous holidays spent with his wife and daughter illustrates his descent into the underclass (Bauman 1988). Norms are sites of comparison (Butler 2004; Rose 1998, 1999); however, Otto qualifies his life in the shelter as "normal life for me" but one that is inherently abnormal and thus deviant with reference to the wider social body (Butler 1990; Kendall 2000). He sees his abnormality as coming from his contentment with being a passive recipient of services rather than actively managing his own life. In this way, Otto embodies Milan's critique that the comfort of the shelter encourages complacency. A more nuanced reading of Otto's narrative, however, reveals both individual and social factors contributing to his continued homelessness. He describes a series of attempts at stabilizing his life by attending college and finding employment that are complicated by failed relationships, limited opportunities due to his criminal record, unrecognized credentials, substance use, and distress (he is diagnosed with attention-deficit hyperactivity disorder (ADHD), bi-polar disorder, and unspecified 'social disorders'). Certainly Otto's moral career of the homeless person is not simply one of laziness and passivity and after multiple recovery programs, job interviews, and attempts at independent living, Otto conceded that his normal is different than the standards of normality.

In the final section, I reflect on the power differentials between staff and residents and how this unequal relationship reinforces institutionalization.

The bubble boys: Staff as producers of the total institution

Goffman (1961: 9) writes at length about the demarcation of power between staff and inmates. He refers to the two groups as exhibiting “different social and cultural worlds”, characterized by a large, subjugated, and managed group and a small, powerful group of professionals and para-professionals. Given the power dynamics, inmates and staff often have a strained relationship where “...staff often see[] inmates as bitter, secretive, and untrustworthy, while inmates often see staff as condescending, highhanded and mean” (Goffman 1961: 7). True to classic total institutions, research participants described their encounters with staff in much the same way, often comparing shelter staff with correctional officers and mental health workers. The ways in which staff exert power, even when coming from compassionate intentions (Moore 2011), reinforces the homeless population as incompetent and in need of management. As such, the role staff play in prioritizing the security of the shelter (Ranasinghe 2013a) harkens back to a more disciplinary conceptualization of total institutions albeit from within a neo-liberal veil (Moore & Hannah-Moffat 2005) that assumes a voluntary acceptance of the regime.

This section speaks to conflicts between shelter residents and staff, in particular how staff members use their power to assert dominance over homeless men and women. However, an analysis of power relations in the shelter would not be complete without making sense of the substantial number of positive comments interviewees made regarding shelter workers. Greg advised that as long as you respect staff, they would respect you. Jon, who stayed at the same shelter as Greg, claimed that case managers and counsellors “bend over backwards” to help those

in need. Most (but not all) of the research participants mentioned at least one staff member they felt they could open up to. For example, Katie, who lives in supportive housing, emphasized the importance of staff to her mental well-being:

Meds don't work. It's Charlene, Charlene's the one I talk to the most. Because she'll know if I show up and I'm in a pissed off mood. Like one of the... [a resident] actually said something to me and it was Charlene that was working. She said something really bad about my kids. I forget what it was, but it was really bad. So she goes running to her room. I turn around and I said something to Charlene, I'm like, you heard that right? She's like yeah. She opened the door to her room and let me in there.

Katie, a thirty-two year old mother of five who has spent more than sixteen years in the homeless community, identifies as struggling with anxiety. Although she does not have custody of her children, she maintains a relationship with them and strongly relates to her role as mother (Barrow & Laborde 2008; Kilty & Dej 2012). Stressful situations such as the one described above often lead Katie to experience panic attacks or angry outbursts. Katie does not find that Seroquel helps her cope in times like this and relies heavily on staff members (with whom she has built a relationship over many years) that know her triggers and strategies for deescalating the situation. In conjunction with the shelterization discourse described above (Grunberg & Eagle 1990), Katie recognizes that she is dependent on staff as an integral component of her mental health care.

At the conclusion of each interview, I asked participants if there was anything further that they would like to discuss. Matilda used this opportunity to speak positively about the shelter staff. She added: “Yes, I'd like to put in and, um, a mention to the staff because they have their hands full and they do a lot, and they try and do a good job, and they're good and it must be difficult at times but they, and they get frustrated too sometimes but they, they're really good”. Matilda's narrative identifies that she sometimes has a tense relationship with staff but one borne

out of a stressful work environment and compassion fatigue (Fahy 2007). Although Matilda expressed gratitude, she is hesitant to approach staff because “they get bugged so much”. Instead, she volunteers her time folding laundry and cleaning the shelter’s kitchen to maintain a favourable relationship with staff. In this way, power takes on a productive rather than repressive form (Foucault 1980b). Performing the redeemable role paid off for Matilda, as she was offered a coveted spot in another shelter with a reputation for less violence and drug use. As I explore below, a homeless individual’s relationship with frontline staff and para-professionals, such as case managers, can have a profound effect on their quality of life in the homeless community.

“We’re not the enemy”: Frontline staff as police

In the same vein as noting the similarities between the shelter and the prison, some research participants compared frontline staff to police and correctional officers when describing their overt displays of power. The front desk is commonly referred to as ‘the bubble’ (Ranasinghe 2013a), a term borrowed from prison to describe the glass office where correctional officers are located. In turn, front desk staff are referred to as ‘bubble boys’.⁹⁰ The bubble acts as a symbolic display of the power, where frontline staff wear a “badge of privilege” (Bauman 2004: 104) that comes from accessing spaces and enforcing rules that are unavailable to shelter residents. Daniel finds the title ‘frontline’, which is embroidered onto their uniform at shelter one, to be a display of power:

You know, they call themselves frontline like we’re the enemy? We’re not the enemy, you’re not against us, you’re not punishing us, we’re not in the penal system, we’re in a supportive environment. Not frontline, no, no, no, no. Helper. Support worker. Service delivery agent, or something. Not frontline.

⁹⁰ ‘The bubble’ and ‘bubble boys’ was a term I heard only in the men’s shelter, used to describe multiple men’s shelters, despite the fact that the women’s shelter has a similar glass office. The use of ‘boys’ connotes the gendered representation of security work (Prokos & Padavic 2002). Although exact numbers are not available, the men’s shelter employs many female front desk staff. In the women’s shelter most, but not all, of the front line staff are women.

It is interesting to note that Daniel was among the interviewees who described the shelter as “halfway between the ROH and Innes Road”.⁹¹ Daniel’s description of shelter staff’s authoritative presence is consistent with classic total institutions. He highlights the paradoxical nature of staff roles that requires them to be compassionate and tolerant while upholding strict rules: “These members of staff who are in continuous contact with inmates may feel that they, too, are being set a contradictory task, having to coerce inmates into obedience while at the same time giving the impression that humane standards are being maintained and the rational goals of the institution realized” (Goffman 1961: 92). Daniel is describing the tension arising from staff using predominantly disciplinary tactics, such as sanctions for rule violations and conducting surveillance, within a neo-liberal total institution. The residents of the shelter get caught up in the confusion and inconsistency of trying to balance security and care.

Arbitrary rule enforcement and the division of redeemable and irredeemable residents

Ranasinghe (2014) writes that shelter staff have divergent perspectives on what constitutes an ethic of care⁹² and that the lack of a common understanding about how to perform tasks through this ethic leads to inconsistent rule application and enforcement. For example, Ranasinghe (2013b, 2014) describes one staff member as subscribing to the tough love method of care and who is therefore strict with rule enforcement. Another staff member who has personal experience with homelessness takes a more nurturing approach to care and is much more flexible with how rules are applied. Similarly, a number of participants in this research expressed their frustration that rules are often created and applied differently depending on which staff are working at any given time. Seamus was obviously annoyed when he stated:

⁹¹ Innes Road refers to the street where the OCDC is located.

⁹² An ethic of care is a theoretical construct used to assess the imperative we have to meet the needs of others and the moral ambiguity of what constitutes good care (Held 2006).

They need to be less cop-like and more social worker type. Or find a nice blend... And I know that there's rules and there has to be rules, has to be, not black and white though. I've never been black and white rule guy. And they do that but they do it really poorly because they do it black and white for one day and then grey the next and then black, white, and grey in the same day.

Seamus describes the arbitrariness of how rules are maintained in the shelter and the challenge residents have of knowing how to act or what they can do on any given day. While Ranasinghe's analysis that this discrepancy is due to ideological differences between staff, I argue that much of the discretion in rule enforcement lies in whether the resident is considered redeemable, and thus afforded the privilege of bending the rules.

Wanda is a quiet and meek sixty-one year old woman who had lived in the shelter for ten months at the time of the interview. She has a host of physical illnesses, including bleeding from her eyes, chronic foot pain, suspected osteoporosis and was in remission for cancer. Wanda tries to avoid trouble but was assaulted by other shelter residents and hospitalized six months prior to the interview. She was very nervous to come back to the shelter once released from hospital, but after a brief stay in a motel ran out of money and had no choice but to return. Upon her return she found that the frontline staff provided her with more assistance:

You know, they let me, I know it's not, it's not much to ask for, that I ask for a piece of toast this morning and a little bit of tea because I'm not eating and usually the hours they'd say no, and they did say yes, so that was, you know, I know it's not asking a lot but, but... when they get to see like that and they say, let me, they'll let more, but they let me have a cup of tea for my throat and a piece of toast... They have certain hours so they, they could have said no, but maybe they, they, I asked [a staff member] personally, I said, if you say no it's ok.

Wanda is aware that among the included circuit having a cup of tea and a piece of toast at one's leisure is of no concern. At the shelter, however, where staff strictly control meal times and access to different rooms, Wanda's request for food beyond the schedule is a request rarely granted. Goffman (1961) contends that one of the primary methods of mortification in a total

institution is having to request permission of staff for minor activities. Wanda acknowledges the power differential between her and the staff, but she also qualifies her request for ‘special treatment’ by stating “if you say no it’s ok”. In this way, Wanda pays deference to her subjugated position and confers upon staff her willingness to abide by the rules even if they do not meet her needs. Since her return to the shelter staff members have been cognizant of Wanda’s vulnerability and have taken a renewed interest in her care, finding her specialists and helping her navigate the health system. Staff characterized Wanda as redeemable given her willingness to submit to the disciplinary regime of the shelter and as such, her seemingly small but significant request for tea and toast was granted.

Louise stayed at the same shelter as Wanda but had a decidedly different experience dealing with staff. Louise is a forty-eight year old woman from Boston who came to Canada seven months before the interview after being extradited from the US following a prison term. She was barred from the shelter a few months back for fighting but returned after being evicted from a rooming house for drug and alcohol use. Since her return she was in a number of other fights but is often the victim; she claims women assault her while she is passed out from smoking crack. Louise was diagnosed with bipolar disorder and depression and found that her prescription to Seroquel and Prozac are not as effective as alcohol in relieving anxiety. Louise made several requests to stay in her room during the day due to her physical and mental distress but staff were unwilling to bend the rules:

You go get an x-ray on your lungs because I had pneumonia here. Three months I was stuck in bed, three months this winter. Nobody even knew I was alive. And then all of a sudden one day I get a, ok, so no more bedtime. I said, who are you? How do you know how I feel? Because pneumonia is, is like, mono, you’re just exhausted.

Later, Louise recounted asking for bed rest on account of her distress:

I don't think people recognize, like, when I say I want to stay in my bed and it's because I'm depressed and I don't want to do anything, I don't want to go out, I don't want to see anybody. It's almost like a panic feeling, a paranoia, and you know, they're get up! You've got no bed rest. And I said I'm depressed. Uh, you'll feel better when you get up. It's like, are you a doctor?

Louise describes the shelter staff as unsympathetic and judgemental. She was afforded bed rest when she was acutely ill with pneumonia but this exception was only temporary. Louise believes she is entitled to stay in bed when she wants and does not appreciate having to make a request to do so. Unlike Wanda, Louise does not defer to the staff's power and is instead confrontational, demanding "who are you?" and "are you a doctor?". Because Louise is resistant to shelter policies and the staff who enforce these rules she is not positioned as redeemable and thus not afforded the perks that come with playing by the rules. As Chico reminded me: "You've gotta get along with staff man. These are the guys that are running the place". Resistance is a form of power relations (Bosworth & Carrabine 2001) and because Louise does not play the part of the docile subject working to "get along" with staff she is not privy to relaxed rule enforcement.

Louise is not alone in her frustration with the seemingly arbitrary rules applied by staff. My field notes recount an incident between frontline staff and Alyson, who staff identify as difficult to handle due to her attempts at sobriety and subsequent relapses:

She wanted to get into her room and the staff wouldn't let her. She began to get very upset, quite surprising from what I've seen from her. She was still quite rational though. She said she just wanted to get into her room to get something. She knew it was against the rules but as she said: "I'm dying and all I want to do is get into my room". She was very frustrated with staff, saying that she was not doing well and she was just looking for some flexibility.

My interactions with Alyson were always pleasant and courteous, but the power imbalance between Alyson and staff created a hostile environment where she felt that her needs were subjugated by shelter bureaucracy (Foucault 1980b). Alyson's distress was so acute that she

cried out “I’m dying” and begged for “some flexibility” on the part of staff. Although Alyson’s participation in detox programs is a sign of her potential redeemability, her often quick and continuous relapses have left staff with compassion fatigue and they were unwilling to soften the rules for her. Once again, Chico’s advice that “I don’t like to rock the boat... Therefore I’ve had no problems” rings true. Although Alyson was not as openly defiant of staff as Louise, her opposition to the “black and white” rule enforcement as described by Seamus is a small act of resistance that brings to the fore the hidden and marginalized voices of those who are often unseen and unheard (O’Malley 2001). In her plea for flexibility, Alyson articulates what is obvious to most shelter residents – that the rules are flexible for some, but not for others. In this way, frontline staff members maintain authority during these every day struggles for power (Bosworth & Carrabine 2001) through their ability to qualify who is granted flexibility.

Conclusion

In this chapter I argued that despite the critiques, homeless shelters are not just near total institutions, but rather embody the qualities of a neo-liberal total institution. Emergency shelters act as unique spaces where they are meant to emit a social welfarist ideology while in practice much emphasis is placed on security and surveillance. Shelters exist as part of a complex and heterogeneous network of institutions that regulate risky populations through their freedom. In this way, I argue that shelters share many of the same characteristics as classic total institutions, such as its strict regulation of space; the regimentation of time; and the demarcation of power between staff and residents. Shelters differ, however, in that their ability to engage in social control exists in tandem with the socio-political environment that limits alternative arrangements to shelter living and where homeless men and women are positioned as voluntary subjects in their institutionalization.

While I make the distinction between traditional total institutions and the shelter as its neo-liberal counterpart, it is also essential to note their similarities. Total institutions are places of deculturation and identity loss. By characterizing the shelter as a kind of total institution we can recognize the ways in which homeless men and women are excluded from the social body and are compelled to adopt the moral career of the homeless person. Institutionalization takes on a neo-liberal form by bearing witness to its subversive power within the broader homeless community as part of the punitive city (Cohen 1979). Research participants described the ways in which they were institutionalized given their dependence on the shelter for a warm place to sleep, food to eat, and, as many interviewees highlighted, for the opportunity to work on the project of the self. That homeless shelters exist within the wider (transcarceral) net (Cohen 1985) of neo-liberal governance demonstrates how total institutions have transformed in the twenty-first century. The shelter as a neo-liberal total institution exists in and among the downtown condominiums, high-end restaurants and shopping malls as a space of exclusion. While it is just as visible as any other building the distress, marginality, and pains of homelessness remain invisible to the included citizenry that matriculate in and around it. Those who reside in a shelter may be free to leave during the day but they cannot so easily escape the homeless identity or the poverty, racism, and discrimination that often come with living on the margins. In the next chapter I consider the homeless, mentally ill and addict identities and how men and women negotiate and manage what it means to be homeless.

Chapter 6 – Identity Management: Performing the Homeless, Mentally Ill and Addict Identities

Introduction

In this chapter I explore how the mentally ill and addict identities⁹³ are shaped within the homelessness context. A tension exists in the way that identities are actively and consciously created and performed within the confines of marginality. This incongruence mirrors the theoretical quagmire of identity performance discussed in chapter three. Butler (1990, 2004) and Goffman's (1959, 1963) seemingly opposing contentions in relation to acting out a social identity can be aligned when we consider the manifestation of identity performance as occurring within specific social, temporal and structural parameters. Homeless men and women engage in identity performance, but the types of identities that they perform and the effectiveness or believability of these performances are directly related to their status as homeless. By analyzing identity performance as existing within a broader social system, we can highlight the intersection of individual and socio-structural factors and the complexity of what it means to adopt the homeless, mentally ill, and/or addict identities.

In order to assess how identity is managed among homeless men and women, I first consider how research participants make sense of their marginal status. To be excluded from the broader social world carries with it certain expectations of how one should relate to the self, such as having a sense of shame and accepting the distance between oneself and the broader community. Next, I uncover the characterization of the homeless, mentally ill, and addict

⁹³ In the forthcoming analysis, I do not assume that there is an 'authentic' or 'true' identity that participants build upon. Instead, as per the discussion in chapter three, I regard identity construction as a performance borne of particular social, cultural and historical discourses (Butler 1990; Gergen 2000; Goffman 1963; Roseneil & Seymour 1999). Interviewees use discursive constructs, such as mental illness diagnoses, as tool to illustrate particular subjectivities that resonates with them (Ussher 2003). In this way, I do not suggest that a diagnosis or a label such as 'depressed' or 'addict' is a 'truth' but acts as an identity descriptor for some research participants.

identities with special attention to how exclusion is experienced (Rose 2000). Most participants attempt to achieve and maintain a redeemable status through their negotiation of these identities, although some cast themselves as impossible/irredeemable. Finally, using Goffman's dramaturgical approach to examine identity performance and stigma management, I consider how interviewees negotiate particular identities as a way to situate themselves as redeemable and worthy of services and support and to distance themselves from the irredeemable homeless.

The marginalized identity: Shame and 'Otherness'

A common theme throughout many of the interviews was a sense of shame. Whether it be in discussing their status as homeless, their relationships with family, or their contribution to society, many of the narratives were situated within a discourse that expressed a deep sense of embarrassment and sadness. In this section I will explore how shame was expressed and consider why this emotion dominates how individuals frame their stories.

The shamed poor

Research participants commonly expressed feelings of shame and despair from being 'Othered'. The loss of self-esteem and sense of place in the world is in keeping with the neo-liberal expectation of individual accountability, often leaving those who receive public assistance feeling ashamed, dehumanized and excluded for their reliance on the state. Castel (2003: 34) argues that "the poor must display a good deal of humility and exhibit convincing proofs of their unhappy condition in order to deflect suspicions that they are 'bad poor'". Like some authors (Allen 2000; Chunn & Gavigan 2004; Katz 2013), I argue that performing the 'shamed poor' role is expected by those receiving social assistance, especially those who have a history of social exclusion and reliance on publicly funded institutions such as Children's Aid, hospitals, and homeless shelters. In this sense, the poor must 'earn' assistance (Katz 2013; Rose 1999) and

will only be considered redeemable if they demonstrate an adherence to inclusive norms such as acting civilly, obtaining employment, and being able to self-govern; should they fail to do so, they are expected to remain unhappy and unsatisfied while living an excluded life (Bauman 1988).

Participants articulated their sense of shame in a variety of ways. Daniel recalled his hesitation to enter a homeless shelter because he considered it to be “the end of the universe”, while Karla expressed her shame through her unhappiness in having to live in a homeless shelter: “That’s all I want. I just want to be happy, I’m not happy... It really says something about your life when you’re fucking happy while you’re living in this hell over here”. For Karla, the homeless identity is a negative, crippling, and lonely experience. Karla identifies as coming from a middle class background where each member is employed and contributes to the family and broader community. Karla remarked on the shame she felt when she was arrested for drug dealing because her cousin is a police officer. She described feeling abandoned by her family due to her charges: “My cousin doesn’t talk to me now. He’s like I can’t believe you got a record, he knows that, he goes you know both sides, he goes why would you, he goes, I can’t, he goes, conflict of interest, I can’t talk to you until you’re off all your conditions”. Karla was unsure whether it is truly a conflict of interest for her cousin to maintain a relationship with her. In keeping with Goffman’s (1963) description of the sticky quality of stigmatic attributes, Karla instead feels that the stigma of her criminalization has by extension also shamed her family.

Karla’s sense of shame was echoed by other participants. Many of those who come from relatively stable families lamented their demise into social and familial exclusion. Julien called himself “the black sheep” of his family because unlike him, his sister is employed and does not suffer with addiction. Matilda compared herself to her children: “Like if I had it all together I

wouldn't be here. My daughter has it all together, she's a social worker, she just became a social worker. My son is going to Humber College taking business. They have it together. I don't have it together". As a result of her shame, Matilda tries to hide her homelessness status from her children and thus limits her contact with them so they do not ask questions. Shame then, can lead to isolation and loneliness. Bauman (1998) describes feelings of shame and guilt that come with being a member of the underclass. He argues that the inability to live up to the standards of the included society leaves the poor in "...distress, agony and self-mortification" (Bauman 1998: 37). This sense of shame causes many homeless to pre-emptively exclude themselves by avoiding public places (Hermer & Mosher 2002), but as Matilda's experience demonstrates some will also exclude themselves from private spaces and personal relationships. Matilda wants to avoid the sense of abandonment that Karla experienced by distancing herself from her children. DeOllos (1997) suggests that extended time in the homeless community creates distance between the homeless individual and her relatives and friends⁹⁴ in part because they cannot relate to her but also because of the felt embarrassment of being unable to repay charitable acts, such as financial support or being allowed to sleep on a couch for a few nights. Matilda's narrative acts as a reminder that the notion of inclusion and exclusion are not simply abstract theoretical tools but instead shape the lived spatial, social and emotional distances experienced by the excluded.

Like Matilda, Mustang developed a sense of shame by comparing himself to his family. Although Mustang acknowledged that he grew up in a "dysfunctional family" mired by addiction and egregious physical and sexual abuse, he contrasted his life with his siblings' success:

I have a brother. I have two older sisters... Um, they're all doing well. None of them struggle with addictions I am. Um, everybody's married, everybody's got a home, kids,

⁹⁴ DeOllos' (1997) study of homeless families only refers friends and family who are included. In some cases, histories of homelessness span across generations (MacKenzie & Chamberlain 2003).

etc. Um, I had a rough childhood and for some odd reason I chose to grow up living rough, and, um, and this is where I sit today.

Mustang describes his bipolar diagnosis, alcohol addiction and homelessness as a choice he made that his siblings did not. Although Mustang reveals a sense of shame in his homeless, addict and mentally ill identities, he suggested that his siblings are also emotionally dysfunctional and he finds solace in the fact that he is aware of his self-described abnormality and has “more peace” than his siblings. Despite this assertion, Mustang’s narrative of difference, similar to Karla, Matilda and Julien’s, is deeply imbued with a sense of shame.

Shame is visible in the homeless community. In my time at the shelters, I witnessed quiet voices and bowed heads when asking staff for psychotropic medication, razor blades, or even something as mundane as a pair of socks. The loss of dignity felt by some homeless men and women is palatable. By shame, I am referring to: “... a painful emotion responding to a sense of failure to attain some ideal state... In shame, one feels inadequate, lacking some desired type of completeness or perfection” (Nussbaum 2006: 184). I happened to be visiting one of the shelters on the day of the annual Christmas dinner complete with camera crew from local news stations. Several individuals told me they were not going to attend the dinner, despite the copious amounts of food and their being served to rather than having to line up cafeteria-style, because they did not want their faces to be shown on TV.

I was also privy to the gendered component of shame. From my field notes:

I learned today that women have to ask for a [menstrual] pad each time they need one from front desk staff (sometimes from male staff). They are only allowed one pad at a time. One woman who I’ve never seen before shuffled over to the staff counter. She was obviously embarrassed to ask and was almost whispering it to the woman staff member through the glass partition. When the staff member figured out what she was saying she jumped up and loudly said they have some, ignoring the woman’s desire for discretion. The woman told the staff that she thinks she won’t have to ask for too many more.

Dignity, the feeling of self-worth, is not a possession, but rather an ontological manifestation of humanity. Our sense of dignity comes from both internal and external experiences (Seltser & Miller 1993). Shame denotes a vulnerability that comes from the outside world bearing witness to one's inner world (Nussbaum 2006). Although many practitioners and researchers dismiss dignity as a focus when managing homelessness given more immediate concerns such as shelter, food, and clothing in fact many of the homeless are deeply concerned about their sense of self-worth (Snow & Anderson 1993). Miller and Keys (2001) found that professionals and para-professionals' interactions with the homeless, how programs are structured, and how rules are enforced influence homeless men and women's sense of dignity. In the instances described above even the most innocuous encounters can instill shame in homeless individuals. The woman asking for a sanitary napkin not only experiences shame from her immediate social environment in a homeless community, but given the rules and bureaucracy of the shelter her shame is turned inward and exerted onto her body and womanhood. That women are socialized to feel shame towards their bodies is not new (Bessenoff & Snow 2006; Butler 1990, 1993, 2004a; Nussbaum 2006; Ussher 1991) but takes on a more complex dimension when homeless women are not afforded privacy and discretion. That homeless women's bodies exist almost permanently within the public gaze because they have no home, bathroom, or bedroom to find solitude is even more problematic when we consider the histories of physical and sexual trauma many homeless women face (Paradis & Stermac 2001; Tolman & Rosen 2001).

Because dignity is intimately related to one's sense of humanity (Seltser & Miller 1993) it is troubling that homeless individuals encounter sites of shame on a daily basis. Butler (2004b: 98) suggests that the de-subjectification of a group of persons is a technology of control, writing: "Finally, it seems important to recognize that one way of 'managing' a population is to constitute

them as the less than human without entitlement to rights, as the humanly unrecognizable”.

Indeed, the sense of shame that participants exhibit is directly related to the assumption that the homeless are largely ‘undeserving’ of dignity (Chunn & Gavigan 2004; Katz 2013). Assuming that the homeless are unworthy of social assistance, care and treatment limits the public’s obligations towards those in need (Katz 2013). Butler’s insights suggest that such populations are thought to be irredeemable unless proven otherwise.

Vince’s story offers a glimpse into the assumption that to be homeless is to be irredeemable. Vince is embarrassed by his addiction and homeless status, causing him to disconnect from supportive people and programs when he is actively using drugs:

My, my support network, um, when I’m clean and I still have this support network, but, um.... Whether I choose to reach out... which I’m not using all my support network right now. Some of those reasons are because of some shame and guilt I have for relapsing and not showing up at meetings.

Vince situates himself as a member of the ‘undeserving poor’ and does not believe he is worthy of assistance and support when he relapses. He qualifies those services as only available to those who take responsibility for their actions – something he did not feel he could do at the time.

Vince uses the rhetoric of ‘earned assistance’ (Rose 1999), where social support is only available to those who demonstrate merit (Katz 2013) and who have hope that they can be redeemed.

Although Vince characterized himself as irredeemable at the time of the interview, this does not preclude him from adopting responsabilization techniques in the future and gaining the redeemable status. Because exclusion exists along a continuum (Castel 2003) the redeemable subjectivity requires constant maintenance and negotiation. Of equal importance for effective governance through freedom is the hope (Novas 2006; Rose & Novas 2005) that people such as

Vince can once again become redeemable, although maintaining hope for inclusion is exceptionally difficult for those individuals that are repeatedly separated from the community.

Separate from community

Quintessential to exclusion is the individual's awareness of her precariousness. Only if one recognizes her excluded status can she begin to work on positioning themselves as the 'redeemable excluded'. Interviewees described in detail the felt experience of being 'Othered'. Part of this sense of 'Otherness' comes from white, middle-class, masculine, and heteronormative ideals of normality. Jamie explained his definition of normal:

Jamie: This isn't a life. Life's, I've said I can survive here. That's really it, survival. It's basic instinct. It's shelter, food, clothing provided for you. It's easy.

Erin: What's, what's a life then, if this isn't, what's a life?

Jamie: Uh... a house, two cars, two point five kids, you know what I mean [laughs]. No, uh... I guess people would call it product, being productive in society.

When probed further about the meaning of "productive in society", Jamie said that it means being normal, but admitted to hating that word: "Well, define normal. But in today's society that's what's expected of you, so, and I'm not trying to make blasé of my situation here". Jamie is critical of normalization but still accepts its dominant discourses. He juxtaposes the inclusionary ideals with his experiences in youth shelters, prison, and now adult shelters and concludes that "this isn't a life" because it does not live up to the norm. Jamie's portrayal of the stark contrast between being an included or excluded member of society does not account for the myriad ways otherwise excluded people may feel included. Examples provided by other research participants include: having positive relationships with friends or family; volunteering at drop-in centres; and being connected to community resources. Jamie's dichotomous thinking likely comes from his isolation and lack of ties to people or places. A self-described "loner" with no

familial contact, Jamie goes out of his way to keep distance from his homeless peers. He never stays in a city for more than a few months at a time. Jamie characterized himself as “institutionalized” in that he learned skills to “get by” but does not set down roots anywhere. It is no wonder that Jamie regards inclusion and exclusion as binaries given that his narrative is one of complete separation from the community, indoctrinated from years spent in jails and shelters, and self-imposed exclusion to cope with his depression.

Several participants situated themselves as separate from the community as a result of prevailing heteronormativity (Schilt & Westbrook 2009). Gaston claimed that from a young age he knew he was different because he identified as gay and as such has felt isolated and alone throughout his life for failing to be ‘normal’: “I think, I don’t know what it is, but I know I was different. I know I was different chaos in my head. I didn’t fit in”. Gaston revealed that his introduction to the mental health system came from his parents’ concern with his sexuality. His sexual identity continues to cause Gaston to avoid making friends because of his perception of the homeless community as homophobic and his fear of victimization (Cochran et al. 2002). Likewise, Tom’s experiences as a popular actor in gay pornography films in the 1970s and 80s led him to deduce that he can never be normal. He too hides his sexual orientation from those in the homeless community, but is out among his friends and family. Similarly, Gerry expressed shame because of his lack of sexual experience, stating:

Gerry: Well maybe it’s just because of a deeper problem, because being a virgin is a problem.

Erin: Why is it a problem?

Gerry: Well, if it wasn’t a problem and if I was happy with my everyday life I wouldn’t be stuck, I wouldn’t have come here. I would have just kept working for McDonald’s forever.

Gerry noted that because he does not know other thirty-four year old virgins he must be abnormal, which causes chaos in his life, such as quitting his job at McDonald's unexpectedly. Gerry subscribes to the discourse that he should be happy if he is working, irrespective of the fact that the job that consists of menial labour for little pay. Encouraging the working class to thankfully and uncritically accept precarious, underpaid labour out of an ingrained sense of civility is part of the neo-liberal mechanism to govern poverty – policies and norms that Wacquant (2009) refers to as 'desocialized wage work'. Normalization discourses are exceptionally powerful (Bauman 1988), so much so that despite their exclusion, many people adhere to inclusionary ideals (Young 1999) and embrace neo-liberal doctrines of individualization and choice.

While Gerry internalizes his self-described 'abnormality', he departed briefly from the shamed poor script to question whether he wants to be normal:

Gerry: The whole being happy, like, trying to do what everyone else is trying to do what everyone else is trying to do, make it to retirement and, uh, be happy with money and stuff. It's kind of boring... The whole, do the same thing over and over again forever. The same job, the same life, the same roof for thirty years. It's, it's a long time.

Erin: So why do you want to be normal then?

Gerry: Well you don't always have a choice, you just have to, you know, suck it up and just play it out.

Gerry sees no alternative but to strive for standard norms in order to exist as a civilized member of society despite his reservations with normality and the lack of resources to perform as such.

Gerry has difficulty maintaining a job, securing housing, and having a sexual relationship, but he perseveres through (so far unsuccessful) attempts to earn his General Education Development (GED) and using counselling to try and improve his prospects.

Only one other participant described resisting the standards of normality. In fact, Lenny expressed no desire to become ‘normal’:

I’m finding people who are normal by society’s definition of the word are very unhappy. They’re just very unhappy. They spend, they spend their lives just replacing their TVs and replacing their cars and watching mindless television and complaining about the way the world is and I don’t see any happiness there whatsoever. I just see this, you know, what Thoreau says, ‘the mass of men who live in quiet desperation’, and I think that’s exactly what’s happening.

Lenny firmly rejects middle-class expectations of consumption. However, Lenny may be more apt to do so than many of his homeless peers because despite his critique, he has an abundance of human and social capital. Human capital refers to acquired skills and knowledge such as education and employment (Reisig, Holtfreter & Morash 2002). Social capital, coined by Bourdieu (1980), refers to the combination of real and potential resources associated with strong relationships built on a common network. Portes (1988) elaborates on Bourdieu’s definition by suggesting that social capital is not static; rather an individual must fulfill obligations and provide exchanges between members to maintain relationships. Lenny’s position as homeless leaves him unable to fully participate in the bonds of social capital (CPHI 2009), but he continues to have a strong relationship with family and friends, an education, and valuable work experience. The notion of ‘linking social capital’ acknowledges differences in power relations between members of a group and describes situations where an individual will forge alliances with someone who has more status or wealth to leverage resources (Woolcock 2001). The prospect of maintaining these social bonds and reinvigorating his social capital allows Lenny some flexibility to speak critically of normative standards and cultural values while maintaining a ‘redeemable’ status within the homeless community.

Lenny's response was unique. Above all, participants spoke of their isolation, describing the shelter specifically and the broader homeless community as existing within but separate from the world around them. I knew Daniel for a little over a year when we conducted the interview. Knowing a bit about me, he differentiated between my life as representative of the included and his life in a homeless shelter:

Daniel: Because, you know, I'm, I'm put in a different pile, you know that's you guys over there and these rules and opportunities are there for you and everybody else is frolicking in the meadows and I'm stuck in the urban jungle, you know, just trying to survive on a day to day basis.

Daniel echoes Jamie's description of homelessness as survival rather than truly living. Having previously had a successful career, owned a home, and been married with two children (read, included), Daniel is also acutely aware of the symbiotic relationship between 'rules' and 'opportunities' that are available to those who self-govern appropriately (Rose 1998, 1999).

When Daniel suffered a self-described "breakdown" because he felt like he was "a slave to work and taxes" he "stepped out of the machine", but by abandoning adherence to the rules he also lost the opportunities that come from following them.

Likewise, Jon witnessed his 'Otherness' when he compared his poverty to the gentrification of the neighbourhood where the homeless shelter is located: "You know, you, you've got all this money there to throw around on condos but you, you're, you're looking at us.... as nothing. We don't exist. We're not a part of this community. We're alcoholics. We're drug addicts... Well, so what? We're human beings. We do have feelings". Jon's comment echoes Ruddick's (1996, 2002) notion of 'social death' whereby homeless men and women are disenfranchised from the included group. Jon is acutely aware of how the homeless are perceived and expressed a desire to talk to politicians in an attempt to re-humanize the homeless identity.

Ironically, by being excluded Jon does not have the social capital to attract the necessary audience to listen to his argument about why he should not be excluded.

In a similar vein, Otto used the term “bottom feeder” to describe his disassociation from, but reliance on, the included circuit:

Um, and yeah, there are people like myself, uh, and, if I call myself a bottom feeder I don't think that they're, that I can't fall any farther. I mean, I know there's, you know, plenty more space down there for me to go, but uh yeah, I'm, I'm. My success or failure is dependent upon the whims and generosity of the rest of society at this point. Uh, if society were to turn around and chop me off and, right now, uh, you know, I don't get welfare and my rent's not going to be paid, uh, I don't get free meals, um... maybe, maybe I would get off my sorry ass and go out and get a God damn job and, and, make something of myself. Maybe I'd become a crook. Maybe I'd kill myself. Who knows what would happen.

Young's (1999) beach analogy comes to mind when reading Otto's narrative. As described in chapter three, exclusion exists along a continuum, with cocktail sipping partygoers at the top of the beach and sea creatures lurking at the bottom of the ocean, and the beach acting as a gradient between these two extremes. Otto is aware of his exclusion by situating himself as a “bottom feeder”, but he also understands that his exclusion is part of a continuum. Otto considers himself a ‘redeemable’ excluded subject because he knows that the ocean depths breed even greater marginality. Otto had recently begun taking an interest in the attention deficit hyperactivity diagnosis (ADHD) he received a year prior (he consciously disregards his bipolar diagnosis) and was set to meet a mental health specialist a week after the interview. He exhibited shame for his dependence on public services to house, feed, and clothe him and to provide mental health and addiction support, saying “I'm not proud of where I am in life”. Having witnessed the suffering and death of his homeless peers (primarily from illnesses related to addiction such as liver failure and AIDS), for Otto, maintaining his status as a redeemable citizen and subject that is worthy of services (Rose 1999) is a matter of life and death.

Otto's comment captures the essence of the excluded identity. The only way to access services in the late modern world is to demonstrate that one is capable of change and worthy of assistance. In this case it means taking up and demonstrating an enthusiasm for the services and programs offered by the mental health system in the homeless community. Interventions consist of taking psychotropic medication, attending AA/NA meetings, anger management classes, and a variety of educational and work-ready programs. The alternative to demonstrating one's worthiness is to be considered impossible/irredeemable and become further separated from the social world, as Vince described. Bauman (1988: 91) articulates:

Society would be much better off if the poor just burnt their tents and left. The world would be that much more pleasant without them. The poor are not needed, and so they are unwanted. And because they are unwanted, they can be, without much regret or compunction, forsaken.

These are harsh words but with significant cuts to social assistance (Lankin & Sheikh 2012) and the criminalization of poverty (Gustafson 2009), such as Ontario's *Safe Streets Act* (Esmonde 2002; Hermer & Mosher 2002; O'Grady, Gaetz & Buccieri 2011), it is apparent that excommunicating the 'bad investments' (Bauman 1988) is not merely metaphorical. Here we are reminded of Foucault's (1988) description of the physical and social exclusion of lepers in the Middle Ages. Jon and Otto, like many of their peers, are more easily cast into the irredeemable camp given the unfounded but popularized notion that those diagnosed with a mental illness are unmanageable, incurable, and exceptionally dangerous (Elbogen & Johnson 2009); in essence, the mentally ill are unworthy. As I will explore, many marginalized men and women attempt to perform the homeless, mentally ill, and addict identities so as to align themselves with the ideals of the included group. To do so requires acknowledging that one's thoughts, behaviours, and environment are disordered and demonstrating a willingness to be disciplined in an effort to

become included. As Rose (2000) points out, however, conceding to one's exclusion further entrenches the excluded status and being open to responsabilization techniques requires accepting the individualization and decontextualization of social problems.

Situating the homeless/mentally ill/addict identities

So far in this chapter I have explored the expression of felt 'Otherness' as described by the research participants. Not only are they acutely aware of their exclusion, but true to the internalization of normative ideals (Rose 1998, 1999; Young 1999), most situate themselves as 'shamed poor' (Castel 2003). By bearing witness to their own exclusion and marking their status as inherently negative and necessarily shameful, we begin to see how marginalized individuals in some ways consciously perform their identities so as to present themselves as redeemable and to distance themselves from subjects considered impossible. In the following sections I outline how participants constituted the intersection of these marginalized identities.

The homeless identity

The common identity marker amongst the participants was their status as homeless or precariously housed. Their histories of housing varied, where some lived on the street (9/38); almost all currently live (30/38) or have experience living in a homeless shelter (37/38); and some live in community housing (2/38) or subsidized housing (6/38) Despite deep entrenchment in the homeless community, participants forged their own unique sense of what it means to be a homeless person.

Certainly the literature points to variability within the homeless identity. Feldman (2004) critically engages with four 'types' of homeless identities: the non-person; the bad/dangerous person; the helpless victim; and the pathologized. Likewise, Rosenthal (2000) characterizes the homeless as 'slackers' (lazy); 'lackers' (lacking competency to care for themselves through no

fault of their own; often pathologized) and victims. While Feldman and Rosenthal refer to these types as singular characters, my research reveals a more complex account of the homeless identity. A support worker in Ottawa's homeless community for over thirty years remarked upon the changing nature of the homeless population over time:

...when I started working in shelters it was really traditionally, uh, hobo, like your, rubby dub people, uh, tended to be older guys, uh, um, and, just before I left in the mid-eighties you started to see more youth and, uh, you were mentioning about, like, uh, new immigrants here, it was very homogenized, like, uh thirty years ago, it was white [chuckle]. It was, uh, you know, uh, yeah it was predominately... uh, you have more woman now, also, like, uh, on the streets, uh, uh, what's the name of that. Or perhaps because there was no woman's shelter in Ottawa before, I think probably, it was 86, 87 before [a women's shelter] opened, uh, you didn't have that... that, segment, you didn't have women, uh come into the shelters, uh... So there's, it's a, there's a diversity of people here... (Rick)

Despite the discourses representing homelessness through homogenized categories (Young 1999) Rick's narrative reflects on the changing dynamics of homelessness, especially as neo-liberal ideology began to reshape the social assistance landscape (Little 2001) and more people lost their housing (Pomeroy 2001). The invisibility of women's poverty is widely described in the literature (Bukowski & Buetow 2011; Klodawsky 2006) and Rick articulates what Pearce (1978) describes as the 'feminization of poverty', whereby the increase in women-headed households, the decrease in the income level of these households, and the destruction of the welfare system coalesce to make women more visible in the homeless community. Although most of the participants responded with indifference when asked about gender dynamics within the homeless community, Karla offered insight on the specific challenges facing women:

Karla: I think women have more to deal with if they're living in a shelter... 'Cause they've got their mental health and their physical health and they don't know whether they're going or whether they're coming, you know? So they're struggling with the, people are just coming from living in apartments for years and just coming in here and it's hard. Like, I think men can adjust easily because they don't deal with everything. They just keep, plugging at it away in pairs and then one day they blow up and they start

beating everybody up, you know? So it's a lot harder for women. There's a lot more emotions and everything else.

Karla expresses the familiar trope that women are more emotional and thus less stable than men (Kendall 2000; Ussher 1991, 2010) and characterizes men as more aggressive and potentially violent. She also alludes to the reality that women are often solely responsible for the family and the home, whereas men "don't deal with everything", both in terms of emotionality and domestic responsibilities. More than this though, Karla notes how segments of the population cope with homelessness differently. Not only is heterogeneity visible in terms of coping mechanisms, but also in terms of the structural impediments for women trying to manage homelessness. For example, Wanda found:

Yeah, yeah, there's no help out there for us and there's a lot of women in here that need it, mentally, I mean really mentally, they talk to themselves, but people like me and there's another few women that need a roof over their head but they need counselling to talk to, um, that should, there should be more beds or there should be more shelters or, like they, the women only have this one and the one on [names street]. There's a few other ones but when I did call there was abused women or kids.

Segments of the homeless population access services and experience homelessness differently; single women in particular are limited in terms of the programs and assistance that are available (Barrow & Laborde 2008), especially with respect to emergency shelter beds, the bulk of which are designated for men. The emphasis on providing resources to families represents Rosenthal's (2000) 'lacker' category, where children in particular are seen as in greater need of assistance and are part of the 'deserving poor'.

Rick's comment also pointed to the racialization of poverty. A plethora of literature identifies the disproportionate rates of poverty among Black men and women in the United States (Rankin & Quane 2000; Wacquant 2002) and the deplorable living conditions facing many Aboriginal, Métis, and Inuit peoples in Canada (Kendall 2001; Wilson & Macdonald

2010). Giles is a fifty-one year old Black man who came to Canada from Rwanda as a refugee in the 1980s. He described his childhood as being without a sense of home. He does not consider himself Rwandan; rather, he finally feels as though he has roots in Canada. It is ironic that Giles finds a sense of home in a country where he has spent much of his time homeless. Moreover, his precarious status as a refugee left him continually feeling at risk of being displaced:

Giles: Yeah when I was in Montreal. We did everything, I have a lawyer [mumbles] but uh, they seem to be interested in me. They said you are, you cannot do anything, you cannot work but you, we send you back to Africa. Why they did that, so I [short pause] I worked, I was always, I had nothing to do so I... I so I, they didn't like, uh, they didn't let me to work or do something...

The threat of being 'sent back to Africa' was unsettling for Giles who has never considered Rwanda home. Giles identifies as schizophrenic and struggles to communicate his needs to others. He has difficulty finding support in the homeless community because of his legal, cultural, and social needs. As Rick mentioned, homelessness was historically framed as a white problem, perhaps because of the sense that white people are entitled to housing whereas it is a privilege for racialized minorities (Wacquant 2002, 2008). The predominance of people of colour in the homeless community does not demystify this attitude, but instead perpetuates racist explanations of homelessness. For example, Chico, a fifty year old white man, suggested that Inuit people do not deserve assistance from frontline staff: "But still there are guys here who treat [staff] like shit and for a while, you know. It, it's usually the, well I know not to say it but it's usually the Inuits and stuff, you know, and I mean they get right rowdy at them. But they beat the crap out of each other too". It is interesting that Chico commented "I know not to say it", implying that he was aware of the racist tone of his comment, but said it anyway. Chico's statement suggests that Inuit residents are not worthy of assistance because of his perception that they are disrespectful, violent, and dangerous (Harding 2006). Here we see the beginnings of a

division between redeemable and irredeemably excluded subjects, where racial status in part dictates the types of interactions individuals in the homeless community face and how these assessments influence interpretations of assistance worthiness.

Resisting the homeless identity

The heterogeneity of the people who make up the homeless community is reflected in the diversity of participants' personal attributes, histories, and identity narratives. Indeed, similar to the literature (Allen 2000; Huey 2012), some participants reject the homeless identity outright. For example, Jon problematized his felt sense of home at the shelter: "Well, see I'm not homeless. I'm, I have a home. I call this home right now, but I shouldn't because you, when you call this place home then you're getting a little too comfortable". As described in chapter five, shelters offer the material conditions of home but lack its symbolic significance (Gounis 1992). Jon is aware that emergency shelters are not organized to give a sense of home. In fact, within forty-eight hours of entering most shelters residents are required to meet with a counsellor to devise a plan to leave the shelter. Still, others agreed with Jon's perspective. Chico, who resided at the same shelter as Jon, suggested that he was not homeless:

Chico: ... but I mean, I don't even consider, I've been homeless man, I mean I've slept in a park, you know. This is not homeless. Being at [shelter three],⁹⁵ that would be friggin' homeless. That would be absolutely scary homeless to me. Because I wouldn't be, I can't, I can't live with people like that. I can't live with... I'd get myself a tent and move up to Rockcliffe Park or something [laughs].

Erin: There you go. So why isn't this homeless?

Chico: Because it doesn't, because I know some of the people in there and that's one thing that's scary because I leave and I'm gone for six or eight months and the same guys are still there and that's another reason why I never get any flack in there because I come for two months and I leave for two, three years sometimes, and then I'll come back. The only time I've ever got a letter on my bed, and to, to go for the interview to see what my plans were and she said what are your plans and I said well my plans are to get out of

⁹⁵ Shelter three is another large men's shelter in Ottawa.

here today and she said you're, yeah, you know how often I hear that? And I said I guarantee you by noon I'll have a place and I'll be out of here. And I went out and got a room and I came back at noon, had my promise everything on time and she was like, you're the only person I've ever, and then I was, I had a place down on [a residence run by another shelter]. That was four years ago.

In this passage, Chico demonstrates that he obtains a sense of home from the people who live at the shelter rather than the building or the shelter system itself. It is the same shelter that pressured him to leave four years prior, and despite his pride in being able to secure housing (albeit from another shelter), he considered his return as a return home.

For Chico, homelessness is living on the street or in a shelter where he does not feel safe. As Huey (2012; see also Bukowski & Buetow 2011) claims, a sense of security is the hallmark of a sense of home. The definition of precarious housing includes homes that are deemed unsafe, either because of buildings that do not meet regulations or because they do not give occupants a sense of safety (often through a lack of privacy, inability to lock doors, or location in a high-crime neighbourhood) (Shapcott et al. 2010). Although both Chico and Jon reject the homeless identity, they qualify their rebuttal with an acknowledgement that their living situation is not ideal and is certainly not meant to be permanent. The homeless identity, then, exists along a continuum where 'true' homelessness may be understood as sleeping rough and some semblance of 'home' can be formed within emergency shelters, despite spatial and regulative mechanisms meant to deter this sense of comfort. Moreover, Jon and Chico's narratives demonstrate the degree to which they resist or reject the homeless identity and instead perform the worthy and redeemable subjectivity in part by expressing appreciation for the support offered by the shelter.

Framing the mentally ill identity

The vast majority of the research participants identify as experiencing mental illness (32/38). Given this project's focus on self-governance, it is important to note that some (5/38) of

these mental illness labels are strictly self-diagnosed. Self-diagnoses include claims of suffering with ADHD, depression, anxiety, obsessive-compulsive disorder (OCD), and bipolar disorder.⁹⁶ Mark, for example, identified as suffering with “a bit” of ADD and “extreme” OCD. Further probing revealed that he only uses the OCD construct when he acquires a lot of money: “Like when I got my income tax return, I blew it. Yeah, I don’t even know where I was for a week. And then I ended up [at the shelter], shaking pretty bad”. The objective of this project is not to assess whether Mark’s distress meets the criteria for OCD according to the *DSM-V* (2013) or the validity of the diagnosis altogether. What is more interesting is that Mark, like others in the study, use psy language and in turn the mentally ill identity to describe their actions. This suggests that members of the homeless community are actively reframing definitions of diagnoses to make them useful in the context of homelessness, reminiscent of Hacking’s (1995, 2004) looping effect. For Hacking, identities are fluid and as individuals engage with and shape identity, such as through acceptance and resistance of mental illness labels, so too does the social understanding of the identity change. As I explore throughout this project, mental illness is used, negotiated, and resisted within the homeless community, fostering its own unique discourse that comes from both social conceptions of mental illness as well as individual identity construction.

The proliferation of psy-rhetoric in everyday discourse is not unique to the homeless community (Rimke 2000). In both the included and excluded sphere, terms such as OCD, schizophrenia, anxiety and depression are used as hyperbole to emphasize a chaotic or atypical characteristic or situation. It is not uncommon to hear someone say “I’m totally OCD” with reference to something as benign as being annoyed with dirty clothes on the floor. Fennell and

⁹⁶ Self-diagnoses are likely facilitated by the heavy reliance on psychotropic medication as the preeminent mental health intervention in the community, which is often prescribed without a corresponding diagnosis.

Boyd (2014) find that media representations of OCD are misleading given that the term is used to characterize a broad array of qualities, including being infatuated with a potential lover. In turn, OCD is portrayed as endearing more so than as causing distress. The flourishing use of psy-language is common in the late modern era (Rimke 2000) but arguably has distinct qualities when used in the homeless community. Among the homeless population mental illness is more often regarded as dangerous (Fischer et al 2008; Greenberg & Rosenheck 2008) than it is quirky.

The finding that many homeless men and women embrace psy discourse is contrary to the literature that cites people's reluctance to adopt a mental illness identity because of its stigmatizing effects (Hansen, Bourgois & Drucker 2014; O'Reilly, Taylor & Vostanis 2009). Throughout this project, I explore how and why some homeless individuals take up psy-discourses, arguably because it aligns with the included ideals and allows them to be framed as redeemable (but never redeemed/included) subjects. For now, it is compelling to investigate how individuals negotiate the mentally ill identity.

Perhaps because professional and self-diagnoses are commonplace in the homeless community some interviewees normalize mental illness and reject its common tropes as abnormal and stigmatizing. Mental illness is understood as universal but as more evident in and problematic for some: "Everybody's got mental problems but some are just worse than others. Like a lot of people actually have depression and not realize it" (Courtney). Normalizing mental illness may be a method of stigma management amongst a highly stigmatized group that is otherwise considered abnormal (Goffman 1963), but as Jamie described, the medicalization of problems in living (Szasz 1974) is evident in late modern society as a whole:

But is there a stigma attached, there still is. It's... a thousand times better than ten years ago. Uh, you told somebody you were seeing a shrink, uh, even if it was just for something like minor depression or something or hell, just for dealing with life, it's like,

you were looked down upon. But that's changing. Uh, you see it every day. Uh, now it's almost the *in* thing... [In excited voice] Oh yeah, I'm seeing a shrink!... It's... it's swung the opposite way. I think it's... it's almost like, are you normal if you're not seeing, like how are you dealing with life if you're not talking to somebody about it?

Jamie's reflection articulates the anxiety and uncertainty of the late modern period (Gergen 2000; Giddens 1991) and the notion that a responsabilized subject will have the common sense and the resources to seek treatment to cope with insecurity. Interestingly, Jamie uses his mental illness identity to connect himself to the included circuit by normalizing mental illness as part of living within (as opposed to outside of) modern society. "Just dealing with life" requires professional assistance (Rose 1998). Those who present the mentally ill identity as normal and in keeping with the included society who also struggle to 'deal with life' attempt to minimize the difference between the included and excluded. However, those living in a homeless shelter or who are precariously housed face different and often extreme sources of stress, such as challenges meeting basic needs including securing shelter, food, and clothing, as well as threats to their security (Huey 2012). The rapid change occurring in the late modern world brings about a sense of helplessness and powerlessness (Hunt 1999). This anxiety is magnified for those in the homeless community and exacerbated by their limited resources to mitigate insecurity, such as a safe and secure home, and financial and social capital.

The mentally ill and the addict – one in the same?

Like mental illness, most of the research participants identified as being addicted to a variety of licit and illicit substances (34/38). As described in chapter two, the medicalization of distress and addiction have divergent but overlapping histories (Conrad & Schneider 1992; Kerwin 2012). The contemporary shift to treating concurrent disorders (Crawford, Crome & Clancy 2003) emphasizes that substance use may 'lead to' or exacerbate psychiatric symptoms

or that individuals use illicit substances to manage or cope with psychiatric symptoms. Toby, a forty-eight year old Two-Spirited⁹⁷ Inuk woman who was in an intensive substance abuse treatment program, connected her bipolar diagnosis to her cravings for alcohol:

Maybe, maybe like it's crazy to want to drink all the time... I don't know. For some people, yeah, but for others it's like, 'cause they enjoy it. Like their body enjoys being drunk. And those are the ones who have fun when they're drinking, not like [makes quiet screaming noise].

During my time in the shelter I witnessed Toby screaming and acting out when she was heavily intoxicated. Toby stated that her body does not enjoy being drunk and so she equates her cravings for alcohol as being 'crazy' and in need of mental health treatment and management. Medical literature on dual diagnosis considers mental illness and addiction as separate but related; however, when we concentrate on how distress is materially experienced, many of the research participants found them to be indistinguishable.

Despite the paradigm shift from a treatment first model to integrated treatment (Crawford, Crome & Clancy 2003; Kuehn 2010),⁹⁸ members of the focus group voiced their frustration at the lack of coherency between the public mental health and addiction systems:

And related to that, uh, even if he goes to get assessed, um, often, uh, mental health professionals will say well, look you've been using then I can't assess your mental health issues. [Everyone nods in agreement] You can't separate what the difference is, what your symptoms [are and] if their symptoms are related to your drug abuse or if they're related to your mental health. So there's so many outs, right, for somebody not to be assessed (Chuck).

⁹⁷ Two-Spirit is a term derived from Aboriginal languages to describe those who house both male and female spirits. Although originally understood as a gift and privilege that saw Two-Spirited people as leaders in their community, the colonization of Indigenous people and the imposition of European conceptions of spirituality, sexuality and the family, led to the oppression of many Two-Spirited people (Balestrery 2012). In the past few decades, however, Aboriginal peoples have sought to reclaim the term as part of a queer identity within their specific cultural context (Cameron 2005).

⁹⁸ As described in chapter two, ideological and practical barriers remain that limit the implementation of integrated treatment (Kuehn 2010; Sterling et al. 2012).

Not only does Chuck, a front line worker at a shelter, note the ‘silo effect’ (MHCC 2012) of mental health and addiction services, he also regards the inability to assess someone’s mental health status as an ‘out’, suggesting that practitioners in an over-burdened mental health system use addiction to lessen their workload. Hartwell (2004) found that because dually diagnosed individuals are less likely to be accepted into programming, they are at greater risk of homelessness and, not surprisingly, criminalization. Vince noted that in the addiction programming he’s encountered, mental health care is lacking and individuals need to take it upon themselves to seek counselling: “But if you’re working, you know, [different addiction programs], you’re going to look at your mental issues. You still need to follow that up with, like, there’s professionals here in addiction but not necessarily in mental health”. These discussions remind us that although this research reveals that many people who are dually diagnosed understand their mental health and addiction issues as interchangeable, the two are still often managed and governed separately.

The distinction between mental illness and addiction is visible in treatment options. As described in chapter two, addiction treatment relies heavily on self-help and talk therapy, concentrating on the moral underpinnings of addiction discourse (Conrad & Schneider 1992; Valverde 1998). With the exception of methadone maintenance (Joseph, Stancliff & Langrod 2000) there are few pharmaceutical interventions to treat addiction. Participants in this research project attended predominantly outpatient group therapy run by counsellors in the shelters and community health centres. Many had experiences with in-patient treatment centres ranging from thirty day to five month intensive programs offered by public, private, charitable or for profit organizations. CMHA, for example, runs a weekly concurrent disorder therapy group. Hospitals

such as the Royal Ottawa Hospital and the Centre for Addiction and Mental Health in Toronto also provide in- and out-patient addiction treatment.

In contrast, there are few programs available strictly for mental health. Some programs exist such as anger management and The Men's Project; however, these programs deal with emotions but not mental illness specifically. When asked about mental health treatment only two research participants noted specific mental health programs. Giles, who is deeply entrenched in the mental health system, attends group cognitive behavioural therapy (CBT) run by the ROH. Doug was the only other interviewee to mention a mental health program in the city, the wellness recovery action plan (WRAP) that teaches self-management skills to help cope with and decrease psychiatric symptoms (Fukui et al. 2011). At the time of the interview Doug had not yet attended a WRAP meeting because he was unsure whether the program required participants to be sober, a criterion he felt he could not meet. Instead, and as I will explore in depth in chapter eight, the mode of treatment for the vast majority of individuals in the homeless community is psychotropic medication. Most of the people I spoke with were taking some form of psychotropic medication (25/38) with half of those who disclosed the types of medication (12/23) taking two or more daily. Less than five percent of the sample (8/38) had no experience taking psychotropic medication. These divergent approaches to mental illness and addiction demonstrate how the former is deeply ingrained in the medical model while the latter sits at the periphery, guided by a discourse of self-discipline.

Managing the mentally ill and homeless identity performance

So far we have considered some of the ways the mentally ill and homeless identities take shape. Many adopt the common stereotypes and expectations of being visibly homeless and/or being diagnosed with a mental illness, for example feeling shame for being poor and bearing

witness to their ‘Othering’. Some resist the identities, such as those who find a sense of home in the shelter system and those who normalize mental illness. In this section, I consider how the homeless and mentally ill constitute and perform these identities.

The limits of identity performance

Our ability to manipulate and transform identities depends in large part upon our social and human capital. Financial resources, knowledge and education, and our corporeality (including factors such as gender, race, ability and sexuality among others) influence our ability to perform certain identities (Bauman 1988; Butler 1990). Many individuals experiencing homelessness and/or distress are limited in what identities they can effectively perform. For example, it would be extremely difficult for someone living in an emergency shelter to perform the role of CEO of a successful company. The traits that accompany such an identity – well educated, an influential network of friends, and opulent displays of wealth – cannot be translated to an individual living in the homeless community. Indeed, inadequately performing an identity is often characterized as a delusion and considered a symptom of mental illness (Kendler 1982).

People come to the homeless community from all walks of life, including those who were previously financially secure. Despite this knowledge, these past identities often surprised staff members because they are incongruent with the stereotype of the homeless and mentally ill as permanently excluded, as evidenced by a discussion during the focus group:

Rick: ...I have client, uh, uh, from Bangladesh and he was a GP, uh... Just for me, even with all the years I have, it just blew my mind, how can someone end up in a shelter who's a doctor?...

Chuck: We had a client recently who was an OPP officer in Southern Ontario for twenty-one years...

[Gasps all around]

Chuck: And he, this, this.... There was a guy who had, an MA... he was staying here. I mean it's, uh, it's shocking sometimes, with what background some guys have.

It is arguable that the shock that someone with a graduate degree can become homeless is attributable in part to the realization that those who are included (such as myself and the participants in the focus group) are not immune from descending on the continuum towards exclusion. The awareness that the inclusive status is unstable is evidence that the included and excluded groups are not differentiated by moral absolutes (Rose 2000). The reaction from the group to Chuck's story of a former police officer living in a homeless shelter draws attention to the limits of identity performance. Those who present a history of a previously successful life are viewed as anomalies. Although as Goffman (1959; Roseneil & Seymour 1999) articulates, identities are created and managed, the types of identities available to the homeless/mentally ill and their ability to transform those identities (Hacking 1999) are limited by their marginality (Bauman 1988; Butler 1990).

Shadow, a forty-three year old white male who identifies as having depression and bipolar disorder along with an addiction to alcohol, uses his social capital as evidence of his included status, despite his lengthy criminal record and the fact that he currently lives in a rooming house and is dependent upon shelters for his food and clothing:

So I went through St. FX⁹⁹ ... learned some things there. Um, I uh, did a year with... Nova Scotia as [a] coordinator to the first family court.... I was kinda like a prosecutor. I had a career that covered several departments including security. And Brian Mulroney who also carries a ring for St. FX made me downsize... and uh, I was babysitting political appointees from Quebec and I said no way. So I stopped being a babysitter. I took my money. I went into the Byward Market in the eighties. Um, I spent a year at Innes Road, did trial like Conrad Black. Um, I was resigned to a time with the feds, which I did receive. I was there for a couple of years. Came back to Ottawa, ended up here. First my contacts, rebuilt my credentials and got a place with [a rooming house].

⁹⁹ St. Francis Xavier University, in Antigonish, Nova Scotia.

Shadow was adamant that he is an educated, intelligent individual who has a great deal of power through his own intellect and personal connections. He suggested that he reported directly to the Prime Minister. Even when he accounted for his time spent in prison, he likened himself to Conrad Black¹⁰⁰ as an identifier of his status. Shadow's presentation of self can be characterized as misrepresentation, as he displays a status that he cannot adequately perform given his vulnerable social positioning (Goffman 1959). Whether Shadow has such powerful allies is irrelevant. What is important here is that he equates himself with prominent members of the included society, and as a member of the homeless community he will likely be considered an imposter by professionals, para-professionals, and his homeless peers (Goffman 1959). Perhaps at one time Shadow was able to perform this identity authentically. Now, however, Shadow must re-identify himself within the social framework of the homeless community, otherwise his performance may be assessed as a symptom of mental illness that further entrenches his excluded, rather than included, status. Presenting himself as redeemed will be ineffective as the *redeemable* subjectivity is a permanent, rather than transitive state (Castel 2003; Rose 2000).

Identity is flexible and malleable within the specificity of time and space built from pre-existing norms, and contingent upon how others perceive the performance. Daniel's conflict with staff over his self-identity illustrates how identity is actively managed but framed through structure, in this case the rules of the homeless shelter:

Craig is my first name. And when I showed my ID here, well, Craig. So they've been calling me Craig for two years. They won't call, they refused to call me Daniel because we have to go by your first name. Well that causes a whole detachment thing. That's not even me, that's some Craig guy, you know... Imagine somebody asks you your name and you tell them but they refuse to call you that they're calling you something else. Like,

¹⁰⁰ Conrad Black was an exceptionally wealthy and influential man; he ran numerous international newspapers, was a member of the Order of Canada, and is conferred as a Baron in the British House of Lords. In 2007 Black was convicted of fraud and obstruction of justice and served just over two years in an American prison. He was subsequently stripped of many of his titles and positions in business.

who am I then? And then, that's actually pretty detrimental thing, you know... Of course people are hey Daniel, this and that, so [front desk staff] says, finally, well what is your name? Well my name is Craig Daniel. I'm Daniel. Oh, I'm going to start calling you Daniel now. And, ahhhh!!

Daniel's struggle to convince staff to use his preferred name is characteristic of the structural impediments to identity management. One's name is fundamental to a sense of self (Hook 1984). To be denied a name on account of bureaucracy is to invalidate self-identity. While filling out government forms using a given name may be of little consequence to members of the included group, Daniel encounters this mismatched identity on a daily basis on account of his reliance on public assistance. His homelessness sets parameters to his self-identity not experienced by housed individuals. Daniel's story illustrates Butler's (2004b: 130) contention that demands upon our identity often come from elsewhere: "...what binds us morally has to do with how we are addressed by others in ways that we cannot avert or avoid; this impingement by the other's address constitutes us first and foremost against our will or, perhaps put more appropriately, prior to the formation of our will". Butler refers to this as obligations of specific identity types. For Daniel, his unwillingness to submit to shelter policies regarding given names reminds us that where there are limits to identity production there are also spaces to contest and shape identity.

Goffman in practice: Impression management and distancing

In *The Presentation of Self in Everyday Life*, Goffman (1959) set out the dramaturgical method of impression management. Likewise, in *Stigma* Goffman (1963) expands on impression management to include undesirable characteristics, such as being identified as mentally ill and/or homeless. One strategy is to create distance between 'us' and 'them'; in essence, to 'Other' members of the same group. Young (1999) suggests that marginalized people essentialize other members of the homeless community because excluded people face a greater sense of

ontological insecurity than the included group. Creating a hierarchy amongst the homeless and/or mentally ill can be recognized as an attempt to situate the self as redeemable by characterizing others as irredeemable.

In response to my question regarding his favourable relationship with police, Gerry stated: “Well I try not to think of myself as better than anybody else but, in a way I am because I don’t cause any problems, you know? I just try to be good”. Gerry ‘tries to be good’ by refraining from using licit or illicit substances and not engaging in criminal activity. Gerry also expressed great concern that a catastrophe is soon going to strike the globe and that he will be responsible for forming a new civilization amongst the survivors who will look up to him as their leader. He uses these premonitions as motivation to hold himself to a higher standard of social status than what other homeless individuals experience. He cited his difference from others in the homeless community as characteristic of his leadership abilities: “Like if I did the same thing as everyone else it might lead to tragedy. What’s the point of being the same as everyone else if you’re supposed to do something to *help*, maybe even survive the whole thing”. As described above, Gerry feels he is ‘abnormal’ because of his impulsive decision-making and his lack of sexual experience. I got to know Gerry over the course of two years and although he predominately spoke about himself in negative terms, this comment demonstrates the complexity of identity construction and management. In this instance at least, Gerry transforms his ‘abnormality’ into a distinguishing characteristic that will lead him to success in a post-apocalyptic society.

Similarly, Chico also distanced himself from other alcoholics:

No, because I know, I know I mean I never like, sparky in the cage there¹⁰¹ or drinking Listerine or shit like that. You know, if there's pretty much not a beer, I'm pretty much not going to drink, you know? I would, I wouldn't get to that because I seen people drink aftershave and I just, that doesn't compute to me.

Chico identifies as an alcoholic, but considers other manifestations of substance abuse abhorrent. Referencing the poor in particular, Rosenthal (2000) suggests that many homeless individuals condemn others in similar circumstances. To accept oneself as a member of a stigmatized group is to adopt the 'unworthy' status of the group (Bauman 1988; Goffman 1963). Chico characterizes himself as a more worthy addict than individuals who ingest Listerine, thereby situating himself as redeemable.

Some research participants attempted to achieve and/or maintain a position as a redeemable subject amongst professionals, para-professionals and other members of the homeless community by performing an idealized presentation of self: "Thus, when the individual presents himself before others, his performance will tend to incorporate and exemplify the officially accredited values of the society, more so, in fact, than does his behaviour as a whole" (Goffman 1959: 35). Interestingly, some of the women who were willing to talk about their children spoke about pregnancy and motherhood as a site for impression management. This is not surprising given that motherhood is often a fundamental component of a woman's identity (Kilty & Dej 2012). When I asked about her children, Christine stated that she did not want to talk about them; however, before I was able to move on to the next question she wanted me to know that despite her current addiction, she successfully abstained from drugs and cigarettes during her pregnancies. Although losing custody of her children was obviously painful for Christine, she made sure to present herself as a 'good' mother. Louise shared a similar story:

¹⁰¹ Chico characterized individuals who are unilaterally driven by their addiction as animalistic in nature; he may also be referring to the small, gated terrace adjacent to one of the shelters as the 'cage' where people are 'confined'.

It was hard for me being an addict and all of a sudden being pregnant. And they'd say just quit, you're pregnant and, I can't believe you're pregnant, you know, and you're having that child, or... And it was like, I felt bad about it, although I just I'd have one beer, you know, sometimes the doctor says one glass of wine won't hurt, and I was trying to justify, but it was extremely difficult for me to stay clean until the end... which I did for the first three months for each child, where I heard that's the most crucial time.

Louise acquires a great deal of satisfaction from having been able to abstain from drugs for the first trimester of both of her pregnancies. Like Christine, Louise is deeply aware of the importance of motherhood as an identifier and presents an idealized version of herself as mother, despite her actions failing to live up to the expectations of neo-liberal motherhood (Douglas & Michaels 2004; Kilty & Dej 2012; Phoenix & Woolett 1991).

Tom's narrative provided an example of overt impression management. When Tom signed up to participate in the research he told me that he had a story that I would never forget; his past experience as a gay pornographic film actor was a source of great pride for Tom. He insisted I bring my laptop to our interview to show me online photos of cassette covers of the videos he was in. He named several high profile celebrities that he had relationships with. Several times during the interview Tom sought reassurance that his was indeed the most shocking interview I had encountered. Tom performed a carefully crafted and well-rehearsed presentation of self so as to create the impression that he is unique, sensational, and above all, "...not like the other people here". Like Gerry, Tom transforms what might otherwise be a stigmatizing trait into a unique and interesting characteristic that makes him memorable. Given the homogenization of the homeless identity (Young 1999) Tom uses his difference to set himself apart from the typical homeless identity. In this way, Tom articulates being 'abnormal'

as a positive quality.¹⁰² Distinguishing oneself from other members of the homeless community was a key identity management strategy for most participants.

Creating a 'second skin'

Beyond distancing, another method of impression management adopted by some participants was creating a façade to cope with the anxiety, vulnerability, and the loneliness of living in the homeless community. Giddens (1991) and Gergen (2000) argue that the lack of an authentic identity in late modernity means that we all create a façade. As I described in chapter three, performativity elucidates the ways that identity is situated within the normative constructs of a particular time and place but is flexible, negotiable and lacks an essentializing quality (Butler 1990; Goffman 1959). The “masks” (Mick) to which some participants refer are much more consciously employed than those described by Giddens and Gergen. For example, Sheila referred to the persona she builds to survive in the homeless shelter:

Sheela: Sometimes it can be very frightening. Frightening in here.

Erin: Yeah, how do you deal with it when you're surrounded by it?

Sheela: You have to build a persona. You have to, um, my daughter's noticed that too. She goes, if you're gonna live on the street you have to wear a coat that changes you, who you are, and um... sometimes you have to act a little bit more crazy than what you are to keep people away from you. And I think a lot of us women do that here to protect ourselves. We have to build ourselves up more than what we're accustomed to, um... To keep these other people away.

Erin: How does it make you feel that day in, day out you have to wear this... persona, like?

Sheela: It's tiring, it's tiring and sometimes, uh, you find that you even carry it when you're away from here.

¹⁰² Given that Tom does not disclose his sexuality to other members of the homeless community, it is important to note that this distancing strategy is only available in certain contexts, such as with an 'outsider' like myself, and is likely not very useful for him to negotiate his status within the shelter itself.

Interestingly, Sheela's daughter suggests that her persona consists of acting "a little more crazy than what you are" in order to isolate and protect herself. The seriously mentally ill identity is thus 'Othered' and characterized as something to be feared within the homeless community.¹⁰³ Sheela's description of the "coat" she wears is demonstrative of Goffman's (1959) disguise. However, she notes how difficult it becomes to remove the coat. The autonomy to decide when to use the persona in lieu of the 'true' self can become blurred. Here, Butler's (1990) explanation of identity as dependent upon social and cultural constructs becomes useful. Sheela consciously creates a mentally ill persona but the frightening and violent surroundings of the emergency shelter require her to be continually vigilant and to don the coat permanently, perhaps explaining her decision to seek out a diagnosis of depression.

Like Sheela, Jamie reported creating a façade as a passing mechanism (Boydell, Goering & Morell-Bellai 2000; Goffman 1963) to hide his depression from others. He offered that the jokes and cheerfulness he exhibits during activity nights at the shelter are part of this façade: "That's not me but that's the façade I put off". Jamie described in detail the tension between choosing to create a façade and losing his sense of self within this created identity:

It's second skin. It is. For me it's just another piece of clothing I put on every day.... So just, it's things like that, it's a façade I put on that is so much a part of me now that it's, once again, it's who I am. Honestly, right now, it's probably, it would probably be a lot harder for me to get better, for lack of a better word, today than it would have been ten, fifteen years ago, just because so much of who I am today is built around my experiences, my mental health up 'til now and what I've had to do to make it through just some days.

Interestingly, Sheela creates a persona of a mentally ill woman to hide her vulnerability. Jamie, on the other hand, uses a façade to conceal his depression. The mentally ill identity, then, can be

¹⁰³ In chapter eight I will look closely at how the 'seriously mentally ill', those who are at risk of hurting themselves or others and who have significant challenges meeting their basic needs, are regarded in the homeless community, in contrast with those otherwise functional individuals who negotiate the mental illness identity more deliberately.

characterized as both a stigmatizing trait and a tool for identity management, although both interpretations see the façade as contributing to their mental ill health. Jamie continued, stating:

It's who I am. Late at night when I'm lying in bed, but I won't even think of it that way because, like with this, in this relationship or dealing with the staff here or dealing with the people at the library, dealing with somebody, somebody who's not a serious, close relationship is like, that's who I am. Maybe that's the outer layer of me, like an onion. You start peeling back an onion, there's different layers there, but that is who I am.

Like Sheela's conceptualization of donning a coat as a façade, Jamie uses the metaphor of peeling an onion to depict the façade as a second skin that is a consciously created artefact that is difficult to distinguish from his 'true' self. While Jamie expressed certainty that he embodies a separate identity for those he is close to and that truly 'know' him, it is together that the façade and this 'authentic' identity make up his whole self (Mead 1934). Also, given that Jamie is a self-described 'loner' and has no one to show this 'true' identity to, does that identity exist? Developing a "second skin" as a form of identity management is a deliberate and conscious act but given the constant stress and vulnerabilities experienced by the homeless community, the façade soon becomes a permanent fixture in an individual's identity construction, which begs us to question how much of the identity performance is consciously performed. The necessity of creating a persona as a form of self-protection adds a level of complexity to Goffman's dramaturgic approach.

Conclusion

Identity management can be simultaneously conscious and deliberate while also shaped by social and structural factors that limit the types of identity that are available to be effectively performed, creating the stressful conditions that might warrant a permanent adoption of a façade. In this chapter, I examined the quality and nature of the homeless, mentally ill, and addict identities. While there is heterogeneity in how the participants performed these identities,

commonality was exemplified through their excluded status. Some participants attempted to mitigate their exclusion by presenting themselves as redeemable subjects. They did so by selectively choosing the types of identities they embraced and carefully reconstructing what it means to be homeless and/or mentally ill. For example, Chico's account of his addict identity as superior to that of others in the homeless community because he refrained from consuming mouthwash demonstrates that while these identities are vilified, they may still be performed in such a way that maintains a hierarchy of marginalization. Sheela and Jamie's descriptions of their façades revealed a multifaceted approach to identity construction – one that exists as unique to each individual's performance, but that is also highly constrained by the homeless environment. In the next chapter, I will further complicate the mental illness identity as it takes shape in the homeless community by exploring the paradox between the medicalization of distress within the parameters of responsabilization discourses.

Chapter 7 – Taking the Blame: Responsibilization Strategies to Manage Mental Illness and Addiction

Introduction

In this chapter I explore how participants essentialize the mentally ill and addict identities as biologically determined yet also re-orient the narrative to emphasize personal blame for their distress and marginality. Allen's (2000) research on Vancouver's homeless community found that many people living in poverty adopt an ideology of self-blame and individual fault for that hardship. The decontextualization of poverty and distress is well documented (Lyon-Callo 2000), particularly as it relates to criminalized women (Hannah-Moffat 2005; Kilty 2011; Maidment 2006; Pollack 2005). Unique to this project is an assessment of how biological understandings of mental illness and addiction are framed as amenable to responsabilization and self-government discourses. Maruna (2001) found that prisoners highlight a tension between their 'true' and 'untrue' (i.e. criminalized or addict) self¹⁰⁴ that is antithetical to the accountability expected in rehabilitation discourse. Claiming that the 'untrue' self commits crime or engages in substance abuse is a form of identity management that creates a distinction between bad behaviours conducted by otherwise good people and those who are irredeemably bad (Maruna 2001). In her study of the addict identity, Kilty (2011) found that active drug users gravitated towards the disease model to account for their powerlessness, while those who are sober are inclined to use choice and responsabilization discourses to emphasize their active role in their success. My findings differ slightly in that even those who identify as using substances and who are living in distress adopt the choice narrative. Despite accepting biological explanations of distress,

¹⁰⁴ This notion of a 'true' self is similar to but distinct from the 'true' self characterized in chapter six. There, the true self described the personal identity hidden underneath the social identity (Goffman 1959). In this case, the 'true' self has a biological status – to be healthy or mentally well. In both cases participants who use this language are referring to an intangible core reality that exists outside of their cognitions, actions, and behaviours.

participants take responsibility for their behaviour and are hopeful that the ‘true’, mentally well self can flourish.

In order to flesh out the seeming inconsistency between biologically determinist and responsabilization discourses I begin by addressing how homeless men and women frame the biological underpinnings of distress, keeping in mind that some participants resist biological explanations of mental illness. In the next section, I describe the work of Gabor Maté¹⁰⁵ whose teachings are widely used in Ottawa’s addiction treatment programs. I argue that Maté’s work is popular because it allows for a biological explanation of mental illness and addiction while rejecting its fatalism. Maté and his followers argue that adopting responsible and civil lifestyles can change the biological processes that demarcate mental illness and addiction. The notion of ‘taking the blame’ is deeply entrenched in the homeless community, so much so that those who use mental illness and/or addiction as an explanation for their marginality are often vilified by their peers for failing to take ownership for their circumstances. Finally, I consider how being accountable for one’s distress is characterized as a form of empowerment.

‘The island of broken toys’¹⁰⁶: Medicalizing distress

The biological determinism of the medical model of mental illness presents itself in unique ways in the homeless community. In this section I analyze how biological explanations for distress are adopted and sometimes resisted by members of the homeless community.

¹⁰⁵ Gabor Maté is a physician working in Vancouver’s Downtown Eastside, including at Vancouver’s Supervised Injection Site, Insite.

¹⁰⁶ Although the correct reference is the Christmas TV special *Rudolph the Red-Nosed Reindeer* and the adventures on the Island of *Misfit Toys*, Max’s reference to being ‘broken’ is more in keeping with his and other participants’ narratives of mental illness as having a biological etiology, where they feel their brains, synapses, and/or chemical make-up are maladaptive or ‘broken’ (Ussher 2005).

The biological imperative

The medicalization of problems in living (Conrad 2007; Szasz 1974) makes sense of and attempts to manage or treat distress from a strictly biological perspective, or what Foucault (1988) terms ‘medicine of the mind’. This is not to say that those who prescribe to the medical model ignore external circumstances, but “...biological psychiatry has made a travesty of the biopsychological paradigm, either by largely omitting psychosocial factors in its clinical formulations or by downgrading them to mere incidental ‘triggers’” (Ross & Pam 1995: 4; see also Tew 2005). Responses to the definition of mental illness and addiction are overwhelmingly biological in nature. Most participants have a mental illness diagnosis and are prescribed medication by a physician, psychiatrist or nurse. Several of the addiction treatment programs available in the homeless community teach from a medical model, which characterizes genetics, biology, and family lineage as common explanations of the cause of mental illness. Pam (1995) points out the faulty logic inherent in presuming that family members suffering with distress is necessarily genetic or that because symptoms respond to medication they must be biologically caused. Still, participants referred to genetics and chemical imbalances to situate their distress in a biological explanatory model. For example, Sheela was extremely concerned that she might have passed on the mental illness gene to her grandchildren:

...I have a fear of mine that it's going to go to my grandchildren. I have a fear, um... that, that it's going to pass on to the next generation, the mental illness or, you know what I mean? So, um, I'm scared of that. But I know if I can stay, if I can stay and live my life to whatever fullness that I can find and happiness that I can find that will give hope for my grandchildren, for those that are coming, if she did, I can do it, I can live and I don't need this unhappiness to bring me down and destroy my life, you know.

Sheela previously engaged in disordered eating, is self-diagnosed with depression, and has had several suicide attempts. She experienced sexual abuse as a child, was housed in numerous foster homes, and was cut off from her family's Native culture. Although her grandchildren have not

experienced this kind of trauma, Sheela believes it is inevitable that they will inherit her mental illness because of its biological nature.¹⁰⁷ She is hesitant to visit her grandchildren until she can act as a proper role model for how to responsibly cope with distress.

Max also framed mental illness as biologically determined and used a heartbreaking analogy to explain where his depression comes from:

Max: [sigh] You know... honestly, I, I... I don't have a great answer, but I, I... I don't think it's as complicated as some people make it out. I mean, you ever see the Christmas cartoon, the little puppets are shown every Christmas it's Santa Claus and the Island of Broken Toys. I'm just a broken toy. Sometimes who knows why, a million of units come out fine and one of them's broken. Maybe, and I, you know, and I think it's just I'm broken somewhere... and I've also not helped that brokenness by years of, you know, drug addiction and... and, and alcohol and, and, you know, depression and not dealing with it and just running through life. That of course, I think had [laughs] had probably had a lot to do with it. I think I'm just... you, you know, I own this. Maybe a chemical imbalance, I don't know.

Max articulates his decades long cycle of distress, addiction, homelessness, and criminalization as coming from a fragmentation in his biochemical make-up. At the same time that he explained his brokenness as a sort of biological determinism, he was also quick to point out that he exacerbated his depression by using drugs, asserting "I own this". Although Max claimed that mental illness can be explained simply, the description of his distress is a paradox whereby he is at once a victim of his biology but also responsible for the thoughts and behaviours that led to and/or aggravated his depression.

Just as the literature suggests that substance use can exacerbate mental illness (Crawford, Crome & Clancy 2003), the participants also make this connection. Like Max, Milan connected the two: "I think a part of it is in my genes but I think that all the alcohol abuse must have triggered something. I'm sure about that. All the alcohol and drug abuse and not sleeping and

¹⁰⁷ Sheela's fear of the ramifications of her victimization on her grandchildren is testament to the long-term effects of colonization and oppression of Aboriginal communities, as evidenced in the multi-generational consequences of Canada's residential schools (Jiwani 2001; Lavalley & Poole 2010).

neglecting my body, I'm sure it had a big part to do with, uh, yeah". This quote affirms the perceived connection between mental illness and addiction discussed in the previous chapter, but it also redefines the conversation around mental illness as both biological and grounded in individual decision-making. Milan equates his substance use, party-going lifestyle, and lack of self-care as triggering a biological response that led to his distress.

Participants framed addiction as partially responsible for their distress and primarily interpreted addiction through a medical paradigm. The medicalization of addiction by participants is distinct from the literature that conceptualizes it as a largely moral rather than medical concern (Conrad & Schneider 1992; Valverde 1998). Gaston described mental illness and addiction as intimately connected through their similar biological foundations:

Gaston: Uh, I define it as, uh, as a disease. I define it as something... I, I, I, something chemically... different inside the brain. It's almost like, uh, alcoholic, that's me. I find that alcoholic... it's almost like alcoholic is a mental illness, it's uh, uh, almost in itself because it's, uh, it's chemically, uh, different than most of other people.

Gaston described mental illness as a comparative biological condition. He went on to equate addiction with diabetes and allergies, both organic physiological conditions. The allergy model, popularized by AA/NA groups (Valverde 1998) is taught by many of the out-patient addiction programs in the Ottawa community and resonated with some participants. As Vince explained:

I don't, for myself I believe in the allergy concept... a normal person can have a drink or two drinks or three drinks and shut it down. Whereas with... we're calling it the disease addiction, then, and I know for myself, maybe one, or one day I can have a few drinks. Maybe even the twelfth time I can have a couple drinks, but eventually it's gonna get me because I do have this allergy, where, eventually I'm not going to be able to shut it down. I can't stop at two drinks, you know, more often than not and it's this, I need another drink, another drink, another drink.

As described in chapter two, scholars suggest that the allergy model resonates with people because it legitimates addiction as an illness rather than a moral fault and creates a 'sick' addict

identity (Miller 2010; Valverde 1998). The twelve step AA/NA programs are built on the premise of *powerlessness*. Step one requires an admission of powerlessness over the addictive substance. Because of this lack of power, the program touts that one will forever be an addict, but may learn to manage addiction (if responsabilized). In this way, mental illness and addiction are similarly constructed, in that they are both seen as chronic incurable diseases that may be managed by responsabilized subjects who actively govern their thoughts, desires and actions.

The permanence of mental illness and addiction creates the conditions where a combination of surveillance, professional guidance, and the aim of self-governance become regulatory tools. Whether it is medication or group therapy sessions, the position of mental illness and addiction as ‘chronic illnesses’, similar to HIV or Parkinson’s disease, connotes an ongoing, long-term relationship with professionals and para-professionals. Kathy, a public health nurse, found it useful to compare mental illness to physical chronic illnesses in order to emphasise its permanence and thus the necessity of life-long medication compliance:

And that’s how I explain it to clients too, because there’s so much stigma around it, that just like you treat hyper-tension and you have to take medication every day for hyper-tension, if you have depression you have to take medication every day for depression. And just like hyper-tension you need to eat well, exercise, do things in your environment to help manage your hyper-tension. Same goes for depression. So I think like seeing it like that for me is important, not only for reducing the stigma but also in helping people understand this is something you have to take care of for the rest of your life. And that sucks for people, right? Like that’s not, you know, uh, people, uh a question you always get is am I going to have to take this medication for the rest of my life? Probably. Some people don’t, but most of our clients will have to take it for the rest of their life just because... most of them have had such chaotic lifestyles and terrible lives that, that the likelihood of them not needing medication is very, very slim.

Kathy not only equates the need for life-long psychopharmaceuticals as medical treatment but also implies that medication is necessary to govern ‘chaotic lifestyles’ and ‘terrible lives’.

Framing distress or a failure to live up to particular norms (Conrad 2007; Lyon-Callo 2000) as a

medical problem legitimates a space to encourage, or if necessary enforce, permanent intervention from medical authority figures. The assumption is that many marginalized individuals will never learn to self-govern and will require ongoing disciplinary technologies to create and maintain docile bodies (Foucault 1977, 1988; Rose 1999) – that is, many are thought to be irredeemable and must be managed for the long term.

Resisting the biological model

Not all of the interviewees accepted biological explanations of distress. Instead, some took an overtly critical position on psychiatry that mirrors what is found in much of the critical psy (Caplan 1995; Conrad 2007; Kutchins & Kirk 1997) and mad movement literature (Burstow 2013; Fabris 2006; Laing 1960, 1967, 1971; Shimrat 1997; Szasz 1974, 1989, 2003). Daniel, for example, questioned the role of medication in treating distress that he did not think was biologically situated:

The thing is to get your head above the water just from talking and, you know, some counselling and not through medication because, I mean, depression is psychological. It's not psychiatric. It does not indicate any pharmacology needed, it's just to get everything in line. Make sense out of those, you know, self-destructive ideas that are floating around in your head, you know. No drug is going to change that self-talk I mean it's only self-talk, you know that will change it.

Daniel called for increased availability of counsellors and group therapy, forms of mental health care that are sorely lacking in the homeless community, and was reluctant to take medication for depression. Daniel regards his low self-esteem and feelings of isolation as cognitive distortions (Fennell 2004; Hall & Tarrier 2003; McManus, Waite & Shafran 2009) rather than bio-chemical problems. Similar to the popularization of cognitive and dialectical behavioural therapy in the correctional system (Kemshall 2002; Pollack 2005) Daniel blames his thoughts and feelings for

his depression rather than his body, in keeping with the Cartesian dualism between mind and body (Kendell 2001).

Lenny also finds the medicalization of addiction problematic; he suggested that different explanations and treatments of addiction are trendy rather than rooted in science:

You know, I don't believe in alcoholism as a disease. I believe it's uh, it's a result more of, um, situational, it's environmental, um, I think that's the whole problem with uh, a lot of people's recovery is, is... you know they're being told they have this disease and the whole disease concept of, um, alcoholism is nothing more than a model. The disease model is exactly that. It is a model. In 1990 there was nineteen different models, you know, and here we are. Twenty years later, I don't know how many more models are out there, I just stopped reading them.

Lenny went on to heavily criticize increasingly popular harm reduction models such as safe injection sites and managed alcohol programs (Fischer et al. 2004; Hathaway & Tousaw 2008), largely due to the sheer number of programs Lenny has experienced through his interaction with the mental health, addiction, and correctional systems, which, for him, nullifies their validity. Lenny is honing in on what Valverde (1998) argues is the sordid history of managing alcohol. Because addiction is not intimately tied to the medical model in the same way as psychiatry (Foucault 1988; Valverde 2006), the definition of addiction, its causes, and treatment have changed several times over the past century. This being the case, Lenny is cynical of AA/NA's disease approach, which he sees as pseudo-scientific and too focused on the neo-liberal project of the self (Valverde 2006)¹⁰⁸ which fails to account for the "spiritual sickness" that he regards as the root of addiction.

¹⁰⁸ Valverde (2006) acknowledges the tension in AA between its Protestant history, the theory of addiction as a disease, and the focus on habit-based governing techniques and suggests that it is its hybridity between these theories and ideological positions that accounts for AA's longevity.

Finally, both Giles and Al suggest that their distress is directly linked to their experiences of racism. Giles accepts his schizophrenia diagnosis, but claimed that the onset of his distress was social rather than biological:

Yeah, [mumbles] yeah. And um, what I'm... my illness is caused not by, uh... natural things but by harassment from people, from the police. Harassment from the police, harassment from, uh, bureaucrats, bureaucrats, yeah. That... that... the time I lived, that time I lived was stressful so I become ill, [mumbles] sick. But when I arrived here I was ok. Yeah, I was ok.

Erin: So, do you, so you're saying that um, do you think schizophrenia or mental illness is um...

Giles: Caused by something. Harassment from the police, yeah, yeah. Feeling followed by the police.

Giles suggests that the stress of coming to Canada as a refugee triggered symptoms associated with schizophrenia. Although claiming to suffer with an illness, he does not see its cause as "natural". Psychiatrists would almost certainly associate his feelings of being followed by the police as paranoia and as a symptom of schizophrenia, but as Laing (1960) suggests, regardless of whether the police are in fact following Giles, his perception of being targeted on account of his race is significant, regardless of how this information is communicated.

Similarly, although Al does not identify as having a mental illness, he finds that the systemic racism he encounters negatively affects his mental well-being. Al recounted a number of stories where he experienced overt racism. He described an incident where he claims a police officer killed his friend because he was a Rastafarian, of being unable to walk in downtown Ottawa holding hands with a white woman for fear of being assaulted, and of being hit by a taxi and left for dead on account of his race. In the latter instance, Al felt completely abandoned by society: "When he just ran me over and left me like that, it just made me like, feel really worthless, as a person. Like to not even have rights. Like even a dog, they would have picked up

off the street, you know”. Al suggests that it is the cumulative emotional effects of these events that led to his poor mental health:

... and I think you grow up with that, like your mom telling you, you have to work twice as hard to get half as far, like you know and people are like abusing you for certain things. And I’m not saying I was an angel but that played a lot, over the years it just festers and festers and festers so it got to the point where I was like, I mean I’m like not killing somebody or killing myself, I was just like I didn’t know how to deal with it anymore and after all the shit...

Al’s sense of self-worth is impacted by systemic racism and he pinpoints a racist police culture as particularly harmful following several negative and abusive encounters with the police. His comment mirrors the recent fatal shootings of unarmed Black men by white police officers in the US (Brunson & Miller 2006) and the heightened police presence in the homeless community (Bernier et al. 2011). Al does not dismiss a biological foundation for serious mental illnesses but believes his mental health could be managed by eliminating racism rather than taking medication.

Finding the ‘true’ self

Despite a handful of outliers, the vast majority of participants accepted the medical model interpretation of mental health and illness. Some research participants personified biological determinism by explaining that their mental health and addiction statuses take over their bodies and are therefore not representative of their ‘true’ selves (Kilty 2011; Maruna 2001; Maruna & Copes 2005; Pollack 2005). Unique to this project is how participants describe the embodiment of mental illness as shifting blame away from their core self.

Mia, a fifty-seven year old Métis woman, was clear about the biological transformation that takes place when her bipolar disorder “kicks in”:

It feels like somebody else is in my body. Somebody else is taking over my body and I really want to hurt the person but me, I don’t want to hurt the person. I’d rather walk

away but I can't because of this bipolar that took over my body... I can be talking to a person really, really nice and want, just, if they make me mad, get me angry and I can't fight the anger that's when it kicks in and that's when, uh, when it seems like this other person is in my body and they're, they're fighting. Not me. I told [my sister] that and she said yeah, well why, Mia, that, that is... that is one part of your brain she said.

Despite Mia's small stature and frail outward appearance she is often aggressive and is known to hit and punch other women at the shelter. At the time of the interview Mia's arm was in a cast from an altercation she had with another woman who made fun of Katie, whom Mia affectionately calls her daughter. Mia causally links her short temper to her bipolar diagnosis and explains that it feels like something or someone is taking over her body and states that her sister, a medical doctor, explained that her brain has two sides. She told conflicting stories of how her bipolar disease originated, once citing a concussion as an infant and then later suggesting it was a result of giving birth to her children. In both scenarios Mia sees a direct biological foundation between her lack of self-control and her mental health status. When referring to another situation where she hit someone, Mia said that her bipolar "flared up" in the same way many refer to arthritis. Like Daniel, Mia retains a Cartesian dualist divide by employing a narrative of 'disembodied irrationality'¹⁰⁹ where she feels she is no longer in control of her own bodily movements.

Mia's narrative mirrors Kilty's (2011) description of substance using women who create a division between their addict and 'true' selves as a way to manage shame. Both accounts describe an 'untrue' self taking over one's decision making capacity. The distinction lies in the biological underpinning of mental illness where the 'untrue' self is thought to be embedded within Mia's body and cannot be parsed from her 'core' self, whereas among Kilty's respondents

¹⁰⁹ Mulvany (2000) refers to 'embodied irrationality' whereby the biologically reductionist understanding of the mind/body dualism is rejected and the mental illness identity is understood as both corporally and socially constituted (see Butler 1990, 2004a). Mia's narrative counters Mulvany's argument by reasserting the division between mind and body.

becoming sober can effectively divide the two selves. The fatalistic quality of Mia's account of bipolar disorder is countered with her speaking excitedly about beginning an anger management program at a shelter she moved to the week before the interview. Mia often referred to the impossibility of managing bipolar disorder as it is like attempting to assert dominance over a completely different person, but she remained open to learning how to try to control it.

Mia's account of her mental illness as a separate entity was unique. Most participant references to a 'true' self that is hidden by mental illness and addiction followed the commonly cited attempts to explain shameful behaviour by citing biological influences, notably substance use (Kilty 2011; Maruna 2001; Pollack 2005). Mac claimed that his alcohol and drug use transformed him into someone else and "...it's not who I really am". Similarly Otto talked about substances "...overtaking my personality...", which he used to explain his absence as a father to his child, following a similar narrative to substance using mothers (Boyd 2004; Kilty & Dej 2012; Kilty 2011). J.J. told the story of why he didn't commit suicide when he was using:

You know what one of my, uh, sponsors said to me I think... he said to me, and this is when I was contemplating stopping using, I was still using, and I was in and out type of deal of, of the program and or sobriety...he said, 'you know, J.J., people who are using or are in early recovery should not consider suicide because the person they're killing may be a stranger.' Now think of that wisdom. You're right, we're so miserable, we don't even know who we are or why we're killing ourselves...

J.J. told me this story many times throughout my fieldwork in the shelters and during our formal interview. The advice he received from his sponsor changed his outlook on addiction, mental health, and his sense of self. Echoing Mia, J.J. argues that committing suicide while heavily addicted is tantamount to murder because the addict self is disembodied from the 'true' self. For these participants, the body is understood as two separate entities, the sober and mentally well self, and the "miserable" addict self.

Like many of the participants in this project, Maruna (2001; Maruna & Ramsden 2004) found that former prisoners differentiate their ‘core self’ from their behaviours as part of their redemption script. Pollack (2005; see Kilty 2011) similarly found that women prisoners identify with the medical model of distress largely because it acts as a ‘shield’ to protect them from taking responsibility. Kathy, a public health nurse, agreed with the assertion that framing distress as a disease creates a narrative that minimizes individual responsibility:

Because it’s, I mean, literally you have, I had a guy... who um... was, got hospitalized, who was drinking his own pee for, he thought it was helping him get well. Got him into the hospital, came out, came back to us, he was doing really well. The voices went away, he got depressed, because here he was an herbalist, a doctor, he was working with [doctors] to, in the hospital, saving all these people and now he’s a guy living in the streets that had a really abusive wife, his kids in the shelter, like, like, it’s insane, right? I mean, so that’s part of mental illness that people don’t think about. You know it gives people meaning in their life. Like it’s a lot easier to be grandiose when I’m the queen of England than see, oh shit I’m living in a shelter.

For some, cognitive distortions are preferable to facing the reality of living life on the margins. The biological determinism associated with the medical model, although touted by the mental health and correctional systems, is antithetical to the attempt to discipline and responsabilize subjects (Maruna 2001). Paradoxically, as Kilty (2011) points out, correctionalist discourses emphasize prisoners’ choice making as central to their rehabilitation, which aligns with neo-liberal responsabilization discourses (Rose 1999). Kilty suggests that prisoners are able to use choice and disease discourses simultaneously to create their redemption script because they both individualize problems in living. Likewise, my findings do not reflect the common understandings of the disease model. Complicating the notion of mental illness as a singular, biological identity is especially challenging given that mental illness, unlike addiction, is firmly established within the medical model and is therefore not as easily amenable to fluctuating disease/choice narratives described by Kilty’s (2011) participants. In the next section, I explore

how most of the homeless men and women I spoke with take the blame for their marginality, regardless of their belief in a biological foundation for mental illness and its impact on their quality of life. This fact highlights the tension between explanatory models where biological determinism does not wholly fit with the late modern insistence on accountability, self-governance, and individual responsibility.

Responsibilization: Fixing the flaw

The medical model of distress is commonly used in mental health and addiction services and programming, although calling for marginalized people to be accountable for their homeless and mentally ill identities is counterintuitive to biological determinism. Literature on mental illness and stigma (Phelan 2002; Schnittker 2008) often conflates the adoption of a biological model with the pathologized/victim status akin to Parson's (1975) 'sick role'. If one's mental illness, symptoms, and potentially deviant behaviour are *destined* through bodily make-up, then blame is diverted and the pathologized character is guilt-free but hopeless (Bauman 1988; Feldman 2004; Rosenthal 2000). A poignant example was the sustained pressure in the 1990s and 2000s to find a 'gay gene' that would supposedly reduce the stigmatization of homosexuality but instead created the conditions to further pathologize sexuality (Hamer & Copeland 1994).¹¹⁰

Professionals and para-professionals perpetuate the discourse that a biological framework reduces stigma and deflects blame. As cited above, Kathy compares hyper-tension and mental illness as examples of chronic illness. Similarly, Arnold, a manager at a shelter, compared mental illness with a broken arm: "We would not hesitate to seek medical attention if we broke a bone, and would not be judged for doing so, and the same should be said for mental illness". In contrast, Schnittker (2008) found that biological explanations of distress do not necessarily

¹¹⁰ For a history of the pathologization of homosexuality see Metcalfe & Caplan (2004) and Zucker & Spitzer (2005).

reduce stigma and in fact can have the opposite effect, where the public is more fearful of the potential dangerousness of those diagnosed with a mental illness (in particular schizophrenia)¹¹¹ because the fatalism of the medical model suggests it is difficult or impossible to manage or treat the individual. Literature that is critical of the disease model of mental illness, however, is often uncritical of the construction of a physical illness as a ‘true’ illness (Sedgwick 1982). Physical illnesses are not immune to blameworthiness despite obvious biological foundations. Scholars suggest that individuals are often blamed for their physical ailments because they do not manage their risks, take preventative measures, or adhere to suggestions offered by health promotion discourses (Lupton 1995; Rose 2007).

Lupton (1995) refers to fatalism versus lifestylism to differentiate between static risk factors such as genetic predispositions or gender, and those that can be altered with lifestyle changes, such as diet and exercise. The two are often conflated and so a space opens up where individuals are held accountable for their physical illnesses. For example, literature on self-perception among cancer patients indicates that people experience tremendous guilt and shame for their diagnosis (Else-Quest et al. 2009). Lung cancer in particular carries a significant amount of stigma because of its association with smoking cigarettes, which is conceptualized as a poor lifestyle choice. Even amongst those with lung cancer who do not smoke, the level of felt judgement and shame by association is reportedly high (Chapple, Ziebland & McPherson 2004). The responsabilization of lung cancer patients comes from an assumption that individuals make bad choices and are thus at least somewhat deserving of their illness. If we can assert that a biological explanation of illness does not *ipso facto* eliminate blame, we can consider how self-

¹¹¹ Schnittker (2008) suggests that compared with depression, schizophrenia is associated with unpredictability and violence and genetic arguments further enhance this perception of dangerousness.

governance discourses can be disseminated by those in authority and internalized by homeless men and women experiencing distress within a medical model framework.

The Maté effect

Gabor Maté is an internationally renowned physician working in Vancouver's Downtown Eastside whose influential books and speaker series bring together the seemingly opposing concepts of the biological foundation of mental illness and addiction and individual responsabilization. His perspective is used in a number of programs in Ottawa and several interviewees referenced his work¹¹². To briefly summarize, Maté (1999, 2008) argues there are a variety of biological and environmental factors that influence mental illness and addiction but at its core they are a manifestation of an abnormality in the brain caused by undeveloped or impeded dopamine receptors in the cerebral cortex, the part of the brain responsible for rational decision making and emotional control. Maté uses this logic to account for both the symptoms of ADD (1999) and addiction (2008),¹¹³ furthering the premise of this project that addiction and mental illness are conflated constructs among professionals, para-professionals, and many individuals with lived experience of distress. Considering addiction in particular, Maté questions an addicted person's ability to make informed choices:

People choose, decide and act in a context – and to a large degree, that context is determined by how their brains function. The brain itself also develops in the real world, influenced by conditions over which the individual, as a young child, had no choice whatsoever (2008: 174).

¹¹² One third of the men I interviewed made direct reference to Maté and his work. Interestingly, none of the women participants mentioned Maté, perhaps because the programmes for women do not reference his material.

¹¹³ Maté (2008: 128) understands addiction as "...any repeated behaviour, substance-related or not..." and uses his self-diagnosed addiction to buying classical music albums as an example of a repeated behaviour that has a negative influence on his life.

Maté dismisses a genetic predisposition to mental illness and addiction and instead focuses on ‘gene expression’ based on pre- and post-natal environments. Describing the causes of ADD, Maté writes:

Even more than breast-feeding, healthy brain development requires emotional security and warmth in the infant’s environment. This security is more than the love and best possible intentions of the parents. It depends also on a less controllable variable: their freedom from stress that can undermine their psychological equilibrium. A calm and consistent emotional milieu throughout infancy is an essential requirement for the wiring of the neuro-psychological circuits of self-regulation. When interfered with, as it often is in our society, brain development is adversely affected. ADD is one of the possible consequences. (Maté 1999: 68)

Maté is careful to accentuate the impact a stressful environment has on an infant while attempting to reduce the level of blame he attributes to parents, and mothers specifically. He suggests that the brain’s development in utero is highly influenced by the mother’s anxiety levels, where higher levels of cortisol in her body can lead to permanent cognitive, behavioural, and emotional problems for the fetus, but also argues that her “freedom from stress” may be beyond her control, arguably based on class, race, and social circumstances.¹¹⁴ Maté (1999: 55-56) regards parents’ “unconscious attitude towards a child” including, “...the tension in a father’s body as he holds his infant or to record whether a mother’s gaze is clouded by worry or clear with calm anticipation” as affecting the microcircuitry of the child’s brain and fracturing the relationship between parent and child. An unstable environment leads to poor self-regulation, which can account for both the symptoms of ADD as well as addiction.

¹¹⁴ The mother-blaming found in Maté’s work is reminiscent of the discourses on mothers who consume any alcohol whatsoever during pregnancy as responsible for a whole host of potential impairments. As Armstrong (2003) notes, this kind of hyper-sensitivity to risk causes pregnant women undue anxiety, which, ironically, Maté suggests causes similar neurological impairments that the mother was trying to avoid. Maté’s mother-blaming is not limited to pregnant women. He also finds that loving but anxious new mothers can impede the development of the child’s frontal cortex and thus the child and future adult will seek emotional comfort from external sources (i.e. drugs). Maté (2008: 231) writes: “a child with a depressed mother feels constant deprivation and deep distress”. In his work with KidCareCanada (kidcarecanada.org), he describes the importance that women with post-partum depression feel no judgement for their distress, yet his written work conveys a different message.

Proponents of the impact of social and environmental factors on mental health, such as victimization, seek to gain legitimacy by situating them within the medical model. In order to establish and maintain itself as a rigorous scientific discipline, only overt, observable symptoms of an underlying biological abnormality can be understood as causes of mental disorders. Reacting to a stressful situation, such as living in a homeless shelter, cannot qualify as a mental illness (Horwitz 2002). For this reason, the only way environmental factors can be recognized by the psy-disciplines is to qualify them as ‘triggers’ to an underlying biological impairment. This framework expands the medical jurisdiction to cover social and human behaviour (Conrad 2007). In this way, the medical profession, of which Maté is a part, requires him to locate the impact of poor parenting or trauma in the chemical changes and imbalances in the brain.

Despite his focus on the neurological aspect of addiction, Maté eschews a strict disease model approach and suggests that environmental and behavioural changes can directly affect the body and reprogram the brain. Herein lies the crux of his argument and, I suggest, one of the reasons for his popularity. Maté adopts the biological determinism framework that situates the mentally ill and/or addict individual as a victim, but he rejects its fatalism. Maté contributes to the political economy of hope (Novas 2006; Rose & Novas 2005) by using scientific evidence that the brain’s internal environment can be manipulated. Using research on individuals with OCD, Maté (2008) suggests that the neuroplasticity of the brain allows for its circuitry to be over-ridden and new nerve cells to form, even in adults, if an individual provides her brain with an ‘enriched environment’. An enriched environment can be as simple as doing puzzles to ward off dementia or as difficult as re-orienting the ‘salience attribution’ in the brain that prioritizes a drug over love, happiness, and safety. Similarly, in reference to treating ADD, Maté (1999) describes ‘self-parenting’, where individuals create for themselves a physical and emotional

space where they feel safe, healthy, creative, and open to self-insight so as to form new neural circuits that process emotions in a ‘healthy’ way.

Borrowing heavily from the AA/NA paradigm, Maté highlights the powerlessness of addiction, but through the brain’s reconfiguration he argues that an individual can regain the freedom of choice:

Life, until now, has created you. You’ve been acting according to ingrained mechanism wired into your brain before you had a choice in the matter, and it’s out of those automatic mechanisms that you’ve created the life you have now. It’s time to re-create: to choose a different life... In place of a life blighted by your addictive need for acquisition, self-soothing, admiration, oblivion, meaningless activity, what is the life you really want? What do you choose to create? (Maté 2008: 361)

Maté characterises the addict as a victim in childhood but as empowerable as an adult. He does not make light of the immense difficulty that comes with creating an enriched environment or ability to ‘self-parent’. He is keenly aware of the personal, economic, and social impediments his deeply marginalized patients face. He is especially frustrated by the criminalization of addiction and the dearth of public health approaches, in particular harm reduction strategies such as prescription heroin (Oviedo-Joekes et al. 2009). Despite these dire circumstances, Maté’s work provides hope – hope that the brain can be changed if those in distress gain enough will-power to make good choices. From Maté’s perspective those who suffer with mental illness and/or addiction are victims, but victims who can achieve freedom through responsible choices. Because the thing to be changed is the brain, the individual ultimately remains responsible for her freedom.¹¹⁵

The influence of Maté’s work on the interviewees is apparent. A number of individuals who participate in out-patient addiction treatment programs re-narrated their past upon learning

¹¹⁵ Maté (1999, 2008) quite clearly expresses the need for significant support to be able to make responsible choices, including medication in some cases.

about brain development. This discursive shift is an example of Hacking's (1999: 130) looping effect, whereby: "events in a life can now be seen as events of a new kind, a kind that may not have been conceptualized when the event was experienced or the act performed". Maté's theories allow homeless men and women to reconfigure past events as biologically triggered. Mick explained: "Growing up as a kid in a stress environment, or stress caregivers, um, the brain circuits don't form properly. But the brain is very plastic, eh, this stuff can be fixed". Mustang explained the etiology of mental illness in the same way: "[Mental illness] is brought on, from my understanding, is brought on from the environment that's exposed to me from birth to... however long. So however I gone through stressors, trauma, whatnot, yeah, I believe something got interrupted, uh, while the brain was being formed or as it's aging or whatever". Maté's discourse allows participants to add a biological component to their experiences of abuse and neglect. More than this, though, the addiction programs use Maté's work on both mental illness and substance abuse to provide the sense of hope that is required to 'fix' the brain:

Gabor Maté empowers you... He says that if you acclaim it to genetics then nobody's responsible and you might as well give up because you're an addict and you have no hope of recovering, right? But if it's from an experience, right, and you can, you, uh, what does he call his something, L P [left prefrontal hemisphere] brain, uh, it's the malleable brain that you can, re, uh, it can form new pathways, L P whatever, I forget. So basically in time, and that's where I had hope, in time these brain, um... patterns or whatever, connections, will no longer be used because I'll no longer be using so they'll, they'll create newer ones that will be, you know, relevant to my new lifestyle (Ron).

Ron is a forty-one year old white, bi-sexual man who is diagnosed with a raft of mental illnesses (including, post-traumatic stress disorder (PTSD), bipolar disorder, depression, and anti-social personality disorder) and who identifies as actively using cocaine, crack, heroin and alcohol. At the time of the interview, he lived in a homeless shelter and had spent considerable time in prison. In short, Ron's situation can easily be described as hopeless. Instead, he uses the material

provided in the addictions programs as a source of hope and empowerment through which to write his redemption script (Kilty 2011; Maruna 2004). As Cruikshank (1999) describes in her analysis of empowerment, a key to self-regulation is to reflexively objectify the self so that it does not need to be made into an object by external authority figures. Ron uses the biological model of mental illness and addiction to objectify his body (brain) and provide a framework for being well – namely through self-regulation and forging a new ‘lifestyle’. Ron’s limited understanding of neuroplasticity and the absorption of dopamine by the cerebral cortex is irrelevant; what matters is that his biology caused his mental illness and addiction but it is his will-power that will cure him.

It thus becomes Ron’s responsibility to adopt a normative lifestyle (Rose 1998, 1999) that will create the ‘enriched environment’ his brain needs to grow new nerve cells; through this discourse, Ron is simultaneously pathologized and responsabilized. Ron explained that the knowledge that he needs to create a whole new life for himself is actually empowering: “Now I know so I know, even if I have to run with a thousand pounds on my back around the block every day, at least I know that’s what I have to do. Whereas before... it’s hopeless”. Ron did not elaborate on how this ‘thousand pounds’, related to securing safe and permanent housing, finding counselling, becoming sober, staying out of jail, dealing with past trauma, and building positive relationships, can be lifted off his back. There is a disconnect in Ron’s narrative similar to Maté’s writing, where discussions of how the socio-structural reality of living on the margins can be transformed into an ‘enriched environment’ is either left unaddressed or is described simplistically as emerging from the ability to make better choices. In this instance we see how some marginalized people are framed as redeemable. If their brain can be fixed by adopting a normative lifestyle then it is theoretically possible to become included, which affords vulnerable

people, like Ron, a degree of hope. This hope provides the necessary motivation to take responsibility for one's distress. The discourse is tautological; in order to fix the brain the individual must act responsibly by adopting a normative lifestyle, but to act responsibly requires that the brain be fixed. In the next section I explore how, despite this tautology, homeless men and women expect themselves and their peers to be completely accountable for their exclusion.

No Excuses: Taking responsibility for the mentally ill and addict identities

So far in this chapter I have scrutinized the complex ways biology and responsibility are combined to act as an explanatory tool for the distress many homeless individuals experience. In this section I consider those narratives that do not fit this framework. In particular I examine the importance many homeless individuals place on accepting blame for their social circumstances and the derision of those individuals who are regarded as making excuses for their distress.

Taking the blame

The cornerstone of governing through freedom is an individual's ability to make autonomous, rational decisions (Rose 1998, 1999). Freedom comes with obligations to choose correctly, mitigate risks, and live with the consequences of our choices (Bauman 1988; Rose 1999). Although many of the research participants frame the mentally ill and addict identities as biologically situated, the notion that the brain can be fixed through a responsible, civilized lifestyle reinvigorates discourses of self-government. Although I did not ask direct questions about the participant's history of trauma, most participants volunteered information about the physical, sexual and emotional abuse they endured as children and adults. This victimization, while understood as acting as a causal feature in abnormal brain development, does not diminish the felt responsibility to govern oneself according to socially accepted norms. In order to simultaneously perform the roles of the shamed poor and responsabilized citizen those in the

homeless community who are identified as mentally ill/addicted must hold themselves accountable for their current ‘unenriched’ environment and are thus also responsible for creating an enriched environment (Maté 2008) conducive to neurological, psychological and emotional growth. As Maruna (2001: 132) notes, individuals seeking redemption are expected to assume “... complete and unmediated blame...” for their marginal status. This unequivocal blame is the only way to exhibit the necessary shame to be considered redeemable and worthy of services.

The common refrain from participants was that, notwithstanding the biological nature of their condition(s) or the social context in which they lived, they must assume responsibility for the state of their lives should they wish to escape homelessness, manage their mental illness, and/or become sober. For example, Christine takes full responsibility for her depression, OCD, and bipolar disorder diagnoses as well as her addiction to crack. When asked how living in a shelter affects her mental health, she responded: “Uh, no matter where I am, I can’t blame the environment because that would be me being in denial”. Christine uses psy-language like “being in denial” to explain why she will not acknowledge living in a homeless shelter as having a negative impact upon her mental health. In this way, Christine is judging herself through psy-language (Rose 1998) and internalizes external distress factors as part of her responsabilization narrative and redemption script.

Karla uses a similar narrative to take ownership of her addiction: “My addictions started because I liked it, so, and I’m not blaming nobody and I’m not screaming telling the government to pay me because you had me addicted for two years, you know what I mean, you fucked my life up. I fucked my own life up. I chose to take the pills. It was up to me not to take them”. Karla became addicted to opiates after they were prescribed to manage pain and first came to the shelter to escape an abusive relationship. Still, she blames herself for her addiction and

depression. Part of Karla's responsabilization narrative is to make it known that she only uses the public assistance she absolutely requires – shelter, food, and mental health care – which enables her to differentiate herself as a redeemable subject from the irredeemable who take advantage of the system and fail to take responsibility for their life circumstances. Her claim that she is not “screaming” at the government establishes that she is not demanding compensation or care that she feels she may be entitled to. Instead, she is only using the most basic services and relegating the rest of her recovery to her own will-power.

Like Karla, Jon spoke at length about the importance of taking ownership for his anxiety and addiction. When asked how mental illness might mitigate this responsibility, he adamantly denied its relevance:

Well, I, I don't see... I don't see too much difference with, with, that. Well... uh, a little, a little because if I'm taking care of myself, and I'm being responsible, uh... if I, if I'm in recovery and I'm taking care of myself and being responsible for my actions, and, and, uh, you know my negativity.... If, if I'm doing that, that makes me that much more happier, and and, happy for.... For being in [addiction] recovery.

Once again we see the conflation of mental illness and addiction. Jon feels mentally well when he is participating in an addiction recovery program and noted that it is his responsibility to access and remain in the program. Being in distress, therefore, is a consequence of his inability to ‘choose correctly’ (Bauman 1988) between following the rules set out by the para-professionals in the programs and leaving himself to his own devices. On the morning of the interview Jon was ecstatic that he was admitted into the first stage of a three tier process to being accepted into a publicly funded in-patient addiction treatment program. In this way Jon is performing the redeemable identity. He is aware that he cannot govern himself (Bauman 1988; Foucault 1977; Rose 1999) but, ironically, his willingness to be managed in the disciplinary sense is an act of responsabilization necessary to be admitted into the addiction program.

'It's weakness': Rejecting common excuses for explaining distress

The research participants that took ownership of their distress were subsequently critical of those who use mental illness, addiction, or histories of trauma to explain their marginalized status. Maruna (2001) argues that individuals who use these experiences as justifications for their behaviour are demonstrating that they continue to embrace normative values and are victims of illness or circumstance rather than their 'core self' being irredeemable. In this sense, using an excuse is indicative of a desire to be included. The participants in this research project would disagree with this premise. The paramount normative value in the neo-liberal era is responsibility, one that is emphasized by empowerment programming in corrections and the homeless community (Kilty 2011; Maruna 2001). Self-governance is a coveted trait that stands in opposition to making excuses. As the participants claimed, using excuses does not allow you to perform the redeemable identity, one that calls for uncompromising responsabilization.

Seamus was frustrated by those who use mental illness as an excuse for their marginality:

I think a lot more of it is done by choice or by decision. Sorry, not by choice by decision. They make a bad decision at one point and it maybe snowballs, and they make...then they end up making more bad decisions. And that, those decisions may very well be based on a mental illness... It's, 'cause I always thought, growing up, always, even though I was mid-twenties, I'm like, these guys are just weak. They could have got help before if they needed [it], they're not that bad, they were just lazy and blah blah blah.

This discourse harkens back to the vagabond typology (Castel 2003), which presents the homeless as manipulative and lazy. Upon further probing, Seamus remarked that despite recently becoming homeless himself, he maintains his opinion that homeless people are weak. His assertion that "they're not that bad, they are just lazy" exemplifies the continuum of exclusion, where avoiding the 'bad guy' identity does not mean the 'good guy' status is achievable.

Seamus' thoughts on addiction are similar; for example, he recounted an argument he had with his brother:

I said no it's a choice. Sure it's a disease, they call it a disease. It's a choice. Every morning you decide whether or not you're gonna have a drink that day. Well it's not that easy for... I know it's not that easy. I didn't say that. I said they still decide at some point during that day that they're going to have a drink or they're going to, you know, smoke a joint or, or do some crack or whatever. They decide that. It's a decision. It's a conscious decision. So, this, yeah, but it's a disease, people can't control their diseases. Well, uhhh, I disagree. I do, I, and again, I'm not saying it's easy for people. It'd probably be the hardest thing they do, *but* every day they do make that choice. They decide. They make a conscious decision whether or not they're going to go to the liquor store and get a, get a drink, or go to their dealer and get some weed, get whatever they're on. It's a decision they make that day, every day, and every time they do it.

On several occasions during the interview Seamus referred to the distress that other homeless people face as a consequence of their unwillingness to act responsibly. Seamus does not identify as having a mental illness or an addiction, although he admitted that his drinking was a factor in losing his wife, children, and home and that he lost several bartending jobs because he drank too much while working. Seamus has trouble identifying himself as a 'lazy' and 'weak' homeless person but recognizes his increased exclusion comes from his poor decisions. While Maté (2008) would disagree that an addict's decisions are conscious, Seamus considers any mitigating factors beyond the immediate decision to be an excuse for inappropriate behaviour.

Unlike Seamus, Max recognizes his past trauma as contributing to his mental illness and addiction but feels he cannot let that deflect from becoming accountable:

I was raped by, uh, by men, you know. It wasn't in prison, this was when I was younger and uh, several times. And I've a really hard time blaming my life and my addiction on something that happened forty years ago, but everybody says, that's what people say, no it's, that's what you need help with, but to me that's too much of an excuse, that gets me off too easy... You know 'cause we all, you know, I don't think there's anybody without problems. Some, you know... I think it's a factor but I don't, I don't think I can let myself off that way.

Max, who has participated in a number of mental health and addiction programs, believes in the disease model of mental illness and addiction and is aware of the impact that trauma can have on brain development, but just like Seamus, he feels his past victimization cannot excuse the daily decisions he makes to drink and use drugs. He attributes his sometimes crippling depression to his inability to be assertive, stay motivated, and be content with everyday life. In Max's case his victimization as a young man caused distress, for which he turned to illicit substances to cope. He was in turn criminalized for this behaviour, which further entrenched his social exclusion. This 'evolution of marginality' can begin to explain how a series of events forty years in the making impacts Max's decisions today. Max's contention that framing his distress as a consequence of past trauma "gets me off too easy" retains the individualization of neo-liberal governance arrangements. Rose (1999, 2000) defines the 'anti-citizen' as someone who fails to manage her own risk. In this sense, and echoing Seamus, Max is complicit in his own marginality for getting himself into risky situations. Of course, discourses of risk management and crime prevention would never blame a young person for his or her sexual assault (Eriksson 2009), but as I argue elsewhere (Dej 2011b) there is a gross distinction between the victimized child and the deviant adult where the latter is responsabilized for her actions irrespective of the social and historical context..

A number of participants felt that there are people in the homeless community that waste their time finding excuses for their marginality rather than using that time to transform the self.

For example, Milan lamented that the men he lives with at the shelter complain too much:

Well instead of complaining all day long, do [you], make, make steps to improve your life, you know? All there is, is complain, complain, complain I hear. Just go and change your life, do something about it. If you want to be here, or if you don't want to be here, just don't complain about it.

Milan takes pride in his father's graduate degrees and the emphasis he placed on intellectual pursuits during his childhood. He recently enrolled in a university program and sees his desire to learn and study as a characteristic of a redeemable subjectivity. For Milan, people who place blame elsewhere are missing key opportunities to work on the project of the self so as to establish and/or reassert their redeemable status.

It is interesting to note that it was predominantly men who voiced intolerance for those using excuses to explain their marginality. Although the women participants judged other homeless women for their drug use (especially if they were a mother), cleanliness (or lack thereof), and attitude (rudeness, aggressiveness), among other things, there was greater acceptance that one's history of trauma and the social context impact distress. The women accepted personal blame but were less likely to project blame onto other women. For example, although Matilda does not feel safe at the shelter and is concerned about some of the aggressive and unpredictable women, she has a great deal of sympathy for them:

So I just, don't, you know, they're doing the best they can and you know, but, but there's people that, um, don't, are not conscious of what they do when... their behaviour, you know, how they hurt other people... That can be upsetting because, you never realize how sometimes people are hurting, eh? And it makes you realize just how hard it is.

Like Seamus, Matilda does not identify as having a mental illness or an addiction, but unlike Seamus, she sympathizes with women in distress and somewhat excuses their conduct on account of their mental illness and/or addiction. I offer two reasons why this might be. First, women are socialized to take on the caregiver role (Treas & Drobnič 2010), which may bring about a kind of solidarity amongst women in the shelter more so than their male counterparts. Examinations of gendered socialization practices suggest that women seek attachment and sustained relationships and thus demonstrate a more established 'ethic of care' than men

(Gilligan 1982). An ethics of care is deeply entrenched in the normalization of womanhood, for example, in the essentialization of women within their role as mothers (McQuillan et al. 2008). These sentiments are often internalized by women and may manifest in the homeless community as a refrain from judgement and a general concern for others' well-being.

Second, it is probable that because women are commonly victims of assault and abuse (Brownridge 2008; Tolman & Rosen 2001) there is a greater understanding of how trauma and distress might impact another woman's social conditions. Having greater sympathy and empathy for another woman's history of violent victimization seems to allow the women participants to contextualize the mentally ill and addict identities differently than the men, enabling them to recognize the degree to which individualization fails to account for the lasting effects of victimization.

Becoming empowered through responsabilization

Although many women recognize the historical and social causes of marginality, most self-help and empowerment strategies actually decontextualize and individualize distress (Hannah-Moffat 2000b). Given the prominence of self-blaming discourses revealed above, it is not surprising that participants found the individualized approaches advanced by treatment programs in the homeless community to be an attempt to boost self-esteem and encourage the adoption of a responsabilized lifestyle. Daniel offered compelling insight into how his one-on-one therapy with an addiction counsellor and participation in an out-patient drug treatment program reinvigorated a sense of responsibility that he lost before he "stepped out of the machine":

Daniel: I'm breaking myself down to nothing and I was really given the opportunity to assess who am I? Do I want to? You know and without any pressure, no, no inner fear or persuasion. It's all up to me. And that's one thing for sure. So I can say ah those guys aren't doing this and this but, really it's all a choice. Life is all choice. Every day, you

know as soon as you open your eyes you make a choice... That empowers you when you realize that everybody is in life exactly where they've chosen to be... But you constantly have to take responsibility, take ownership over your choices and realize that nobody did this, nobody caused that. It was the way I reacted. Instead of responding, you know and on and on and on. Then it becomes empowering because you click, I'll choose different next time.

In this passage, Daniel brings together the notions of self-blame and responsabilization that were discussed throughout this chapter. For Daniel, empowerment comes from having the personal power to escape homelessness and distress. If he 'broke' himself, then arguably he can 'fix' himself too. Daniel's comment that he is "breaking myself down to nothing" exemplifies the reflexive self-objectification of self-help programs (Cruikshank 1999; Vaz & Bruno 2003) that encourages him to treat his mind like a separate transformative project. The responsible, objective, fearless Daniel will mould and build a new self. As is the goal of empowerment strategies, he engages in self-scrutiny in the hope that he will not have to rely on professional surveillance in the future.

While Daniel finds the freedom of self-government empowering, the more prominent discourse among interviewees was that empowerment comes from a restraint on freedom. Participants struggled to control their desires (a quintessential requirement in self-governance) and gain a more positive sense of self when authority figures steer their choices (Hannah-Moffat 2000b).¹¹⁶ For some participants, there is such a thing as 'too much freedom'. Mick suggested the freedom he gained when he separated from his spouse was his undoing: "I guess 2004 I separated. 2006, um, I started getting really bored of my free life [chuckles]. I, I, and I was, uh... hanging around bars more. And I never did that before, like I was a drinker but it was, I never hung around bars". Mick associates the lack of restrictions on his time that stemmed from the

¹¹⁶ In most cases there are several para-professionals and professionals engaged in 'therapeutic surveillance' (Moore 2011), either separately or as a team.

dissolution of his role as husband and active parent with his increasing propensity to drink excessively. The minimization of responsibility in one part of his life leads to irresponsibility in another. Jon recounts the anxiety he felt upon his discharge from an in-patient treatment program because he felt he did not have the will-power to stay sober without the structure of an insulated treatment environment: “I knew I was going to pick up... because I had that freedom. I had no one there to say, uh.... You know, don’t do it... about two or three days later I picked up”. As Bauman (1988) argues, people who are controlled are incapable of being free. Describing the onerous rules applied to welfare recipients, Bauman (1988: 69) writes: “Set in operation, such rules accomplish what they assume: they systematically deprive welfare clients of initiative, de-train them in the art of free choice, force them to remain passive and socially useless”. As recounted in the criminological literature (Bosworth 2007; Kilty 2012a; Pollack 2009), when deprived of opportunities to exercise freedom, some individuals become weighed down by disciplinary technologies and lose the motivation and self-assuredness to practice freedom. Reminiscent of the discussion of shelterization in chapter five, Rose echoes Bauman’s suggestion that disciplinary regimes can exclude people to such an extent that gaining independence no longer seems viable or preferable:

Those ‘excluded’ from the benefits of a life of choice and self-fulfillment are no longer merely the passive support of a set of social determinations: they are people whose self-responsibility and self-fulfilling aspirations have been deformed by the dependency culture, whose efforts at self-advancement have been frustrated for so long that they suffer from ‘learned helplessness’, whose self-esteem has been destroyed (Rose 1996: 59)

Mick and Jon, both of whom have spent years in jail, treatment centres and homeless shelters, do not feel capable of managing their lives independently and making decisions that are conducive to securing housing, managing distress, and maintaining sobriety. As per responsabilization discourses, Mick and Jon see their potential failure as an individual fault rather

than as affected in part by structural barriers. In this case, empowerment and in turn the redeemable status comes from being accountable and self-aware enough to defer the freedom to make decisions regarding housing, time and money management, and treatment options to authority figures. Achieving the redeemable status requires an acknowledgement that an individual cannot meet the ideals of inclusion without professional support.

Interestingly, J.J. is the only participant who spoke directly about his personal sense of freedom, or lack thereof:

Freedom is a good thing or a bad thing. Okay. You know...you know...when...freedom can be...you can have so much freedom that we get to pick our own poison. You know what I mean? You don't have...we have too much freedom in this country sometimes. So...don't abuse that. Find some balance in you...in your decisions. Your freedom is your decision to make...but it's also your consequences to suffer. So freedom...is a good thing if you don't abuse it.

J.J.'s comment parallels Bauman's take on freedom:

One is free to pursue (and, with luck, to achieve) one's aims, but one is also free to err. The first comes with the second, in a package deal. Being free, you can be sure that no one will prohibit the actions you wish to undertake. But you are not offered any certainty that what you wish to do, and do, will bring you the benefit you expect, or benefit at all for that matter (Bauman 1988: 1-2).

Both J.J. and Bauman refer to the obligations of freedom. After years of mental health and addiction treatment J.J. found that it is in his best interest to abdicate his freedom to make day-to-day decisions regarding his routine and lifestyle to others. He began the interview by emphasizing his substantial support system, made up of a CMHA worker, counsellors in the shelter, his AA sponsor, and the counsellor who runs a trauma group, among others. J.J. uses these authority figures to instruct him in how to manage his feelings and change his behaviour. Combined, these para-professionals are responsible for his housing, psychotropic medication, and time management. Both Jon and J.J.'s narratives reinforce the discourse that in order to be

considered redeemable you have to have enough self-discipline to know that you need assistance to govern yourself appropriately.

J.J. identifies himself as a redeemable subject because he adopts self-help discourses. When asked why he has success accessing services when so many other members of the homeless community struggle to find adequate resources or are kept on wait lists for counselling or housing for years¹¹⁷, J.J. replied “I got with the program. I, I got with the program where I was becoming one of the poster child[ren]”, which earned him praise from para-professionals because he was obeying the rules and regulations set out in the program’s disciplinary strategy. His sense of self-worth comes from his openness to being managed by others. He is, as Moore and Hirai (2014) contend, a ‘true believer’ in that he unquestionably accepts the disciplinary strategies invoked by the various mental health and addiction programs. Moore and Hirai (2014) found that even among those participants of the drug treatment court who obey all of the rules and internalize the responsabilization discourses touted by its programs, they remain excluded because those same strategies that seek to empower them also call on them to acknowledge and cement their excluded status. The same can be said for J.J. His prospects for becoming included are minimal; indeed, the disciplinary tactics he engages in do not align with the included circuit. Instead, J.J. remains excluded, but amongst the most redeemable of the excluded.

Conclusion

In this chapter I revealed the paradox of a discourse that simultaneously adopts a medicalized paradigm of mental illness and addiction while holding individuals accountable for their distress and marginality. Gabor Maté’s work positions ‘addicts’ as victims of improper gene

¹¹⁷ As mentioned in chapter five, the city of Ottawa has at least a five year wait list for social housing (The Registry 2015). There are no statistics on the overall wait times for free or low-cost counselling services, but Melissa, a case worker who participated in the focus group, claims that the average wait time in Ottawa is three months.

expression on account of poor pre- and post-natal care but who can be empowered through self-discipline and a civilized lifestyle, which can change or ‘fix’ chemical reactions in the brain. The majority of the research participants described both the biological nature of their distress and their desire to change their life through individual accountability. We must consider as well the small but vocal segment of the population who are critical of the medical model, but in turn appear to emphasize self-blame to an even greater degree. By focusing on finding solutions to distress and empowering people through individualized but decontextualized treatment responses (Cruikshank 1999), the reality of living on the margins and the immense difficulty of escaping homelessness is minimized, if not disregarded altogether. In the next chapter I consider how some participants situate themselves as homeless mental health consumers in order to demonstrate their redeemability.

Chapter 8 – The Homeless Mental Health Consumer: Managing Exclusion through Redeemability

Introduction

Throughout this dissertation I have examined various ways homeless men and women are managed and their responses to these forms of social control: including how space and time are regulated in shelters; how the homeless, mentally ill, and addict identities inform ways of knowing and being; and how homelessness is simultaneously pathologized and responsabilized. While these analyses have pointed to sites of negotiation and resistance, overall they demonstrate the limited autonomy the homeless face (Rose 1999). There are copious examples of disciplinary strategies that are tailored to manage the homeless such as curfews, expectations of sobriety in order to access certain services, and the criminalization of panhandling, to name a few; however, it is imperative that we consider the ways in which homeless men and women attempt to assert control over their lives and maintain a sense of freedom. I argue that many research participants use the mental health system in an attempt to situate themselves as included citizens within an otherwise exclusionary environment. Some homeless individuals perceive mental health resources as tools to assert their autonomy by choosing which modes of intervention best suit their particular project of the self, empower them, and aid in self-surveillance.

In this chapter I will explore how mental health resources are embedded within a political economy of hope that touts inclusion for those who accept the pathologization and individualization of social problems. Next, I assess the reality of a homeless mental health consumer and the ways that the mental health system situates homeless individuals as permanently *redeemable* but never fully *redeemed*. Finally, I consider the fate of those who cannot/will not play the homeless mental health consumer role and who are cast as irredeemable.

In order to gain a clear sense of how and why some homeless men and women seek to position themselves as homeless mental health consumers¹¹⁸ while others reject this role, we must first understand the broader consumer culture that equates buying power with good citizenship and excludes those who do not have the means to participate in contemporary consumption practices.

Rags where riches are required: Poverty and homelessness in consumer society

Consumption, as a concept, is benign. To consume is to use up. Consumption is reframed as consumerism when the ability to appropriate an ever-expanding list of desirable items “underpins the economy of human togetherness” (Bauman 2007: 26). According to Bauman (1998, 2007) consumerism denotes a shift in social arrangements from individual consumption to the creation of a society of consumers where society is organized through consumption. Individuals form social groupings via similarities in self-identity and are systematically regulated through their consumption.¹¹⁹ In a consumer society an individual’s social identity becomes intimately associated with her consumptive habits. Rose (1999: 165) argues that citizenship rights are transformed into the “...rights of the consumer in the marketplace”. As described in chapter three, freedom in the neo-liberal era is articulated as the capacity to realize our desires (Burchell 1991; Reindal 1999; Rose 1999). It is no surprise that neo-liberalism and consumerism go hand-in-hand as freedom in the consumer society hinges on one’s autonomy to access the market at will (Bauman 1988). In this way, our obligations as good, neo-liberal citizens rest upon

¹¹⁸ In keeping with the theoretical paradigm of performativity outlined in chapter three, I nuance the autonomy homeless men and women have to ‘play a role’. As Butler (1990, 1993) articulates, performances are not necessarily actively constructed and some individuals who access mental health resources do not do so with the implicit goal of becoming a homeless mental health consumer. By combining Goffman’s (1959) analysis of role playing with Butler’s conceptions of social construction and sedimentation, we can situate research participants’ autonomy within the social, temporal, and cultural constraints of the twenty-first century homeless community.

¹¹⁹ An example of systematic regulation through consumption is the cost associated with acquiring a Canadian passport (\$120 for a 5-year adult passport, plus the cost of approved photos). These fees effectively disqualify some individuals from accessing one of the privileges of being a Canadian citizen, namely the freedom of mobility.

our willingness to consume¹²⁰: “It’s a matter of choosing what – not choosing if one wants to consume at all” (Bauman 1998: 26). Consumption is an end in and of itself.

The consumer society emphasizes fulfilling desire. Consumers are in a perpetual state of want. In this way, the consumer society is built on the political economy of hope (Novas 2006; Rose & Novas 2005), where the act of purchasing is marketed as a way to secure happiness:

The value most characteristic of the society of consumers, indeed its supreme value in relation to which all other values are called on to justify their worth, is a happy life, indeed, the society of consumers is perhaps the only society in human history to promise happiness in earthly life, and happiness here and now and in every successive ‘now’; in short, an instant and perpetual happiness. It is the only society that stubbornly refrains from justifying and/or legitimizing any variety of unhappiness (except the pain visited upon criminals as the ‘just deserts’ for their crimes), refuses to tolerate it and presents it as an abomination calling for punishment and compensation (Bauman 2007: 44).

With the exception of those who do not ‘deserve’ happiness (the irredeemable) consumer society calls on people to give in to their desires in order to feel satisfied. According to Ahmed (2010) the happiness industry reinforces the correlation between purchasing good and feeling happy. Happiness as a goal worth pursuing is imbued with moral discourses about what objects, activities, and behaviours will lead to happiness.¹²¹ Parallel to the discussion below on the reality of inclusion among the homeless, Bauman (2007) argues that it is too simplistic to argue that consumerism brings happiness; rather consumerism builds upon the political economy of hope. In order to ensure people continue to consume, individuals must remain unsatisfied. The contentment an individual may feel by acquiring the latest iPhone quickly dissipates when a few months later a newer, flashier model is released, rendering the ‘old’ product obsolete. The

¹²⁰ Consider the 2008 global economic crisis. Governments and central banks stressed upon its citizens their obligation to spend money (Collins 2011), creating incentives such as low interest rates to encourage people to buy homes and cars (Evans & Albo 2011; Gaetz 2010).

¹²¹ Ahmed (2010) disrupts the notion of happiness as necessarily ‘pleasure seeking’ or ‘feeling good’ by constructing a genealogy of happiness that bears witness to how happiness is used to justify oppressive social structures, such as the ‘happy’ housewife and the ‘happy’ slave.

promise of happiness, coupled with the reality that products are not designed to create long-term feelings of satisfaction, allows consumer society to propel itself forward without ever reaching an end.

Given the political economy of hope that is ensconced in the consumer society, it is no wonder that consumerism is positioned as a method for realizing the neo-liberal project of the self. To properly work on the self necessarily means to consume. Rose (1999: 84) finds that consumption is aligned with psy technologies, whereby psy uses the market to disseminate its brand of “care for the soul”. Both consumption and the project of the self rely on individuals to identify their needs and be pro-active and enterprising in seeking out what goods and services will help them achieve self-actualization (du Gay et al. 1996; Rose 1999), be it therapy, psychotropic medication, or self-help books (Rimke 2000). Bauman (2001a, 2007) argues that the goal of consumerism is to continually make and re-make oneself. In keeping with the perpetual dissatisfaction built into the consumption model, the project of the self is a never-ending search for improvement and perfection that requires a continuous acquisition of consumer goods. If the project of the self necessitates consumptive practices, we must trouble how and why these techniques are used by homeless men and women who do not have the resources to be consumers. The ability to consume is equated with an individual’s moral character (McDonald et al. 2007) and in a society of free consumers failure to consume or consume inappropriately (such as consuming illicit substances) is regarded as a poor choice (Bauman 2007). In line with Young’s (1999) dialectics of exclusion, those who do not adequately participate in the consumer culture, whom Bauman (1998, 2007) refers to as ‘flawed consumers’, reinforce consumerism as worthy of pursuit, which subsequently individualizes their failure and positions them as members of the outgroup.

The flawed consumer

Individuals who fail to consume are regarded as ‘waste’, ‘redundant’ and indeed, as ‘flawed’ or ‘failed’ consumers (Bauman 2004, 2007). Those who cannot or choose not to take on the consumer role are merely spectators, passively watching others consume (Young 1999).

Reith outlines how addiction, for example, is constituted as consumerism run amok:

The notion of addiction turns the sovereign consumer on its head, transforming freedom into determinism and desire into need. Rather than consuming to realize the self, in the state of addiction, the individual is consumed *by* consumption; the self destroyed. Whereas the consumer *chooses* to act, addicts are *forced* to do so. [emphasis in original] (Reith 2004: 286).

Here, consumption is inextricably linked with the obligations of freedom described in chapter three. Flawed consumers do not consume products that are in keeping with notions of civility and fail to demonstrate self-regulation through their consumptive habits.¹²²

Flawed consumers are not only excluded but are constituted as enemies of consumer society (Bauman 1998) because their reliance on social assistance comes at the expense of good neo-liberal consumer citizens, thereby limiting (in however minor a way) included individuals’ ability to consume. As consumption is used as a mode of regulation, those living on the margins are regarded as “...outside of the ‘consuming civility’” (Rose 1999: 87) and are thus subject to disciplinary measures. While in many cases this is true, I argue that a number of vulnerable individuals do not position themselves as necessarily and completely outside of consuming society. Critical criminological scholarship tells us that rather than being separate from the consuming world, flawed consumers may be framed as clients of disciplinary systems (Donohue & Moore 2009).

¹²² Reith (2004) points out the ironic relationship between neo-liberal conceptualizations of freedom that include self-control and a search for self-actualization with a consumerist framework that encourages people to constantly consume, act on their desires, and aim for short-term happiness.

Tracing the client in the prison and mental hospital

As described in chapter two, broadly conceived, the mad movement is made up of psychiatric survivors and consumers. While survivors tend to reject medical intervention and perceive the psychiatric system as causing violence, oppression and coercion, consumers tend to view their role within the mental health system as collaborators and partners (Diamond 2013; McLean 2000). Framing the mad person as a consumer is a strategy readily adopted by some individuals, families, psy professionals, mental health care administrators and government agencies because it presents the mental health client as an autonomous, self-determining individual within the mental health system (Burstow 2013; McLean 2000).

Likewise, the addict (specifically those who use illicit substances) and the criminal are constituted as clients looking for guidance in treatment centres, harm reduction sites, and prison programs to gain the skills and competencies necessary to become self-sufficient, active citizens (Fischer et al. 2004). Aligned with the redeemable subject, those in conflict with the law are positioned as clients when they are characterized as damaged individuals in need, rather than inherently deviant and irredeemable (Donohue & Moore 2009; Moore 2007).

Donohue and Moore (2009) note that managerialism and consumerism are under-theorized. It is unclear how subjugated individuals can be imbued with the features of a consumer – that is free and empowered – within oppressive regimes such as the prison, mental hospital, or I argue, the homeless community. I explore this question throughout this chapter. For now, it is clear that in order to orient some members of the underclass as clients, it is imperative that they accept their pathologization and the individualization of their problems in living (Szasz 1989). As described in chapter seven, in order to be empowered to work on the project of the self, individuals must recognize the personal failings that led to their exclusion (Cruikshank

1999; Hannah-Moffat 2000b). The narrow focus on individual problems and the pathologization of social conditions, such as poverty, fits well within a consumerist ethos that is concerned with maximizing personal gain. It is difficult to imagine consumable products aimed at alleviating unequal and unfair wage distribution (Heathcote, Perri & Violante 2010), reducing the explosive rate of young Black men and First Nations, Métis, and Inuit peoples in American and Canadian prisons respectively (Brunson & Miller 2006; Martel, Brassard & Jaccoud 2011; OCI 2012) and eliminating gender-based violence (Johnson & Dawson 2011); but it is easy to create products and programs that target impulse control problems, dependency issues, and irrational cognitive patterns. To be considered a client of the social welfare, mental health, or criminal justice systems an individual must be prepared to accept their personal failings in order to consume the available remedies.

The critical criminological and mad movement literatures emphasize that clients undertake a ‘moral enterprise’ that requires them to work towards a healthier lifestyle (see chapter seven) and align themselves with the characteristics of good neo-liberal citizens (Fischer et al. 2004). Situating oneself as a consumer of treatment and services can be seemingly positive and empowering; as a consumer an individual can assess her needs and choose among the services offered for what best suits her (Donohue & Moore 2009; Prior 2011). Of course, having the choice of programs is a privilege that has to be earned (Cook & Jonikas 2002) once the individual successfully positions herself as redeemable (that is, demonstrates a willingness to adopt normative ways of being). It also assumes that there are multiple products to choose from.¹²³ For those taken up by the criminal justice and/or mental health systems, there is a constant threat that their freedom of choice will be withdrawn if they fail to make ‘appropriate’

¹²³ Many facilities, especially provincial prisons, have a dearth of programming (Dodge & McIntosh 2014).

choices. Donohue and Moore find (2009) that in the criminal justice system the very notion of ‘client subjectivity’ recruits individuals to participate in their own punishment and correction. The same can be said of the mental health system where compliance with treatment plans, primarily medication regimes, is required to be discharged from the hospital or to maintain access to services (Fabris 2006; Kilty 2012a; O’Reilly 2004). The consumer model, when applied to marginalized groups, uses the obligations of freedom (Rose 1999) to manipulate and ultimately forgo the notion of choice.

Mad scholars argue that when subjugated individuals are brought into a system that is built on the dominant discourses of elite professionals, consumer choice is often relegated to tokenism rather than effectively working to transform the mental health system (Fabris 2013;). Moreover, the consumer discourse veils the coerciveness of social control institutions and re-imagines disciplinary tactics as a matter of choice (Burstow 2013). To practice consumerism is to engage in choice-making, a quality that is not found among mental health consumers or prisoners as clients. As Donohue and Moore (2009: 329) write: “The notion that people in conflict with the law have choice or empowerment or agency afforded to them by the State is perhaps one of the greatest (if not most effective) mythologies of contemporary punishment”. Prisoners and those identified as mentally ill may have some choice in which services they use, but it is often mandatory that they work on the project of the self in some sort of formal, expert-driven, and normalized capacity (Bauman 1998). In this way, the homeless consumer presents slightly differently than the client in the criminal justice system or the mental patient. As I will explore, there is strong incentive to participate in treatment programs and connect with mental health services but because homeless shelters act as neo-liberal total institutions (see chapter five) many of the overtly coercive elements found in prisons and mental hospitals are masked in

the homeless community through empowerment rhetoric (Cruikshank 1999; Moore & Hannah-Moffat 2005). Most homeless individuals are not *required* to participate in any programming, and many interviewees, such as Seamus, Lenny, Matilda, and Al, assert that freedom. However, as I will explore in the final section of this chapter, failure to take responsibility for one's situation and self-discipline may result in being cast as irredeemable.

Crook and Wood (2014: 62) argue that those on the margins are not consumers: "Because they can't be true consumers they have little incentive to try to be consumers at all". Bauman's (1998, 2007) concept of the 'flawed consumer' and the problematic use of the consumer/client paradigm in coercive settings such as the prison and the mental hospital support this claim. Still, I argue that in the homeless community, the notion of the flawed consumer plays out differently. Rather than resist consumer culture, many homeless men and women attempt to practice consumerism by positioning themselves as clients of the mental health system. Many homeless people have the freedom to choose if and how they manage their pathologies, but in order to be considered redeemable and reap the rewards of that status they must adopt individualized and medicalized explanations for their homelessness and its treatment. As I explore in the next section, the goal of the homeless mental health consumer is ultimately to escape exclusion and gain acceptance into mainstream society.

Aiming for inclusion

Many (although not all) participants sought inclusion, with some taking steps to demonstrate their adherence to the normalizing qualities of the included society. In this section I argue that many homeless individuals use the mental health system as one of the key avenues to perform the redeemable status. These methods are founded upon a sense of hope that with persistence they will achieve their goal for inclusion.

Becoming a better person: Performing the homeless mental health consumer role

The driving goal for many individuals experiencing homelessness is to escape marginalization and become an included member of society. The precipice for inclusion is that the homeless target for reform their individual biography, personal flaws, and lack of skills as the sources of their exclusion (Hannah-Moffat 2000b; Lyon-Callo 2000, 2004). The individualization of problems in living is reinforced by the services offered in the homeless community, such as mental health treatment (almost exclusively medication), addiction treatment (largely group therapy and some in-patient treatment centres, one-on-one counselling), and CBT such as anger management programming, to the detriment of energies focused on wealth redistribution, reducing the vacancy rate,¹²⁴ or increasing the affordable housing stock (Gaetz, Gulliver & Richter 2014; Layton 2000; Lyon-Callo 2004) . In order to be accepted into the included circuit, a number of interviewees emphasized the importance of working on the project of the self. Many had visions of what it meant to be a better version of themselves and importantly, that becoming the new-and-improved self would lead to inclusion. Mick explained:

Like I look at a bigger picture... so that I know that ok, whatever I have to do now is really key... I'll learn to have fun again, and you know, meet somebody, get in another relationship, have a, um, a normal life, and... But I know I have to be healthy to do that... you know then I can grow, grow and be a better person and a better friend and a partner and a, and a worker, and a father, and a brother, and a son, you know. I'll be better at those things. I'll be healthier, so that's a lifelong journey... I'm doing better. And that's, that's the other thing is that I measure, I measure my progress, or I measure my... yeah, I measure my progress and, and, and, and, and as long, I don't care how small the increment is, as long as it's, I'm better now than I was yesterday.

Mick was ecstatic that he was starting to find order and peace in his life. Based on programs that tout inclusive ideals, he believes that this self-improvement will inevitably lead to inclusion.

¹²⁴ The vacancy rate for a one bedroom apartment in Ottawa is 2.6 percent. The Canadian average is 2.8 percent (CMHC 2014). A low vacancy rate usually indicates higher and thus less affordable rental prices because of the high demand.

Mick stated that the effort he puts into his project of the self is part of a “bigger picture”, one that he identifies as becoming “normal” and being reintegrated into the community through his personal relationships. The obligations of freedom that are necessary for inclusion require that an individual behave civilly, engage in self-surveillance, and make responsible choices (Cruikshank 1993, 1999; Rose 1999). He works on himself primarily through mental health and addiction treatment. At the time of the interview Mick attended several group therapy sessions each week (AA, NA, the out-patient treatment program run by the shelter, and The Men’s Project) and was having his PTSD, OCD, social phobia and ADD diagnoses reassessed by a psychiatrist.

By noting “that’s a lifelong journey” Mick reiterates the commonly held discourse that self-actualization can never truly be achieved and that the project of the self is permanently ongoing (Rimke 2000; Rose 1999). That being said, Mick and others do aspire to a time when, as included citizens, they can work on themselves independently from the direct supervision of psy experts and para-professionals. The self as an unfinished project suits the consumer society where perpetual dissatisfaction is necessary for continual consumption (Bauman 2007). The proliferation of the self-help/self-improvement industry, from literature to meditation retreats (Rimke 2000), exemplifies the symbiotic relationship between self-regulative techniques and consumerism. In the case of individuals living in the homeless community, their consumptive habits are geared towards publicly funded mental health resources – specifically medication.

In order to position themselves as moving towards inclusion, many research participants sought out mental health services. This trajectory is in contrast to the critical discourse that the mental health system is a coercive and oppressive method of social control that is used against peoples’ will (Wynn 2006). The system can and does invoke coercive strategies, as evidenced through involuntary hospitalization and CTOs to enforce medication compliance. However, for

those seeking a path to inclusion, the mental health system is regarded as a tool for self-improvement, accountability, and normalization through their position as homeless mental health consumers. Similar to Donohue and Moore's (2009) argument that prisoners are participants in their own punishment, some homeless men and women actively seek to engage with the control strategies offered by the mental health system that inevitably lead to stricter disciplinary controls. Perhaps the voluntary acceptance of the mentally ill identity can be explained in part because as long as the homeless individual is regarded as redeemable, management techniques are conceptualized as voluntary, which demonstrates an important distinction between the prisoner and homeless subjectivities.¹²⁵

Diagnosis as entrée into mental health consumption

Obtaining a mental illness diagnosis is a popular (although not always necessary)¹²⁶ method for becoming a mental health consumer. Many interviewees were passive recipients of mental illness diagnoses throughout their moral career as a mental health patient (Goffman 1961). Participants were diagnosed by general practitioners (Julien), addiction specialists (Mac, Otto, Mick), and psychiatrists visiting the homeless shelter (Toby, Jamie, Ronan). Some were diagnosed as children (Chico, Courtney, Gaston), in hospital after suicide attempts (Max, Doug, Giles, Mustang), and while incarcerated (Lenny, Shadow). Still, some individuals actively sought a diagnosis as a way to participate in mental health consumerism. Milan pursued a mental health

¹²⁵ Donohue and Moore (2009: 320) explain how the prisoner and the homeless individual can be constituted differently, despite the significant overlap in the populations: "We are careful here not to see offenders and clients as different people. Instead, we follow Foucault (1977), to see these characters as different subjectivities who exist in the same body and whose expressions are dependent on the relationships, locations and actions of the individual".

¹²⁶ Some mental health nurses and general practitioners do not require a formal diagnosis to prescribe psychotropic medication. Moreover, some programs do not require a diagnosis in order to access their services, such as CMHA. Anecdotally, however, I have not met a CMHA 'client' who does not have a diagnosis, suggesting that the demand for services is so high that those with diagnoses are prioritized as 'in need' or because once someone becomes a client, the case worker's first task is to get them a mental health assessment. I suspect that both of these scenarios occur regularly.

assessment so that he could ‘fix’ the personal flaws that he identified as leading to his exclusion: “I’m just happy that I know that, you know, I have a name I can put on and I can use medicine or exercise and I just want to move forward, just, not knowing what’s wrong with your head is the worst, is the worst part”.¹²⁷ Milan was diagnosed with bipolar disorder four months prior to the interview. He saw a diagnosis as the first step to becoming a homeless mental health consumer. Because he was looking to pursue post-secondary education he felt he needed a diagnosis to adequately perform:

I had a miniature depression two years ago and I still didn’t go see the doctor, I just left for a couple of months but this time it’s because I was in school and it affected my school work so, and my interest went spinning with too many, thousand miles an hour, and it was affecting my school so I went to see a mental, uh, health nurse, and uh, she referred me to a, uh, psychiatric doctor and uh, they diagnosed me with bi-polar.

Given his father’s emphasis on education, Milan wholeheartedly believes that a university degree is the key to escaping exclusion. Milan joins the growing number of students who use psychotropic medication to create an advantage in a highly competitive education environment (Vrecko 2015). Milan differs from his classroom peers in that he uses his prescription mood stabilizers and anti-depressants as a way to gain entrée into and keep up with the included circuit, rather than be a frontrunner. By identifying his exclusion as the result of mental illness (Feldman 2004; Lyon-Callo 2004) Milan must act responsibly by adopting the homeless mental health consumer role and working on his project of the self.

Not everyone is keen to pursue a mental illness diagnosis. Christine offers one such example. After being referred to a psychiatrist by a shelter counsellor she was diagnosed with OCD. She did not accept the diagnosis and did not feel that the psychiatrist was truly interested

¹²⁷ See Frigon & Duhamel (2006) for an analysis of the varying perceptions of receiving a mental illness diagnosis, including an acknowledgement that for some, a diagnosis acts as an explanatory tool that provides emotional relief.

in helping her resolve the issues she identified as leading to her incarceration and homelessness (drug addiction, an abusive relationship, and her brother's suicide): "I told her, I said that, go to walk in my shoes for one week and uh, instead of reading that book there, like can you, you know, you're probably born with a silver spoon in your mouth... I said, walk a week in my shoes and then come talk to me, you know?" Christine calls out the psychiatrist's class privilege (Magnus & Mick 2000) to reorient the doctor/patient power dynamics (Foucault 1980a) and subsequently dismisses the diagnosis and medication offered. Instead, Christine accesses Clonazepam¹²⁸ on the street, a drug she was prescribed when she was twelve years old and has since been found to be addictive. Christine's limited use of the mental health system can be characterized as a transgression (Bosworth & Carrabine 2001; Pickett 1996) where she discounts the sane/insane binary and uses the mental health system in a way that suits her needs. Christine rejected the OCD diagnosis but wanted to find a mental health worker and one-on-one counselling. She intended to use these services as a way to develop a relationship with a confidante¹²⁹ rather than simply accepting a medicalized understanding of her homelessness. Christine embodies the client role by choosing how and what aspects of the mental health system she employs. At the same time Christine's situation highlights the paucity of support systems available in the homeless community that exist outside of the mental health and addiction systems. This, along with her inability to access the medication of her choice, reveals the limitations of what it means to be a homeless mental health consumer.

¹²⁸ Clonazepam is a benzodiazepine used to treat anxiety and panic disorders.

¹²⁹ Christine's strategy for finding someone to open up to sheds light on the isolation felt by many homeless individuals (Rokach 2005).

Hope at the bottom of a pill bottle

In order to position herself as a homeless mental health consumer one must, of course, consume something. If citizenship in the late modern era is concomitant with participating in the economic market (Bauman 2007; Rose 1999), those striving for inclusion must use up appropriate goods and services that have monetary worth. Because most homeless men and women do not have the financial capital to participate meaningfully in the market, I argue they are able to act out the consumer role by using publicly funded resources, thus fuelling the homeless sheltering industry and psy-complex. Welfarist programming is antithetical to the neo-liberal capitalist system that decries public intervention in the market, so homeless mental health consumers must consume public products that demonstrate their redeemability and movement towards inclusion to counteract longstanding criticisms that they are permanently dependent on good consuming citizens (Gounis 1992; Misra, Moller & Karides 2003) and are not 'enemies' of the inclusive consuming society (Bauman 1998; Reith 2004). If the homeless mental health consumer can demonstrate her dedication to responsabilized and normalized ways of being, using public resources can be considered an investment in the consumerist project.

A few of the interviewees remarked on what it means to be a 'client' of a shelter.

Referencing the power imbalance between staff and residents discussed in chapter five, Seamus contended:

Um, and I hate to say it but bottom line is, you know, they're getting paid to serve us. Really. And, and they act the other way, like they're doing us a service. Which, I, I, it's kinda of a, again, another huge grey area. They are doing this huge, huge service but it's not them personally it's [shelter one] doing us a *huge* service, a huge service. But these guys take it upon themselves and, and they seem to feel that they're doing it personally as a, you know, you know, if it wasn't for us where would you guys be?

Like all programs, the homeless sheltering industry (Lyon-Callo 2000, 2004) requires people to fill its beds and register for its programs in order to receive funding.¹³⁰ Seamus reframes the homeless person's position as necessary for the continued employment of shelter staff. In this way, the homeless person is a client whom the industry must solicit to remain viable (for example, the city requires statistics on the number of individuals staying in a shelter each night and many grants require programs to demonstrate their effectiveness/output in order to renew funding). By asserting that "they're getting paid to serve us" Seamus resists the dominant discourse (Castel 1988; O'Malley 2001; O'Malley, Weir & Shearing 1997) of marginalized people as passive recipients of welfarist assistance and reorients the homeless as clients of the homeless industry.

The most common form of consumption in the mental health system is psychotropic medication. As outlined in chapter two, the pathologization of homelessness (Bresson 2003; Christensen 2009; Davis 2006; Sullivan, Burnam & Koegel 2000) comes with the widespread use of psychopharmaceuticals in the homeless community as well as the public at large (Sajatovic et al. 2013).¹³¹ Kathy, a public health nurse, acknowledged that she "definitely get[s] labelled like Seroquel Queen"¹³² for using medication as the sole method of treatment, noting:

¹³⁰ Most funding for Ottawa's shelters comes from the city. They also receive grants and program-specific funding from other public agencies and private corporations. Organizations that serve homeless people, such as CMHA and community health centres, are generally funded through multiple levels of government.

¹³¹ An abundance of research demonstrates the widespread use psychotropic medication in the prison system, particularly among women prisoners (Kilty 2008, 2012a; Maidment 2006; Pollack 2005). While there is scant literature on the number of homeless individuals with a prescription for antipsychotic medication, the overlap between the homeless and prison populations (Fischer et al. 2008), the plethora of research on the subject of medication non-compliance among the homeless (Bradford et al. 2005; Dixon et al. 1997; Muir-Cochrane et al. 2006), and the fact that seventy-three percent of this research sample had experience with psychotropic medication allows us to infer a high proportion of psychotropic medication prescriptions in the homeless community.

¹³² Seroquel is an antipsychotic often used to treat bi-polar disorder. Kilty (2008, 2012a) found that Seroquel is the latest drug of choice in Canada's correctional system. All of the women in her sample were prescribed Seroquel or its predecessor, Valium, while incarcerated. Kilty accounts for the over-prescription of Seroquel in prisons because its sedative effects render the population more docile (Foucault 1977) and manageable.

“...My job is primarily to see people, assess if there’s any mental health issues, if they’re agreeable, and if necessary help them start on medication. I monitor them, try to treat with medication. So I don’t do counselling”. Medication is the first and almost always the only response to distress in the homeless community.

Still, many of the research participants spoke very positively about their experiences with medication. Julien, for example is hopeful that with the right medication he can build a new life: “there’s always hope and there’s better days coming”. Julien’s narratives speaks to Rose’s (2007: 135) conception of hope as “our gaze to the horizon”, noting that hope for a better future is fuelled by the choices and behaviours we make today. By taking his medication consistently, subjecting himself to mental health assessments and reassessments, and supplanting his medication regime with out-patient addiction treatment programs, Julien maintains a positive outlook on his future, believing that by acting responsibly he will one day gain the privilege of acting as an independent consumer.

Echoing Julien, Mac never misses a dose of his cocktail of Effexor¹³³, Seroquel and methadone treatment to help him keep his composure:

Um, they, they help with violence, um, they keep me calm. Um, they help with depression ’cause I, I do, I still do suffer, uh... they help, uh, so that I can, uh, stay washed and clean, and get up out of bed. And uh, help me to look after myself. And... so, like I’m doing well... on them, as opposed to when I wasn’t on them and I was, uh, lost.

Mac finds that the medication allows him to gain some self-control (Rose 1999). He explains that medication helps him fulfill the obligations of daily life, such as maintaining basic hygiene. Mac sees his efforts towards sobriety and mental well-being as his job in order to become an inclusive citizen. Remarking on the in-patient addiction treatment where he was diagnosed with PTSD,

¹³³ Effexor is a selective serotonin and norepinephrine reuptake inhibitor (SSNRI) used to treat depression and anxiety.

depression and anxiety, Mac described his recovery efforts as work: “It was really hard actually, and uh, I worked thirteen hours a day on myself... My counsellor was on afternoons so when he would start at three o’clock, I continued to... work ’til eleven o’clock at night so, I was basically working twelve hours a day”. Mac likens the time he spent writing his life story¹³⁴ and participating in group and one-on-one therapy to the kind of paid work practiced by the included circuit, taking literally Goffman’s notion of the moral ‘career’ of the mental patient. By noting “I worked thirteen hours a day on myself” Mac positions his self as an object to evaluate, discipline and judge (Cruikshank 1999; Foucault 1977; Rimke 2000; Vaz & Bruno 2003) under the guidance of psy-experts and para-professionals. Mac’s narrative exemplifies Rimke’s (2000) assertion that the self is simultaneously an object of knowledge and a subject of governance. Mac’s self is a product of the recovery industry¹³⁵ (Crook & Wood 2014; McCulloch & McNeill 2007), one that he has a hand in creating, while simultaneously acting as a client of the mental health system¹³⁶, consuming medication and treatment programs with the aim of bettering himself.

Mac’s moral career, like so many other participants, involves a combination of addiction and mental health services that formulate a complex web of treatment and social control strategies that have been explored by critical scholars (Arrigo 2004; Cohen 1985; Garland 2001; Hannah-Moffat & Yule 2011; Ingleby 1985; Kilty 2011; Moore 2007). Only Giles had access to mental health specific group therapy and Mac, Courtney and Katie attended a concurrent

¹³⁴ Mac notes that his counsellor had him re-write his life story multiple times saying “it’s not right”, in keeping with Maruna and Ramsden’s (2004) conception of narrative reconstruction as shame management.

¹³⁵ Travis (2009) finds that the recovery industry can be divided into three groups: those spiritually focused, non-commercialized twelve-step programmes; professional therapeutic entities such as counsellors and treatment centres; and ‘post-twelve-step’ groups made up of grassroots movements and are often more politically oriented.

¹³⁶ Although Mac’s programming concerns his addiction rather than his mental illness diagnoses, given that the in-patient addiction treatment is run by and out of the ROH it is clear that for Mac, his addiction and mental health treatments are part and parcel to one another.

disorders group run by CMHA and the ROH. Instead, mental health treatment beyond medication consists primarily of crisis counselling run out of drop-in centres, conversations with case managers in a shelter, and most commonly, discussions of mental health in addiction treatment programs.¹³⁷ Indeed, as noted above, some individuals received mental illness diagnoses from addiction specialists. Research participants spoke often of learning about PTSD, anxiety, and ADHD in out-patient addiction treatment programs run by the shelters. The tools they were taught to cope with addiction, such as mindfulness and emotional control are understood by participants to be useful for managing mental distress.

Consuming medication and acting as clients of the services offered in the homeless community provides homeless men and women with the tools to act out the consumer role and thus to display their potential for inclusion. Despite the prospect of inclusion that is offered by many of these resources, the reality is that few chronically homeless people escape marginality and are accepted into the included circuit. In the next section I consider what it means to be a homeless mental health consumer and how redeemability acts as the threshold of inclusion.

Redeemable but never redeemed: The reality of the homeless mental health consumer

Despite its footing within a political economy of hope, the reality for many homeless mental health consumers is that inclusion in mainstream society remains elusive. In this section I account for how the redeemable status plays out in the homeless community and consider the reasons why some individuals accept the limits of being always already redeemable but not redeemed.

¹³⁷ Although other mental health programmes, such as ACT teams exist in Ottawa (Farrell 2005), none of the participants in this research project indicated that they had ever accessed these treatment methods.

“Just like prostitutes”: Critically assessing the mental health consumer role

The mental health and treatment services in the homeless community play into the political economy of hope (Novas 2006; Rose & Novas 2005). Many of the research participants in this project spoke very positively about their choice to access the mental health system, take psychotropic medication and their prospects for future inclusion. Like Gabor Maté's (1999, 2008) contention that creating an 'enriched environment' and learning to 'self-parent' can rewire the brain to help the individual make healthy and safe choices, many homeless individuals internalize the hopeful future professed by the psy-complex and recovery industry. Nevertheless, not all interviewees were optimistic about the outcomes of identifying as a homeless mental health consumer. Otto, for example, was acutely aware of how positioning himself as a client of the mental health and addiction systems benefits the recovery industry more than himself:

I always thought ADHD was one more little catch phrase or excuse to sell drugs by pharmaceutical companies. Um, I think that in large part, despite, I'm taking aside all they've done for people, addictions programs, addictions services are largely, um, self-serving. It is, you know, why, they, I mean I know that for example at [the out-patient addiction treatment program], as much as I've gotten out of it and as much as I appreciate it, uh, putting that aside, I, I think that in large part, if, if it didn't generate money for these people, for example, and I'm not saying that [shelter one] is a for profit giant, but they make a decent salary, they make salary I would be very happy to have in, in, life and you know, stuff like that, and it, it's almost, uh, it's almost a self-perpetuating need. All of a sudden, you know, you're, you've decided to admit you're an alcoholic or a drug user, whatever the case, started going to these programs, well one common theme throughout every AA, NA, day program, is that you're always going to have to come back, or you're going to be sick. Now some people will go so far as to say, oh you might be able to make it on your own but I doubt it, kind of [laugh]. I mean, it's sorta like, you know like, now that you're in, now that you're in you've gotta stay in or you're just gonna not get better. It's things like that and, uh, so I've had this sort of sub-conscious mental battle against help for that reason I guess.

Otto makes several important remarks in this excerpt. First, we must note Otto's conflation of mental health and addiction, where he conceives of his recent interest in his ADHD diagnosis (meeting with a mental health specialist at a community health centre, contemplating taking

psychopharmaceuticals) and what he's learned about ADHD in the out-patient addiction treatment program that he attends for his drinking, as part of an indistinguishable continuum of care (Wong, Park & Nemon 2006) offered in the homeless community.

Second, Otto takes a critical stance on what Mick described as the "lifelong journey" towards wellness. For Otto, the permanency of the mental illness and addiction identities is a strategic, economically motivated discourse propagated by the recovery industry (Travis 2009) to ensure an unending supply of clientele. The addict subjectivity, in particular, reinforces the notion that "you're always going to have to come back, or you're going to be sick" by situating the addict as essentially different than those who can consume alcohol, gamble, shop, or use some recreational drugs 'normally' (Reith 2004). Although Otto resists the 'everyday discourses' (O'Malley, Weir & Shearing 1997) of addiction, his recent interest in mental health and addiction resources serves as an example of the limited options for support offered in the homeless community. Otto's goal to be stable by the time his daughter turns eighteen is laudable but the only goods and services that Otto can consume in an attempt to fulfil this goal are publicly funded resources built on a pathologized understanding of homelessness.

It is troubling that Otto's limited options for consumption leave him compelled to use services that he is critical of because, true to his analysis, the permanency of adopting the mental health consumer role is juxtaposed with the political economy of hope upon which these programs are built. In our consumer society, one's consumptive practices are meant to give individuals the freedom to create and recreate a fluid sense of self (Bauman 2007; Gergen 2000; Giddens 1991; Rose 1999; Roseneil & Seymour 1999). The flexibility of the late modern self is contrasted with the pathologized identity: "This is an identification with an essential identity that is stable and unchanging; based on an incurable disease and defined by a complete and

irreversible loss of control” (Reith 2004: 293).¹³⁸ Adopting the homeless mental health consumer role creates the impression that the person accepts the rigid conceptions of this identity and the individualized explanations for their exclusion. As Moore and Hirai (2014) note, responsabilization strategies may in fact lead to further marginalization. If the mental health consumer is a static identity that entails an acceptance of one’s permanent inability for self-control (i.e. the assertion made by many interviewees that they accept that they will have to take psychotropic medication for the rest of their lives and those who adopt AA’s premise that addiction is a lifelong demon requiring constant vigilance), then the standards of inclusion are unattainable – namely normalization (including appropriate consumptive practices) and self-governance (Horsell 2006; Rose 2000; Young 1999). Although Otto discursively problematizes the recovery industry, his consumption of its services renders his goal for inclusion moot.

Like Otto, Lenny actively resists the mental health system. Although he was diagnosed with anxiety while incarcerated, he does not perform the mental health consumer role (i.e. he does not take medication or participate in programming) because he believes that the recovery industry is strictly interested in social control:

People that are going mental, you know, mostly due to the fact that they pump, pump drugs by the friggin’ pharmaceutical industry and um, I think basically that’s all the recovery industry is doing too, with all their psychology. They’re basically just trying to give them all pills. No you’re, you’re not taking care of them. We can all become healthy. Stop perpetuating this bullshit on people. They don’t need to know about [small pause] They don’t need all their emotions drawn into a thing and, and being told how, how they should *act* or how they should walk through this, you know? They’re being, they need to be given compassion. I see, I see psychology and psychiatry as, um, nothing more than a just a level of prostitution. You know we go to those people, we pay these people... to be loved. Just like prostitutes do, you know. Let’s pay them for some physical love. Let’s pay them for some mental love.

¹³⁸ Reith refers to the addict subjectivity but her analysis can also be extrapolated to the mentally ill identity.

Lenny rejects the discourse that mental health interventions lead to inclusion. Instead, he articulated what critical scholars note is the appropriation of techniques of support, healing and empowerment, for greater managerialism and social control (Hannah-Moffat 2000a; Kendall 2000; Kilty 2012a; Pollack 2005, 2009). Lenny criticizes the mental health system as it exists in the homeless community for situating itself within a political economy of hope, and is skeptical that “we can all become healthy. Stop perpetuating this bullshit on people”. Lenny views the mental health system as manipulative because it professes benevolence and compassion (Moore 2011) but its latent goal is to act as a system of social control by creating docile bodies (Foucault 1977), dictating “how they should act or how they should walk”. For Lenny the mental health system is designed to normalize, discipline and conduct surveillance, not create a space for individual freedom tantamount to inclusion.

By comparing the psy-disciplines to prostitution¹³⁹, Lenny positions mental health consumers as clients but rejects the discourse that they are empowered to choose the goods and services that will help them achieve self-actualization. Lenny’s comment that clients are paying for “physical love” and “mental love” infers that psy-experts are insincere in their demonstrations of care and compassion and will not provide meaningful assistance. Just as sex trade workers often feign sexual interest in their clients (Sanders 2005, 2008) Lenny suggests that psy-professionals appear to have a benevolent interest in clothing, feeding, and helping the poor escape exclusion but are in fact looking to “pump drugs” into the homeless community as a way to sedate the excluded and propel Big Pharma (Frances 2013). His contention that psy-professionals are little more than spokespeople for the pharmaceutical industry was a common

¹³⁹ Lenny’s use of the term ‘prostitution’ connotes sex work as an inherently negative, disreputable and deviant occupation and identity marker. Valuable research by Bruckert (2012; Bruckert & Frigon 2003) and others (Bernstein 2007; Sanders 2005), along with advocacy/activist groups such as POWER and Stella aim to break down the stigma associated with labour practices involving the skin trades.

theme among disenchanting homeless mental health consumers. A fundamental quality of the consumer is that they are active, empowered citizens who are able to choose what to consume in order to fulfil their desires (Bauman 1998, 2007); on the contrary, the role of the homeless mental health consumer is restricted and mediated by psy-experts and para-professionals.

The voiceless consumer

Most psychiatric survivors are skeptical of mental health consumers' inclusion at the organizational and policy levels and as equal partners with medical professionals in their mental health care (Crossley & Crossley 2001; Fabris 2013). Many research participants expressed this same disenchantment with the system that was meant to lead to their inclusion. While many homeless men and women began their mental health career with hope and optimism, the reality that they are not 'real' consumers with the autonomy to choose what, how, and when to consume mental health care left them feeling disappointed and defeated. Max described his experience with the mental health system as feeling invisible:

They don't listen... There's a lot of great doctors out there that do but I, I've just met so many that... I was at the Royal Ottawa. Very nice gentleman and I was there with my worker and sitting like this in a room having a really bad time, that's why they called him in, and just, and, all he wanted was my file, my file, my file. He kept telling my worker my file. And I felt, I just wanted to grab him and say talk to me! You know, talk to me. I know there's information in the file that can be useful, but, you know, I get that, but, as a guy I have respect for what intelligence he has, but sometimes I think they forget, you know, I'm not just your, your appointment, or a body, you know, I'm listening but, you know, like I just, I felt like getting up and walking out.

Max articulated his sense of objectification and disembodiment in the hands of a disciplinary system that was looking to manage him through an assessment of his file (Foucault 1977; Jones 2000; Kilty 2012a)¹⁴⁰ rather than respond to his own perceived needs. The principles of self-determination, empowerment, individual biography/narrative, and recovery, recognized as the

¹⁴⁰ See chapter five for a discussion of the mentally ill homeless person as a case file.

pillars of person-centered mental health care by the mad movement (Burstow 2004; Chamberlin 1990; Crossley & Crossley 2001; McLean 1995, 2000), are absent from Max's interaction with the psy-expert. Moreover, his CMHA worker, who is meant to act as an advocate and support person, did not intervene on his behalf at a time when Max was in deep distress and unable to assert himself. Max's personhood is ignored in his interaction with the mental health system and he is relegated to the sum of his file.

Max attributed his voicelessness to his position as a 'flawed' consumer (Bauman 1998). He has attended multiple in-patient treatment programs for both mental health and addiction over his career, one of which was a private, for-profit treatment centre. Max ascribes the level of care and importantly, attention to his wishes, to his status as a 'true' consumer:

That was one of the things, I, I found... that the better places that cost money, they do listen. And maybe it's because they're paid [laughs]. I don't know why, but they do seem to listen to you a little more. And I understand if you, you're, like [a doctor at the ROH] doesn't have the time of some private doctor that I'm paying, 'cause he's trying to see forty addicts a day.

When the mental health client has the financial freedom to choose among a variety of treatment options, a range of top-tier mental health services are available that concentrate on fulfilling the client's desires (Bauman 2001b) to win business. The public mental health system, like the overall national health care crisis (Asanin & Wilson 2008), must contend with a demand that it does not have the resources to meet, resulting in a lack of personal attention (Cobb 2015).¹⁴¹ But Max's comments speak to something more problematic than simply feeling rushed in the doctor's office. Systematically, mental health care is available to those who can participate as

¹⁴¹ The lack of mental health resources in the correctional system especially is alarming. OCDC has a waiting list of over one hundred people to see the staff psychologist (NUPGE 2013).

consumers. For ‘flawed’ consumers who are simply playing the part of the client in a publicly funded setting, their status as citizens (Rose 1999) and indeed as people, is compromised.

The absence of voice was most sharply felt with regards to psychotropic medication. Interviewees commonly remarked on psy-professionals as “pill pushers” who are simply interested in medicating, rather than helping, those in distress. But even when homeless mental health consumers were interested in pursuing medication their voices were still silenced (Castel 1988). Like Christine’s narrative above, Max and Wanda asked psy-professionals for Clonazepam to help cope with their anxiety because they had positive experiences with the drug in the past; however, each was refused their drug of choice because of its addictive properties:

Wanda: No, she won’t [prescribe Clonazepam]. Because it’s addictive but it’s not to me... No, they won’t give it out. And yet I admit, and I wouldn’t admit this so you know I’m on there, um, uh, there’s this girl around here that sell pills and I don’t like that. I’m not a pill pusher but I asked one of the girls before she moved if she had her Clonazepam and it would calm you right down. I didn’t... but I mean you’re talking a good forty bucks for two or three.

Max: Because it’s addictive. Again, that’s makes me angry with doctors. Like, you know, it shows arrogance, you know? I know it’s addictive, I’ve spent my life addicted to drugs, I know I’ll have to take it every day for the rest of my life and probably have it filled up... I know these things. It should be my choice at some point, you know?

Both interviewees take a unique perspective on their inability to attain their medication of choice. Wanda was frustrated with her lack of physical and mental health care because she does not have a family doctor with whom to build rapport and who may then prescribe her the medication she deems necessary to cope with her anxiety. Although obviously ashamed (Nussbaum 2006), Wanda considered buying Clonazepam on the street as a way to manage her distress herself, but the high cost of street drugs and her absolute poverty make this option unviable. Once again the lack of financial capital reinforces the homeless as flawed rather than ‘true’ consumers.

Unlike Christine and Wanda who claim that their past experience with Clonazepam did not result in addiction, Max takes a different approach stating, “I know it’s addictive” but citing his expert knowledge as a long-time addict argues “it should be my choice at some point”. Max’s statement represents the subjugation of the homeless mental health consumer’s experiential knowledge. Kathy, a mental health nurse who prescribes psychotropic medication on a regular basis, addressed the issue of not fulfilling her clients’ requests:

We don’t prescribe benzos¹⁴² because of their addictive nature and it’s not best practice. So that’s what I say it’s not best practice, we’re not doing that... Like they’ll come in and they’re like, I need to be on Celexa, which is an anti-depressant and I’m like, you’re not looking depressed at all. And they’re like I’ve been on anti-depressants since I was eighteen and I need to be, but you know they’re using, they’re all over the place and you kind of think, I think you need more mood stabilizers, so we have that discussion.

Although not privy to Kathy’s conversations in particular, comments from research participants leave us wondering how open minded these “discussions” are. The opinions of those experiencing distress are subjugated by dominant psy-knowledge. As Foucault (1980a: 82) describes, subjugated knowledges are “...a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity”. The insights of those with lived experience of anxiety and addiction are minimized by psy-discourses that claim a superior understanding of how to manage distress. Kathy’s comment that “but you know they’re using, they’re all over the place” reinforces the mentally ill and addict identities as irrevocably out of control (Reith 2004), which situates the individual as unable to make ‘good’ decisions about their care. The homeless mental health consumer will rarely qualify as a full-fledged included consumer, even if she gains the financial means, because she cannot adopt the self-regulative

¹⁴² Benzodiazepine is a drug classification referring to tranquilizers that are most often prescribed for anxiety. Clonazepam is a benzodiazepine.

qualities associated with appropriate consumption (Bauman 2007; Rose 2000). Dominant psychologies constitute what normalized, self-governance looks like and while the homeless may be able to exhibit some responsabilized qualities, such as complying with their medication regime, participating in programming, and checking in with professionals and para-professionals, they are constituted as permanently unable to engage in self-control without professional surveillance. Given the disappointing reality of the homeless mental health consumer subjectivity we must consider why some individuals continue to perform the consumer role.

Inclusion among the excluded

In chapter three I described in detail how the social junk/redeemable subject is constituted (Spitzer 1975; Rose 2000, 2002). Homeless men and women identified as redeemable by experts, para-professionals and staff are considered to be a 'semi-permanent, quasi-criminal population' who often interact with disciplinary regimes such as the criminal justice system, but who are generally expected to take on the responsabilization and empowerment strategies offered in the homeless community (Cruikshank 1999; Rose 1999; Young 1999). The majority of the research participants in this project are likely considered 'redeemable'. Although eighty-four percent (32/38) of interviewees had some experience with the criminal justice system, with eighteen percent (7/38) identifying as having spent time in a federal institution, their considerable length of time out of prison distinguishes them from the 'monsters' (Garland 2001), 'impossibles' (Spitzer 1975), and the irredeemable (Rose 2000) who are beyond hope. In order for homeless men and women to gain and maintain redeemable status, they must accept the individualization of their problems in living and demonstrate their willingness to work on their project of the self (Cruikshank 1996, 1999; Rose 1998, 1999, 2000). These practices are described throughout this project, by showing deference to authority figures; adopting the

homeless/mentally ill/addict identities; accepting responsibility for their social situation and taking it upon themselves to ‘solve’ their homelessness problem. For those willing to ‘play the game’, redeemability has its perks.

To an outsider, the privileges of redeemability are not immediately visible. Unlike the gangs who DeOllos (1997) describes as the unofficial authority figures of the New York shelter she studied, the hierarchy of Ottawa shelters is not nearly as well-defined. None of the interviewees described a firm subculture in any of the shelters, but they did note that deference is paid to those who have considerable experience in the homeless community. Seamus explains:

Oh there’s a whole hierarchy... You just know, you can tell the guys who’ve been here for, you know, since Christ decided to grow his hair long, kinda thing. They’ve been here a long time anyway, right, so they know everything and, and they’re the guys who butt in line and they’re the guys, you know, it’s the stupidest little miniscule thing but you can tell the guys who, who’ve been here a long time and, they don’t run the place but... it’s, one of those intangibles that, you just know, you know? They’re just, you know, and it’s got nothing to do with big burly mean guys or anything else, it’s just you know that these guys have been here and they, whoa whoa whoa, no, I go before you, or whatever else.

Seamus explains the complicated power dynamic found amongst homeless people in the shelters. In keeping with Foucault’s (1980a, 2005) concept of dynamic power relations, although marginalized people are generally regarded as powerless, there are spaces to exert power within the homeless community. Seemingly insignificant actions such as cutting the lunch line or getting first dibs on the snack tray carry tremendous symbolic value. Among the included circuit homeless people are often ignored, ridiculed, and victimized (Desjarlais 1997; Huey 2012), but within the community itself, some are able to gain a sense of superiority from being the most seasoned and knowledgeable. Seamus is clear that “they don’t run the place” but that deference is paid to those who have “been here a long time” and who “know everything” about how to survive in what can be a hostile and vulnerable environment. Perhaps surprisingly given the high

level of insecurity and victimization in the homeless community (Huey 2012), power is not achieved through physical dominance and being “big burly mean guys”,¹⁴³ but by having the wherewithal to survive years in the shelter system and knowledge of how to navigate the complicated array of services and bureaucratic red tape typical of accessing social assistance.

Jamie, who is likely not identified as redeemable given his resistance to the mental health system and homeless sheltering industry, could not hide his anger when I ask him about whether he thought there are consequences to forgoing programming:

I will hold myself to five minutes for this response. They have everything, we have nothing. *Every single perk* this place offers... you either must be working and even then you don't get a lot, or you are in one of the programs. The programs are the poster child for this place. Dry wing, [the in-patient addiction treatment program], everything is built for them to the point where they even get to come in and be special and eat ten minutes before us. How do you think that makes me feel? Half the people, I can't say about [the in-patient treatment program], half the people in the dry wing or in [a transition addiction program] are fucking there for the perks. They get drunk once a week, at least. I know they do, I see them do it. So how does that, oh yeah just say you're addicted to something and you want to change and you get in and you get bed rest all the time, you get to watch movies on weekends, Sundays there's absolutely nothing, the libraries during the summer are closed on Sundays, I can't even go to the library. You're in the program? You can sit in the chapel all day and watch movies. You're not in the program, tough shit.

I often witnessed these perks during my participant-observation in the shelter one. Individuals who participate in the in or out-patient addiction treatment program run by the shelter have a designated meal time that is earlier than the general shelter population. This ensures their meals are the warmest and they get first choice of where to sit in the dining room. At the time of my observations the rule that only individuals in programming are allowed to watch movies on weekends was flexible. Over time, however, the shelter has become more scrupulous, locking the door to the chapel for those who are not permitted to watch movies. The significance of watching

¹⁴³ Seamus' comment about physical dominance refers to a hyper-masculine concept of power (Beasley 2008) that can be found in an all-male emergency shelter. Unfortunately, none of the women research participants discussed internal power dynamics in this way to allow for a comparative analysis.

movies undisturbed should not be underestimated. As described in chapter five, the communal television is only turned on at six o'clock in the evening. Even then, frontline staff members determine what everyone will watch. Given the reality of living within the strict rules of the shelter (DeWard & Moe 2010; Dordick 1996), we can begin to appreciate the luxury of having the autonomy to choose a movie, pause it at one's leisure for smoke breaks, and the sense of privacy that comes with watching television with only a handful of people.

Only those participating in programming are afforded these distinct advantages. Although Jamie and some other interviewees call into question their dedication to sobriety and self-improvement, what matters is that those who participate in programming are willing to accept responsibility for their marginality and display their intention to work on their project of the self by attending programming (Rose 1999). Whether they are successful (i.e. become sober, manage their anger, find gainful employment, etc.) is not especially important given that they are unlikely to be redeemed. Instead, it is their continual consumption of the mental health and treatment systems that distinguishes them as deserving of reward. Bed rest and structured leisure time, for example, are likely conceived by shelter administrators as conducive to recovery; but for those who do not benefit from these advantages, it resembles favouritism and exclusion.

Jamie noted that homeless mental health consumers receive more perks than individuals in the work wing. Homeless men and women often find physically intensive, insecure, low-paying jobs through single-day contract employers (Snow & Anderson 1993; Williams 2009)¹⁴⁴ that do not provide the financial stability necessary to become members of the included society.

¹⁴⁴ While it is beyond the scope of this project to discuss the relationship between homelessness and work (Lyon-Callo 2004), a number of research participants spoke of the difficulty finding meaningful work and the disincentives of doing single-day contracts with employers like Labor Ready: "I mean, if I knew there was a job waiting for me at Labor Ready I could go there but as a friend of mine told me, or roommate there, he said, you show up at Labor Ready at five, they find you a job at eight, so you wait three hours unpaid, then you work a full day... it's tough" (Joseph).

In this way, the homeless mental health consumer, although flawed in many ways, is able to perform the consumer role better than her working counterpart. Whereas the working poor do not have the financial resources to engage in meaningful consumption, by relying on the public system, the homeless mental health consumer can indefinitely consume more psy-based goods and services. Not only this, but as consumerism is so profoundly connected with self-regulation (Bauman 1988; Rose 2000), the mental health consumer is able to demonstrate her commitment to and efforts made towards self-responsibilization and individual improvement (albeit under the guidance/surveillance of psy-experts and para-professionals) and thus her desire for normality (Cruikshank 1999), whereas the working homeless are unlikely to be able to afford private counselling and treatment centres that would have the same effect. In this way, the homeless mental health consumer's redeemability is more apparent and is thus deemed more deserving (Katz 2013) of reward than that of the working poor.

Identifying as mentally ill can provide benefits outside of the shelter system as well. Although I did not ask interviewees specifically about their financial situation, nine research participants volunteered that they receive Ontario Disability Support Payments (ODSP) rather than the standard Ontario Works (OW) social assistance.¹⁴⁵ Most were eligible for ODSP based on both physical and mental disabilities. Only Vince, who receives ODSP for his PTSD and severe clinical depression diagnoses, was candid that his interest in receiving a mental illness diagnosis was originally purely financial: "I knew what depression was about but to me that was... Well what that looked like to me is, now I can get on ODSP... It's just about, you know, getting, just getting on the system and collecting, you know, this X amount of dollars a month

¹⁴⁵ Individuals who reside in a shelter receive substantially reduced rates for OW and ODSP because their room and board is provided.

because, even then I wasn't going to get clean". Recent figures show that a single person on ODSP receives \$460 more a month than those on OW.¹⁴⁶ The discrepancy in assistance between those who are deemed simply unemployed and those who claim disability leads to the medicalization of poverty (Hansen, Bourgeois & Drucker 2014) where accepting a pathologized subjectivity becomes a strategic means for navigating a system that so acutely distinguishes between the 'slackers' and the 'lackers' (Rosenthal 2000). Using the mental health system to access greater funds through ODSP can be characterized as a form of resistance (Castel 1988; Moore 2007; Rose 1998) but as Hansen et al. (2014) conclude, it does not negate the distress that many who are suggested to manipulate the system face. Instead, it shows the wherewithal that many marginalized people have to situate their narrative within the rhetoric of the psy-complex (Maruna & Ramsden 2004) in order to access resources; but in doing so, it also reasserts the tired dichotomy between the deserving and undeserving poor (Chunn & Gavigan 2004; Katz 2013).

The homeless mental health consumer comes out ahead in the homeless community: greater entitlement to counselling through programs, small but considerable perks such as first access to meals and clothing, and improved chances of receiving subsidized or supportive housing (through CMHA, for example). These privileges, however, do not necessarily (and indeed, it is unlikely) lead to redemption within the included circuit. Instead redeemability acts to solidify one's status as excluded:

Measured against their condition, even a modicum of mobility feels like unbridled freedom, and the steely grip of the 'flexible labour market' seems like a benign embrace. Helping others to bear the hardships of a precarious life is the last function which the otherwise useless outcasts, now incarcerated in their ghetto dwellings or prison cells, have been allowed to perform by affluent, consumer, 'liquid modern' society. (Bauman 2001b: 121)

¹⁴⁶ A single person on OW receives \$250 for basic needs and up to \$376 a month for shelter costs. A single person on ODSP receives \$607 in basic needs and up to \$479 a month for shelter costs (ISAC 2014).

I cannot understate the importance of perks that help homeless men and women endure the ‘pains of homelessness’. Small rewards act as symbols of care, worthiness, and dignity, attributes sorely lacking in the homeless community (Hoffman & Coffey 2008; Miller & Keys 2001). Choosing where to sit or what to watch on television amount to a “modicum of mobility” and provide individuals with a sense of freedom (Dumm 1996; Rose 1999), however minute. That being said, Bauman recognizes that much of the guidance provided by professionals, para-professionals and many of the programs, does not lead to inclusion. Instead, they are meant to help “bear the hardships of a precarious life” and assist in becoming included among the excluded. Members of the included circuit are generally uninterested in accepting the redeemable (Katz 2013; Rose 2000) but are able to adhere to the lingering principles of social citizenship exalted by the welfare state (Cohen 1985; Garland 2001; Rice, Goodin & Parpo 2006) by helping willing participants manage their exclusion.

As I argued above, many of the research participants sought out the mental health consumer role in the hopes of future inclusion; contrarily, a few interviewees spoke candidly about their more modest goal of becoming included among the excluded. Otto explained his marginality as stemming in part from the mental health and treatment systems:

It can't just be me, so, you know, I gotta pick something. Well, I'll go with the ADHD I heard about six years ago. That sounds good. Yeah, and alcoholic too, yeah, I'll sign up for that. I get free coffee in the morning, I get to go to the clothing room on Tuesdays, I get meals, why not be an alcoholic, life's great. All I gotta do is not drink and stuff. There are benefits to those who are willing to admit that their, you know, indiscretions in the mental world, uh, but, uh, it, it also boxes you in. You know, like uh, 'cause for the life of me, it doesn't matter what my own philosophy is. It doesn't matter what my actions are. If I were to sit down with my family right now and say you know, I change my mind I'm not really an alcoholic. Oh! You're in denial.

Otto describes both the advantages and pitfalls of situating oneself as a homeless mental health consumer. He acknowledges the rewards that come with the role, such as coffee and first access

to donated clothing but notes that in order to receive these perks individuals must be “willing to admit their, you know, indiscretions in the mental world”. Otto’s reluctant adoption of individualized and pathologized explanations for his situation (Lyon-Callo 2004) acts as the key to accessing privileges but also plants him firmly in the excluded realm. This characterization is in keeping with Young’s (1999) concept of the bulimic society that was described in chapter three. According to Young, the underclass is subsumed by the inclusive ideals that are touted through consumer culture. When the excluded fail to meet inclusive expectations, the included society expels them. It is the attempt at adopting inclusive norms, such as Otto’s quest for self-governance that ultimately highlights and reinforces his ‘Otherness’. As described above, given its relationship with the twelve-step model, the alcoholic identity in particular is framed as a lifelong master status and any resistance to recovery discourses is characterized as a symptom of the pathology (Reith 2004). Having spent six years in the homeless community, for Otto, the benefits of being included among the excluded outweigh the costs of being permanently tied to disciplinary systems.

Not everyone in the homeless community has the opportunity to choose the mental health consumer role. Next, I discuss the other end of the inclusion-exclusion continuum: those identified as irredeemable/impossible and who are subject to disciplinary regimes.

The hopeless

The irredeemable are those who do not or cannot demonstrate their ability to engage in the self-discipline required to live up to the standards of normality and civility (Bauman 1988, 2001a, 2004; Rose 2000; Young 1999). In emergency shelters the irredeemable are those who sit outside of the typical homeless community; they are the excluded among the excluded. Snow and Anderson (1993: 66) qualify some of their research subjects as ‘severely impaired

psychiatrically' because their conduct is "...so bizarre and situationally inappropriate that it would be likely to be construed as symptomatic of mental illness by most observers".¹⁴⁷ During my participant observations I witnessed many of these behaviours, such as those who pace manically, those who mutter to themselves and sometimes call out, and individuals who argue or laugh with the empty chair beside them. It is the individuals that are overcome by distress who are often classified as irredeemable.

Whereas many who model themselves as homeless mental health consumers do so within a political economy of hope, irredeemability connotes an absence of hope. As Bauman (1998: 93) articulates: "Flawed consumers are lonely, and when they are left lonely for a long time they tend to become loners; they do not see how society can help, they do not hope to be helped, they do not believe that their lot can be changed by anything but football pools or a lottery win". The irredeemable are not provided with words of encouragement (however unsubstantiated they may be), are not offered the promise of a brighter future, and are certainly not given the opportunity to consume mental health and treatment resources of their choosing. Instead, the irredeemable are met with the heavy hand of disciplinary regimes, in particular the mental health and criminal justice systems, in order to manage their risk (Castel 1981, 1991; Rose 1998). The irredeemable are to be contained not corrected or empowered (Donohue & Moore 2009; Garland 1990).

Irredeemability as a subjectivity is not static. Donohue and Moore (2009) contend that the client and offender subjectivities depend on the individual's social environment, relationships and behaviours. Rose elaborates in his description of risk allocation among those identified as mentally ill who reside in the community:

¹⁴⁷ I am not suggesting that the irredeemable constitute the 'true' mentally ill. In keeping with the critical foundation of this project, I do not assume that those who exhibit qualities typical of mental illness symptoms embody its subjectivity. It is important, however, to bear witness (Caron 2014; Ussher 2005) to the deep distress facing many of the homeless community's most vulnerable.

This is not so much a fixed division of sub-populations, as a configuration premised on the belief that different regimes of control are appropriate for different conditions. The location of each individual within this configuration is fluid, in that individuals can be allocated and reallocated to one or other such regime in relation to their responses to particular kinds of treatment or care (Rose 1998: 182).

The irredeemable status comes from assessments made by those in positions of power, in particular psy-professionals. In the case of homeless individuals who are identified as ‘seriously’ mentally ill, psy-authority is dispersed among psy-experts, para-professionals, and staff to assess one’s redeemability in order to properly manage those who are deemed beyond hope.

Giving up

Focus group participants were forthcoming with their perspective on homeless individuals whom they identify as irredeemable. Chuck, a frontline staff member at shelter one, gave his perspective on what to do with those who cannot/will not adopt responsabilization strategies:

I think there’s also a, problem with sometimes with the way we prioritize, like, eventually you have to ask yourself, you know, this person has some very serious mental health issues, we’ve tried this method, we’ve tried that method, and now at this point how badly is it affecting his quality of life? If he doesn’t say anything that indicates that it’s negatively affecting his quality of life and we don’t really perceive that he’s in distress,¹⁴⁸ then maybe it’s time to move on to somebody else and use the resources for somebody else who is maybe more acute. Prioritize right? You can always revisit.

Focus group participants suggested that non-compliance with psychotropic medication and being involuntarily hospitalized, or “formed”, as two indications that someone is irredeemable. Both of these techniques, forming in particular, are oppressive and disciplinary in nature. The irredeemable designation comes when an individual rejects or resists coercive technologies – someone who does not gain a sense of empowerment by techniques that seek to shape her desires and conduct (Cruikshank 1999).

¹⁴⁸ Chuck uses the term distress differently than I do. Here, he is referring to the criteria for involuntary incapacitation in a mental hospital – risk of harm to the self or others.

The excerpt above also clearly identifies the hopelessness through which the irredeemable are defined. As Chuck claims, “maybe it’s time to move on to somebody else”. Other members of the focus group concurred; for example, Arnold, a shelter manager, noted “some..., they probably can’t be helped”. All of the focus group members expressed dismay at their inability to support some individuals who suffer with profound and long-term distress but also noted resource constraints and the need to prioritize those who will accept help (read: adopt normalization discourses). In the late modern era of austerity measures, fiscal constraint, and program evaluation and demonstrated efficiency, program administrators look for ‘clients’ who will properly and effectively consume mental health products and allow programs to meet measurable outcome targets (Woolford & Curran 2011), leaving behind those who do not meet objective success markers. Chuck’s narrative is in keeping with Bauman’s (2004) contention that some members of the underclass are beyond help and that those who cannot consume publicly funded goods and services are disposable in the consumer society.

Members of the focus group were quick to point out that it is not the homeless community alone who gives up on the irredeemable. They expressed their extreme frustration with the lack of mental health care in the public health system, citing common problems with individuals being discharged from the mental hospital with only a week’s worth of psychotropic medication and no avenues to help them access pharmaceuticals in the community.¹⁴⁹ There is a similar lack of discharge planning evidenced in jails and prisons (Gaetz & O’Grady 2009; John Howard Society 2010). The focus group complained that there is not enough access to mental health care workers, in particular psychiatrists. At the time of the interview the mental health

¹⁴⁹ Thifault et al. (2012) note that regional, linguistic and cultural factors influence an individual’s access to mental health services as well.

nurse who routinely visited Ottawa's shelters had recently retired and had not been replaced, leaving Melissa, a case worker, to lament: "I would have a pile of referrals but I can't refer them to anybody". This leaves shelter staff to "pick up the slack" (Chuck) and manage those in deep distress within a chaotic and insecure environment. It also highlights the narrow conception of mental health care as deriving solely from the medical model, rather than considering alternative methods of care, such as peer support.

Beyond "bat shit bananas": Expanding the psy-complex to manage the irredeemable

The expanding role of shelter staff as mental health providers is not new. Seamus explained that frontline staff sometimes bribe individuals to take a shower and change their clothes: "Hey, do you want a smoke? Yeah. Go have a shower. And the other guy's like, no no, not taking that shower. Then you're not getting a cigarette. So the guy will go and take a shower and come back. Nope, here's some clothes, change your clothes. Give him the cigarettes and he'll go". Frontline staff intervene in shelter residents' hygiene practices to maintain order in the shelter when "other guys complain about it" (Seamus) rather than as a method of treatment. Still, it acts as an example of staff assuming the role of mental health care worker and is indicative of the broad application of psy-expertise among those in positions of power (Rose 1998). Chuck was vocal about his thoughts on the need for frontline staff to take on a more formal role in the mental health system:

So if we [frontline staff] had more training with basic pharmacology, terminology, how to do mental health assessment. I mean, there's no reason why front desk couldn't be doing a mental health assessment over a period of a couple days as opposed to a half-hour directed interview. Right? We could, these things could be done so that when we do possibly get a mental health nurse back in here, we can give her a file on a client saying this is what has been observed, using standard language that is respected, that is understood, that, so that when papers pass through the psych emerg they're like [claps hands] yeah, I understand what this person's saying as opposed to using, you know, words like, 'this guy has gone bat shit bananas', or he is, you know... it's important to be

descriptive about what's going on but again, there's a whole terminology that's used that is probably necessary for a lot of us to know.

Chuck called for a dramatic reformulation of the frontline staff role to perform the normalizing work of psy-experts. In Chuck's re-imagination of shelter work, frontline staff would use their position of authority, including the panoptic gaze of the shelters' CCTV cameras (Hier, Walby & Greenberg 2006; Norris & McCahill 2006) and the production of a resident's 'file' to perform psy's role in terms of observation and judgment (Foucault 1977) and to be in a position to assess the mental health status of homeless men and women. The expansion of the medical gaze (Foucault 2006) to frontline staff would further erode any semblance of privacy and autonomy for shelter residents, but as Chuck argues, transferring assessment responsibilities to staff would ease some of the pressure felt by the lack of mental health resources in the homeless community.

Chuck emphasized the professionalization of the frontline staff role by acquiring proficiency in psy-language. As described in chapter five, staff observations are sometimes used by psychiatrists to involuntarily hospitalize distressed individuals. Chuck is looking for a formalization of this process by adopting the common technical, rational, and objective psy-vocabulary to demonstrate staff competence to conduct mental health assessments (Goffman 1961). The psy-disciplines found their legitimacy in the medical field through their use of language, in particular nosology (Foucault 2006). Using the psy-professions' discursive formations would allow frontline staff to act as para-professionals (Cohen 1985; Foucault 1972). Chuck is seeking to translate¹⁵⁰ observations (Rose 1998, 1999) such as "this guy has gone bat shit bananas" into terminology that can be understood and made useful by psy-experts to assess,

¹⁵⁰ Rose (1999: 48) explains the concept of translation: "In the dynamics of translation, alignments are forged between the objectives of authorities wishing to govern and the personal projects of those organizations, groups and individuals who are the subjects of government". For an in-depth look at how psy is translated in the legal system, see Moore (2007).

classify, and ultimately discipline an individual deemed ‘seriously’ mentally ill. While translation usually refers to moving from the general to the particular – from the political regime to its application on the ground (Rose 1999) – here translation is inversed, where the irredeemable subject’s day to day movements and behaviours are translated into criteria for disciplinary intervention. The surveillance, judgement, and ‘administration of persons’ (Rose 1998) that frontline staff already conduct would be legitimized and made even more powerful through its alignment and adherence to psy-discourses.

Criminalizing the irredeemable

Those individuals identified as ‘seriously’ mentally ill in the homeless community are more likely to be subject to police intervention. Emergency shelters use police presence to manage men and women who do not engage in self-control (Bernier et al. 2011). As the focus group explained:

Chuck: We de-escalate them as best we can. We use our words and we ask them... we try to either calm them down, keep them safe, keep the other clients safe, or we try to get them removed. Either we guide them out the door ourselves, uh, as gently as possible, uh, and as calmly as possible, ask them to take a walk, cool down, come back. Depending on the severity of the incident, they might be barred for an amount of time because, I mean, as much as we feel for these guys we can’t have them... in, with two hundred other guys... like if it’s not during regular business hours, if front desk can’t de-escalate the situation it becomes a police problem.

Arnold: There’s no buffer.

Melissa: No, there’s no buffer. If there, if it’s after business hours, frontline staff are on their own. If someone is going to hurt themselves or others, then, we call the police.

The criminalization of poverty acts as the ultimate form of degradation and exclusion (Bauman 2001a; Wacquant 2000, 2009). For individuals suffering with deep distress, their interactions with police stem largely from their status as homeless. Chuck’s comment “I mean, as much as we feel for these guys we can’t have them... in, with two hundred other guys...” underscores the

reality of experiencing distress while living in a public space. Signs of distress do not *ipso facto* require police intervention, but in an emergency shelter with few or no mental health or familial supports available it is regarded as the only viable solution to maintain order in the shelter. The goal of reducing individual distress is secondary to maintaining the security of the shelter (Ranasinghe 2013a). Although anecdotally referred to as ‘street-corner psychiatrists’ (Steadman et al. 2000) evidence suggests that police interaction does little to relieve people’s distress and often exacerbates the situation (Watson et al. 2010). For those homeless individuals who do not/cannot embody the consumer role “there is no buffer” and the only services available “after business hours” are the traditional, disciplinary, and coercive technologies of social control operating via the police and criminal justice systems.

The quote above provides another example of how frontline staff are often put in the position of acting as mental health care workers. They are responsible for managing a crisis and de-escalating the situation. This is a problematic role for frontline staff to take on because as recalled in chapter five, many shelter residents view them as ‘bubble boys’ and correctional officers, rather than support workers. Because their role is first and foremost to maintain security, common practice is to eject the distressed individual from the premises, either briefly to “cool down” or for longer periods by being “barred for an amount of time”. Although not positioned as punishment, exclusion from the shelter is indeed a sanction in that it acts as a form of condemnation by authority figures who dictate normalized standards for conduct (Garland 1990). Contrary to other cities (Feldman 2004; Lyon-Callo 2004), in Ottawa it is standard practice that if someone is barred from one location, that shelter will find another to take her so that no one is forced to sleep outside. That being said, Chico and others told me that they would rather sleep outside than reside in some of Ottawa’s shelters. Although, from the shelter

management's perspective being barred from one shelter is not akin to being kicked onto the streets for many homeless individuals, in particular those experiencing distress who are more likely to be victimized (Maniglio 2009; Paradis & Stermac 2001), another shelter may not be a viable option.

The irredeemable are subject to disciplinary systems, be it the criminal justice and/or mental health systems, because they cannot/do not demonstrate their ability to become empowered, self-regulating, redeemable subjects. While the focus group cited limited resources as the primary cause of allocating supports to some individuals over others, Katz's (2013) genealogy of poverty suggests that there has always been a group of 'undeserving' poor who are regarded as hopeless whether based on moral or biological grounds. I argue that those who are deemed 'seriously' mentally ill are among this group of irredeemables (along with, and often related to, homeless individuals who have spent a long time in prison) and are not afforded the same opportunities to 'bear the pains of homelessness' as are their redeemable counterparts. Instead, they face the possibility of criminalization and/or involuntary hospitalization, tools meant to manage and contain the distressed rather than support recovery.

Conclusion

In the late modern era, inclusion, exclusion, and techniques of governance must be situated within the context of our consumer society. Bauman (1998, 2007) describes consumerism as the foundation for our contemporary understanding of the self, our goals and desires, and it mediates how we govern others and ourselves. In this chapter I considered what happens to those who cannot participate in the consumer society on account of their poverty. The 'flawed' consumer (Bauman 2007) is an especially problematic character because we are expected to consume goods and services that will aid in self-regulation and normalization (Rose

1999). I argue that because most homeless men and women do not have the financial and social capital to act as proper consumers, some position themselves as homeless mental health consumers. In this way, homeless individuals are able to perform the responsabilized, active, and empowered consumer role through publicly funded programs and services that primarily emphasize psychopharmacological intervention.

The hope for inclusion that encourages homeless individuals to accept mental illness diagnoses, treatment (almost exclusively psychotropic medication), and the individualization of problems in living is often nothing more than that – hope. The reality of the homeless mental health consumer is that their autonomy in the public mental health system is minimal and it is exceptionally difficult to move beyond the redeemable status and into the included circuit. Although discouraging, redeemability has its benefits. I argue that homeless mental health consumers are positioned as the included among the excluded. The perks awarded to the redeemable, such as earlier meal times and access to leisure activities allow individuals to ‘bear the hardships’ (Bauman 2001b) of homelessness. These rewards are important to many who have experienced long-term homelessness with little prospect of exiting the homeless community; however, by accepting their status as mentally ill and/or addicted they are reiterating their position as permanent members of the excluded circuit.

While the redeemable may be designated as the included amongst the excluded, the irredeemable are understood as the always-already excluded. Most often attributed to individuals conceptualized as ‘seriously’ mentally ill, the irredeemable are thought to be hopeless. The staff, para-professionals and psy-experts that identify them have no expectation that they will become responsible, self-governing citizens and so subject them to disciplinary techniques. Be it involuntary hospitalization or interactions with police, the irredeemable are managed through

coercive strategies to contain rather than empower them (Donohue & Moore 2009). The result is further exclusion of the most marginalized and vulnerable subset of the homeless population. For those who cannot or will not participate in the consumer society, even as a flawed consumer, there is little illusion of hope for a different and improved sociality.

Chapter 9 – Conclusion: Beyond managing the homeless

In this project I set out to uncover how different forms of mental health managerialism are used to govern homeless men and women and how individuals respond to, negotiate, and make sense of the mental illness identity. In order to tease out the messy and nuanced understandings of mental health rationalities in the homelessness context I asked questions related to identity construction, taking up projects of the self, responsabilization techniques, and how people experience, accept, mediate and/or resist exclusion. Built from hours of participant observation, thirty-eight semi-structured qualitative interviews with homeless men and women, as well as a focus group with professionals and para-professionals, I constructed an analysis of the multifarious methods of mental health intervention that act as tools of governance. This analysis was grounded in the everyday lived experiences of homeless men and women in Ottawa (Campbell 1998; Smith 1987) and sought to stay true to the research participants' narratives while acknowledging how my own voice influenced the shape and results of the inquiry.

Throughout this dissertation I used a theoretical toolbox to chronicle how homeless men and women 'do' their mental health status (West & Fenstermaker 1995; West & Zimmerman 1987). I used critical constructs such as governing through freedom (Rose 1999), empowerment (Cruikshank 1999), identity construction and performativity (Goffman 1959, 1961, 1963; Butler 1990, 2004), exclusion (Bauman 1988; Young 1999), and resistance (Bosworth & Carrabine 2001) to highlight the complex relations between marginalized people, dominant social structures, interpersonal interactions between homeless individuals and professionals/para-professionals as well as between homeless citizens, all mediated in part through the mental health complex. Inspired by mad studies (Burstow & Weitz 1988; Burstow, LeFrançois & Diamond 2014; Chamberlin 1990; Fabris 2006; McLean 1995, 2000; Shimrat 1997) I

problematized the seemingly innate relationship between homelessness and mental illness and sought to explicate the ways that those experiencing homelessness contend with the involuntary but more often the voluntary forms of mental health treatment.

I made several arguments in this project. In chapter five I provided a critical analysis of the shelterization literature that claimed that emergency shelters act as ‘near-total’ but incomplete total institutions (Goffman 1961) because, unlike prisons or mental hospitals, shelters are thought to be permeable and voluntary. While I agree that homeless shelters have unique characteristics to the traditional total institution, using Cohen’s (1979) notion of the ‘punitive city’ and Beckett and Murakawa’s (2012) ‘shadow carceral state’, I find it useful to think of emergency shelters as neo-liberal total institutions. This formulation allows us to concentrate on the ways in which neo-liberal governing techniques highlight an individual’s autonomy and minimize the constraints and limitations imposed on the notion of freedom. For those facing homelessness the ‘freedom’ to leave the shelter and assimilate with the included circuit is dubious, yet the discourses regarding transitioning out of homelessness and the policy structures and developments in homeless shelters are built on this premise.

In chapter six I described the various ways homeless men and women manage the homeless, mentally ill and addict identities. I argue that some individuals experiencing homelessness attempt to create a hierarchy of marginalization so as to position themselves as more redeemable than other members of the homeless community. Moreover, I articulate the complicated way mental health is used in research participants’ identity performances, namely the use of a ‘façade’ or ‘second skin’ as a means to cope with the vulnerability of homelessness.

Along with the hyper-individualization of problems in living is the continued reliance on a biological determinist framework of understanding mental illness. The medical model is a

widely used explanatory tool in the homeless community and carries a fatalistic quality because it suggests that if the causes of distress are strictly physiological there is little someone can do to rectify their situation. However, I argue that a paradox exists whereby homeless individuals are identified as mentally ill through the medical model but are responsabilized to adopt a civilized lifestyle with the aim of ‘fixing’ their brain. Maté’s (1999, 2008) work on creating an ‘enriched environment’ or engaging in ‘self-parenting’ is highly influential in Ottawa’s homeless community because it marries otherwise opposing explanatory paradigms.

In chapter eight I use Bauman’s (1998, 2007) scholarship on the consumer society to argue that some homeless individuals use publicly funded mental health resources to perform the consumer role. Given the prominence of consumption in the late modern social body, many marginalized people feel compelled to perform the consumer role despite their poverty. I argue that this strategy has the effect of situating homeless mental health consumers as permanently *redeemable* but unable to escape exclusion. By demonstrating their worthiness of mental health resources by accepting their pathologization, redeemable subjects become included among the excluded as a way to manage the ‘pains of homelessness’ yet they rarely achieve their goal of inclusion..

Theoretical contributions

One of the contributions of this research is advancing the political economy of hope as a conceptual tool. The notion of hope is taken up most notably by Carlos Novas (2006, 2007; Rose & Novas 2005) to describe the ways pharmaceutical companies interact with patient advocacy groups to gain valuable biological information with the promise of future benefits for patients. Novas’ work on the dimensions of biovalue as a vehicle of one’s future potential is useful not only in the realm of bioethics; I argue that we can also use the concept to shed light on how

governing strategies, particularly those enmeshed in the mental health system, work through political economics of hope to establish permanent relationships with those it seeks to manage.

Rose (2007: 135) uses the political economy of hope to advance his notion of biological citizenship, specifically the ways in which hope mitigates our understanding of risk management and our reliance on experts (including, but not limited to psy-experts) to act responsibly in the present in order to “master the future”. Throughout this project I have used the political economy of hope to make sense of how and why some governing strategies profess future inclusion when in reality few chronically homeless people escape marginalization completely. Offering hope among the hopeless is a strong incentive for many individuals to adopt self-regulatory regimes, thus enabling shelters, case managers, and other para-professionals to better manage those who choose to be compliant. In this way the political economy of hope is intimately connected with neo-liberal projects of the self and governing through freedom (Rose 1998, 1999, 2000). As a future-oriented perspective, hope discourse is engaged so that we modify our present actions and beliefs (Novas 2006; Rose 2007). We cannot dismiss the psychological value of hope for mental well-being; as many research participants described, we all need a reason to get up in the morning. However, we must also be cognizant of the ways that hope is used as a form of empowerment, in Cruikshank’s (1999) sense of the term. Hope is a useful tool through which to align the individual’s interests with institutional assemblages (e.g., shelters, community centres, local police, and the criminal justice system, to name a few) that work together to manage and govern individuals and populations.

The most significant theoretical contribution made in the dissertation is the emerging notion of redeemability. As described in chapter two, much of the literature discussion inclusion and exclusion as distinct binaries but some scholars describe a continuum of exclusion, to

varying degrees of success (Castel 2003; Rose 2000; Young 1999). Building on Spitzer's (1975) notions of social junk and social dynamite and Rose's (2000) division between the redeemable and the impossible, I develop more fully what redeemability looks like and how it is used as a governing tool among marginalized people.

Throughout this dissertation I argue that many homeless individuals seek inclusion and are offered inclusionary programs (i.e. employment training programs, life skills programming) despite the improbability that they will be welcomed into the included circuit. As Young (1999: 87-88) argues, in the bulimic society many of these inclusionary strategies have the effect of further "expelling" those who participate. This research supports that claim, as explored in chapter eight, whereby those who accept their pathologization and the individualization of their problems in living are able to access resources, but that this process simultaneously reinforces determinist and neo-liberal discourses.

This research further develops the concept of exclusion by suggesting that redeemability itself can be characterized as a worthwhile goal. In chapter five I described some of the pains of homelessness: adhering to strict and sometimes arbitrary rules; a lack of privacy and security; felt isolation; and a loss of dignity and autonomy. Considering these factors, coupled with poor health, exclusion from public and semi-public spaces, criminalization, and contending with past and current victimization, it is no wonder that many of the research participants in this project sought coping mechanisms to make life in the homeless community more tolerable. It is in this regard that I parsed out what it means to be included among the excluded. If inclusion and exclusion exist along a continuum it is worth thinking about how members of the excluded group negotiate this status and how exclusion is reinforced through governing strategies.

Regarding exclusion as a mutually constitutive process, however intentionally or unintentionally it is produced, complicates how we come to understand personal autonomy among marginalized people within dominant social structures. Certainly there are extreme power differentials at play; however, beyond strictly analyzing small acts of resistance among subjugated people, it is imperative that we consider the ways individuals participate in, accept, and sometimes even seek out, excluding practices. There is insightful literature that troubles the notion of 'freedom' and 'choice' (Garland 2001; Hannah-Moffat 2000; Kilty 2012a; Moore 2007; Pollack 2005, 2009) and astutely acknowledges the ways in which choice is constrained through circumstance. This research highlights the various ways exclusion takes shape where certain kinds of exclusion are preferable to others and subjects may work towards achieving a form of exclusion that offers more privileges and opportunities. This is not merely being strategic, although it may certainly be a factor, particularly in the climate of the deserving/undeserving poor (Chunn & Gavigan 2004; Katz 2013). Vying for redeemability acts as a kind of status, in the same way that late modern projects of the self require good consumers to choose appropriate lifestyles. Identifying oneself and being recognized by professionals and para-professionals as redeemable provides a positive sense-of-self and hope that is difficult to come by in the homeless community. By troubling exclusion as a static identity marker or category in the social world, we open up new avenues to consider how individuals navigate exclusion, the way degrees of exclusion/inclusion are used in different modes of governance, and how autonomy and coercion exist alongside and relate to one another.

Practical contributions

Not only do I endeavour to add theoretic contributions to the academic literature but this research also provides practical recommendations to support those experiencing homelessness

and distress and to move towards ending chronic homelessness. The Alliance to End Homelessness recently launched the 20,000 Homes Campaign that seeks to house twenty thousand homeless Canadians by July 1st, 2018.¹⁵¹ Ottawa is participating in this campaign (ATEH 2015) in conjunction with the City's ten year plan to end homelessness by 2024. The City of Ottawa cites the aim to build more affordable housing units, renovate existing units, move people out of emergency shelters within thirty days of entry, and provide housing with supports to one hundred individuals among its many goals.¹⁵² These initiatives come from an adoption of the Housing First model that advocates providing individuals with safe and permanent housing of their choosing immediately and without conditions (such as sobriety or medication compliance) (Gaetz 2013; Goering et al. 2014). Beyond any of the policy recommendations provided below, prioritizing the development and preservation of affordable housing and reducing the wait list for those seeking housing support is essential if we are to make substantive changes in trying to end homelessness.

Part of the usefulness of this project was assessing what kinds of resources might be valuable in supporting the chronically and/or episodically homeless in Ottawa. Although not explored in-depth in the dissertation, I asked each research participant questions on what resources they found most helpful and what was lacking in the community that they believed would be beneficial. Although many respondents complained about some frontline staff and/or case workers, almost all mentioned at least one staff member either at a shelter, in supportive housing, or at a community organization that they could talk to in times of crisis. In particular, those who used Aboriginal specific resources lauded the sense of community and support they

¹⁵¹ For more information, please see <http://www.20khomes.ca/>

¹⁵² Please see <http://ottawa.ca/en/residents/social-services/housing/our-ten-year-plan> for more information.

received. Moreover, those research participants who were housed found the work of housing coordinators based out of shelters or drop-in centres as well as the housing provided by CMHA to be beneficial.

Unsurprisingly, participants noted a number of areas for improvement in the homeless community. With regards to mental health, there was a widespread call for greater access to long-term counselling beyond immediate crisis counselling or sporadic and short appointments with a psychiatrist where only medication is discussed. This recommendation is echoed for homeless and housed people alike by some of Canada's most renowned mental health specialists (MHCC 2012; Peachey et al. 2013). Furthermore, some research participants noted that they require immediate access to in-patient treatment centres after leaving detoxification centres; waiting anywhere from three months to a year to access treatment is simply not realistic in terms of addiction recovery maintenance (Wenzel et al. 2001).

A number of respondents voiced concern over the lack of access they have to their mental health care or caseworker. Some found it difficult to obtain a caseworker at all. It would be useful for homeless organizations in Ottawa to come together and create a living document regarding 'the homeless sector 101' where individuals new to Ottawa or experiencing homelessness for the first time can find information on how to access all of the available services in one place so as to ease their ability in navigating the often complicated and siloed homeless sheltering industry. Of those who did have access to mental health or caseworkers, many felt like they rarely spent time with them and when they did that the workers were unable to provide the kind of substantive support they needed (i.e. accessing housing, treatment programs). Relatedly, a common theme across the interviews was the lack of consistency in terms of who their caseworker was. Many found that they were assigned new workers so often that they struggled to

build a trusting relationship with them. Some individuals, such as Mustang, found that through his time in the homeless community, staff turnover in the shelters and in community organizations was so high that he stopped engaging with support persons altogether. Given the nature of frontline work it is not surprising that there is a high turnover due to career advancement or burnout; however, it would be useful to develop policies to better address the challenges this presents for homeless men and women. For example, when staff members give enough notice, it would be beneficial to implement a transition period where outgoing and incoming workers meet with an individual together to facilitate relationship building. At the very least it is imperative that new frontline workers are cognizant of and sensitive to the potentially upsetting nature that change brings to some people.

Finally, individuals expressed a desire for greater flexibility within homeless shelters. Most notably, many found it disconcerting that they do not have access to their rooms during the day, even when they feel unwell. Shelters implement this policy for a variety of reasons: to allow for daily cleaning; to minimize security risks; and, as discussed in chapter five, in an attempt to discourage dependency as described in the shelterization literature (DeWard & Moe 2010; Dordick 1997; Gounis 1992; Gounis & Susser 1990). It is advisable that shelters seek ways to maintain the safety of its residents while also acknowledging the poor and chronic health conditions many homeless individuals face (Hwang 2001). For example, shelters and community organizations could develop quiet rooms to allow individuals to lie down and/or escape the chaotic environment. Above all, it is extremely helpful when shelters and community organizations are transparent about their policy decisions or rules. I see this first hand in my continued volunteer role during activity nights at shelter one. Occasionally (approximately three to four times a year) the activity night is cancelled because the shelter requires the space for

some other purpose. Although the shelter has adapted its practice to provide ample notice of the cancellation, the announcement continues to be met with a great deal of upset by shelter residents. On one of the occasions where I had to make the announcement, I happened to know the reason for the cancellation, namely a celebration for individuals graduating from an employment development program. I noticed with surprise how much calmer and more accepting people were when I explained why activity night was being cancelled. A simple change in best practices where organizations find a venue to explain changes (such as posters, announcements) can go a long way in providing reassurance to those who rely on the shelter for some degree of consistency in their lives.

These are only some of the policy recommendations that stem from this research project. As I look forward to disseminating my research findings with homeless individuals and community organizations I will provide tailored recommendations that are relevant to the specific audience. Moreover, in addition to my continued volunteer work in shelter one I work with the Alliance to End Homelessness Ottawa as chair of the Ask Me Campaign and on the Communications Committee. Through these roles I aim to support those experiencing homelessness and find solutions to the homelessness crisis in Ottawa.

Insights from the research

Throughout the analysis several themes emerged that were not part of the original framework and thus the data could not fully explicate some of the findings. Still, they are of such value that they warrant further investigation. Specifically, the complicated relationship between addiction and mental illness along with the destigmatization of mental illness in the homeless community will be addressed below.

Reconsidering the relationship between addiction and mental illness subjectivities

In every chapter of this dissertation I have grappled with how addiction and mental illness fit together. Although I was always aware of the congruence between the two issues, addiction was not meant to be a focus of this research project. However, as I began conducting interviews with homeless men and women it became obvious that the two could not be distinguished as neatly as it appears in the literature. In chapter two I described the similar but ultimately different trajectories mental illness and addiction took with regards to medicalization, where in the United States and to a lesser extent in Canada addiction remains firmly planted in the purview of morality based governing schemes (Conrad & Schneider 1992; Valverde 1998). In chapter six I outlined the ways in which research participants made sense of the addiction and mental illness identities as seemingly interchangeable. Despite calls for addiction and mental illness to be treated concurrently (Crawford, Crome & Clancy 2003) available treatment programs often remain distinct. In chapter seven I outlined how Gabor Maté's (1999, 2008) biological causality framework with treatment oriented towards lifestyle changes is used for both addiction and mental illness. Finally, in chapter eight I described how individuals who are identified as mentally ill and/or addicts are regarded as 'failed consumers' (Bauman 1988, 2007).

It is fascinating that while mental illness and addiction are regarded as intimately connected, if not synonymous, in the homeless community a sharp divide remains in the academic scholarship. Indeed, there is little research that accounts for the ways the mentally ill and addict subjectivities are mutually constituted. For example, in the two more recent collective works written about and by the mad community, *Mad Matters* (2013) and *Psychiatry Disrupted* (2014), there are only token mentions of addiction. Similarly, recent literature on substance use and addiction do not address mental illness in a significant way (Connors et al. 2013; McKay

2009). There is disconnect between the theoretical and macro analysis of addiction and mental illness research and how it is experienced and expressed in the material life experiences of individual citizens. My hunch is that research participants equate the two in part because the addiction treatment programs offered in the homeless community frequently discuss mental health issues and because of the dearth of mental health specific resources. This would mean that the conflation of the mental illness and addiction identities are class based, where someone with the financial means to purchase private treatment of their choosing would be able to find specific and focused care, rather than the under-funded public care offered in the homeless community that attempts to cater to a heterogeneous group. Because I did not conduct an ethnography of the out-patient treatment programming in the homeless community I cannot be certain of treatment groups' influence on homeless individuals' understanding of the connection between mental illness and addiction. The data does allude to a reorientation of how we think about the relationship between mental health and addiction. Moreover, it reveals a novel way of orienting subjectivities as constituted from the ground up rather than the top down approach that is so often cited (Gill 2008; Rose 1998, 2007). Certainly there is cause for more extensive research in this area.

At the outset of this research project I was interested in exploring how stigma impacts homeless men and women's sense of self, in particular the stigma surrounding mental illness. For example, one of the questions in the interview guide was "are you forthcoming with your friends and/or family about your mental health status? Why or why not?" I expected stigma management to play an integral role in identity management as it does for many marginalized groups (Harter et al. 2005; Hartwell 2004; Hannem 2012; Kilty 2012b; Phelan 2002). Surprisingly, however, very few research participants responded that they felt stigma in their daily lives. Often when I

probed further, asking if they did/would reveal their homeless status or mental illness diagnosis to employers some shrugged saying that they might not say anything, but others saw it as a non-issue. Most revealing was that most participants seemed to dismiss my questions about stigma. This may have been because stigmatizing experiences were too difficult to discuss or perhaps as a form of impression management in the interview. Still, the disregard for questions about stigma is worth noting.

This is not to say that research participants did not tell stories of some of the stigmatizing experiences they have had and their methods of managing stigma, but it is interesting that very few identified these events as related to stigma, even when probed. Moreover, very few of these stigma narratives were described in relation to a mentally ill identity or to mental/emotional distress. While this is not to say that stigma does not impact homeless and distressed individuals, given that this research project is founded upon the lived experiences of homeless men and women it is worth paying attention to the ways in which they employ (or do not) the concept of stigma to describe their materiality. As Charmaz (2006) contends, we must be attuned to the silences.

Although beyond the scope of this dissertation to analyze in detail, it is interesting to think about the ways in which mental illness stigma is experienced in the homeless community. Hansen, Bourgois and Drucker (2014) have begun to unpack this phenomenon, arguing that mental illness diagnoses are a useful tool to accrue greater social assistance in light of the growth in austerity measures and a diminishing welfare state. Instead of a diagnosis being attributed to weakness and disability, it may be regarded as an asset:

The potential stigma of disability and mental illness is reinterpreted as a legitimate responsibility locally among low income people because it is one of the few available routes to stable survival income. Consequently, it generates respect. In the context of

poverty, using disability and illness to gain benefits can be interpreted at the street and family level as a marker of competence and social responsibility, or at least as a viable harm reduction strategy in a post-welfare state that offers few alternative solutions to unemployment (Hansen, Bourgeois & Drucker 2014: 81)

I have already suggested some of the ways mental illness may becoming destigmatized in the homeless community: the common (normative) use of mental health resources as methods of self-government and social control; the widespread psychiatrization of society at large; and, most notably, the usefulness of the mental illness identity when positioning oneself as a homeless mental health consumer. The uniqueness of mental health stigma in the homeless community requires further study.

Final remarks

In this chapter I described the theoretical and practical contributions this research has to offer. Additionally, I suggest two areas of interest that were notable in the findings but have yet to be fully explored. I hope to continue to conduct research in relation to homelessness and mental illness. I am interested in conducting a research project that explores the best practices in using participatory action research in the homeless community. I would also like to design a research project that looks at how small charity organizations that sit outside of the homelessness sheltering industry make sense of their role as charitable organizations within the broader governing regime that requires community organizations to ‘govern at a distance’. I am interested in how micro-programs, whose core funding sits outside of government grants (for example, church-based collectives), orient their position as bodies of surveillance, accountability and risk management.

On a personal level, I remain committed to Ottawa’s homeless community and the national homelessness crisis. My perspective on dignity, humanity, and compassion was forever

changed because of the time I have spent with those I interact with at the shelters. As I wrote elsewhere:

Almost daily, someone in need thanks me for giving up my time to volunteer with them. What they do not know, and what I find so difficult to express, is how thankful I am for them. How they have made my heart grow beyond capacity. How they demonstrate to me the power of hope in a place that seems so hopeless. How the talents we have can be shared with others regardless of our wealth (Dej 2011a).

I am faithful to the small but hopefully useful role I play in Ottawa's homeless community. The question of reciprocity to those in the field outlined by Kaler and Beres (2010; see Kilty 2014) speaks volumes to me. I have learned so much through the course of this research and built meaningful relationships with many of the homeless individuals I spend time with. I will do my best to embody the resiliency, courage, and determination that the research participants live on a daily basis in my effort to support the homeless community with the ultimate goal of ending homelessness.

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Appendix A: Research and Ethics Board (REB) Approval Letter

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Social Science and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Jennifer M.	Kilty	Social Sciences / Criminology	Supervisor
Sylvie	Frigon	Social Sciences / Criminology	Co-Supervisor
Erin	Dej	Social Sciences / Criminology	Student Researcher

File Number: 03-11-06

Type of Project: PhD Thesis

Title: Insisting on or resisting mental illness: Re-imagining mental health amongst criminalized homeless individuals

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
04/11/2011	04/10/2012	Ia
		Ia: Full Approval

Special Conditions / Comments:

Recruitment may begin at [REDACTED] and at [REDACTED]

389

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<http://www.recherche.uottawa.ca/deontologie/index.html>

389



Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche
Integrity

University of Ottawa

Office of Research Ethics and

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at:
ethics@uOttawa.ca.

Signature:

Leslie-Anne Barber
Protocol Officer for Ethics in Research
For Barbara Graves, Chair of the Social Sciences and Humanities REB

390

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<http://www.recherche.uottawa.ca/deontologie/index.html>

Appendix B: Shelter Flyer

Looking for people to participate in a research interview

Questions will be asked about your day to day life, mental health, and how you cope.

If interested, please contact:

Erin Dej
Faculty of Social Sciences
University of Ottawa
Cell Phone:
Email:



Or see [REDACTED] in Case Management for more information

Participants will be compensated \$25 for their time.

Research is taking place here.

Erin Dej, a volunteer here, is doing research for her PhD thesis. This means she may write down non-identifying information about what she sees and hears. If you do not want to be part of the observation, please inform Erin.

Appendix C: Consent Form for Interviews

Title of the study: **Insisting on or resisting mental illness: Re-imagining mental health amongst criminalized homeless individuals**

Erin Dej

Cell Phone:

Email:

Supervisors: Dr. Jennifer Kilty and Dr. Sylvie Frigon

Department of Criminology

Faculty of Social Sciences

University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Erin Dej with the support of the Social Sciences and Humanities Research Council.

Purpose of the Study: The purpose of the study is to learn about the lives of people in the Ottawa homeless community and about their health, mental health, and coping strategies.

Participation: My participation will consist of an interview, approximately one hour in length, during which I will be asked questions. The interviews will be scheduled at a place and time that is agreeable to myself and the researcher. I will also be asked to speak my opinion about issues related to homelessness, health, and mental health. The interview will be audio-recorded.

Risks: My participation in this study will entail that I volunteer personal information and this may cause me to feel upset. I have received assurance from the researcher that every effort will be made to minimize these risks by allowing me to only answer the questions I feel comfortable answering, giving me the ability to stop the interview at any time, and by providing me with a list of phone numbers and counseling services.

Benefits: My participation in this study will give me an opportunity to tell my story and have my opinions heard. I will also be participating in research that may impact policy decisions in the future.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents will be used only for the completion of the researcher's PhD dissertation and publication in standard academic outlets such as books and journals, available to researchers, students, policy makers and the general public. My confidentiality will be protected

because only the researcher will know that I am participating in the interview. If, during the course of the interview, I mention an intention to harm myself or others, the researcher will by law be required to tell appropriate authorities. Anonymity will be protected by using pseudonyms and removing all identifying material from the interview transcripts.

Conservation of data: The data collected, such as the tape recordings of the interviews, and the hard and electronic copies of the interviews will be securely stored in a locked filing cabinet in the researcher's home and electronically on a password protected and locked computer, for up to 10 years post defence. A copy of the data will be kept at the university. Only the researcher and her supervisors will have access to the interviews.

Compensation: I will receive \$25 for my participation in this research. I will receive this compensation at the beginning of the interview and if I choose to stop the interview at any time, I keep the money.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, the data gathered until the time of withdrawal will be used in the research, unless I specify that none of it will be used, in which case, the researcher will destroy the interview.

Acceptance: I, _____, agree to participate in the above research study conducted by Erin Dej of the Department of Criminology, Faculty of Social science, which is under the supervision of Professor Jennifer Kilty and Professor Sylvie Frigon.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5
Tel.: (613) 562-5841
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature:

Date:

Researcher's signature:

Date:

Appendix D: Consent Form for Focus Group

Title of the study: Insisting on or resisting mental illness: Re-imagining mental health amongst criminalized homeless individuals

Erin Dej

Cell Phone:

Email:

Supervisors: Dr. Jennifer Kilty and Dr. Sylvie Frigon

Department of Criminology

Faculty of Social Sciences

University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Erin Dej with the support of the Social Sciences and Humanities Research Council.

Purpose of the Study: The purpose of the study is to learn about the lives of people in the Ottawa homeless community and about their health, mental health, and coping strategies.

Participation: My participation will consist of a focus group, approximately 45 minutes in length, during which I will be asked questions. The focus group will be scheduled to follow the mental health meeting in the shelter. I will be asked to comment upon the current issues facing homeless individuals with mental illness and the subsequent programming available to them. The focus group will be audio-recorded.

Risks: My participation in this study will entail that I volunteer professional information and opinion. There are no known physical, psychological, economic or social risks involved with participating in the research.

Benefits: My participation in this study will give me an opportunity to provide my opinion on the current state of mental health programming in Ottawa. I will also be participating in research that may impact policy decisions in the future.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain confidential. I understand that the contents will be used only for the completion of the researcher's PhD dissertation and publication in standard academic outlets such as books and journals, available to researchers, students, policy makers and the general public. My confidentiality will be protected because only the researcher and the other participants in the focus group will know that I am participating. I must also keep the contents of the

focus group confidential. **Anonymity** will be protected by using pseudonyms and removing all identifying material from the interview transcripts.

Conservation of data: The data collected, such as the tape recordings of the interviews, and the hard and electronic copies of the interviews will be securely stored in a locked filing cabinet in the researcher's home and electronically on a password protected and locked computer, for up to 10 years post defence. A copy of the data will be kept at the university. Only the researcher and her supervisors will have access to the interviews.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, the data gathered until the time of withdrawal will be used in the research, unless I specify that none of it will be used, in which case, the researcher will destroy the interview.

Acceptance: I, _____, agree to participate in the above research study conducted by Erin Dej of the Department of Criminology, Faculty of Social science, and under the supervision of Professor Jennifer Kilty and Professor Sylvie Frigon.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5
Tel.: (613) 562-5841
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature:

Date:

Researcher's signature:

Date:

Appendix E: Interview Guide

Qualifying questions:

- 1) How old are you?
- 2) Have you lived in a shelter, assisted living, or subsidized housing sometime in the past three months?
- 3) What is your current living situation?

Health / Mental health - general

- 1) Tell me about yourself. What do you do on a day to day basis?
- 2) Can you talk to me about some of the people/issues/events that cause stress/distress/concern in your life?
- 3) How do you cope with these stressful events?
- 4) How/do you relate any of these issues or coping strategies with taking care of your mental health?
- 5) Do you identify as having a mental illness? If so, what? Have you been officially diagnosed with a mental illness?
- 6) Can you explain if/any involvement you may have had with the criminal justice system and if/how it relates to your mental health?
- 7) How do you define mental health/mental illness?

Participation in mental health treatment

- 8) How did you come to receive your mental health diagnosis (formally or informally)?
- 9) How do you feel about your mental health status?
- 10) What forms of treatment do you undergo to manage your mental health? (i.e. medication)

Medication

- 11) Have you been prescribed any psychotropic medication? If so, what?
- 12) Tell me about your experiences and feelings taking or not taking medication to maintain mental health.
- 13) How often do you keep to the medication schedule? Why?

Programming

- 14) What sorts of programming/services are offered in the community to help deal with mental health issues? Do you take part in any of these resources? Why or why not?
- 15) Are these programs helpful? Why or why not?
- 16) If you do not take medication and/or participate in programming, why not?

Mental health and addiction

- 17) Do you see a connection between mental health and addiction? If so, what?
- 18) How do prescribed medication compare to illicit drugs?
- 19) How do you define addiction?

Social identity and mental health

Family/Friends

- 20) Are you forthcoming with your friends and/or family about your mental health status? Why or why not?
- 21) What role do your family and/or friends play in your decision to talk about mental health? To participate in treatment/services?

Professionals/Para-Professionals

- 22) Can you tell me about some of the relationships you have with service providers? Are they generally positive or negative? Why?
- 23) Do you talk about/work with any service providers regarding mental health issues/treatment/support? Why or why not?
- 24) Can you speak to some of the potential advantages and/or disadvantages of working with these service providers for help with your mental health?

Regulating mental health treatment

- 25) Does anyone encourage and/or pressure you to participate in mental health programming? If so, who? If so, how do they encourage and/or pressure you? Tell me what you think about being encouraged and/or pressured to participate in mental health programming. Is it useful to have this kind of encouragement or not?
- 26) Does anyone encourage and/or pressure you NOT to participate in mental health programming? If so, who? If so, how do they encourage and/or pressure you? Tell me what you think about being encouraged and/or pressured to participate in mental health programming. Is it useful to have this kind of encouragement or not?

Alternative treatments

- 27) What supports would you like to see to allow for mental well-being?
- 28) Can you tell me about any alternatives to medication that you have been offered to cope with mental health? Have you participated in these alternatives? Why or why not?

Concluding Questions

- 29) Is there anything else that you would like to talk about that we haven't covered?
- 30) Demographic questions: age, gender, race/ethnicity, sexual orientation, hometown, length of time in the homeless community

Appendix F: Focus Group Interview Guide

1) Identification

- a) How do homeless men and women become identified as mentally ill and what are the most common mental illnesses homeless individuals face?
- b) How are the more serious and less serious cases distinguished?

2) Intervention/treatment

- a) What are the current methods of intervention/treatment used on this community?
- c) Which of these methods are most/least effective?
- e) What are some of the difficulties you face in doing this type of frontline work and what would help you work with this population more effectively?

3) Medication

- a) What are the most popular medications currently prescribed to the homeless men and how is the medication managed?
- c) How are issues of (non)compliance dealt with?
- d) What are your thoughts on medication (and alternatives)?

4) Dual Diagnosis

- a) How/do you distinguish between someone's mental illness and substance abuse problems and how is the course of treatment different?

5) Long term

- a) What are the long-term strategies for dealing with mental illness amongst homeless individuals?

6) Are there any final comments someone would like to make?

Appendix G: Participant Attributes

Participant	Age	Sex	Race	Sexual orientation	Time in homeless community	Current residence	CJS	MH diagnosis	Medication	Addiction
Al	46	Male	Black	N/A	On/off 5 years	Shelter 1	No	No	No	Drugs
Chico	50	Male	White	Straight	3-4 years	Shelter 1	Prison	No	No	Alcohol
Christine	39	Female	White	Straight	8 months	Shelter 2	Jail	Mild depression, OCD, Bi-polar	Clorazepam	Crack
Courtney	33	Female	White	Straight	15+ years	Subsidized housing	Probation	Anxiety, bi-polar, mood disorder	Seroquel, Epival, Wellbutrin	Heroin
Daniel	47	Male	White	Straight	10 years	Shelter 1	Probation	PTSD, depression	No	Alcohol
Doug	55	Male	N/A	Straight	3+ years	Subsidized housing	Interaction with police	Bi-polar, Anxiety	Effexor, Trazodone, Seroquel, Amitriptyline	Alcohol
Gaston	59	Male	White	Gay	4+ years	Subsidized housing	Drunk tank	Bi-polar, ADHD	Apivol, Zoloft, Topomax, Wellbutrin	Alcohol
Gerry	34	Male	White	Asexual	9 months	Shelter 1	No	Depression	Cipralax	No
Giles	51	Male	Black	Straight	1 year	Shelter 1	Probation	Schizophrenia	Zyprexa, Seroquel, Lorazepam, Cymbalta	No
Greg	29	Male	White	Straight	7 months	Shelter 1	No	ADD	No	Alcohol
J.J.	50	Male	White	Straight	3+ years	Subsidized housing	No	OCD	Effexor	Crack, Alcohol
Julien	45	Male	White	Straight	6 years	Shelter 1	Jail	Anxiety	Lorazepam	Alcohol
Jamie	35	Male	White	Bisexual	16 years	Shelter 1	Jail	Depression	No	None
Jon	47	Male	White	Straight	On/off for years	Shelter 1	Jail	Anxiety	Undisclosed	Drugs, Alcohol
Joseph	49	Male	Bi-racial	Straight	On/off 4 years	Shelter 1	Interaction with police	OCD	No	No
Karla	32	Female	White	Straight	8 months	Shelter 2	Probation	Depression, Anxiety	Zyprexa	Opiates
Katie	29	Female	White	Bisexual	16 years	Supportive housing	Jail	Anxiety	Seroquel	Crack, Ecstasy, Alcohol
Lenny	57	Male	White	Straight	5 months	Shelter 1	Prison	Anxiety	No	Cocaine, Alcohol
Louise	48	Female	White	Straight	3 years	Shelter 2	Prison	Bi-polar, Depression	Seroquel, Prozac	Crack, Alcohol
Mac	57	Male	White	Straight	3 years	Rooming house	Prison	PTSD, Depression, Anxiety	Effexor, Seroquel, methadone	Heroin, Alcohol
Mark	42	Male	White	Straight	3 months	Shelter 3	Jail	OCD	No	Alcohol
Mary	55	Female	Inuit	Straight	Many years	Shelter 2	Jail	No	Seroquel	Alcohol
Matilda	63	Female	Native	Straight	10 years	Shelter 2	None	No	No	No
Max	52	Male	White	Straight	6 years	Subsidized housing	Jail	Depression	Ativan	Cocaine, Alcohol
Mia	57	Female	Metis	Straight	3 years	Shelter 4	None	Bi-polar	Undisclosed	Alcohol
Mick	53	Male	White	Straight	1 year	Shelter 1	Jail	PTSD, OCD, Social phobia, ADD	Paxil	Cocaine, Crack, Alcohol
Milan	38	Male	White	Straight	9 years	Shelter 1	Probation	Bi-polar	Mood stabilizer, anti-depressant	Alcohol

Participant	Age	Sex	Race	Sexual orientation	Time in homeless community	Current residence	CJS	MH diagnosis	Medication	Addiction
Mustang	38	Male	Native/white	Straight	On/off 3 months	Shelter 1	Prison	Depression, Bi-polar	Seroquel	Drugs, Alcohol
Otto	43	Male	White	Straight	6 years	Shelter 1	Drunk tank	ADHD, Social disorders or bi-polar	No	Alcohol, Oxycotin
Ron	41	Male	White	Bisexual	6 months	Shelter 1	Prison	ADHD, PTSD, Bi-polar, Depression, Anti-social personality disorder	Epival, Effexor, Paxil, Methadone, Prozac	Cocaine, Crack, Alcohol, Heroin
Ronan	59	Male	White	Straight	3.5 months	Shelter 1	Probation	Depression	Anti-Depressants	Alcohol
Seamus	42	Male	White	Straight	5 months	Shelter 1	None	No	No	Alcohol
Shadow	43	Male	White	Straight	15 years	Rooming house	Prison	Depression, Bi-polar	Paxil, Seroquel	Alcohol
Sheela	48	Female	Native	Bisexual	4 months	Shelter 2	Jail	Depression	Zoloft	Marijuana, Cocaine, Alcohol
Toby	48	Female	Inuit	Gay	5 months	Shelter 2	Jail	Bi-polar	Undisclosed	Alcohol
Tom	54	Male	White	Gay	9 months	Shelter 1	Jail	No	No	Cocaine
Vince	36	Male	White	Straight	4 years	Shelter 1	Jail	PTSD, ADHD, Severe clinical depression	Wellbutrin, Concerta	Alcohol, Oxycotin, Heroin
Wanda	61	Female	White	Straight	10 months	Shelter 2	None	Anxiety	Anti-anxiety meds.	Alcohol