MASTER THESIS

**The Hero's Journey:
Poverty and Mental Health amongst Ottawa's Low-Income Men**

by

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Chapter 1: Introduction

I first became interested in the relationship between poverty and mental health shortly after beginning my first social work field placement at Centre 454 in the autumn of 2008. At that time, Centre 454 was one of the busiest drop-in centres in Ottawa — a central hub which provided a variety of much needed services and support to homeless and other at-risk individuals. My curiosity continued to grow over the next few years, as I began working in supportive housing with men and women facing both mental health and addiction issues, problems which only appeared to be compounded by their experience of living in poverty. Not long after beginning my job at St Luke's Table — a drop-in centre similar to Centre 454 — I began to wonder if many of the individuals who walked through our door every day were silently battling issues related to their mental health. Due to my concern that so many economically disadvantaged participants appeared not to be receiving the same level of attention for their mental wellbeing as for their physical wellbeing and practical needs, I decided to address the issue by making it the focus of my Master's thesis.

1.1 Significance of the Study

While the relationship between poverty and poor mental health has been studied extensively and many interesting findings have been uncovered, there remain definite gaps in the research with respect to certain groups. Much of the research has focused on certain marginalized groups of interest, such as impoverished children (Lipman & Boyle, 2008) or newcomers to Canada (Hansson et al., 2009; UNHCR, 2015). Meanwhile, others have received far less attention in the way of academic research — namely, those groups which are not typically viewed as marginalized. As a result, very little research has delved into the experiences of adult men who live in poverty (Buck, 1997) and who, while not homeless, remain vulnerably housed.[1] The findings presented in this thesis are an effort to begin addressing that gap by drawing attention to a group whose experiences have remained largely unseen and unvalidated.

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[1] In Canada, to be vulnerably housed often means living in a rooming house or other low-income housing, where the individual is still very much at risk of becoming homeless, among other things. The issues surrounding this will be discussed more in-depth later on.

1.2 Background

Research location. The research for this thesis was conducted in Canada's capital city of Ottawa, Ontario. More specifically, data was collected from participants of St Luke's Table, a busy drop-in centre located in Chinatown. St Luke's Table is a day centre which has been offering services and support to those who are homeless or at-risk of homelessness, as well as to those who are low-income and/or living in rooming houses for more than thirty years (St Luke's Table, 2015). According to their website, the program is meant to to cultivate "a supportive environment where visitors can maintain and improve their personal and mental health" (St Luke's Table, 2015).

St Luke's Table is an important resource for many of the residents who live in its surrounding neighbourhood, an area of the city which is particularly low-income. In Ottawa, there are more than 120 *licensed* rooming houses (with many more that are unlicensed) and the area surrounding St Luke's contains the highest concentration of such housing in the city (Sailus, 2014). Rooming houses can be defined as "residential dwellings that contain four or more rental units with shared use of a bathroom and/or kitchen" (Hwang et al., 2003, p. 437). Because the rental of a single room with shared common areas tends to cost considerably less than rental of a private apartment, the existence of rooming houses do help to meet the demand of low-cost housing options for individuals surviving on extremely low-income, including "those experiencing social, physical, or psychological crises who might otherwise be on the streets or in shelters" (Mifflin & Wilton, 2005, p. 403). However, while rooming houses may indeed help to put a roof over someone's head, enabling some level of privacy and independence, in many cases, the rooms also come to represent what Mifflin and Wilton describe as "a marginal, isolating, and potentially harmful, environment" (2005, p. 403). Thus, it is not surprising that they are often viewed as a "last resort" living facility (Mifflin & Wilton, 2005, p. 403), only to be considered after all other options have been exhausted. For many in receipt of Ontario Works benefits, considering how little they receive each month, a room is often their only option.

Poverty. Poverty is a serious concern in Ottawa. Recent statistics indicate that 15.2 percent of residents in Ottawa are living in poverty (Daling et al., 2010). Interestingly, the rates were highest among individuals of middle age and, in particular, middle-aged men

(Ottawa Public Health, 2014). Many low-income Ottawa residents rely on social assistance programs such as Ontario Works (OW) or the Ontario Disability Support Program (ODSP) to help meet at least some of their basic needs. Realistically, however, social assistance rarely provides enough for people to live on. In the province of Ontario, the average monthly income for a single person receiving OW is $585 (Daling et al., 2010). And while the rates are higher for those on disability (the average ODSP recipient receives $1,042 per month), considering that the average market rent for a private, single-occupancy apartment is $853 per month, still it rarely provides enough to cover even the most basic necessities.

Mental health. Mental health issues are a concern because they are common and can affect anyone at any stage of their life. Between 2011 and 2012, 16% of individuals in Ottawa reported seeking help for a mental health concern at least once in the past 12 months (Ottawa Public Health, 2014). In fact, research suggests that one in three Canadians will suffer from a mental health problem at least once in their lifetime (MHCC, 2011). These rates help to illustrate the prevalence of poverty and poor mental health among Ottawa residents and demand more attention.

1.3 Research Questions

In order to address the concerns mentioned above, I set out to answer three key research questions which would become the focus of this study:

- First and foremost, how does the experience of poverty impact the mental health of low-income men in Ottawa?
- What do these men identify as their most pressing concerns? (Is their mental health and wellbeing even a priority?)
- And finally, what can be done to improve their quality of life, given the reality of their current situation (i.e. being economically disadvantaged)?

In answering these questions, I hope to cultivate a better understanding of the complex relationship between poverty and mental health as uniquely experienced by unattached men, which I believe is important given that they make up such a significant portion of Ottawa's poor. In addition to this, the remaining research questions have allowed space for these men to voice what is most concerning to them, and what they believe is needed in order to move

their lives forward in a positive direction. Ultimately, the aim of this study is to improve the quality of life for low-income men in Ottawa by facilitating a better understanding of their current situation, as well as identified urgent needs.

I also hope to give back to the community by offering findings which may be of beneficial use to the drop-in centre from which I gathered my data, along with others like it. When management and frontline workers alike have a better understanding of the issues participants are facing, participants are in a much better position to receive the help they need.

1.4 Research Design

Given the open-ended nature of my research questions, much of this research was exploratory in nature. Thus I opted for a qualitative approach to the research design, which I hoped would allow me to produce findings with as much depth and meaning as possible. And while my small-scale findings may not be generalizable to the larger population, I do hope that this framework will allow for a deeper understanding of these men's experiences.

1.5 Theoretical Positioning

Systems theory, the theoretical framework which has guided my research, has been noted for its "substantial influence on the knowledge base of professional social work" (Healy, 2005, p. 148). General systems theory emerged in the 1930s with the work of Austrian biologist Karl Ludwig von Bertalanffy. Von Bertalanffy's ideas went on to inspire the works of many scholars in the social work field, including Howard Goldstein's *Social Work Practice: Model and Method* (1973), which would challenge "the psychoanalytic approach of looking to the individual for the source of the problem" and instead encouraged professionals to connect both "the person and problem with the environment" (Lundy, 2011, p. 64; Healy, p. 134).

According to systems theory, individuals experience difficulties due to problematic interactions within and across the various social systems in their lives (Healy, 2005; Lundy, 2011). These systems are said to exist at the micro-, meso- and macro-level, and could refer to one's immediate family, the welfare system, and/or society as a whole.

I found systems theory to be particularly relevant to my topic of study because the men I interviewed identified and interacted with a variety of systems on all levels, many of

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which they described as having a significant impact on their lives. One of my research questions involved asking what can be done to improve participants' quality of life, given the reality of their current situation. A question such as this offers an ideal opportunity to apply systems theory, which essentially provides "a framework for understanding and responding to people in their environments," while simultaneously discouraging "the pathologization of either the individual or their environment" (Healy, 2005, p. 146).

Chapter 2: Literature Review

This chapter contains an in-depth discussion of the key concepts pertaining to this research project — that is, poverty and mental health. Before we can consider the ways in which poverty and mental health relate to one another, it is first necessary to determine what is meant by each of these concepts, specifically within the context of Canadian culture and society. The purpose of this chapter then is to reference what is already known about poverty and mental health in Canada — how these issues are defined and measured, as well as the rate at which they are known to affect Canadians.

2.1 Poverty in Canada

More than two decades ago, the World Health Organization identified poverty as the single "greatest cause of ill-health and suffering" worldwide (1995, p. 1). Narayan et al. refer to poverty as a "multidimensional social phenomenon" (2000, p. 32) which significantly limits an individual's right to freedom and dignity (Fasting, 2001; Ventres & Gusoff, 2014). Despite our ranking as one of the wealthiest countries in the world, poverty is a serious concern for many Canadians because of its prevalence as well as the multitude of social problems which can arise as a result of it. One of the more extreme consequences of poverty, of course, is homelessness. In 2014, 3058 single men accessed Ottawa's emergency shelter system, where they stayed an average of 64 nights (Alliance to End Homelessness, 2015). In fact, around 47% of those who used emergency shelter services in Ottawa that year (2014) were single adult men (Alliance to End Homelessness, 2015). This is more than that of single women and youth *combined*, making unattached, middle-aged men the single largest group of homeless people in Ottawa.

It is important to understand that experiences of poverty constitute more than just lack of material wealth, however. While these are indeed important factors in understanding poverty, they do not account for the social, mental, emotional, or physiological impacts of living in poverty. A review of the literature demonstrates that poverty can result in serious consequences to an individual's overall health and wellbeing, both physically and mentally (Murali & Oyebode, 2004; Wilton, 2003). It also has the power to negatively impact an individual's education level, social relationships and social integration (Buck, 1997; Wilton, 2003; Jacob & Kuruvilla, 2007). In addition to this, inadequate (substandard) housing,

feelings of disempowerment, difficulty accessing resources, and barriers to employment have also been found to be associated with poverty (Buck, 1997; Jacob & Kuruvilla, 2007).

Defining poverty. Experiences of poverty can vary widely depending on one's social and geographical location. As a result, there are a number of definitions which may be similar in many ways, but no one definition accepted as universal (Auger et al., 2004). As exerted by Patel (2005), such "definitions vary depending on the social, cultural and political system in a particular region and country, and according to who might be the user of the data on poverty" (p. 26). This notion of the data "user" is particularly interesting, as it suggests that how one chooses to define and measure poverty may well depend on what they are looking to find. Of course, bias is a risk with any subject of research, though the lack of a consistent and universally applicable definition in this case makes poverty a particularly vulnerable target. Because there is no simple definition of poverty, it is usually most helpful to conceptualize it in terms of *absolute*, *relative*, or *subjective* poverty (Phipps, 2003; Auger et al., 2004). A brief explanation of each of these terms (along with their corresponding measures) has been outlined below:

Absolute poverty — "usually refers to having less than an absolute minimum income level based on the cost of basic needs" (Auger et al., 2004, p. 40). From this viewpoint, there is no room for subjective interpretation or bias. The poverty line is clear, and basic needs are determined based on the minimum necessary to *survive*, not to thrive. However, the trouble with defining poverty in this way is that it can be "difficult to objectively select a minimum set of necessities" (Auger et al., 2004, p. 40).

Absolute poverty measures. Absolute poverty measures are commonly used in the developing world, and are even the preferred method in the United States. Canada does measure *income* in this way, but makes no claim of attempting to measure poverty per se. One way of measuring absolute poverty is through the use of a poverty line. Poverty lines are typically created based on the minimum income needed in order to sustain oneself in a particular geographical region. Essentially this refers to the ability of one's income to meet their basic needs. Anyone whose income falls below the established poverty line is then considered to be impoverished. Meanwhile, anyone whose income happens to fall on or just

above the poverty line is not considered to be significantly deprived, but rather members of a different demographic — typically labelled as the lower middle-class or working poor. This, of course, can be problematic.

Canada does not have nor does it make use of a poverty line. Rather than attempting to measure poverty, we focus instead on measuring income. While poverty and low-income may be related in many ways, these terms are not interchangeable. A low-income status is not always an indicator of poverty. A good example of this is university students. While many university students in Canada are low-income, most would likely not identify themselves as impoverished. Oftentimes, students have outside support to help them along during their years of study — social safety-nets such as student loans, scholarships, grants or even help from family. Alternatively, for a low-income adult who is *not* eligible for any such loans and who, for whatever reason, does *not* have any social safety-net to fall back on, it is likely that they would indeed describe themselves as impoverished.

Relative poverty — Alternatively, relative poverty typically "refers to having less than the average standard in society" (Auger et al., 2004, p. 40). Thus, poverty can be understood only in relation to the rest of society. In this case, poverty is recognized not only in terms of marked material deprivation, but also in terms of its wider sociological impact on individuals and groups.

Relative poverty measures. Relative poverty is typically "measured as the proportion of individuals below a certain percentage of the median income" (Auger et al., 2004, p. 40). These measures tend to be used more commonly in industrialized nations such as Canada (Auger et al., 2004, p. 40), where poverty exists as a result of growing inequality between the rich and the poor.

Subjective poverty — "refers to individuals [who feel] they do not have enough to meet their needs" (Auger et al., 2004, p. 40). This is the least commonly referenced way of understanding poverty.

Subjective poverty measures. This form of poverty is primary measured through the use of surveys (Auger et al., 2004).

In Canada, it would seem that our definition of poverty has in many ways become synonymous with our measurement of it. Each of these measures has its strengths as well as its limitations. None can be said to be perfectly effective for accurately measuring poverty in every context, but, as noted above, some measures may be more appropriate for use in certain situations than others. It is also possible to use more than one measure in order to facilitate a broader understanding of poverty within a certain context.

Many scholars have become critical of our efforts both to define and to measure poverty, which typically involve some measure of income (Auger et al., 2004). Tony Novak (1995) has been especially critical in this regard, insisting that such attempts to quantify poverty have only resulted in further confusion, where the measurements have actually *become* the definition. He goes on to argue that the problem which inevitably results from this is a never-ending competition as to which measurement is able to provide us with the most accurate reflection of poverty at any given time and in any given context (Novak, 1995). As a result, poverty statistics have been criticized by some scholars as being little more than arbitrary numbers which fail to reveal the true scope and/or depth of the many lives impacted by poverty (Novak, 1995). As mentioned earlier, poverty statistics may be easily manipulated, so findings often depend greatly upon the standpoint from which we choose to view poverty in the first place.

Traditional measures of poverty, which focus almost exclusively on income, have also been viewed as problematic (Novak, 1995). This is because income measures rarely take into account the "social aspects of poverty," including "factors such as social deprivation and social capital" (Auger et al., 2004, p. 40). We see this evidenced here in Canada. While we may not have an official poverty line, there has long been an emphasis on low-income measures (LIM) and the low-income cut-off (LICO). Statistics Canada is adamant that such measures are only intended to measure low-income, never poverty (Statistics Canada, 2013). Yet without any official alternative to look to, low-income measures have inevitably become crucial in our conceptualization of poverty as well (Phipps, 2003; Auger et al., 2004). And as Novak illustrates, this can indeed be problematic, as experiences of poverty often encompass so much more:

> Money is of course crucial in understanding poverty, but poverty is also much more
> than just a lack of money. It is about insecurity and powerlessness: about not knowing

how you're going to get through to the end of the week, about having no or little

control over your future, few choices, no chances to plan ahead, no prospect or hope

of escape from an interminable struggle simply to survive. It is to be faced by a world

which constantly offers more than can ever be achieved […] Poverty is a condition of

existence and it is this condition, and what creates it, that we need to understand. What

is more, it is a condition that is experienced by many more than those who fall within

existing measurements of the poor. (1995, p. 62-63)

Questioning the ways in which poverty is measured is a critical step in expanding our limited

view on poverty. In order to understand poverty in all its complexities, it is, of course,

necessary to look beyond income alone.

Stigma. In many prosperous nations such as Canada, poverty is still largely viewed as

an individual rather than a societal problem — a problem which individuals should have the

ability to resolve on their own. Because wealthier nations have, to some extent, "overcome

the important challenge of inequality of opportunity, […] more emphasis and responsibility

[becomes] placed on the individual to help themselves get out of their predicament" (Shah,

2011). Thus, many are under the impression that with enough hard work and determination,

anyone can overcome the systemic barriers which poverty puts in place and experience

success. This is a problematic misconception, however, for it implies that for the 1 in 7

Canadians currently living in poverty (Canada Without Poverty, 2016), they simply have not

worked hard enough or they must not have the desire to succeed.

It is stereotypes such as this that may lead to stigmatization of the poor, for the reality

is that hard work alone does not guarantee one's way out of poverty. The truth is that

surviving day-to-day despite limited resources, while feeling the walls of poverty

continuously closing in, is hard work in itself. Novak describes this experience as a

relationship:

It is to be in a particular relationship to the wider society and to the dominant value

systems and ideologies through which it operates. It is to be in a dependent

relationship to employers, social security officials, housing officers, […] social

workers: to a society with very considerable power to label you as inadequate, stupid,

lazy, feckless, deserving or undeserving […] The stigma of poverty is so deep-rooted

in western history and culture that the struggle against poverty is not just a struggle to make impossible ends meet, but also one to maintain a sense of self-worth and dignity against a society that creates you as a failure. (1995, p. 63)

Research by Wilton (2003) supports this idea as well. In a qualitative study which looked at experiences of poverty among mental health consumers in Hamilton, Ontario, Wilton found that "relative deprivation contributed to a stigmatized self-image," indicating a "devaluing of self as an outcome of marked and persistent relative deprivation" (2003, p. 150-151).

Shame. For many who live in poverty, stigmatization can become internalized, resulting in profound feelings of shame — and once negative those self-beliefs become internalized, they are not easily forgotten. As a product of poverty herself, Dr. Janice Gasker (1999) described the discomfort she felt working in academia, despite having been a successful Ivy League professor. Regardless of her academic achievements and financial success, she insists that the "class-consciousness" of her past has never truly left her: "It's a small voice that is forever reminding me that I come from poverty. Poverty is where I belong […] Having been poor, I always feel poor. And I always feel ashamed" (1999, p. 93-94). Gasker's experience helps illustrate an important point: that the experience of poverty is far more complex than simply acute financial deprivation. Evidently, one's experience of poverty does not necessarily end with financial wealth and security. Poverty can leave scars on the soul — the wounds may heal, but just as Gasker describes, for many, the scars continue to serve as a painful reminder of where they came from.

> Reflecting on the legitimacy of relative poverty, Gasker gently reminds us that:
> With due concern for the dire need that exists in developing nations, it is the sharp economic contrast that exists here as it does nowhere else on this planet that causes the shame that is poverty in this country. […] It's knowing that liberty and opportunity exist, but reserved for others, that erodes the soul. (1999, p. 96)

Ventres and Gusoff (2014) also speak to this with their discussion on the docile compliance which has come to exist in so many individuals who have been continuously "beaten down" in their experience of poverty. The authors insist that such behaviour has been "triggered by internalized shame in the face of rampant inequality" (2014, p. 55). As a result, they say that "the poor see poverty as a natural and unchangeable reality rather than as a social

phenomenon created by and subject to the forces of human action" (2014, p. 55).

Understanding poverty is not about comparing whose struggle is worse or which group lacks more of their basic needs. It is about acknowledging inequality in all its forms, and this is apparent even in the wealthiest of nations.

2.2 Mental Health in Canada

Defining mental health and mental health issues can also be challenging. Like poverty, it may be interpreted differently depending on one's geographical and social location. However, most would at least agree that it is indeed an important factor in overall health. For nearly 70 years now, the World Health Organization has clearly defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948). The inextricable connection between physical and mental health has also been evidenced by scholars such as Bhugra, Till and Sartorius (2013), who note both the direct and indirect impact they have upon one another. Where a person finds themselves along the mental health spectrum is largely dependent on a unique combination of social, environmental, biological and psychological factors (Bhugra et al., 2013).

In Canada, the prevalence of mental health issues has created cause for concern, along with its social and economic impact. Research suggests that one in three Canadians will suffer from a mental health problem at some point in their life (MHCC, 2011).

With that said, however, it is important to be aware that statistics on mental health can be grossly misleading. Despite the fact that mental health problems are becoming increasingly more common, many Canadians remain hesitant to seek help (MHCC, 2011). As a result, most statistics are likely to be a low estimate (Buck, 1997). Also concerning is the question of how honest people truly are about their mental health issues (Mental Health First Aid, 2014). Due to the stigma still attached to certain mental health issues, as well as the same social conditioning which may cause some professionals to over-diagnose certain groups of people while under-diagnosing others, it is possible that many individuals have not felt comfortable enough to be entirely honest about their struggles (even to themselves).

The Mental Health Commission of Canada. Established in 2007, the Mental Health Commission of Canada (MHCC) identifies its primary goals as creating a platform for clear

and honest communication surrounding the realities of mental health issues, as well as facilitating change in the way we understand and treat mental health issues in Canada. I will be referencing the MHCC frequently in this section, for I have found them to be a wealth of valuable information in terms of understanding mental health in a Canadian context.

        Mental health discourse. As we manage to cultivate greater insight into the world of mental health, the language we use continues to evolve. In Canada, it is common to use terms such as "mental health problem," "mental disorder, mental illness, poor mental health, [and/or] psychiatric illness" (MHCC, 2011, Section 1: p. 1). Our choice in language is powerful, and it is important to maintain an awareness of this.

        For instance, while the term "mental illness" is still frequently used here in Canada, there have been opposing views as to whether or not it is helpful in reducing the stigma surrounding mental health issues. On one hand, a medical diagnosis of "mental illness" can be helpful in shifting the blame from the individual by attributing their illness to factors which have been largely outside of their control. For many, this sort of validation from a medical professional can provide long-sought relief and reassurance that their illness has not been a choice. However, there is another important message which is sent when someone is labelled in this way — that just as they were powerless over the deterioration of their mental health, so too will they remain powerless in their recovery. While validation is important, it can also keep people "stuck" by making them feel as though their current situation is inevitable (Pasman, 2011).

        It is also worthwhile to know that just as our state of physical health fluctuates over the course of our lives, so too does our mental health. In other words, a mental health diagnosis is not a death sentence. Even in more extreme cases, where individuals have "more serious, long-term or recurring problems," it is important to understand that with proper maintenance and support, they are still free to live "meaningful and satisfying lives" (MHCC, 2011, Section 1, p. 6). Therefore, it is important that professionals exercise caution so as not to disempower mental health consumers in the process of providing support.

        Throughout this section, I will primarily refer to terms such as "mental health issues" or, at times, "poor mental health" in an effort to remain as inclusive and as non-judgemental as possible. I believe this is important as it allows us to see the individual as a whole person

who happens to be experiencing a mental health issue, as opposed to stripping them of their identity by labelling their whole being as mentally ill.

Defining mental health. As mentioned earlier, mental health is integral to our overall health and wellbeing. According to Bhugra et al., *positive* mental health is characterized by "a strong sense of self and others," where an individual is both willing and able to form healthy relationships, while also comfortable spending time on their own (2013, p. 3). Meanwhile, the Public Health Agency of Canada defines positive mental health as:

> the capacity of each and all of us to feel, think, act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. (2014)

The MHCC clearly distinguishes between *mental disorder* and *mental health problem*, recognizing that not everyone who experiences a mental health problem necessarily meets the criteria for formal diagnosis. At the same time, they in no way discount the struggles faced by those experiencing mental health problems. Definitions of both terms may be found below:

Mental health disorder. A mental disorder is characterized by significant changes in an individual's thoughts, behaviours and emotional state to the point of negatively impacting their capacity to work as well as maintain interpersonal relationships (MHCC, 2011). As in the United States, professionals in Canada typically refer to the Diagnostic Statistic Manual IV (DSM-IV) as a guide in helping them to properly diagnose mental health disorders (MHCC, 2011).

Mental health problem. Alternatively, a mental health problem is said to be "a broader term that encompasses both mental disorders and symptoms of mental disorders which may not be severe enough to warrant the diagnosis of a mental disorder" (MHCC, 2011, Section 1, p. 2). Even without the diagnosis of a mental health disorder, however, mental health problems can be just as disruptive to people's lives (MHCC, 2011). In fact, it is possible that *not* having a formal diagnosis could contribute to the problem (Pasman, 2011), as the individual may feel that their struggle is somehow invalid and, therefore, unworthy of

professional attention. As mentioned earlier, one potentially positive outcome of a formal diagnosis is validation (Pasman, 2011). Conversely, those with no diagnosis (and therefore no validation for their suffering) may, in turn, feel overlooked by the mental health system — as though further deterioration is the only path to receiving the help they need.

Vulnerabilities and risk factors. Mental health issues are complex and while certain risk factors have been identified, their presence alone does not guarantee that an individual will experience a mental health problem during their lifetime. Conversely, there are also individuals who suffer from serious mental health problems who may have been exposed to very few, if any, risk factors. With this in mind, it is important to remember that human beings are unique and, therefore, may respond to seemingly similar circumstances very differently. So while the awareness of various risk factors may help contribute to a more thorough understanding of mental health, in no way can they function as perfect predictors of individual outcomes. In short, vulnerabilities to poor mental health (i.e. risk factors) may be categorized as follows:

- *Internal factors* — refer to what is going on *inside* the individual. Vulnerabilities may include "a lack of emotional resilience, poor self-esteem and social status, feeling trapped and helpless, and problems associated with sexuality or sexual orientation, isolation and poor integration" (Bhugra et al., 2013, p. 3).
- *External factors* — refer to what is going on *outside* the individual — circumstances typically considered to be beyond their control. Such circumstances may include "poor social conditions (housing, poverty, unemployment), discrimination or abuse, cultural conflict, stigma and poor autonomy," etc. (Bhugra et al., 2013, p. 3).

Other risk factors may include biological and environmental factors such as educational and family background, which are known to impact a person's psychological health (Buck, 1997).

The danger with labels. Similar to poverty, defining poor mental health can present a challenge. What may be considered normal, reasonable behaviour in one context may be cause for concern in another. Indeed, many scholars have called attention to some of the problems associated with efforts both to define and to measure mental health issues (Payne, 1991; Buck, 1997; Jacob & Kuruvilla, 2007).

For one thing, individuals and the professionals who work with them may have vastly different views on their mental health issues (Jacob & Kuruvilla, 2007), though, inevitably, it is the professional's opinion which is given more weight. From a medical perspective, the individual experiencing mental health issues is often considered the least credible not only in determining a diagnosis, but also when deciding on the best course of action regarding treatment. In Social Work, mental health consumers are often valued as "experts" in their own lives, but this is certainly not a popularly-held belief among medical professionals. As a result, there is the danger of attributing labels (i.e. diagnoses) which do not fit (and subsequently prescribing medication which is not appropriate), all of which can be confusing and even detrimental to an individual's already fragile mental state.

There is also the risk of mental health professionals minimizing or ignoring legitimate mental health concerns. This can be particularly damaging for someone who may have been hesitant to ask for help in the first place. In either case, the individual is far less likely to seek help in the future if they do not feel they were truly heard or adequately cared for during that first critical interaction. Furthermore, the potential for bias within the mental health field also presents cause for concern (Jacob & Kuruvilla, 2007). For instance, mental health professionals may have certain pre-conceived notions as to which issues they expect to find within certain subsets of the population (such as being more likely to diagnose homeless men with psychotic disorders such as schizophrenia).

Stigma. Mental health sufferers have had a long history of stigmatization in Canada. According to the Mental Health Commission of Canada, it is a combination of "[m]yths, misinformation and lack of knowledge" which has led to the stigma surrounding mental health issues (2011, Section 1, p. 1). Certainly there is no doubt that Canadians have a better understanding of mental health problems today than in the past, but while we have indeed made progress, there is still work to be done. In general, most individuals are still more willing to discuss physical health issues than mental health issues. According to research from the Canadian Medical Association, 72% of Canadians said they would feel comfortable discussing a family member's cancer diagnosis with co-workers or friends, compared to just 50% who reported feeling comfortable discussing a family member's mental illness (CAMH). In reality, mental health problems are no different than physical health problems, in the sense

that "people of all ages, cultures, and education and income levels" can be affected (MHCC, 2011, Section 1: p. 6). Yet the stigma surrounding mental health remains.

This stigmatization of mental health sufferers is concerning for a number of reasons. Perhaps one of the most damaging consequences of stigmatization is social exclusion. Ironically, it tends to follow that the more obvious an individual's struggle is, the more severe their exclusion from the rest of society. In this case, those experiencing exclusion are likely also those who are *most* in need of meaningful social connection and acceptance. Furthermore, the experience of exclusion impacts more than just social opportunities — it can also impact one's ability to secure employment, as well as safe and secure housing (MHCC, 2011). Stigmatization may also impact what and how much mental health sufferers choose to share. When stigma becomes internalized, it can result in the underreporting of certain symptoms or issues (Jacob & Kuruvilla, 2007). Also concerning is the impact that stigmatization can have on an individual's willingness to seek or receive help when it is needed. For many individuals who are struggling, this continues to present a significant "barrier to diagnosis and treatment" (MHCC, 2011, Section 1, p. 3).

Stigma also influences our perception of mental illness. While mood and anxiety disorders are two of the most commonly experienced mental health issues in Canada, they are not always recognized as serious mental health conditions. One study found that respondents defined mental illness "as more 'obvious madness' rather than depression or anxiety" (Buck, 1997, p. 84). I believe this to be a common misconception among Canadians as well, although this is changing over time.

Unfortunately, the myths surrounding mental health problems have led many to believe they are a matter of choice and therefore something that sufferers can (and should) resolve on their own (MHCC, 2011). Until we are able to stop perpetuating these stereotypes and instead focus on properly educating the public, many Canadians will continue to suffer the effects of stigmatization.

Shame. Just as stigmatization of the poor can become internalized and produce feelings of shame, the same can be true for those who experience mental health issues. As a leading expert on shame and vulnerability, Dr. Brené Brown defines shame as follows: "the intensely painful feeling or experience of believing that we are flawed and therefore unworthy

of love and belonging – something we've experienced, done, or failed to do makes us unworthy of connection" (2013). Shame ensures that individuals remain silent about their struggles. And so it is a general lack of knowledge as well as feeling disconnected from others which inevitably lead to feelings of profound shame and loneliness — all of which creates an even greater strain on poor mental health.

In many ways, shame implies that an individual has become the ultimate victim of stigmatization, in the sense that they actually begin to *believe* what is being said about them. Mental health consumers are at particularly high risk for this, as they are already experiencing a vulnerable mental state as it is. The internalization of negative thoughts and beliefs typically results in lower self-esteem (due to feelings of shame and guilt), which may in turn reduce a person's willingness to seek help (MHCC, 2011).

In 2002, Health Canada surveyed a number of Canadians struggling with mental health issues (MHCC, 2011). According to findings from this study, 54 percent of Canadians reported feeling "embarrassed" of their mental health issue(s), and the same percentage claimed they had been discriminated against because of their mental health (Government of Canada, 2006, p. 41). In both cases, these numbers were slightly higher in men than in women (Government of Canada, 2006), perhaps reflecting deeper shame and a more profound impact of stigmatization among men dealing with mental health problems.

2.3 The Relationship between Poverty and Mental Health

The connection between poverty and poor mental health has been well established in the literature (Jacob & Kuruvilla, 2007; Murali & Oyebode, 2004; Narayan at al., 2000; Wilton, 2003; Patel, 2005); however, it is also a relationship which is highly complex (Jacob & Kuruvilla, 2007). While it is generally agreed that a correlation of sorts exists, our understanding as to directional cause is limited and thus, debate has been ongoing. While some researchers have identified poverty as a key cause leading to mental health problems, others have noted the ways in which a deteriorating mental health condition can lead an otherwise stable individual into poverty. In any case, it is important to note that not everyone who is poor will develop a serious mental health issue, nor will a mental health problem necessarily end in poverty for every person. Overall, it is generally understood to be a

complex relationship, wherein both issues are likely to "interact with one another" (Patel, 2005, p. 27).

The connection between poverty and mental health has been evidenced in different ways. For instance, many studies have found there to be a significant relationship between low-income (or low-income housing) and an elevated risk for developing certain mood disorders, such as depression (Patel, 2005; Murali & Oyebode, 2004), particularly among those whose experiences of poverty have been long-term or chronic (Jacob & Kuruvilla, 2007). Substance use disorders (Murali & Oyebode, 2004) and psychotic disorders are also said to be more prevalent among the poor (Murali & Oyebode, 2004). According to Jacob and Kuruvilla (2007), areas with high concentrations of poverty and deprivation have been associated with higher rates of mental illness, and especially elevated rates of suicide. Furthermore, both poverty and depression tend to be experienced as chronic conditions (Murali & Oyebode, 2004), which can make it particularly difficult to escape the cycle once a person becomes trapped within it.

Those suffering from mental health issues are also disproportionately affected by poverty (Wilton, 2003). Experiences of poverty can create added stress for those who are already suffering substantially from a mental health issue (Wilton, 2003). For mental health consumers, an adequate income is important not only for satisfying classically considered basic needs such as food and shelter, but also in order to break down barriers which may otherwise prevent them from participating fully in society.

For those who are both poor and struggling with their mental health, poverty is not only about deprivation of basic physiological needs. It also serves as an additional barrier to social integration and participation, which can have a significant impact on a person's quality of life (Wilton, 2003). While they may be able to survive on minimal income, many mental health consumers believe that a more adequate income would greatly improve their quality of life (Wilton, 2003).

Poverty leading to poor mental health. Research has found that the risk for developing a mental health issue is higher among those who are experiencing poverty, unemployment or homelessness (Jacob & Kuruvilla, 2007). The experience of poverty may make otherwise manageable stressors seem insurmountable, and it is commonly understood

that excessive stress can increase a person's risk for developing a mental health issue, such as depression (Patel, 2005). Patel also emphasizes the importance of equality among members of a society:

> Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk to suffer these disorders than those who are at the upper end […] [Thus], overcoming poverty might contribute to the promotion of mental health but it is unlikely to be enough; a more equitable distribution of resources remains important. (2005, p. 27)

One mental heath problem which seems to have an especially strong connection to poverty is depression. According to Murali and Oyebode, the stress of living in poverty "may be causally related to depression" (2004, p. 218). As mentioned in the previous section, depression is one of the most commonly diagnosed mental health conditions in Canada and no doubt, its causes are complex and different for different people. Yet it has been found that among those diagnosed with depression, they often identify financial struggles as the primary reason for their poor mental state (Patel, 2005). Conversely, when poor people were asked what they had experienced as a result of living in poverty, among the most commonly cited difficulties was "feeling depressed" (Jacob & Kuruvilla, 2007, p. 274). Depression is a serious condition, and while it may be one of the most commonly experienced mental health issues among Canadians, it is not to be taken lightly.

Having a safe and secure place to call home is also an important component of one's mental health. Poverty, however, seriously limits an individual's capacity to find and secure housing in any form, never mind the quality of the environment (Jacob & Kuruvilla, 2007). Along with inadequate housing, individuals who are poor are often also dealing with issues such as overcrowding where they live as well as unemployment, all of which contribute to high levels of stress. Disproportionate levels of stress among the poor are believed to be part of the reason why they experience higher rates of mental health problems than the general population (Payne, 1991; Buck, 1997). The poor are disproportionately stressed not only because of stressful living conditions, but also due to a general lack of support. According to Jacob and Kuruvilla, experiences of long-term poverty have often been linked to "lower levels of family and community support, alcoholism, having greater experiences as well as fear of crime and violence, abuse and high rates of family desertion" (2007, p. 275).

Poor mental health leading to poverty. The impact that mental illness can have on socio-economic status has also been documented. There are many ways in which mental health problems can contribute to a decline in socio-economic status. Among these are stigmatization, disability, and the notion of social "drift". The stigma attached to mental health problems can prevent some individuals from participating in activities that many take for granted, such as having a job, the ability to secure safe housing, as well as socializing and maintaining healthy personal relationships (MHCC, 2011). The isolation which sometimes results from stigmatization can put people at risk for poverty, particularly if they are unable to secure employment (Jacob & Kuruvilla, 2007).

In terms of disability, mental illness can be just as debilitating as many physical ailments. According to the Mental Health Commission of Canada, "Of the 10 leading causes of disability worldwide, five are mental health problems: unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder" (2011, Section 1, p. 6). Long-term disability status can have a detrimental impact on income for many Canadians. For too many, this will inevitably equate to a future filled with economic struggle and insecurity. Patel notes that disabling mental disorders such as depression and anxiety carry "adverse economic implications for the individual, their families and society" (2005, p. 27). This can create a vicious cycle of unemployment, poverty, and feelings of low self-worth, accompanied by a general worsening of symptoms in as one attempts to cope with such stressors.

"Drift hypothesis" (which is generally associated with schizophrenia, as opposed to mental illness in general) suggests that, in some cases, schizophrenia can result in a "deterioration in functioning to such an extent that the individual drifts down to a lower socio-economic state" (Jacob & Kuruvilla, 2007, p. 274). Over the past several years, there have been many studies to support this idea of serious mental illness (particularly schizophrenia) leading people into a downward spiral of poverty (Jacob & Kuruvilla, 2007; Murali & Oyebode, 2004).

2.4 Conclusion: The Poor and Mentally Ill

To be part of any stigmatized group presents significant challenges to an individual's wellbeing, self-esteem, and level of inclusion within society. Unfortunately, to experience this on more than one level (such as poverty and poor mental health) can lead to even further difficulty for people where, as Wilton describes, "the stigmatizing effects of poverty [can] intersect with, and exacerbate, the stigma of mental illness" (2003, p. 151-152). In his research, Wilton indeed found that the strain of poverty only added to the stigmatization already felt by mental health consumers, noting that this is a group which is "disproportionately poor" already (2003, p. 150).

The relationship between poverty and mental health in men. As demonstrated throughout this chapter, there is indeed a significant correlation between poverty and poor mental health which has been well-evidenced in the literature. What appears to be largely missing from this body of work, however, is how the connection between poverty and poor mental health impacts low-income men in particular. Buck noted this gap in the literature as well, but expressed that it may be "difficult to know whether studies on men's interpretations of poverty have been attempted and been found difficult, or whether the area has simply been largely ignored by researchers" (1997, p. 87). It is my hope that my own research will begin to address this gap.

<center>**Chapter 3: Methodology**</center>

The term *methodology* as it relates to qualitative research refers to "a comprehensive description of how data was gathered and analyzed" (Berg, 2001, p. 270). According to Snape and Spencer (2003), qualitative research may be defined as "a naturalistic, interpretative approach concerned with understanding the meanings which people attach to phenomena (actions, decisions, beliefs, values etc.) within their social worlds" (p. 3). In this chapter, I outline the methodology I used to produce the qualitative research findings presented in this paper.

3.1 Research Process

The methodology pertaining to this research project involved the use of *semi-structured interviews* as the research method used to gather data, along with a *collaborative social research approach* as a means of analyzing the data. A sample of willing participants was gathered through a combination of *convenience* and *snowball sampling* methods. I also chose a *qualitative* approach which, as Novak (1995) explains, has not always been championed within the realm of social sciences:

> For the past hundred years western social science […] has viewed and understood poverty from within the prism of a cramped and atheoretical empiricism. Apeing the world of the natural sciences, this empiricism establishes the accumulation of 'facts', and in particular the measurement of supposedly scientific data as the foundation of theoretical understanding. (p. 58)

Increasingly, however, it is also becoming better understood that qualitative and quantitative research serve different, yet equally important, roles in helping us to understand the world around us. It is not the case that one method is better or more accurate than the other. Instead, we may choose our methodology with different goals in mind. As noted by Wilton (2003), "representativeness is typically not a goal of qualitative research as the breadth of quantitative survey research is traded for in-depth knowledge afforded by interviews" (p. 143). The reason I chose a qualitative rather than quantitative approach to my own research is partly due to the small-scale nature of this study. As noted earlier, qualitative research is concerned with understanding *meaning*, which aligns with my own goal to produce meaningful data. Gathering only a small group of subjects allowed me to gain deeper insight

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into the issues that felt were most important. Thus, while quantitative research is valuable and useful in many cases, such methods could not have provided with the rich sort of data I was searching for.

3.2 Choice of Research Method

Semi-structured interviews were chosen as the primary research method used to gather data. According to Legard et al. (2003), "In-depth or unstructured interviews are one of the main methods of data collection used in qualitative research, [where] personal accounts are seen as having central importance in social research because of the power of language to illuminate meaning" (p. 138).

All interviews were conducted individually as well as face-to-face. There are extensive benefits to conducting in-depth interviews which, of course, include their "flexible and interactive nature, their ability to achieve depth, the generative nature of the data and the fact that it is captured in its natural form" (Legard et al., 2003, p. 168). Therefore, I personally chose this method as it allowed me to gather a wide range of data, with the flexibility of elaborating on any topic which interviewees found to be especially significant, as well as bypassing any which may have been too painful or uncomfortable to discuss. Most importantly, it allowed participants the time and space to respond to interview questions with as much honesty and consideration as they wished. This freedom allowed eager participants to take on a more leading role in the interview, while simultaneously allowing others more structure and guidance, as they saw fit. This resulted in an interviewing process which felt more like a conversation than an interrogation. Semi-structured interviewing also allowed for flexibility with regard to time, so that participants had more control over how long their interview would last. I chose all of this with the hope that fostering a sense of comfort and mutual respect would lead to more honest and open responses, which are not always easily obtained during interviewing (due to time constraints, unfamiliar settings, and/or distrust of the researcher).

3.3 Sample

All informants were recruited from St Luke's Table, a busy drop-in centre located in the heart of Chinatown. A total of eight participants were selected for interviewing, through a

combination of both convenience and snowball sampling. To gather this sample, I sought out men in Ottawa of mid-range age, who were presently housed yet still considered to be low-income, and who also attended St Luke's Table on a regular basis. Input from the frontline staff at the drop-in centre was particularly valuable in order to prevent researcher bias. The study was not advertised publicly, and incentives were not used (nor were they needed) to gather participants. Gifts cards were eventually gifted to the informants months after the interviewing had finished simply as a thank you for their participation, but informants had no expectation of this.

During the recruitment process, I approached each of the eight informants in person at the drop-in centre. I then briefed them on the nature of the study in order to evaluate their interest in participating. At this point, I also assured them that there was no obligation for them to participate. Interestingly, all those who were approached immediately agreed to take part in the study. This was encouraging, as I was seeking individuals who would be willing to open up about some difficult subject matter.

There are several reasons why I chose to gather my entire sample from St Luke's Table rather than from another day centre, homeless shelter, or some combination of the two. First, I was not interested in interviewing any of Ottawa's emergency shelter residents because while my focus is on low-income men, it is *not* on homeless men. And second, while there are indeed various other drop-in centres in the city, St Luke's was chosen for a number of reasons:

1. *Convenience* — I was already working at the location and, therefore, would not need to travel far to recruit and interview participants.
2. *Rapport* — As I had already been working there for some time, I was a familiar face to participants. While this could potentially be viewed as a problematic bias, my hope was that participants would feel more comfortable opening up to someone who they already recognized as working within and caring for their community, as opposed to yet another anonymous researcher.
3. *Giving back* — Most participants were eager to participate in the study, knowing that their participation would ultimately play a role in helping me to attain my degree. So while the scale of this study may be small and, therefore, not generalizable to the larger population, it is important that the findings in some way serve to benefit the

community they came from — whether that means sparking concrete changes or simply providing a platform for participants to voice what is meaningful to them, particularly those who may have otherwise remained silent.

3.4 Data Collection and Instrumentation

Data was collected over a four month period, by conducting individual interviews with each of the eight participants. All interviews took place in a private setting at St Luke's Table, with only myself and the informant present. Prior to the commencement of interviewing, informants were asked to sign a consent form, of which they would later receive a copy. With the permission of each participant, all interviews were audio-recorded for the purposes of future transcription. Interviews ranged from fifty-five to one hundred and fifty minutes in length, with an average timeframe of approximately ninety minutes (including a short break). Listed below are some of the advantages as well as the challenges of conducting the interviews at St Luke's Table, rather than an agreed upon meeting place elsewhere.

Advantages of the Location:

1. **Convenience** — both for the participants and myself. As mentioned earlier, the informants were already regular visitors of the centre while I, myself, worked there.
2. **Safety** — again, both for the participants and myself. Although the interviews took place in private, staff were always nearby should any issues arise.
3. **Comfort** — While some informants may have felt more comfortable at St Luke's than others, the drop-in was at least a familiar setting for all involved.

Challenges of the Location:

1. **Noise** — Depending on time of day (and month), the drop-in could become very busy at times, so noise was an issue during some of the interviews. In general, this was not a major concern, particularly during the interviews themselves. It did, however, make transcription more difficult at times.
2. **Anonymity** — While the research study was never publicly announced or advertised in any way at St Luke's Table, it was still possible for other members of the community to learn about the study. While I did my best to ensure the privacy of all participants, it is

possible that others knew of what was going on in the interview room and that some informants may have felt uncomfortable with that (though to be clear, this concern was never raised by any of the participants).

Interview guide. Interviews were conducted using a semi-structured interview guide (see Appendix 1), where questions were carefully constructed with the research questions in mind. The interviews were semi-structured in the sense that not all questions were asked of all participants, nor were they necessarily asked in any particular order. In general, each interview began with the same set of demographical questions, but many of the questions following that were adapted or rearranged in a way that best suited the individual. This was important since my goal was to provide respondents with a platform from which they could comfortably share their stories in a way that was meaningful to *them*. I was also aware of the sensitive nature of many of the questions, and so it was important to me that participants did not feel obligated to discuss any area of their lives with which they were not comfortable. Overall, I felt that semi-structured interviewing would allow for me to gather useful and important data, while simultaneously allowing participants to speak as little or as much about a topic as they deemed appropriate.

Preparation. Before conducting the actual interviews, I first practiced one full-length interview with a friend. This allowed me to clarify some of the questions which interviewees might find confusing or perhaps too invasive. It also helped me to realistically prepare for how long each interview would be. I found this practice to be particularly helpful in my preparation.

3.5 Analysis

In his textbook *Qualitative Research Methods for the Social Sciences* (2001), Berg outlines the general steps of qualitative analysis as follows:

- *Step 1*: Data are collected and made into text (e.g., field notes, transcripts, etc.);
- *Step 2*: Codes are analytically developed or inductively identified in the data and affixed to sets of notes or transcript pages;
- *Step 3*: Codes are transformed into categorical labels or themes;

- **Step 4**: Materials are sorted by these categories, identifying similar phases, patterns, relationships, and commonalities or disparities;
- **Step 5**: Sorted materials are examined to isolate meaningful patterns and processes;
- **Step 6**: Identified patterns are considered in light of previous research and theories, and a small set of generalizations are established. (p. 240)

Following this framework for analysis, I was able to analyze my own project data. I began transcribing the interviews soon after they had been completed (**Step 1**). This was a demanding and time-consuming process, but rigour in this area was particularly important as I wanted to ensure that any findings accurately represented participants' responses.

When this phase was complete, I printed each of the transcriptions and proceeded to read through each one, line by line (**Step 2**). At this point, I also began coding the data, taking note of any significant or recurring themes, as well as highlighting any quotations which I found to be particularly meaningful (**Step 3**). This process also required a significant time commitment, as I did not want to risk overlooking any important data.

When all interviews had been coded, I then transferred the data into a new document where several headings and subheadings were created and added to over time (**Step 4**). When all significant data from the interviews had been combined into one such document, I was then able to synthesize my findings by looking at each individual theme in relation to each of the eight participants. Viewing the data in this way, I was eventually able to extract meaning, which has been the ultimate goal of my qualitative research (**Step 5**).

Step 6, of course, would take place later on, as I considered the ways in which my findings fit within already established theories and research.

3.6 Ethical Considerations

This research project has been approved by the Norwegian Social Science Data Services (NSD). It was also accepted by the Executive Director of St Luke's Table, from whom I was given permission to conduct all interviews on site with participants of the drop-in centre. All informants received both oral and written information about the project, and gave their consent to participate. All who participated understood that they were free to withdraw from the study at any time, even after interviewing was complete. Participants were made aware of the fact that they could refuse to answer any questions with which they were not

comfortable, and indeed some opted to do so. I made every effort to ensure that participants felt as comfortable as possible during their interviews and to make this a positive experience for all involved. In fact, I received positive feedback from many of the informants who said they enjoyed being interviewed, and some even mentioned that they found it to be helpful on a personal level. This was somewhat unexpected and particularly rewarding for me as a researcher.

Chapter 4: Results and Discussion

For the purposes of carrying out this research project, a total of eight Canadian men were interviewed. Their ages ranged from 38 to 61 years of age, with an average age of approximately 50 years. Each of the men selected for interviewing accessed St Luke's Table on a fairly regular basis, with the newest participant noting that he had been attending for the past six month (on a regular basis). Most informants had been attending the drop-in for the past two or three years, though one participant noted his involvement since nearly the beginning — when the centre first opened its doors, more than 30 years ago.

For the purposes of anonymity, each of the respondents have been given pseudonyms and their ages will not be identified. Respondents were not given the option of choosing their own pseudonyms. Instead, their pseudonyms were chosen using the "Name Voyager" feature on a baby names website (www.babynamewizard.com). This feature allowed me to choose popular male names from the decade each participant had been born into. Considering the relatively small community from which I gathered my data, I feel this was the best way of ensuring maximum anonymity.

4.1 Experiences of Poverty

Present income source:

- *Social assistance*. The majority of those interviewed were in receipt of Ontario Disability Support Program (ODSP) benefits, while the remainder received social assistance from Ontario Works (OW). Of those on ODSP, more than half attributed their disability to a mental health condition (including chronic addiction). Others cited long-term physical disability.

- *Employment*. In addition to ODSP payments, one participant also cited employment income, but this was highly dependant on his ability to find and secure work each day. This individual further explained that there is a cap on how much ODSP will allow him to earn each month before he must take a cut in his ODSP payment. Similarly, someone else mentioned that he would occasionally pick up the odd job when the opportunity arose, but overall has not had much success in finding or securing work that suits his current abilities.

Another participant also reported having done some work "under the table" in the past, in an effort to supplement his low income.

History of homelessness. While none of the men were homeless at the time of interviewing, the majority did report past experiences of homelessness which I feel is an important piece of the poverty puzzle. In Canada, homelessness may be defined as:

> […] the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it […] Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing. (COH, 2012, p. 1)

More specifically, the experience of homelessness refers to "a range of housing and shelter circumstances, with people being without any shelter at one end, and being insecurely housed at the other" (COH, 2012, p. 1). In short, this includes those who are:

1. **Unsheltered** — absolutely homeless and living on the streets or in places not intended for human habitation;

2. **Emergency sheltered** — including those staying in overnight shelters for people who are homeless;

3. **Provisionally accommodated** — referring to those whose accommodation is temporary or lacks security of tenure; and

4. **At risk of homelessness** — referring to people who are not homeless, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards. (COH, 2012, p. 1)

The causes of homelessness are complex and can vary depending on one's personal circumstances. While the interviews reinforced this notion, there was one precipitating factor which most participants appeared to have in common and that is the lack of a social safety net. For instance, in terms of familial help, some did not have family at all while others had family members who lived far away. Even for those respondents whose family lived nearby, most simply were not in a position to help out financially.

Emergency shelters. More than half of those interviewed had spent time in an emergency shelter at least once in their lives — not only in Ottawa, but in various other

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Canadian cities as well. Only one participant reflected on this experience as being more positive than negative. For him, the shelter was a "safe haven," which is not to say he did not encounter difficulties. During our interview, he reflected on one period of homelessness that was particularly trying:

> It was very hard. I had a mental blocking. And the thing was, I couldn't think properly… […] you can't make a decision. You don't know where you're gonna sleep. You don't know what you're gonna eat. And sometimes you're standing at a corner of a street for hours and hours, standing in the same spot. You don't know what you're gonna do, you're confused. You don't know if you're going North or South or East or West […] You're lost. (Patrick, p. 20)

Some of the participants expressed concern for the danger associated with emergency shelters in Ottawa, particularly the rampant and overt use of street drugs, such as crack cocaine:

> It's terrible what it's like there. I mean, I won't even go in there during the daytime… let alone at night […] I will *not* go in that whole neighbourhood by [the downtown shelters]. Like I will not go on those streets *ever* […] because it's *that* bad […] The people with substance abuse […] addictions, um… narcotics mostly—are really friggin' scary […] and they're doing the transactions on the property. And that's *terrifying*. Because… those people will shoot you for twenty dollars. You know what I mean? (Brian, p. 13)

One participant mentioned that the shelters can be particularly unsafe for gay men, but later clarified that it is not just about sexual orientation: "it depends on how vulnerable you are. You can be taken advantage of for money, smokes, drugs… whatever" (Jeff, p. 23).

Others reported especially negative shelter experiences. These men claimed that they had spent as much time sleeping outside (ex. in parks, under bridges) as they had in emergency shelters. Terry mentioned that this was occasionally by choice (such as choosing to camp out during the warmer months), but often (particularly during the cold, winter months) it was the result of strict shelter rules that he felt were unrealistic. For him, situations such as this resulted in some very long and difficult nights spent outside, including one where he recalled feeling certain that he would not wake up due to subzero temperatures.

Meanwhile, Troy's experience staying at the shelter was so bad that he would only go there when he needed to eat or if it was too cold to sleep outside. He said he avoided the

shelter as much as possible, claiming that he would rather sleep in parks, even if he knew he would have to get up and go to work the next day:

> I found it degrading, I found it immoral […] Like you'd never think […] there'd be places […] like that in Canada, you know? You really wouldn't. That down and out, you know? […] I thought it was just horrible […] I mean, the drugs and the… the dirt […] That's why I would just go to work all day long and just go there and eat and… sleep. Get up, go to work, you know. (Troy, p. 4-5)

Like Brian, to this day Troy refuses to even go near the area where he had stayed in the downtown shelter. When these men avoid the surrounding neighbourhood and would rather sleep outside than in a shelter, even in the dead of winter, clearly they have had some very negative (if not traumatic) experiences there.

Other episodes of homelessness. Respondents also reported past experiences of sleeping outdoors (*unsheltered*), "couch-surfing" (*provisionally accommodated*), as well as sudden and unjust eviction from their home (*at risk of homelessness*).

4.2 Mental Health

Mental health issues. While a mental health diagnosis was not a requirement for participation in this study, I had hypothesized from the beginning that most (if not all) respondents would have experienced a mental health concern at some point in their lives.

As with all questions posed during interviewing, I relied on self-reporting and found that the majority of participants had indeed experienced at least one mental health problem (whether presently or in the past). Depression was the most commonly reported mental health problem (cited by more than half of respondents), which is reflective of current statistics on Canadian mental health. In 2012, the Canadian Community Health Survey on Mental Health found that approximately "3.2 million people, or 11.3%, had symptoms consistent with depression," making it the most commonly experienced mental health problem in Canada (Pearson, Janz & Ali, 2013, p. 2).

Less commonly reported mental health issues included Anxiety Disorders (including Panic Disorder, Social Anxiety Disorder, Generalized Anxiety Disorder) and Schizophrenia. Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder (also categorized as Anxiety Disorders), and Borderline Personality Disorder were among the least commonly reported

mental health problems. Some men also reported past suicide attempts, which is often indicative of an underlying mental health issue (Health Canada, 2002).

Substance use and addiction. While the majority of participants consumed alcohol at least occasionally, relatively few identified drinking as a problem for them. Meanwhile, less than half of the respondents reported using drugs on a regular basis, and even less classified their use as an addiction. Of those who did use drugs, most participants referred to their drug use as a means of self-medicating, while others referred to their recovery as the reason why they no longer use.

Addiction. One participant solely identified alcohol as his drug of choice, while another explained that his was an addiction to substances in general. In terms of alcohol, this participant noted that he could never have just "one or two drinks."

Binge drinking. Others referred to themselves as occasional "binge drinkers." These men expressed a compulsion to drink excessively on occasion, essentially adopting an "all or nothing" approach to alcohol. They also discussed the gravity of coping with the consequences of binge drinking, which usually meant feeling very low (both physically and emotionally) the following day. Brian noted the feeling of guilt that would accompany a day after heavy binge drinking, while Troy expressed:

> I know it's not good for me […] I feel like shit the day after, you know. But I still do it. I still have that compulsion sometimes, just to drink, eh. And […] my body rejects it, I don't like it. (Troy, p. 11)

Self-medication. Using alcohol and/or drugs as a means of self-medicating was relatively common among respondents. Dave, for instance, believed he used substances in an effort to escape reality or just forget for a while. Meanwhile, Terry was adamant that his drug use was due to an overactive mind, which he claimed had been an issue for him since he was a child. For him, drugs were not so much enjoyable as simply helpful in bringing him back down to a more "normal" level:

I have a problem with admitting to myself that I'm using drugs […] My drug use is to

keep me level mentally […] And it's sad that I find that the illegal drugs are the ones

that work best with me […] It's always a thing of up and down, [like] I have enough

finances to use drugs enough to get me level again, and then the money runs out and I

find myself in a depression. And I'm able to secure the drugs that would help me to

get out of that depression. So… (*sighs*) where is the solution? That's the question for

myself right now. (Terry, p. 21)

Terry further noted that he has never considered himself an addict: "What I consider an addict

is somebody who […] takes his *rent* money and spends it on crack, who takes his *food* money

and spends it on crack. Luckily, I haven't got to that point" (p. 21).

Similarly, there were others who, while they did not use the term "self-medicate",

seemed to explain their substance use in a similar manner. For instance, Brian would often

drink as a means of coping with excessive stress, particularly with regard to his current living

situation). For him, drinking functioned as a "release" (Brian). Similarly, Troy described

using substances to numb feelings or "escape in the mind." Evidently, it would seem that

both men relied on alcohol as a sort of coping mechanism during difficult or stressful times.

Jeff, who identified his alcohol use as an addiction, began to list the multitude of

reasons why he himself has turned to substances:

Like you're unhappy with yourself, so you drink. Or you're happy with yourself, and

you drink. You don't wanna admit things, and you drink. Or you're still in the closet,

and you drink. It's like […] "You drink [to] give yourself permission to just let go."

Just let go of that crap, let go of who you're expected to be, let go of who everybody

wants you to be, let go of who *you* wanna be. And just be who you are. (Jeff, p. 24-25)

Family history. Many respondents reported at least some history of mental health and/

or addiction issues within their family, which is not surprising given the statistics on mental

health and substance use disorders in Canada. Nearly half of the participants identified a

history of substance use and/or dependency within their family, and even more noted the

presence of mental health problems (whether suspected or formally diagnosed). One

participant reported that he was unaware of any mental health issues in his family, but that the

subject was never discussed when he was growing up. This, of course, raises an important

point — that due to the stigmatization of such problems, it is likely that respondents would *not* know of some of the issues their family members may have faced. Particularly during the time when most of these men were growing up, many families would have kept issues such as this quiet.

Interactions with mental health system. Respondents who had dealt with mental health and/or addiction issues were asked if they had ever reached out for and/or received professional help (by choice or otherwise). In fact, nearly all respondents had encountered a professional at some point for reasons related to either mental health or addiction issues.

Some participants mentioned that they had accessed a Methadone program, which had been an immense help to them. While it was unclear as to what kind of emotional support (if any) they received while going through the program, there was a consensus that the program had enabled them to recover from very serious drug addictions. In this way, not only had the Methadone program impacted their lives dramatically in a positive way, but considering the severity of their addictions, it very likely saved them.

Others mentioned meeting with a health professional regularly to access the medication needed in order to manage their particular mental health diagnoses. Interestingly, neither of these men mentioned receiving any sort of personal or emotional support along with this service. In fact, it was unclear as to which kind of health professional they saw for their medication, though it is common in Canada for both General Practitioners and Psychiatrists to prescribe medication to patients with little other than a quick check-in. Because basic services such as this are covered by the province, most health professionals are overloaded with patients and, therefore, have little time to connect with their patients on a personal level. Psychologists and Registered Therapists or Counsellors are capable of providing far more in terms of emotional support, but this often involves long wait-lists or else patients paying out-of-pocket. Clearly, this presents a major barrier for many Canadians who are in need of support, yet cannot afford to pay for mental health services.

Making reference to this issue, Patrick mentioned that he was currently seeing a doctor, mental health counsellor and mental health nurse, yet was still waiting for the opportunity to meet with a psychiatrist, which he informed me would be a long wait (p. 13).

In contrast, another participant explained how he had found a more creative (and perhaps more enjoyable) way to fill this gap in services. For him, St Luke's Table represented an supportive alternative to meeting with a mental health professional:

> I believe it necessary to socialize as a healthy part of my life, which is one of the reasons why I come to St Luke's to begin with, is because it's simply healthy for me to get out of my place. As low in my life as I am right now, I recognize that there's a need for me to simply get up, get out, go somewhere, and talk to people […] about something, anything […] To maintain some sort of social standard for social interaction […] While there may be a requirement, potentially later on, to put me in the hospital again, I don't want it to be due to a lack of social graces, or socializing. (Jason, p. 4)

For Jason, the commitment to attend the drop-in on a regular basis was enough to keep him on the right track towards positive mental health.

Meanwhile, Terry shared that he had only recently become open to receiving professional support, which he attributed to his own internal struggle:

> I never really admitted it. I never even admitted to *myself* that I might have a problem. The depression, you know, when I'm feeling good, "Hey, there is no problem! Why go to seek help?" When I'm feeling bad, I'm thinking, "Geez, ya know, maybe I do have a mental problem, maybe I *should* seek help." So just in the last six months I've become proactive about seeking help for depression. Admitting to myself that I *do* have depression. (Terry, p. 17-18)

Terry also mentioned that he was now (at the time of interviewing) willingly receiving help from a team of mental health professionals which, for him, represents a big step in a positive direction.

Jeff, who struggled with addiction, mentioned that he attended various support groups within the city in addition to meeting with an addictions counsellor whenever possible. Jeff had also successfully completed an intensive treatment program in the past, and was hopeful that he would have the opportunity to participate in another treatment program in the near future.

Some participants also cited past experiences of hospitalization (related to their mental health), where they would have interacted with mental health professionals, but this, of

course, was not voluntary. Evidently, it seemed that participants had overall positive and worthwhile experiences with mental health and/or addiction professionals *when they were ready and willing* to receive the help that was being offered to them.

4.3 Relationship between Poverty and Mental Health

When asked whether or not they believed there to be a relationship between poverty and poor mental health (whether personally or on a larger scale), the majority of participants were quick to respond that indeed they felt there was. Some also cited addiction as an equally important aspect of this relationship, which is interesting as it highlights the fact that many do not view addiction as a mental health problem itself. This is a commonly held belief, despite the fact that the "the definitive resource of diagnostic criteria for all mental disorders" (the DSM-IV) clearly classifies substance use disorders as a type of mental health disorder (NIDA, 2010).

Overall, the majority of participants felt there was a strong correlation between poverty and poor mental health. Some also felt the relationship was causal, though views differed in terms of what they thought was the precipitating factor:

Poor mental health leading to poverty. Jason, who believed there to be at least somewhat of a correlation between poverty and poor mental health, explained how he thought mental illness could lead to poverty: "I do believe that there are those who are born [into affluence] that have mental issues, that lose it. That they lose their affluence after they are diagnosed with a problem" (p. 27).

Poverty leading to poor mental health. The general consensus among respondents, however, was that yes a relationship exists and, in fact, it is the experience of living in poverty which can often lead to mental health issues. Patrick in particular stressed the detrimental impact that homelessness can have on the state of one's mental health. He went on to demonstrate this point by reflecting on his own life experience:

> When I was homeless on the street, I didn't know what to do. I was in perfect health
> before — physically, mentally, and emotionally. But when I was on the street […] I

was in bad shape mentally. So the homelessness caused that mental health problem.

(Patrick, p. 20)

Patrick also spoke at length about his current housing situation and how the stress of it has greatly contributed to his mental health issues at this stage in his life.

Speaking only for himself and his own personal situation, Brian also recognized a "huge" link between poverty and mental health which, like Patrick, he attributed largely to his current housing situation. Brian expressed that his mental state was particularly sensitive to his surroundings, so the experience of living in poverty (and feeling trapped within it) had taken its toll:

Because I'm *poor*, I have to live in a certain demographic. I have to live in a certain community, in low-income housing, and all the stuff that goes along with that, whether it's drug-dealing or crime… prostitution […] That for me—my environment for *me* [is] huge. It's very important for me to feel safe. Um, if I don't feel safe, then I start using alcohol or something to kinda relieve the stress […] I find another way to drain that stress out […] because I can't remove myself from the situation because […] financially, I'm not *able* to. So there's a huge, huge link between poverty and mental health, for me. (Brian, p. 16)

At another point during our interview, Brian also referred to a time when he was forced to make a choice between receiving much-needed medication (necessary for his mental health) or catching the last bus home. No one should have to choose between basic needs such as medication and transportation. All of this illustrates the serious impact that poverty can have on a person's mental health and wellbeing.

Meanwhile, Terry felt that, for some, the experience of poverty could create mental health problems that otherwise would not exist:

Keeping people at just survival level indoctrinates them into believing that they are in need of help — brainwashes them into believing that they are not capable of sustaining themselves. Which is a problem with mental health in the first place […] I'm just gonna guess that if you're kept at a survival level, you're going to start to *be* depressed. You're going to develop all the symptoms of depression because of the lack of self-confidence […] So not only do I think […] they're linked, but I think that it may *create* mental health problems […] the lack of financial assistance. (Terry, p. 20)

Jeff also felt there was a link between poverty and mental health (including addiction), and offered his own explanation behind it:

There's a stigma to [living in poverty] that some people would internalize or whatever. And it's, *I'm not really worthy because I'm low-income*, or *my opinion doesn't really matter because I'm low-income*, or *there's nothing available [to] me because I'm low-income*. And being poor well, of course, if you're living on assistance, there's gotta be something wrong with you. So are you mentally unstable? […] Why can't you just get over it? […] and get back to work? Which brings your self-esteem definitely down. And then I think there's definitely a link between addiction and low-income, and addiction and mental health. So it's all three of them […] 'Cause chances are, from my experience, if you *are* low-income, you *do* spend a lot of time alone. And then you do spend a lot of time maybe in your own head thinking… you know, *Why can't this be better? Why can't I be doing this?* and… *Let's have a drink*. Or, *Let's go get some crack* […] You know, just your living environment, especially if you're living in a rooming house. I've never seen a rooming house that doesn't consist of like 75 percent addiction […] And then it depends on what level of poverty you're living in. Like if you can find a nice subsidized apartment where […] even if you are alone, you've got all of your amenities […] You've got your own bathroom, you don't have to share. You don't have to worry about sticking yourself with a needle, or vomit on the floor… urine on the floor… flooding. There's just a lot of worry when you're on low-income —where is your next meal gonna come from? (Jeff, p. 32)

Jeff's response clearly illustrates just how easily someone could develop a mental health problem or addiction (not to mention relapse) in an effort to cope with especially difficult living conditions.

Alternatively, Jason expressed that he did *not* believe that the stress of living in poverty could on its own lead someone to develop a mental health problem, as he believed mental illness to be "genetically inherited" (p. 27). During our discussion, I considered that he and I may have different definitions of mental illness. In his case, his own mental health issues had been entirely beyond his control, and were very likely not triggered by poverty, so it is understandable that he would not share this perspective.

No simple solution. However, despite the overall general consensus that poverty could in many ways lead to the development of mental health problems, several respondents felt that more money was not necessarily the solution. When asked whether or not he felt his financial situation negatively impacted his mental health, Jason elaborated:

> On a profound level, no. On a *superficial* level, yes […] a profound level would be, say on the level of my soul, for example. It doesn't bother my soul in the least. On a superficial level, […] being a material world, I need shelter, I need food, I need clothing, I need hygiene, I need… um, in my case, psychiatric medication. I need money. And I can't escape North American consumerism. Not really. So […] at this point, I can say for my own self, more money isn't necessarily the answer, as I get enough where I should be able to get through […] Because […] I know exactly what I'm doing. Because I *choose* it. And my comfort level is what I'm struggling with at the moment. Not working, not accomplishing anything […] when I know I can do better. I've done it before. I should be able to do it again. While I'm not the most ambitious guy in the world, […] I do have the capacity to be a contributing member of society. (Jason, p. 26)

Meanwhile, others agreed with these sentiments, but for different reasons. For those battling serious addiction, Terry mentioned that more money could actually make matters worse by initiating a downward spiral which could negatively impact both their physical and mental heath:

> I do realize that people who really do have depression, that do have a drug problem, given greater financial support, are going to work themselves into a deeper hole with their depression if the depression is a part of their drug use […] I know the problem with addiction [and] greater financial support would only fuel their addiction problem. Which, the addiction problem itself creates depression. So it's not an easy factor of just saying that greater financial support would solve the mental health problem. In some cases, yes it would. In some cases, it would fuel the drug use, which then would lead to probably fuelling the mental health problems. (Terry, p. 20-21)

Dave was also in agreement with this idea, noting that it was addiction which ultimately caused his own downward spiral into poverty. Due to his addiction Dave indeed felt that more money would only lead to more problems:

I was almost thinking that if I was ever rich, I'd be *dead* because… I wouldn't know when to stop […] I'd love to have lots of money, and then I think about it and I go, 'What am I gonna do with it?' (p. 18, 22)

On a related note, one participant had a simple yet surprisingly profound response to the question of whether or not he felt poverty had affected his own personal mental / emotional wellbeing: "Yes! Yes, of course […] I like a good beer and I can't have one. Especially on a hot day, or watching the World Cup finals (*chuckles*) You know? It's not the drunk part, it's the beer part" (p. 27). This individual's response impacted me more than I could have anticipated, perhaps because I found it so relatable. I can still recall this interview, which took place in the middle of summer (during the 2014 World Cup finals, of course). So while there may indeed be more pressing concerns for those who are surviving in poverty, it is also important to recognize the significance of the small things that can mean so much to people. The freedom to participate in that which brings us joy and meaningful connection is so important to maintaining a sense of positive mental health. For the record, this was the *only* interview that I had to schedule around the 2014 FIFA World Cup finals… Sometimes it is the simplest things that can mean the most, and whose absence can be felt most strongly.

4.4 Living Environment: The Impact of Poor/Inadequate Housing

Probably the most significant finding of all was both the prevalence and severity of participants feeling unsafe in their own home. Though the question was never posed during interviewing, at least half of the respondents mentioned feeling at least some level of insecurity within their present accommodations.

Terry noted that while he would prefer to have his own space, what little he received from OW unfortunately did not allow for this. He felt certain that if only he could be accepted onto ODSP, his circumstances would change dramatically for the better. For Terry, having his own space signified safety, and not having the means to afford that had taken a tremendous toll on his mental health:

For me that's security, that's safety, that's… my castle — my tower in a castle that I could pull the rope ladder up and slam the trap door […] To have a place where I can live in a bachelor apartment is I think the best place for me […] So the inability to have a bachelor apartment I think is detrimental to my mental health because I don't

really feel secure. And security is part of the problem I feel, you know, feeling secure

in my living arrangement […] Yeah. So, not having the finances to be able to afford a

bachelor apartment—I mean, I can barely afford a room. (p. 22)

Meanwhile, even though Dave was fortunate enough to have his own apartment, feeling

secure was very important to him as well. In fact, in his case, having his own space was not

just a matter of comfort, but of survival:

It's not a rooming house. I'm able to afford that because I'm on ODSP—otherwise, I

couldn't […] Yeah, it's the only way I can survive. Because if I had to live with other

people, that'd be too much influence. I have to be on my own. And even *that* is… I get

influenced sometimes. (Dave, p. 9)

Because of Dave's ongoing battle with addiction, he would not feel safe living in a rooming

house (where there tends to be excessive drug and alcohol use). Therefore, having his own

space has (to some extent) functioned to ensure his safety, which he seemed grateful for.

Other respondents noted some particularly awful — even hazardous — living

conditions. The area surrounding St Luke's Table contains the highest concentration of

rooming houses in the city. Empathizing with those who have essentially been forced into

such living arrangements, Troy expressed the following:

It's tough for people on welfare […] they're kind of stuck. 'Cause with the amount of

money they get, there's only one place they *can* go — to a rooming house. And you

know, the rooming houses nowadays, [they're] just infested with, you know, drug use

and alcohol abuse and […] it's kind of almost […] made that way. You know, you're

on welfare, you automatically go into a rooming house […] Welfare […] just doesn't

give a shit, doesn't do enough. 'Cause you can't—like how can you get on with your

life, when after you pay the rent you're left with maybe 30 or 40 dollars? You know…

it's impossible. It really is. (p. 18)

Meanwhile, Patrick, who was living in a rooming house at the time of interviewing, reported

that his housing situation had caused him considerable stress and it is clear to see why:

It's hard to find a good rooming house. Like I live in a rooming house now [and]

people, you know, they break the rules. They drink alcohol, they smoke drugs. And

even last night there was a fight next door at midnight […] I wanna move on and get

my own apartment someday […] I live in a small room. And everything is falling

apart, and there's no hot water in the sink, and there's no shower — there's only an old

bathtub. People wash their dishes in the bathtub so it's full of tomato sauce and that.

So I don't use the bathtub, I go to the clinic or [the shelter] or to a friend's place to

take my shower [...] Walls are starting to crack […] soon it's gonna collapse […] and

it's a fire hazard, so I gotta find a place as soon as possible […] A bachelor would be

nice, to have my own bathroom, you know. 'Cause everyday in there I have to clean

the toilet because it's so dirty. Everyday I have to clean the washroom (Patrick, p. 5-7)

Patrick further noted that his experience staying in emergency homeless shelters was in fact

preferable to what he has experienced living in rooming houses in Ottawa. It is difficult to

imagine that there are Canadians who pay rent to live in homes without basic utilities such as

heat, hot water, or a place to shower. Rooming houses such as the one described here are

clearly not maintained to an adequate standard of living. This is because many landlords take

advantage of the population who is forced to live in these dwellings in order to make as large

a profit as possible.

As touched on in an earlier section, Brian mentioned how, despite having his own

apartment, living in a low-income community (full of "crime") had made him feel unsafe (p.

16). Brian, although grateful to have a subsidy (which many people in Ottawa wait years for),

sometimes wondered if it was worth the distress of living in such a toxic environment. In

fact, it seemed that the subsidy only made him feel trapped in his current situation because he

knew he could not afford to leave.

So safety in regards to housing was a common concern for participants. This is an

issue which is clearly in need of serious attention, as no one should be made to feel unsafe in

their own home. Every Canadian *should* have the right to safe and secure housing.

4.5 Food Insecurity in Ottawa

Among the most pressing concerns to emerge from the interviews was the insufficient

access to food in Ottawa. This was a common issue for both OW and ODSP recipients.

Some respondents referred to food security as a daily struggle.

In 2015, the average monthly payment for ODSP recipients was $1,110, which is

considerably higher than the $681 given to OW recipients (Alliance to End Homelessness

Ottawa, 2016). Since those on ODSP receive almost twice as much as those on basic social

assistance (ie. welfare), then theoretically, being on ODSP *should* make a rather large (positive) difference.

Even still, one respondent in receipt of ODSP disclosed that he continues to frequent various drop-in centres due to the fact that he is "struggling every day" (Patrick, p. 6). This participant described travelling all over the city on a regular basis, as a means of ensuring he had enough to eat each day. Another mentioned that, despite being on ODSP, he would still go to St Luke's for "a decent meal" (Troy, p. 24).

Meanwhile, some respondents (one of whom was on ODSP) recalled many occasions where the drop-in centre provided their *only* source of nourishment. To clarify, the meal program at St Luke's Table offers a light breakfast (ex. toast, tea, coffee), as well as a larger meal at noon. Dinner is not offered, since the centre closes in the afternoon. It is also closed on weekends and statutory holidays. So one can only imagine how challenging it would be to have to rely so heavily on such limited support for all of one's meals.

One participant (on ODSP) informed me that he does not "travel around the city from one soup kitchen to the other" (Jason, p. 10), and that St Luke's is the only place he goes to for food. He further mentioned that he had not been to a food bank in two years. When asked if he had any groceries at home, he responded: "At the moment I do, yes" (Jason, p. 10), as if to imply that this was not always the case.

One respondent (on OW) noted that he would sometimes volunteer in exchange for food: "I can't afford to volunteer everything. I mean, *here* when I volunteer, at least I get paid! (*Pointing to a small container of lunch leftovers*) That to me is payment, when you got *nothing*" (Alan, p. 21).

This was an unexpected finding and certainly the most shocking to me personally. Prior to interviewing, I had been working with the poor in Ottawa for several years, without any concept of the magnitude of this problem. While I knew that there was a need to improve services for the poor, I was also under the impression that it was impossible to go hungry in Ottawa because of the various food banks and free meal programs within the city. What I learned from my research, however, was that while people may not be (literally) starving in this city, there are many who go hungry on a regular basis.

4.6 Personal Growth and the Significance of Social Responsibility

Personal growth. The concept of personal growth ran as a common thread throughout many of the interviews. Some participants spoke of their desire to get back into the workforce. Brian, for instance, mentioned that he had been focusing on self-improvement in an effort to prepare himself for future employment. This was something he hoped to do in spite of his mental health diagnosis and, because he had been successful working full-time in the past while on ODSP, he felt confident that he could do it again. For Brian, his desire to secure employment was not just about increasing his income: "I'm not looking to make billions of dollars, it's just not gonna happen. You know, but I want to be comfortable again and I wanna be productive" (p. 10). On a similar note, Jason spoke of his desire to free himself from the negative cycle he was in and begin making better choices for himself:

> In terms of the cycle that I'm in […] buying beer and… I gotta move on with my life, I know I can do better. It's not a question, I've done it before. I just have to get off my ass and get myself into the workforce. (p. 18)

Interestingly, both participants had confidence in their abilities as the result of past successes. Both Brian and Jason also appeared to be at a point where they were either in the process of making changes or, at the very least, felt motivated enough to begin taking steps in a positive direction.

Regarding another aspect of personal growth, Brian also acknowledged a desire to make better choices in terms of his drinking habits. For him, this meant finding other "more productive" ways to cope with stress. While Brian did not identify his drinking habits as an addiction, he still wanted to work on living a healthier life, which, for him, meant drinking less. Meanwhile, Jeff referred to his addictive behaviour with great insight, identifying what he felt were his primary triggers. Indeed, this demonstrated significant personal growth despite the many obstacles he had faced along the road to recovery.

For Troy, his personal growth had required much forgiveness over the years. Rather than becoming justifiably angry or bitter toward the world, Troy chose to use his traumatic past as a tool for personal growth and wisdom:

> I'm not angry at the world no more and my mindset is totally different now […] I could've turned out to be a really angry person, but I'm not […] I hold no grudge

against the system. They did what they did. At the time, you know, at the time that's all they could do. (p. 12, 15)

Meanwhile, Alan spoke of some of the life lessons he had learned, as well as his own personal growth and development as a writer:

I'm not a writer. What I do is I kind of create a scene and then try and marry it to the previous scene. Or the scene before that even, or a scene yet to come. Like the idea is an exercise—*can* I do it? Can I fit ideas together? [...] And until somebody else tells me, "Okay, it works," (*chuckles*) I have no idea, you know? I just keep on going [...] It's not anymore a matter of *Can you do it?* It's a matter of *Can you make a second draft? Can you [...] complete the story?* (p. 29)

Alan's ability to welcome constructive criticism and feedback from others is something which I believe to be critical to personal growth. Writing is a challenging endeavour for most, but the real goal is to strive for progress rather than perfection. It is never about comparing yourself to other writers, but rather to the writer you were yesterday. As a final interview question, I asked Alan what he might attempt if he knew he could not fail. Alan very insightfully responded with the following:

(*Long pause*) I have never been certain about anything… ever, I don't think. But my dad also taught me, it's okay to make mistakes—that you learn more from mistakes than you do from doing it right. So that's a philosophy that I've kept, you know. Don't be afraid of mistakes. As long as [...] you care about it, you'll learn. (p. 30)

Giving back. Though it was not a question respondents were asked about directly, nearly all interviewees spoke about the importance of giving back. In fact, many spoke about experiences of volunteering in the community, particularly at shelters, community centres and drop-in centres (including St Luke's Table). In some cases, participant volunteers may be offered food, gift cards or a small amount of money for their work.

Dave cited at least three different programs for which he had volunteered, noting that his involvement ranged from peeling vegetables to peer support work, while Terry mentioned running a free self-defence course for young women (while he was in college) after learning that a friend of his had been sexually assaulted. Meanwhile, Brian recalled a time when he had moved away from Ottawa and was legitimately happy in his new environment. When a

close family member became sick, however, he gave up his new life and promptly returned home: "I came back […] to take care of her while she was in the hospital, do her laundry and all that kinda stuff. And help her with her therapy and rehabilitation" (Brian, p. 1).

For Patrick, I got the sense that volunteering was a big part of his identity, as we returned to the topic time and again throughout our interview. At one point, he fondly reflected back on a time he spent volunteering at a local emergency shelter:

That's why I was so popular there, because I volunteered, making breakfast and always giving people stuff to eat. That's why they liked me, you know. I was sleeping in the chapel underneath the altar at one time, and I used to get up at six in the morning […] And I stayed there 'til midnight, making sandwiches and cooking turkey […] Sometimes I worked 18 hours a day […] Then I went to bed and the same thing the next day. After a while, I got tired so I just worked a few hours a day. But just, the love of my neighbour, you know? […] I found the strength by helping people […] I was like a social worker from the street […] I was good at what I was doing. (Patrick, p. 4)

Evidently, volunteering provided Patrick with a sense of value and purpose, where he was recognized and appreciated by many for his hard work. Indeed, to feel appreciated and as though the work we do has meaning is what many of us strive for.

Another participant (Jeff) mentioned that he had been volunteering at St Luke's Table for over a decade. Interestingly, the desire to give back was what brought both Patrick and Jeff to the drop-in for the first time — not to use the services themselves, but rather to give back to their community.

Others spoke of a strong desire to give back to their community, despite facing barriers related to their disabilities:

I'm still […] learning how to… just to live and find my way now. But eventually I wanna do something, I wanna give back […] I need more than this, I definitely need more […] I got more to give than this […] I just wanna *do* more. I wanna get up in the morning, have somewhere to go and something to do, you know. (Troy, p. 22)

Again, this demonstrates the need we all have to feel useful, productive, needed. Without clear purpose to our days, it is easy to get down on ourselves and lose confidence in our abilities. For many of us, our job (whether paid or volunteer) plays a major role in identity

formation and our own internal sense of value and purpose. This is true for Troy as well: "I don't wanna be just a burden on society, you know, I wanna be a part of it" (p. 23). For many, our work also offers us regular opportunities to connect with others — something that many do not appreciate the importance of until those opportunities are no longer there.

Overall, the majority of respondents were active volunteers on their community. Even those who were unable to volunteer (due to disability) felt that the act of giving back was vitally important and, in fact, aspired to doing so in the future. This is not surprising, as the desire to improve upon ourselves and the world around us — to want to make a difference somehow — is innate within all of us, though that is not to imply the process is not difficult/ challenging. Ultimately, most individuals need something in their lives to challenge them and make them feel like valued members of society. People do run into barriers in their lives, but to assume that those who live in poverty (or have a disability) have no interest in contributing to the greater good is a myth. As this section clearly demonstrates, no one wants to feel that they are a burden on society. Contributing in our own way, with our own unique talents and abilities is what makes us feel connected to one another and as though we are working towards something worthwhile.

4.7 Conclusion

In summary, data from the interviews brought forth the following important findings:

- The experience of living in poverty — especially in poor neighbourhoods and/or substandard housing — is a major stressor for participants and contributes substantially to mental health struggles.
- Food insecurity is a significant concern for those surviving on social assistance in the city of Ottawa. Individuals who are poor go without regular meals on a regular basis.
- The desire to improve oneself and contribute to the common good is a significant motivating factor both for those facing poverty and/or mental health issues.

At least among this particular sample of low-income men in Ottawa, there is indeed a significant relationship between poverty and poor mental health. There is substantial evidence of this throughout this chapter, and this concept is also backed by the literature.

Chapter 5: Conclusion

In summary, the purpose of this project has been to facilitate a better understanding of the relationship between poverty and mental health among low-income men in Ottawa. As stated in the introductory chapter, I set out to answer the following research questions in an effort to accomplish this goal/purpose:

- How does the experience of poverty impact the mental health of low-income men in Ottawa?
- What do these men identify as their most pressing concerns?
- What can be done to improve their quality of life, given the reality of their current situation?

As demonstrated in *Chapter 4: Results and Discussion*, I found that the experience of poverty had a substantial impact on the mental health of respondents in this study. For these men, living in poverty presented barriers to basic needs including housing and access to food. In many cases, poverty also resulted in unsafe or insecure living environments, which was a primary trigger for substance use and mental health issues.

Overall, issues related to poverty and addiction were among the most pressing concerns for respondents. These related concerns included: feeling unsafe in one's living environment, insufficient access to food, and unemployment. Interestingly, while many spoke of their own experience with mental health issues, this was not identified as a primary concern for most respondents.

In terms of improving the quality of life for low-income men in Ottawa, it became clear that while existing services such as St Luke's Table and ODSP offer invaluable support to these men, they are not enough. As several respondents pointed out, more money is not necessarily the solution. There is, however, a definite need for increased awareness regarding the problems with low-income housing options in Ottawa — particularly regarding the situation of rooming houses. Without a safe and secure environment to return home to, there is little that can be done to truly improve the quality of life for low-income men.

5.1 Personal Reflection

Working on this project has not only provided me with a deeper understanding of the connection between poverty and mental health; I have also developed a greater sense of

empathy for the individuals I work with. This came as a result of the in-depth interviews I had the opportunity to conduct, but it also came from my own personal experience of this whole process. Ultimately, what I learned from studying the relationship between poverty and mental health is that the more I learn, the less I know. The information out there can feel overwhelming at times. I do not feel like an expert in this area per se, but it has certainly sparked a curiosity within me that I know I will carry with me throughout my career. I am still very much interested in devoting my life / time to adults who may be struggling with their mental health whilst living in poverty. In some ways, my focus has begin to shift, to what I hope will be an opportunity to focus on the enhancement of positive mental health and psychology. For me, having the opportunity to interview and work with these men has been a privilege, a learning experience, and truly rewarding.

Appendix 1: Interview Guide

The following interview guide is designed to be **semi-structured**. *This means that questions may not be asked in any particular order, and even that not all respondents will be asked every question. The interviews will be structured in a way that respondents will not feel "put on the spot," and can instead feel free to speak as little or as much about a subject as they like. The idea is for respondents to be given a platform to share their stories in a way that is* **meaningful to them**.

A few basic questions...
- How old are you?
- Where are you from, and how long have you been living here in Ottawa? What led you to the capital city?
- What sort of education and/or special training do you have?
- Are you currently working or receiving social assistance benefits?
    ◦ If on assistance, how long?
    ◦ If on ODSP, what for?
- What are your living arrangements like?
- Have you ever been homeless?
- How long have you been coming to the drop-in? What brought you to St Luke's initially?

Digging deeper:
- Can you tell me a bit about your childhood and your experience growing up? What were some of your best memories?
- Did you have a strong relationship with your parent(s)? Siblings? Do you have a relationship with them now?
- Do you have any children? If so, are you in regular contact with them?
- Are you currently in a relationship? If so, is it supportive?
- Has anyone in your family ever experienced any mental health problems or struggled with addiction? Who, and what sort of mental illness and/or addiction?
    ◦ Did they ever get help for their problem(s)?
    ◦ How do you think this impacted you, both as a child and as an adult?
- Have *you* ever battled with your mental health or addiction issues? Substance abuse? If so, can you tell me about it?
    ◦ Have you ever reached out for help, professionally or otherwise?
    ◦ Who do you talk to when you are feeling down (or unstable)?
- What does a typical day look like for you? (Remember that any information you share within the confines of this interview will remain entirely confidential, and will not be shared with any other staff or used against you in any way). *Must also explain the **limits of confidentiality***
- Do you feel that there are sufficient support services for low-income Canadian-born men in Ottawa? What do you think of the quality of these services?
    ◦ Do you think you would receive better services if you belonged to a different minority group (ie. single mother, youth, new immigrant, Aboriginal, etc.)? Why or why not?

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- Do you ever feel that you are looked down upon, or treated as less than equal? By whom?
- What do you feel has been your biggest obstacle in life thus far?

Asking the direct questions...
- This is a study regarding the link between poverty and mental health. Would you describe yourself as living in poverty? Why, or why not?
  - If yes, how long would you say you have been poor?
    - Do you think it has had any sort of impact on your emotional well-being or state of mind (not necessarily referring to mental *illness* per se)?
  - Do *you* believe there is a link between the two? How so (or how not)?
- According to Statistics Canada, the Low Income Cut-Off in 2012 for a single adult living in a city of this size was $19,597 annually (after tax).
  - What do you think of this number? Is it comparable to your current income?
  - For those of you on ODSP, what kind of message do you think this sends (to you, from our government)?
- Does your current living situation, or lack of financial resources ever cause you to feel anxious or depressed?
- What is your stance on taking prescribed medication(s) for mental health concerns or mood disorders? Do you think they can be helpful for people? Why or why not?
  - Do you think they could ever be helpful for *you*, if you ever found yourself in a position where they were being prescribed?

Looking ahead:
- What is your biggest concern at the moment? In other words, what do *you* feel is the primary source of stress in your life?
- Is there anything that can be done to help reduce that stress? Either by yourself, the staff at St Luke's or other social service organizations, by the Canadian government, or others?
- Are there any short or long-term goals you wish to accomplish? What are they?
  - What do you see as the biggest obstacle(s) to achieving these goals?

Additional Questions:
- Do you feel there is a sense of community at St Luke's? If so, do you feel you are a part of that community? Why or why not?
- Do you think the atmosphere and/or services at the drop-in centre can be improved? How so?
- American pastor Robert Schuller once posed the question, "What would you attempt if you knew you could not fail?" I am going to pose that question to you now... I want to know what *you* would do if you were <u>certain</u> you would succeed.

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