

Tobacco Roads: An Exploration of the Meaning and Situatedness of Smoking
among Homeless Adult Males in Winnipeg

by

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ABSTRACT

Homeless individuals are some of the most marginalized Canadians and most likely to use tobacco daily. The transient nature of homeless smokers contributes to marginalization within health care as well as tobacco control strategies. The purpose of this study was to describe acquisition and smoking behaviors of homeless individuals as a first step in developing essential research evidence to inform tobacco control strategies relevant to this vulnerable population. This ethnographic study investigated the everyday reality of 15 male homeless individuals living in the Salvation Army Shelter in Winnipeg. Tobacco use was explored against their environmental and social contexts, homeless smokers used an informal street-based economy for acquisition, and smoking behaviors were high risk for infectious diseases with sharing and smoking discarded cigarettes. Tobacco control strategies that consider homeless individuals have the potential to reduce morbidity and mortality along with diminishing inequitable health burdens with this population.

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With love and gratitude, Michelle Bobowski

DEDICATION

“For the dead and the living, we must bear witness”

-Ellie Wiesel

It is my great privilege and honor to dedicate this work to my father Yitzhak Ben-Yahtza, "May his soul be bound up in the bonds of eternal life" - who believed that I should get an education because no one could take it away. To a "Mensch" and righteous person who taught me the basis of survival and social justice which was unbeknownst to me at the time. To a man who supported those who could not for themselves, and who gave sandwiches to a homeless man. To him I owe my insight as he bought me books beyond my age, and taught me the perils and joys of the world, and who forever and a day wanted me to write a book. Baruch Hashem.

WHERE ART MEETS SCIENCE

The essence of qualitative work is immersing oneself in the world of the participant; this immersion grew from my experiences of working with psychiatric patients in a hospital setting. In reflecting on the meaning of smoking for this population I have composed the following poem:

Tobacco Butt Garden

Tobacco butt garden you live outside the door,
Located at the Grace Hospital on the psych ward.

Cancer stick garden you litter the lawn,
We say goodbye to the tulips they are forever gone.

It is a gift without a card from an anonymous donor,
A partially smoked butt for a new owner.

Dart garden you go against the rules,
For a patient without smokes you are a real jewel.

As a nurse I am the cigarette police,
As a patient who smokes you forgo the big feast.

Smoke butt garden to nurses who don't care,
You resemble a grave yard of memories and missed prayer.

Cigarette garden you tell a story of chaos and strong emotion,
Histories in each drag holding much devotion and commotion.

Your litter is strewn on the yard with abandonment,
You repulse the visitors and nurses, yet it makes you feel affluent.

The nurses you disgust do not see your beauty,
They ignore your presence and neglect their duty.

Cig butt garden you are immune to attack,
My message is clear your cigarettes are coated with bacteria plaque

I paint this picture and weave this tale,
To give you a fighting chance, a life with an extended time scale.

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CHAPTER 1: INTRODUCTION

1.1. Statement of the Problem

Homeless individuals are both some of the most marginalized Canadians and the most likely to use tobacco products daily. Sadly an absence of research evidence shadows our understanding of, not only the rate of tobacco use among homeless individuals, but also patterns of use. Limited access to economic resources and lack of private personal spaces leaves one curious about the role tobacco products plays in their everyday life. In Canada the current reported daily smoking rate is 18% (Canadian Tobacco Use Monitoring Survey [CTUMS], 2009); however, we know this rate is not representative of individuals without a fixed address and/or telephone. An American study indicated that 70% of homeless people reported using tobacco (Connor, Cook, Herbert, Stephen, & Williams, 2002). Studies of smoking and homeless individuals would increase awareness of how tobacco use is situated within their everyday world along with unique issues related to homelessness and tobacco use. While there is a general awareness of the health risks associated with tobacco use and exposure to tobacco smoke, the same cannot be said for how tobacco use infiltrates and influences homeless individuals. In this qualitative study, an anticipated difference between genders supported a focus on adult male homeless persons.

1.2. My Story

I am a Registered Psychiatric Nurse practicing in an acute adult inpatient ward in Winnipeg. My experiences in this role led to a personal interest in a certain observed behaviour among adult psychiatric patients who smoke; many of whom are also homeless individuals. Over the years I have worked with many homeless men (HM). Often, this

population struggles with both mental illness and substance use/abuse problems. A prevalently used substance is tobacco. Despite being aware of the health hazards associated with smoking cigarettes, many HM go to unusual lengths to attain an ongoing supply of tobacco. It is precisely these efforts that incited my curiosity. I have observed an informal economy sustained to the exclusion of basic health needs that included practices such as bartering, sharing/bumming cigarettes, and “butt picking”. What is it about tobacco that affects such self-destructive behaviour?

“Bob”

Though not homeless himself, my experience with Bob inspired my research.

I first met Bob as a student. A crusty, elderly man large in stature, sporting a beard and cane, he had spent most of his adult life in the Selkirk Mental Health Centre where he was treated for schizophrenia. I met Bob when he was living in the community. His voice was low and gruff and he lived in a single room occupancy building. He liked coffee and cigarettes, and most of his energy revolved around the acquisition of both. As a “student intensive case manager” my big undertaking was to convince Bob to acquire a roll of quarters when he cashed his weekly cheques so he could do his laundry, as this was not a priority for him. It became somewhat of a comedy show – each week we drove to the bank and he would tell me to wait in the car. He would return with his money and curtly order me to drive to the store where he purchased a can of tobacco, rolling papers, and a pack of cigarettes. Despite my “worthy intentions”, Bob had his own priorities – and Psychiatric Rehabilitation promotes independence – “do with, not for”. I marched on. One day, I received an urgent call from Bob – I was to come over to his place right now! I grabbed my coat and shot over quickly, thinking that he was hurt or that some environmental problem was at hand - on the contrary. On arrival, Bob led me over to his

table, brought me a cup of coffee in a semi-clean mug and announced, “I want to show you something”. He then laid out plastic bread bags filled with cigarette butts that he had collected. Bob then proceeded to show me how to remove the tobacco using a ‘one hand technique’, and how to use that tobacco to make a new cigarette adding store-bought tobacco in rolling papers. He shared his resourcefulness with me, taught me his ways. I needed to understand the importance of tobacco to recognize his actions, and subsequently his self-worth, as he perceived them – as worthwhile and self-efficacious. Bob shared his world with me because he trusted me. Trust is fundamental to the therapeutic relationship – and the attainment of such a rapport is indescribable – it touches your soul really. Such richness of experience is often the fertile ground from which innovation is born. Indeed, I was profoundly influenced and inspired to delve into this anomalous behaviour and attempt to understand the omnipotence of tobacco in the lives of people such as Bob.

1.3. Purpose of the Study

Despite numerous significant concerns, it has been my informal experience that many homeless people place a disproportionately high priority on obtaining and using tobacco. Although personal priorities are admittedly subjective, a practice that neglects basic needs to the extent that health is dramatically compromised warrants investigation. In an effort to shed light on and extend the discourse concerning this notoriously neglected population, the purpose of this study is to explore the importance of tobacco in the everyday lives of homeless adult males in Winnipeg. While homeless females who smoke would most likely be driven to the point of neglecting basic needs or personal

safety, the novelty of this study and use of a qualitative approach supported decision to focus on only one gender at this time.

1.4. Research Questions

The research question guiding this study is to explore tobacco in the everyday lives of adult males who are homeless in Winnipeg. This study has the following aims:

1. To describe the behaviours surrounding tobacco use and acquisition unique to this subpopulation
2. To describe their values and beliefs around tobacco
3. To describe the everyday reality or situatedness of tobacco in their lives as homeless male adults in Winnipeg.

1.5. Significance of the study

A well grounded understanding and consideration of the context of poverty, behavior, and addiction as a medical condition, are important catalysts to support policy makers' creation of strategies to reduce tobacco use amongst homeless smokers (Shaw, 2008). The smoking practices of the homeless contribute to their infectious diseases, and their already compromised health due to homelessness, trauma, and violence, and crowded conditions of shelters. Homeless individuals are at greater risk for developing infectious illnesses, like Methicillin-resistant *Staphylococcus aureus* (MRSA) and Vancomycin-resistant enterococci (VRE) which are multi-drug resistant organisms (Kalka-Moll, Lee, Faber, & Seifert, 2008), H Pylori (Woodward, Morrison, & McColl, 2000), Mononucleosis (Peterson & Thompson, 1999), Tuberculosis (Solsana et al., 2000), and Hepatitis (Raoult, Foucault, & Brouqui, 2001). Raoult et al. (2001) explain that substance abuse predisposes the homeless person to these infections due to a weakened

immunity, a poor physical state, and inadequate hygiene; hence the practice of sharing cigarettes and smoking discarded butts may contribute to an outbreak of contagious diseases among the homeless. Finally, since the homeless population tend to use emergency departments for their primary health care needs, these additional health concerns related to their tobacco use strain an already overburdened system (Shaw, 2008).

Tobacco control strategies that consider homeless individuals have the potential to reduce morbidity and mortality along with diminishing the inequitable health burden present within this vulnerable population. Smoking is a public health issue. Public health policy is about reducing the risks and harms of individual harmful behaviors; a harm reductionist approach to smoking amongst homeless could address this health risk along with subsequent additional burdens to personal health and to the health care system as a result of increased chronic health problems. In November of 2011, an expert panel of 22 stakeholders assembled to address tobacco use in homeless populations. The group of panelists is part of Break Free Alliance, which is a national American network focused on ending poverty and tobacco use (Porter, Houston, Anderson & Maryman, 2011). An outcome of that meeting was the identification of questions for future research. My thesis will describe the smoking behaviors of the homeless as a first step in developing essential research evidence to inform tobacco control strategies relevant to this vulnerable population.

1.6. Knowledge Transfer

Fundamental to the professionalism and efficacy of nursing practice is the dissemination of information – or knowledge transfer (KT). KT occurs in nursing in a

number of ways; from everyday “change of shift” reports to the undertaking and publication by nurses of groundbreaking research (Rippy & Baker, 2003). Evidence based practice has become the standard of nursing care – essentially mandating KT within the profession. Indeed, the intrusive and critical nature of human health care prompts both ethical and clinical obligations for clinicians to maintain up to date knowledge – a point emphasized by the requirement of professional licensing bodies for the ongoing fulfillment by health care professionals of educational competencies (Registered Psychiatric Nurses of Canada [RPNC], 2010).

The intention behind my research in terms of KT involves 3 areas. First, I will publish my findings in a peer reviewed journal on completion of my thesis. Secondly, I will draft a document for the host-agency outlining my findings. Finally as described by Thorne, I will engage in “publication and presentation” (2008, p.214), a knowledge transfer project that shares my findings with the general population at the host agency site. In an open community gathering I will distribute a single page document outlining my findings without compromising confidentiality.

1.7. Assumptions

The assumptions I bring to this study are a result of my experiences of working with individuals on inpatient psychiatric wards. The most prominent assumption is that smoking appears to be an integral part of their daily practice of people with mental illness and who are homeless. Over the years I have observed patients structuring their day around smoking and the acquisition of cigarettes. Many of the patients are homeless, estranged from family, unable to hold employment, and have a co-morbid disorder of substance, alcohol and tobacco dependency. Aware of the health hazards of smoking, the

patients have shared with me the ways they attain tobacco while on the street. Their informal economy of bartering, sharing and bumming cigarettes puts them at risk for infectious disease transmission and added health concerns, as well as at risk for potential violence and trauma; the Winnipeg Street Health Survey (WSHS) (Gessler et al., 2011) indicate that 40% of their 300 respondents were physically assaulted in the last year with an average of 3 assaults a year. With public space restrictions and smoking bans, homeless persons often seek tobacco outside the retail system; the sniping (Okuyemi et al, 2006) of cigarette butts from ashtrays or streets is another means to acquire cigarettes that also places them in public view. The basic assumptions of this study are: the existence of an informal and underground economy, that people who are homeless will engage in alternative patterns of smoking, that the experience of being homeless has great variation, and a final assumption is that tobacco is capable of killing half of its users and those who use tobacco need assistance with cessation interventions (WHO, 2010).

1.8. Definitions of Key Terms

Harm Reduction: The Winnipeg Regional Health Authority (WRHA) defines harm reduction as the “...strategies, programs and policies, which aim to reduce the negative health, social and economic outcomes associated with the use of licit or illicit substances” (Winnipeg Regional Health Authority [WRHA], 2007, p. 3)

Homelessness: People who are homeless are a heterogeneous group, and though economic depravity is the commonality, subgroups exist with their own host of vulnerabilities. People who are homeless are abused women, adolescent runaways, divorced males, war veterans, alcohol and substance users, psychiatric patients, incarcerated inmates, the elderly, people with disabilities and illnesses, immigrants and

visible minorities, indigenous people, and even families. Etiology of homelessness also differs per group and with individual differences.

While the definition provided by (Snow & Mulcahy, 2001) is succinct, their definition of the homelessness population as those who are spatially and residentially marginalized is not sufficient. A simple description of homelessness is one who lives in a shelter or on the street (Butler et al., 2002). Okuyemi et al. (2006) state that homelessness includes the characteristics of no fixed address, those who lacks a regular and adequate night time residency, or who stay in temporary public or private supervised shelter, or in a place intended for human occupancy; like abandoned buildings, automobiles, or tents. Stratigos & Katsambus (2003) also define homelessness with temporary residency in institutions intended for individuals to be institutionalized. This study recognizes that a continuum of homelessness exists with episodic or situational homeless differing from chronic, other types include sleeping rough, couch surfing or relative or absolute (Tipple & Speake, 2005).

Based on the diversity of defining features that form definitions of homelessness, I have drawn out the salient points that surround homelessness to construct a definition to fit my study. For the purpose of this study, the homeless are described as those who sleep in public places not meant for human habitation, or rely on drop-in facilities or emergency shelters (either public or private) for sustenance and shelter. These individuals may or may not possess identification, such as a health care card, photo ID, or a social insurance number. These individuals are not currently employed in a conventional job and they may or may not be involved in an underground economy of trade and bartering.

Informal Economy / Underground Economy: May also be referred to as the black-market or bootlegging, or shadow work (Lee, Tyler, & Wright, 2010). Considered to be a real phenomenon which profits are unreported to tax authorities and the income missed in the calculation of a country's worth or national product (NP) (Tanzi, 1999).

Loosies: The unregulated and unauthorized selling and buying of single retail cigarettes, sold one at a time at cost-inflated rates, either from an individual or a small retail store or on the street (Clegg Smith et al., 2007).

Meaning: The “essence” of something; derived from the Greek “Logos” and the basis of Logotherapy, the striving to find meaning in one’s life is a motivating factor (Frankl, 1984). The value placed on a tangible item or experience, the identification and self reflection of this item or experience may or may not give an emotional response with introspection. Meaning is steeped in the individual voice and is directly related to the value set of the person and their motivations.

Mental Illness: Defined by the criteria of the Diagnostic and Statistical Manual of Mental Disorders (2000) published by the American Psychiatric Association (DSM-IV-R).

Situatedness: Situatedness is about context and captures the viewpoints of all participants by valuing all opinions and voices (Curran & Takata, 2009).

Smoker: A person at the time of this study, who smokes any tobacco product either daily or occasionally, may also include smokeless tobacco products, like snuff, snuss, and chewing tobacco (Mackay, Erickson, & Shafey, 2006).

Sniping: The process of salvaging discarded or partially smoked cigarette butts that are discarded in ashtrays, or on the ground to collect the tobacco to reroll and smoke (Okuyemi, Caldwell, Thomas, Born, Richter, Nollen, & Braunstein et al., 2006)

Tobacco: Originating from the plant “*Nicotiana tabacum*” which contains the addictive stimulant “nicotine” and which use includes a toxic insecticide (Mackay et al., 2006, p. 17). When combusted, the tobacco smoke will contain over 4,000 different chemicals, of which 50 of these chemicals are known to cause, trigger, or promote cancer (Health Canada, 2009). This study will use the term *tobacco* to refer to roll-your-own (RYO) cigarettes, manufactured cigarettes from retail stores, contraband or smuggled cigarettes, and moist and dry snuff and chewing tobacco.

Tobacco Control: Based on the World Health Organization (2003), Tobacco Control (TC) will be defined as harm reduction strategies which focus on improving the health of a population by “... eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke” (p.4). “Tobacco Control” is also the name of a high impact peer reviewed Journal.

Tobacco Use: “The consumption of tobacco products by burning, chewing, inhalation, or other forms of ingestion” (Mackay et al., 2006, p. 17).

Vulnerable populations: A term used to reflect the multiple social and economic elements that potentiate poor or ill health; includes the impact of the social determinants of health which affects a person’s inclusion, advantage and equity in situations and life (Greaves et al., 2006).

1.9. Summary

The opening statement of the problem and narrative of my experiences provides the reader with clarity of what brought me to this thesis topic. The research questions identify specific areas of inquiry; describe the behaviours surrounding tobacco use and acquisition, describe their values and beliefs around tobacco, and to describe the everyday reality or situatedness of tobacco in their lives. The significance of this study and knowledge transfer was brought in to explain how this study will contribute to nursing and evidence based practice, and public health policy. I discuss my assumptions and define key terms central to this study. The content of this chapter presents a detailed contextual backdrop for this study.

CHAPTER 2: REVIEWING DIVERSE SOURCES OF EVIDENCE

2.1. Introduction

In this chapter, I address diverse sources of evidence relevant to my thesis topic. I begin with a description of the enumeration of the homeless population in Winnipeg along with reported rates of smoking and homelessness in Canada. The next section touches upon health and homelessness by looking at general health concerns of being homeless, tobacco related health concerns and health disparities among homeless individuals revealed to me through practicum experiences. A discussion of literature specific to homelessness individuals' use of tobacco and cessation studies reveals nascent research evidence. Then I address socio-cultural contextual topics, which includes a brief overview of Aboriginal peoples and the role of tobacco use, mental illness and tobacco use, the acquisition of cigarettes and tobacco among marginalized populations and the presence of an underground economy. I highlight evidence that uses a social justice lens for investigating of tobacco use among marginalized populations. Finally, I outline public policies and tobacco control strategies that affect homeless individuals, their daily lives, survival and smoking.

2.2. a. Statistics and Monitoring

Homeless Counts

In Winnipeg, the number of people homeless on any given night is relatively unknown and can only be an estimate. Local shelter counts are one method to calculate the number of homeless people on any given night. For instance, it is known that at least 220 persons are homeless in Winnipeg based on the combined capacity of two local shelters: Main Street Project and Siloam Mission (B. Bechtal, personal communication,

June 18, 2010; Campbell, 2008). Unfortunately, these shelter counts fail to consider those who are invisible or hidden homeless, or those who are marginally housed or couch homeless (resting on friends or families couches) (Campbell, 2008). Siloam Mission, a Christian based emergency shelter and health centre, estimated the number of homeless in Winnipeg to be approximately 1,700 people (Campbell, 2008) and Perras (2010) estimates this number will rise to 2,000 people by the year 2020. The demographics of homelessness in Winnipeg include one in five people identifying themselves as Aboriginal in the inner core of the city (Carter, Polevychuk, & Sargent, 2003), these numbers may be higher due to self-identification.

Smoking Statistics

People who are homeless tend to be excluded from research, policy reports and initiatives on global, national and local levels of influence. The World Health Organization (WHO) developed a framework in 2003 to address the global epidemic of tobacco use, and while it recognizes a need for targeted programs and strategies to be developed for minors, women and indigenous people, it has not addressed the concerns for populations who are homeless. In 2005 Canada adopted the Federal Tobacco Control Strategy (FTCS) which is focused on decreasing tobacco use through prevention, education, protection, and cessation (Health Canada, 2009). The goal of FTCS is to decrease smoking prevalence from 19% in 2001 to 12% for 2011 (Health Canada, 2009). The priorities of FTCS are to decrease smoking among youth and adults, decrease second hand smoke, decrease contraband activities, and to implement the WHO framework's tenents. Like the WHO framework, FTCS is also not concentrating its efforts on decreasing smoking prevalence in homeless populations.

The Canadian Tobacco Use Monitoring Survey (CTUMS) is a telephone survey conducted by Statistics Canada that looks at tobacco use, and smoking prevalence rates of Canadian residents aged 15 and older. In 2009 the smoking rate of current smokers in Canada was 18% for a total population of 4.8 million (Health Canada, 2009). The smoking rate in Manitoba was 18.8% and among adult males over the age of 25 the rate was 24.3% (Health Canada, 2009). While these statistics paint a picture of tobacco use for the general public, it is important to know that these statistics would likely be higher if it included those who are homeless. Those without a fixed address or telephone are not counted. The omission of those without a fixed address or telephone in Canadian statistics results in a marginalization of the scope of this issue among homeless people; therefore, the magnitude of the problem continues to be underrated. The most recent report in Canada was released in Winnipeg April 2011, the Winnipeg Street Health Report 2011 (WSHR) reported on its findings with over 300 participants who were homeless and recruited from a homeless emergency shelter in the city (Gessler & Maes, 2011). This survey was the first of its kind for Winnipeg and draws its structure from the Toronto Street Report (Khandor & Mason, 2007).

The Toronto Street Health Report (2007) found that out of 368 people surveyed, 87% currently smoked cigarettes when surveyed November 2006 – February 2007. The Ottawa Street Needs Assessment Project of 2002 also reported similar numbers of smokers with 84% of 80 participants reported using cigarettes. The Winnipeg Street Health Report 2011 found that 78% of their respondents smoked, and of those surveyed, 84% smoke daily, 39% are purchasing full packages of cigarettes, 13% are buying a single cigarette at a time, 20% are rolling their own, and almost half (48%) of the

smokers are picking up cigarette butts and smoking the discarded remnants (Gessler & Maes, 2011). The final results from this exploratory and descriptive work has implications for future policy and program development in many areas, including tobacco control and healthcare. The researchers for the WSHR consulted Dr. Schultz and me for the development of the questions in the survey around tobacco use, which has far reaching implications for future dialogue and policy development.

In the United States, rates of tobacco use among homeless have been reported to range between 69% - 82% (Aloot, Vredevoe, & Brecht, 1993; Baggett & Rigotti, 2010; Connor, Cook, Herbert, Stephen, & Williams, 2002; Darmon, Coupel, Deheger, & Briend, 2001; Kim et al., 2008; Lee et al., 2005 Okuyemi et al., 2005, 2006; Sachs-Ericsson, Wise, Debordy, & Paniucki, 1999; Szerlip & Szerlip, 2002). Recently, a secondary analysis of a national data set concerning homeless living in the United States, reported that 75% of the population smoked (Bagget & Rigotti, 2010).

2.2. b. Health and Homelessness

General Health Concerns of the Homeless

There are diverse predisposing factors affecting the health of homeless persons: overcrowding at shelters, dampness and burns, trauma and assault, vehicle accidents, and anxieties about meeting basic sustenance needs, climate extremes of heat and cold, psychiatric illnesses, and cognitive impairments (Lamb, Bachrach, & Koss, 1992; Ramin & Svoboda, 2009; Wrezel, 2009). Wrezel (2009) states that overcrowded shelters are positive environments for infection; and the homeless become susceptible to illness and immune system dysfunction with the added factors of poor nutrition, obesity, a sedentary lifestyle, poor hygiene, alcoholism, drug use, smoking, mental illness, abuse, and trauma.

Rates of infectious diseases and chronic disease conditions are influenced by the compounding of these multiple factors, and there can be much variance among individuals' experience of these factors.

Hepatitis C Virus (HCV) infection is a common transmitted disease among homeless people (Nyamathi, Dixon, Wiley, Christiani, & Lowe, 2006). Nyamathi et al (2006) report that outside of sharing needles for injectable drugs and the sexual transmission of HCV, the sharing of razors and toothbrushes are a viable transmission route amongst a homeless population. Nyamathi et al (2006) state that “[b]ecause sharing of personal items may be a common behaviour among homeless populations with limited resources and dental and gum disease is prevalent in this group, the risk of oral transmucosal transmission of HCV may be higher than previously thought”(p.141). Methicillin-resistant Staphylococcus Aureus (MRSA) and Vancomycin-resistant Enterococcus (VRE) (Kalka-Moll, Lee, & Seifert, 2008), and H Pylori (Woodward, Morrison, & McColl, 2000) are other community transmittable diseases which are highly infectious bacterium and if left untreated by courses of antibiotics, may have fatal results.

Solsona (2001) reports that of 447 homeless persons examined in a shelter in Barcelona, Spain, 335 or 75% were infected with Mycobacterium tuberculosis, and the highest infection rates were observed in the 60-69 years age group, with a mean of 87.8% (Solsona,2001). Wrezel, (2009) states that poverty, malnutrition and overcrowding are risk factors for Tuberculosis, and that respiratory infections are the most common medical issue that brings the homeless to shelters and clinics, which further compromises their asthma, COPD, and “ ...mortality due to respiratory illness is about seven times greater than expected in the homeless” (P.61).

Lee et al. (2005) examined multiple risk factors that lead to cardiovascular disease (CVD) in 202 individuals from 17 homeless shelters in Toronto, Ontario. This study's population (89% male) had uncontrolled diabetes management, severe and untreated hypertension, hypercholesterolemia, and alcoholism with heavy cigarette smoking (78%), as well 29% were using cocaine. The CVD was also heightened with malnutrition and poor nutritional quality of foods obtained from soup kitchens, garbage bins and food banks. Diets high in saturated fats and high sodium are linked to CVD and are considered to be modifiable (Jones et al., 2009; Lee et al., 2005; Ober, Carlson, & Anderson, 1997). The Manitoba Centre for Health Policy put forth a study in 2001 to examine the health status of different community areas in Winnipeg (McLeod & DeCoster, 2001). By using the premature mortality rate (PMR) that specifies how many people die before the age of 75, the researchers found that a high PMR is found in areas which are low economic status, and have high rates of chronic illnesses; mainly hypertension, diabetes, and cancer (McLeod & DeCoster). The least healthy area is Point Douglas, an area of high crime, homelessness and poverty, this area has double the PMR than its more affluent complement of Fort Garry; Point Douglas has a rate of 5 premature deaths per 1000 residents in a year compared to 2.3 in Fort Garry (McLeod & DeCoster). In 2006, THE Point Douglas area also housed the greatest proportion of aboriginal people in Winnipeg over other geographical areas at 29% (Winnipeg Regional Health Authority [WRHA], 2010).

The latest Manitoba statistics compiled for 2010 indicate that 60% of the population or 6 out of 10 people have a chronic disease; the rate among homeless individuals is suggested to be considerably higher. Chronic diseases include: arthritis,

diabetes, asthma, coronary artery disease, chronic obstructive pulmonary disease (COPD), or stroke (Currie, 2010). Homeless adults' use of alcohol, tobacco, or chemical inhalants can lead to damage in the gastrointestinal tract and subsequent associated chronic disorders (Hwang, Wong, & Bargh, 2006). Extreme climatic conditions and nutritional insufficiency are strongly associated with chronic disease to acute exacerbation of illness requiring hospitalization among the population of homeless individuals.

Homeless are at risk for a variety of infectious diseases which are fatal if not properly treated. Factors outside of a person's locus of control, which in the case of homeless individuals can include several modifiable risk factors such as poverty, low education and level of social support a (Rogers, 1997) can move a person from illness to death. Limited availability of resources and decreased access to health care further complicates immediacy of health care treatment options. Homeless individuals are at increased risk for a variety of chronic, infectious and acute health conditions.

Tobacco Related Health Concerns of the Homeless

The use of tobacco further complicates the array of health concerns among this population. The addition of smoking puts the homeless person at greater risk for developing respiratory and cardiovascular diseases (CVD), diabetes, hypertension, and hypercholesterolemia (Kim et al., 2008; Lee et al., 2005; Szerlip & Szerlip, 2002). While smoking is leading risk factors associated with neck and head cancer among homeless populations, Moore & Durden (2010) extend the evidence to suggest that smoking effects gastrovascular and intestinal systems, skin, ear condition, and other growths in the neck or oral regions that commonly influence voice.

Snyder & Eisner (2004) reported on cigarette smoking and obstructive lung disease (OLD) in a sample of 67 homeless individuals in San Francisco; 68% were current smokers and 75% had smoked in their lives. Chronic respiratory symptoms experienced were a chronic cough with phlegm, wheezing, and dyspnea or trouble breathing. Self reported physician diagnoses of respiratory conditions included asthma, chronic bronchitis, chronic obstructive lung disease (COPD) and emphysema (Snyder & Eisner). Wrezel (2009) found that homeless individuals who smoke are also at an increased risk of tuberculosis, as well as influenza, and pneumonia, which Raoult et al (2001) report is due to their already lowered immune systems.

Trench foot or immersion foot is a serious condition caused by improper footwear, wet and moist feet, and lengthy periods of walking and standing, and is the absorption of water on the outer layers of the skin on the feet (Stratigos & Katsambus, 2003). Tobacco is a vasoconstrictive drug which complicates this condition and puts the homeless person at further risk for infection and ischemic injury – or death to these tissues, which requires antibiotic treatment or surgery (Stratigos & Katsambus, 2003). Raoult (2001) states that skin conditions and lower extremity cellulitis are exacerbated by smoking and may lead to systemic infections and amputations.

Smoking is a risk factor for dyspepsia, which is upper stomach pain, heartburn, bloating, and burping and belching, and are considered as symptoms of larger and more serious gastrointestinal conditions, like gastric and duodenal ulcers, gastritis, and reflux esophagitis, and gastric cancer and upper gastrointestinal bleeding (Hwang, Wong, & Bargh, 2006). Hwang et al., report that 59% of 100 homeless people surveyed in shelters in Toronto, Ontario had at least one symptom of dyspepsia that was rated as having a

range of moderate pain to very severe, and 38 participants had a history and diagnosis of gastric or duodenal ulcers, gastritis, esophagitis, reflux, or bleeding from the stomach or bowels. In an earlier Canadian study, it was found that smoking more than six cigarettes was related to increased dyspepsia symptoms of moderate severity (Tougas, Chen, Hwang, Liu, & Eggleston, 1999)

While it might seem that infectious diseases are unrelated to tobacco related illness, research indicates a strong connection. As noted previously, homeless individuals are susceptible to infectious disease transmission, like tuberculosis (Solsona, 2001), HIV and Hepatitis (Raoult, Foucault, & Brouqui, 2001), herpes, MRSA & VRE (Kalka-Moll, Lee, Faber, & Seifert, 2008), Mononucleosis (Peterson & Thompson, 1999), and Helicobacter pylori (h pylori) (Woodward, Morrison, & McColl, 2000). Brutally chapped lips can play host to the transmission of some infectious agents that implant inside minuscule cuts on the lips (Edwards, 2006, p.56). The oral sores are caused by cold weather or adverse climate conditions (Ramin & Svoboda, 2009), recent syphilis, crack smoking, oral sex, HIV infections, intravenous drug use, malnutrition and poor oral hygiene (Sairus et al, 1996). We know a high percentage of homeless smokers (86.4%) engage in sharing a cigarette with others (Aloot, 1993); accordingly this sharing may hold the potential to spread infectious diseases with smokers sharing the same tip of the cigarette.

People who are homeless and smoke are at risk for developing respiratory problems, CVD, cancer, trench foot, dyspepsia and infectious diseases. These health conditions amongst homeless individuals are also tobacco related illnesses that further complicates other general health concerns.

Health Disparities among Homeless Individuals: Practicum Experiences, Insights and Reflections

The reality is that homeless people in Winnipeg have multiple chronic health concerns which are further complicated by mental illness and addiction to alcohol, and tobacco and other substances (Bechtal, 2010). With few options for care, acute exacerbations of illness can lead homeless people to present at the emergency departments in lieu of regular family doctors (Shaw, 2008). With mandates to stabilize and get the patients out quickly (Cocazzo Martins, 2008, p.), hospitals are not equipped to treat withdrawal from alcohol, drugs, or tobacco – or to make referrals to detoxification treatment centres that commonly require a committed sobriety period before acceptance. Moreover, emergency departments have high bed utilization and turnover rates which are not conducive to the formation of the trusting relationship required to successfully address chronic health conditions. The transient nature of homeless individuals, lack of proper identification, a fixed address and a telephone, results in limited, if any, chance for follow up care with a general practitioner, homecare, or for a public health nurse (S. Marshall, personal communication, June 17, 2010). While these barriers highlight the problems of emergency departments as a primary care setting for the homeless, stigmatization of this marginalized population provides an additional layer of difficulty with care. Judgments of perceived lifestyle choices and their harmful behaviors add to their marginalization in this setting. Addictions and sexual street involvement carry stigma and rarely is harm reduction a priority for health care professionals in a busy emergency department. The attitude of “fix them quickly” is a theme found in the literature, and homeless people feel unwelcome in the emergency

departments, feeling they are labeled, part of an experiment, or ignored and invisible (Cocazzo Martins, 2008).

Homeless people face socially and systemically embedded mechanisms that disrupt accessing health care; still, there is evidence that they creatively generate avenues around these to access health care service. The emergency department is a “safety net” for homeless people who have limited resources and access to healthcare (Long, Zielinski, Kunimoto, & Manfreda, 2002), and this holds true for Winnipeg. The homeless access ambulance services for non-emergent health concerns. They seek out nurse practitioners at the Health Access Centre on Main Street who have been hired by WRHA to reduce hospital emergency visits, and who have greater time to spend with each client (V. Katz, personal communication, July 15, 2010). My experiences from Main Street Project emergency shelter in the spring of 2010 inform me of the political health culture of the inner city area. The advanced care paramedics at Main Street Project medically clear those entering the cells of Intoxicated Persons Detention Act (IPDA) to prevent deaths. Between health care related to clearances, the paramedics will attend to non-emergency concerns that staff have other shelter patrons. The homeless learn how to malinger through the emergency department for a psychiatric admission, which includes use of key words such as suicidality, hearing voices, depression and homicidal thoughts. Selling of prescriptions is a way to obtaining cash for other valued needs. Some homeless people ignore their body’s plea for help until systemic infections or toxic reactions form. Another way the homeless seek healthcare is through the jail system which offers an all encompassing access to all services, many seek dental care early in their imprisonment (B. Wallace, personal communication, April 2, 2010). HIV positive individuals seek

healthcare at Nine Circles Community Health Centre, a primary care centre offering sexual health information, and other integrated services such as a specialized food bank, and medical and social supports (Nine Circles Community Health Centre, 2007). The WSHS (Gessler et al., 2011) indicates that 30% of their respondents who were Aboriginal felt an additional burden of accessing healthcare due to their racial origin.

2.2. c. Homelessness and Smoking: A Review of the Literature

My search for relevant literature concerning male homeless individuals and smoking was conducted through the following databases: Academic Search Premier, PubMed, CINAHL, and Google Scholar. Limits placed on the search were: English language, human subjects, adult population, and published between the years of 1993-2010. Search terms used included: homeless, homelessness, homeless persons and “street people”, and smoking, cigarette, or tobacco. Initial search results, were enhanced by looking at relevant articles reference lists and searching websites focused on homelessness and tobacco. In the end, the search yielded eleven articles relevant to this study. See Table 1 for a brief summary of each article (Appendix A).

The articles reviewed focused on adult male populations of homeless individuals and tobacco use and/or cessation with two exceptions: one article reviewed tobacco industry documents for evidence of involvement with the homeless and tobacco marketing ploys (Apollonio & Malone, 2005), and the other focused on long term transitional shelters and receptivity for tobacco control (Arangua, McCarthy, Moscowitz, Gilberg, & Kuo, 2007). All of the articles were published in the United States, there are no Canadian studies known that have examined smoking and homelessness. Of the nine articles reporting on homeless individuals, the majority of participants were African

American with the exception of one study conducted in Boston (Arnsten, Reid, Bierer & Rigotti, 2004). Smoking patterns and behaviours of homeless participants were described in three articles (Aloot, Vredevoe, & Brecht, 1993; Butler et al., 2002; Okuyemi et al., 2006), one also included high-risk smoking practices (Aloot et al, 1993), and eight addressed cessation interest and interventions. There is one qualitative study, focus group discussions (Okuyemi et al., 2006); otherwise, surveys and questionnaires were the methodology used to collect data. Three pilot intervention studies investigated various cessation strategies (Okuyemi et al., 2006; Shelley, Cantrell, Moon-Howard, Ramjohn, & Vandevanter, 2007; Spector, Alpert, & Karem-Hage, 2007). Other cessation topics addressed included: readiness to quit smoking and preferences for smoking cessation treatment (Connor, Cook, Herbert, Stephen, & Williams in 2002) and the impact of health problems, and drug and alcohol use on readiness to quit smoking (Arnsten, Reid, Bierer, & Rigotti, 2004). Baggett and Rigotti (2010) reported on a secondary analysis of a larger national survey from the Health Care for the Homeless User Survey in the United States.

Patterns of Tobacco Use and Characteristics of Smokers

Differences in the smoking practices of homeless individuals begin with how they obtain tobacco. Researchers report that homeless smokers were not purchasing cigarettes from retail outlets instead they engaged in underground economy avenues: borrowing, sharing, bumming, stealing, purchasing single cigarettes, and collecting butts from streets and ashtrays (Aloot et al., 1993; Butler et al., 2002; Connor, Cook, Herbert, Stephen, & Williams, 2002; Okuyemi et al., 2006). The first study to indentify high-risk smoking practices was Aloot et al. (1993); they discussed 7 practices: 86.4% shared cigarettes with

others, 71.2% remade cigarettes from butts, 62.7% smoked cigarettes made by others, 62.7% smoked discarded butts collected in ashtrays and streets, 23.7% blocked the filter vents (which yields more tobacco), 22% used items other than tobacco, and 18.77% smoked discarded filters. These alternative practices increase risk of exposure for infectious diseases.

Aloot and colleagues (1993) also asked about storage of cigarettes for safekeeping and what was used in remaking of cigarettes. The most common place to store loose cigarettes was in shirt pockets (75.1%), followed by storage inside socks (27.1%), tucked behind ears (10.2%), or in pant pockets (10.2%). The most popular cigarette rolling paper for loose tobacco was the commercial type like Zigzag with a 73% user rate, followed by brown paper bags, Bible paper, toilet paper and carbon paper. Aloot et al. discovered that for those who remade cigarettes, 46.2% would augment the tobacco with drugs such as cocaine or marijuana. Interestingly, smoking discarded butts was a practice that was predominant among those receiving income assistance, 48.6% were receiving some form of federal or county aid, or doing odd jobs (29.7%) (Aloot et al.).

Two articles reported on characteristics of the homeless smokers. Aloot and colleagues (1993) reported on an 84 item survey concerning high risk smoking characteristics of 59 homeless people in a mission in downtown Los Angeles. Participants were predominately male with only 3 females, and 76.3% were black. These authors reported that the homeless individuals initiated smoking between ages of 5 and 28 years and consumed on average 14 cigarettes per day (range of 1-60). Butler and colleagues (2002) compared homeless (n=107) and non-homeless smokers (n=491); participants were predominantly African American (59.4% for homeless; 85.7% for non-

homeless). Homeless smokers initiated smoking at a younger age than non-homeless, had a longer smoking history, and smoked more cigarettes a day. These authors also reported a daily average of 14 cigarettes smoked per day; in addition, reported was the maximum number of cigarettes smoked per day over the last 30 days, which for homeless was double the rate of consumption (homeless 45.2 and non-homeless 22.8). Homeless smokers were less willing to smoke menthol cigarettes.

Butler and colleagues (2002) addressed reasons why smoking is important to homeless individuals. Smoking served as a coping mechanism to deal with the daily stress of trying to meet one's basic needs of shelter and nutrition, and also as a means of comradeship, and potential entry into an underground economy of cigarette acquisition. The homeless viewed cigarettes as a reward for "enduring hardships", as a mood regulator, as a reliever of boredom, and a big barrier to quitting was their prescribed membership to a subculture which accepts and endorses smoking (Okuyemi, 2006). The WSHS (Gessler et al., 2011) indicated that 39% of their respondents felt lonely and isolated in Winnipeg.

Butler and colleagues (2002) also explored interest in tobacco cessation programs. While participants were interested in a program to help them quit, their readiness to quit was lower than the non-homeless smokers, and had higher nicotine dependency as screened by the Fagerstrom Test for Nicotine Dependence (FTND). These authors reported high rate of drug use. In addition, findings from responses to the Beck Depression Inventory scale 66% of the homeless demonstrated diagnosable depressive symptoms in comparison to only 44% of non-homeless smokers.

Quitting and Cessation

Nine articles reported on tobacco cessation or motivation for quitting among homeless populations. One study conducted a secondary analysis of a national data set and reported on prevalence and predictors of current smoking and cessation among homeless individuals (Baggett & Rigotti, 2010). One article reviewed 400 tobacco industry documents related to marketing to the homeless (Apollonio and Malone, 2005). Two descriptive survey studies investigated readiness to quit, quit attempts, and preferences for smoking cessation treatments among participants (Arnsten et al., 2004; Connor et al., 2002). A focus group study (Okuyemi et al., 2006) was the first to explore the attitudes and barriers of quitting among homeless smokers. Three articles reported on findings from pilot studies investigating cessation programs that included Nicotine Replacement Therapy and counselling (Okuyemi et al., 2006; Shelley, Cantrell, Moon-Howard, Ramjohn, & Vandevanter, 2007; Spector, Alpert, & Karem-Hage, 2007). One survey study explored emergency and transitional shelters' willingness to support quit attempts with its clientele (Arangua, McCarthy, Moscowitz, Gilberg, & Kuo, 2007).

Baggett & Rigotti (2010) conducted a secondary analysis of the 2003 Health Care for the Homeless User Survey in the United States ($n=460,000$). A sub-population from this data set was analyzed, which included 966 adult respondents that used health clinics. Findings demonstrated that the homeless are less likely to make quit attempts the more times they are homeless. Smokers with more episodes of homelessness had a quit ratio of only 9% compared to 50% of the others. The researchers indicate that half of the respondents had received advice to quit from a health care provider. Those who were Hispanic, who had tobacco-related illnesses like OLD or hypertension, and who were

followed by the clinic closely were more likely to attempt quitting following advice. Baggett & Rigotti state that "...high prevalence of smoking among homeless people is not due primarily to healthcare providers neglecting to address the topic, but more likely due to the considerable comorbidities and barriers to quitting faced by homeless smokers" (P.170).

There is a perception that exists that people who are homeless or mentally ill are not capable of quitting smoking or do not desire to quit. This sentiment is evident in the research by Apollonio and Malone (2005) that looks at the political agenda of the tobacco industry and their marketing ploys. These authors examined over 400 internal tobacco industry documents on the marketing of tobacco to the homeless and mentally ill. Homeless service providers formed the idea that this population was not ready to quit because of the other demands and stresses that homelessness brings, and consequently the tobacco industry capitalized on their vulnerability and addiction with marketing and advertising campaigns, and renewed philanthropic interests. The targeting began in the 1990's with value brand cigarette advertisements for the homeless and images of the "homeless man", free samples and blankets with brand logos were donated to homeless shelters, mental hospitals, and homeless service organizations, as well as sizable charitable donations to shelters (Apollonio et al.). The tobacco industry view the homeless and mentally ill as easily influenced, impressionable and compliant, and "less formed intellectually" (Apollonio et al.).

Connor (2002) examined willingness to quit smoking and preference of treatment amongst 236 homeless persons from 9 Pittsburgh sites. Two thirds or 69% of the sample were current smokers, and of these 37% were ready to quit smoking within the next 6

months. For individuals indicating an interest in quitting, 42.2% wanted nicotine replacement therapy (NRT) alone or in combination with cessation counseling and 14.1% would take the cessation medication Buproprion alone or in combo with other treatment modalities.

Arnsten, Reid, Bierer, & Rigotti (2004) investigation of readiness to quit and interest in smoking cessation counseling, integrated the impact of self-reported tobacco-related health problems and drug and alcohol abuse. Ninety-eight white male smokers from Boston with a mean of 2.75 years of homelessness participated in this study. Almost half reported a health problem that was caused or made worse by smoking: such as coronary, vascular, and pulmonary diseases; 70% screened positive for depression; 43% reported a current alcohol problem; and 20% reported a current problem with heroin or cocaine. This study concurred with Connor (2002), 1/3 were interested in quitting smoking within the next 6 months. In addition, 19% planned to quit within the next 1 month and of these 44% were somewhat or very interested in smoking cessation counseling.

Okuyemi, Caldwell, Thomas, Born, Richter, Nollen, et al. (2006) investigated willingness to quit with 62 homeless individuals by participating in one of six focus group discussions. The majority of the participants were male (69.4%), African American (59%), and participants smoked up to 18 cigarettes a day. Seventy-six percent indicated they wanted to quit within the next six months, which is a higher percentage than reported by Connor (2002) and Arsten et al (2004). Alternately, Okuyemi et al reported on differences between a non-homeless smoking cohort and their participants, while, alcohol and drug consumption was problematic for both groups, the homeless were more

likely to indicate a need for social supports, and nicotine replacement aids in preparation for a quit attempt.

Next Okuyemi, Thomas, Hall, Nollen, Richter, Jeffries, et al. (2006) report on a pilot study investigating a community based smoking cessation intervention. In the pilot study, two groups ($n=46$) were involved in the study; the smoking group and the smoking-plus group (also used alcohol or other substances). Each group received NRT with motivational counseling and the smoking-plus group received support focusing on barriers to quitting, discussions of life events and addictions. The intervention included a community mobilizer; a peer member (homeless person on the research team) was designated as an outreach contact, which reminded participants to attend counseling sessions and supported NRT compliance. Reimbursements included accumulation of redeemable points at the end of the study, transportation costs covered, gift certificates, and free NRT; total worth through completing the study program was \$505. U.S. Unique program features included smoke free group outings and educational support group sessions along with individual counseling and NRT. Reported smoking abstinence rates were 15.4% in the smoking group and 26.7% for the smoking-plus group. Continued smokers reported a decrease in tobacco consumption: smoking group reported a decrease by 6 cigarettes per day and the smoking plus group decreased their consumption by 7 cigarettes. While these changes are promising, it is important to note that retention rate for this study at the end of the 26 week pilot was 68.3%.

A second pilot project, investigated an intervention delivered by second year medical students, which resulted in a reported reduction of daily cigarette consumption among the 11 participants (Spector, Alpert, & Karem-Hage, 2007). The intervention only

included cognitive behavioural therapy (CBT) counseling to change thoughts and smoking behaviour. Smoking frequency as measured by carbon monoxide (CO) measure at the beginning and end of the 3 week project; CO levels measured by a breathalyzer were reduced from 28.0 to 20.2, and a decrease in cigarettes smoked from a mean of 19 to nine, with one individual eventually smoking one per day (Spector et al). The doctor overseeing the project speculates that when trust is established outcomes will improve; thereby, suggested shelter staff be trained in providing the treatment modality. They also speculate that the inclusion of psychopharmacology, such as Bupropion, could increase mood, and other incentives and rewards might be beneficial to compensate for hardships found among this population.

Shelley, Cantrell, Wong and Warn (2010) enrolled 58 homeless smokers in a 12 week cessation program of counseling (cognitive behavioural therapy (CBT) and motivational interviewing (MI)) and pharmacotherapy. At the 4 week mark participants who were ready to quit were offered choices of pharmacotherapy and NRT. Of the 58 participants in the pilot, 70% had attempted to quit smoking in the past, and 75% of the participants completed the 12 week program (n=44); however, this number decreased at the 24 week follow up (n=39). Carbon monoxide measures verified the smoking status of participants at 12 and 24 weeks; results indicate a reduction of 15.5% and 13.6%. Reductions in smoking abstinence rates were seen with the combination of treatment interventions of CBT + MI + pharmacotherapy (Bupropion or Varenicline) or NRT products such as the gum, patch, lozenge, or inhaler (Shelley et al.). This study had offered incentives of a \$10 gift certificate at the 12 week and 24 week assessment points

for participation. This study confirms an interest in quitting among the homeless, and the supports the viability of smoking cessation interventions with a marginalized population.

Arangua, McCarthy, Moscowitz, Gilberg, & Kuo (2007) reported on a novel study that included a telephone survey of transition shelters in Los Angeles County in the United States. Out of 76 transition shelters, 72% surveyed showed an interest in tobacco control and of these, 95% were willing to participate in a tobacco control cessation program. Many of the shelters showed a dedication to adopting environmental tobacco control efforts, 75% of the shelters introduced an indoor “no smoking” policy, and 78% had designated smoking areas outside. A unique factor with these shelters is that 60% of shelter residents were female. The shelters were transitional with length of stay being longer than emergency shelters for overnight use. The ethnicity of the populations served by the study shelters were Hispanic and black, which is similar to other studies. Despite the tobacco industry’s marketing efforts and negative imaging of homeless and their smoking, emerging from this literature is evidence that homeless are interested in quitting and shelter staff are open to treating tobacco dependence.

An expert panel meeting concerning tobacco use in homeless populations was hosted by American national network, The Break Free Alliance, in October 2011 (Porter et al., 2011). This alliance is a network of organizations, regional and state tobacco control partners and researchers collaborating on issues of poverty and tobacco use. During the one day meeting, the panel identified research gaps, which when addressed would support the development of a framework to effectively reduce tobacco use among homeless populations. Of the 11 research questions identified, three are of particular interest to this thesis: questions 1, 9, & 10 from the list below:

1. What is the impact of tobacco control policies and tobacco tax increases on the tobacco use behavior of homeless persons?
2. What strategies can be implemented to increase the demand for tobacco cessation services for homeless individuals?
3. What is the best time to start nicotine addiction treatment for homeless persons (i.e., while in treatment for other co-morbidity issues or when housed)?
4. Are population-based cessation treatment interventions effective and if not, how do interventions need to be tailored?
5. How do we implement clinical practice guidelines for treating tobacco use and dependence and tobacco control policies in organizations serving homeless persons?
6. What is the effect of delivering tobacco cessation services for homeless persons in non-clinical settings?
7. What is the efficacy of a free intervention like Nicotine Anonymous, a 12-step program for tobacco cessation?
8. What is the prevalence of smokeless tobacco use and menthol products among homeless persons?
9. What are the smoking patterns of homeless persons (for example, do they purchase single cigarette vs. packs, smokeless tobacco, etc.)?
10. How does the barter system used by homeless persons impact tobacco use and cessation?
11. How can the medical treatment model be paired with an understanding of social determinants of health? (P.150S).

In summary, the emerging literature focused on homeless males and tobacco use demonstrates a growing interest in reducing consumption among this marginalized population. The patterns of use and reasons the homeless adult males smoke are different than the general population; access to tobacco mirrors their availability to immediate resources, and smoking serves as a task-oriented behaviour to cope with stress and vulnerability. There is emergent evidence that these homeless people are interested in quitting, which counters tobacco industry social marketing efforts. They want assistance with a quit attempt that is readily accessible, which at a minimum could include a combination of NRT and counseling. There is nascent evidence that peer support and social activities could be beneficial in reducing tobacco consumption. While this

literature review offers a glimpse into homeless adult males, tobacco use and cessation, there are some clear gaps. The lack of studies conducted in Canada, limits our understanding of smoking among Canadian homeless individuals and the influence of our diverse demographic and socio-political context. The lack of qualitative exploration into the everyday lives of homeless people who smoke, limits our understanding of intrinsic factors surrounding smoking, tobacco acquisition, and motivations for quitting.

2.2. d. Socio-Cultural Contexts

This section explores the individual person who is homeless and a smoker within broader society contexts. Homelessness and smoking may also be associated with a racial historical context, the effects of mental illness, poverty and segregation, all of which support an underground economy and social exclusion. The areas highlighted include Aboriginal Peoples and traditional smoking practices, mental illness and tobacco use, the underground economy of trade and barter: drugs, alcohol, cigarettes and sex, and aspects of social justice within tobacco research.

Aboriginal Peoples and Traditional Smoking Practices

In Canada, 3.3% of the population identify as Aboriginal (Health Canada, 2007) and 58.8% of the 3.3% report being a smoker. Carter et al (2003) report that 1 in 5 people that are Aboriginal living in Winnipeg will be homeless, with no mention of tobacco use rates. The 2011 Winnipeg Street Health Report (Gessler et al., 2011, p. 10) identified over half of their 300 respondents as Aboriginal (56.7%) – whom further identified themselves as Inuit, Métis, Non-Status Indian and Status Indian. Given these numbers and the rates of tobacco use among Aboriginal or First Nations people, there is a high

likelihood that participants in this thesis would include a disproportionate number of people who identify as Aboriginal or First Nations.

Health Canada makes the distinction between two types of smoking for this “at-risk” population; traditional and non-traditional tobacco use. Traditional tobacco use involves a spiritual and sacred component which is a link between the spiritual world and the earthly human realm (Health Canada, 2007). Further, Health Canada describes that traditional tobacco is used for medicinal and purification purposes, prayer and gratitude, communication with the creator and the spirit world. Restoration and balance are important concepts in traditional healing, tobacco is used as an offering or smoked to ensure equilibrium and create balance, the offerings are made in 4 directions counter clockwise and smoked for the wind to carry and protect from harm’s way (Stuthers, Eschiti, & Patchell, 2004). Blondin (1990) describes tobacco as a ``gift from the creator``, but there has been a shift away from the cultural and medicinal laws to it being viewed as an ``addiction``. Blondin also reports that tobacco was originally grown, cultivated and smoked for medicinal reasons, but now the tobacco is filled with chemicals and additives, which is known to be ``harmful and kill``. The smoking of cigarettes and use of tobacco outside of ceremony is considered to be of disrepute and against the traditional ways.

Non traditional or recreational tobacco is considered addictive and the cause of high morbidity and mortality. Health Canada draws on the research of a 2004 report from the Environics Research Group who surveyed First Nations people On-Reserve and Northern Inuit communities on their smoking prevalence. Health Canada (2007) reports that of those sampled on reserve, 60% of current smokers were between the ages of 18-

34, 52% of the sample initiated smoking between age 13-16. Inuit communities report similar but higher rates with 70% of smokers were 18-45 years of age, and of which 46% started smoking at age 14 and younger. Comparing the tobacco use rates with the general population reveals that Aboriginal people are two times more likely to using tobacco in non traditional ways (Health Canada, 2007). What this tells us is that a small percentage of the population has high smoking rates and is at greater risk for tobacco-related illnesses, which means increased health burdens personally and for the healthcare system.

Quitting is discussed in the literature with the utilization of telephone quit lines by Aboriginal users. Blondin (1990), a healer of the Dene Nation, states that the ``medical profession has a lot of input in how the smoking situation for our native people is and should be`` (p.52). Quit lines in Canada are frequently called by Aboriginal smokers who have health concerns. The suggestion from this research is to target and tailor promotion strategies to reach this population. During the time frame of August 2001- December 2005, 7,082 people called the quit lines. Of the 516 who identified themselves as Aboriginal, 57% quit for 24 hours and at the 6 month evaluation, 16.7% had quit compared to a 9.4% of non-Aboriginal callers (Hayward, Campbell, & Sutherland-Brown, 2007).

The latest research situated in Winnipeg explores the meaning of tobacco among Metis people, and how they view its use and misuse. Mutch (2011) describes strong differences between the use of tobacco commercially and recreationally versus the use of tobacco ceremonially for cultural and traditional purposes. Mutch (2011) found that tobacco misuse occurs with enculturation, where there is a loss of traditional knowledge and customs. Mutch relates that acculturation, adaptation and historical trauma are factors

resulting in cultural loss and identity loss (p.94). This disconnect from Metis Culture attenuates shame, guilt and stigma to recreational smoking, and is considered misuse and a “dirty habit” (p.55), she found a clear distinction between the two worlds of tradition and commercial tobacco use, traditional use was associated with healthier lifestyles and strong identification with their Metis culture.

Mental Illness and Tobacco Use

According to the Canadian Mental Health Association (2010), one in five people suffer mental illness in Canada and this number is likely considerably higher among a homeless demographic, however, the WSHS (Gessler et al., 2011) highlights that only 3% of their respondents reported that their homelessness was due to mental health issues. Lasser (2000) states that smoking and mental illness are intrinsically linked, and that the rates of smoking are higher among people with mental illness than the general population, consuming approximately 44% of all cigarettes in the United States. Apollonio & Malone (2005) captured our attention with the alarming statistic that roughly “...two thirds of the severely mentally ill experience or risk homelessness, and the mentally ill are estimated to buy nearly half the cigarettes sold in the USA” (p.409). People with schizophrenia have a high prevalence of smoking and find smoking rewarding over those with other disorders, like depression, or their non-psychiatric diagnosed smoking cohorts (Spring, Pingitore & McCharge, 2003, p3.16). The rewards associated with smoking centre on a decrease of psychiatric symptoms (i.e. auditory hallucinations or “voices”, anhedonia or low-flat mood, amotivation,), and side effects of medication, and the preference is to smoke over other distractors (Spring et al). The researchers explain that “(n)icotine maybe particularly reinforcing in Schizophrenia

because it stimulates the subcortical reward system and prefrontal cortex, which both appear to be hypofunctional in schizophrenia” (Spring et al, 2003, p.316).

There is an added stress of violence directed at marginalized individuals who are homeless, mentally ill and a smoker. These marginalized individuals have a reduced ability to deal with everyday problems due to their illness to fend off predators. The news media has highlighted stories of people with mental illness who were set afire or beaten to death for a cigarette, the “gentle giant” is an example of a quiet man with mental illness, living in a transitional housing in Winnipeg who was beaten and stabbed to death for a single cigarette by men in his area (CTV, 2008).

Underground Economy of Trade and Barter: Drugs, Alcohol, Cigarettes and Sex

There is evidence to suggest that an underground or informal economy exists for a homeless population. The literature tells us that the underground economy flourishes when barriers are in place for the homeless to access a more formal economy (Thrasher et al., 2009), like untrained skills or illiteracy. An informal economy for this population can include a combination of scavenging, panhandling, recycling, bartering, trade and exchange, street vending and busking, squeegee, prostitution, thievery or drug and alcohol sales (Lee et al., 2010). Lee has also coined the term “shadow” to refer to the informal economy work. With regards to tobacco, the sale of single cigarettes or loosies (Clegg Smith et al., 2007) offers the buyer a commodity that is affordable and accessible (Thrasher et al., 2009), a theme that can be pressed to apply to other items of exchange too, for example street workers exchanging sex for drugs. Street Connections is a WRHA harm reduction program that is built on the needle exchange premises – of handing out clean syringes, safe crack pipes, and condoms and lubrication; street involved women

have reported to public health nurses that they have engaged in an exchange of sex acts for cigarettes (S. Marshall, personal communication, June 17, 2010).

In Winnipeg, there are stores in the inner core area that support the buying of loosies (B. Bechtel, 2010) which is a means for homeless smokers to support their tobacco needs. In the formal economy, the buying of loosies is a way of circumventing public policy, and heavy taxation placed on cigarettes (Shelley, Cantrell, Moon-Howard, Ramjohn, & Vandevanter, 2007; Stillman et al., 2007). For individuals who are homeless, it is a way of smoking without buying a whole package and the justice is that leftover money can be expended for other items, like a can of pressed meat and bread at a discount food store. The appreciation of loosies as a resource amongst the homeless is the convenience and choice it offers the individual, for example with limited finances, a whole pack may seem unobtainable, but a single cigarette is within reach, and even part of a daily routine (Clegg Smith et al., 2007), especially in a community that has pro-smoking norms (Shelley, Cantrell, Moon-Howard, Ramjohn, & Vandevanter, 2007).

Aspects of Social Justice within Tobacco Research

Greaves, Vallone & Velicer (2006) discuss the effects of tobacco policies among women and girls of low socioeconomic stature. The researchers indicate that low SES people are more susceptible to initiating and maintaining smoking, which thus places them at risk for a higher burden of health problems. Health problems may become exacerbated with limited access to healthcare resulting from a myriad of social and economic factors, for example child care or no money for a bus ticket for transportation to the doctor's office. Despite this, Greaves et al. explain that quitting becomes more difficult for this population because they often live and work in environments which

support their smoking, and is permitted, and also women may be subjected to domestic control in their household which prevents their input for change. Greaves (2006) indicates that future tobacco policies must be formed under new conceptual frameworks that are ethical, comprehensive and integrate consideration of issues surrounding disadvantage for women. Greaves and colleagues' work demonstrates how a social justice framework can guide researchers to interact with individuals in exploring how policies negatively or positively affect those most marginalized.

Anderson et al., (2009) refers to the concept of "othering" of those people in society that are not afforded the same rights and access than mainstream society. "Othering" involves silence and a lack of a voice in decision making that includes them, the same idea can be applied to tobacco and the homeless. Healton & Nelson (2004) indicate that those who are marginalized and poor are not receiving smoking cessation products and programs as they are not affordable and not accessible to the poor. Ideally for justice to be revealed, homeless individuals would contribute to the design and implementation of smoking reduction and cessation programs (Healton & Nelson, 2004) – "...to give them a fighting chance to reject tobacco". Healton & Wilson (2004) point out that those who are most exploited are the ones who have the least amount of information about the health risks of smoking, have the fewest social supports, and the least access to cessation services, and suffer from a high burden of tobacco-related illnesses and death. Framing tobacco as a social justice issue can be a useful strategy for exploring the magnitude of tobacco related issue among the homeless in Winnipeg. To support health practitioners and policy makers, revealing how homeless view their tobacco use, how they use it, and even how much they smoke will be beneficial for these

potential social change agents to access more resources and generation of new programs for fair and equitable distribution among all Canadians who use tobacco.

2.2. e. Policies and Programs in Winnipeg related to Homelessness

The utopian ideal of a society free of homelessness is a concept that would make this section moot and unnecessary. Consequently, Winnipeg does have a population of people who are homeless and therefore programs and policies are required for the management of same. While Winnipeg has not espoused a long term plan to end the cycle of homelessness, like larger cities of Toronto and Vancouver, local policies which albeit silo the problem, are still essential and crucial. There are five policies that affect the homeless in Winnipeg, this thesis will not be evaluating the efficacy of these policies, but it is fundamental in understanding the political and social milieu of being homeless and a smoker in Winnipeg.

Cold Weather Strategies

With extreme lows reaching below zero for winter months, the climatic conditions of Winnipeg are considered adverse and dangerous for the smoker venturing outside. Data suggest that Winnipeg, as compared to other Canadian cities, ranks third for the coldest recorded average temperatures for the month of January from 1971 to 2000; colder locals include Whitehorse and Yellowknife in the North (Statistics Canada, 2007). With these cold temperatures, the risk for hypothermia and frostbite increases, and even more with exposed skin freezing within 10 to 30 minutes with wind chills of -28 to -39 Celsius (Environment Canada, 2002). When wind chills surpass -55 people are warned to stay indoors as risk to health is considered dangerous, moreover, constant winds over 55 kilometres per hour can speed up this rate of frostbite transmission. Environment

Canada issues warnings when the wind chill reaches -45 as the risk of frostbite is considered high (Environment Canada, 2002). Environment Canada (2002) indicates that more than 80 people die a year from over-exposure to the cold.

Frostbite-risk factors for the homeless include: a lack of adequate warm clothing with high-insulating properties, exposed skin, decreased body weight and muscle mass, smoking and alcohol intake, which decreases the body's core temperature with cold-induced vasodilatation (Goldman, Newman & Wilson, 1973; Haynes, 2000) and illicit substance use, impairing judgment and insight (American Psychiatric Association, Diagnostic and statistical manual of mental disorders, 2000) (DSM IV-R). The Centers for Disease Control and Prevention warn that cold weather puts an added strain on the heart and heavy exertion can be detrimental for those with heart disease and hypertension (Centers for Disease Control and Prevention, 2007), or those who are elderly, physically disabled, or mentally ill. A 1999 survey conducted by Environment Canada's Meteorological Service of Canada (Environment Canada, 2002) indicated that 82% of Canadians use wind-chill temperatures to inform their daily clothing choices; absolute homeless people were absent from this survey, and often do not have access to these weather forecasts.

The Winnipeg Police Service (WPS) and the Downtown Biz Outreach have partnered to implement the Government of Manitoba's cold weather policy. The policy instructs full-emergency shelters to open up 80 additional beds when temperatures dip below -25 Celsius. This policy takes the place of local shelter policies, which may otherwise refuse admittance to certain homeless individuals (Government of Manitoba, n.d.).

The Intoxicated Persons Detention Act C.C.S.M. c. 190

The Legislative Assembly of Manitoba enacted The Intoxicated Persons Detention Act which outlines the responsibilities of peace officers to take into custody a person who is inebriated. Persons found intoxicated in a “...place to which the public has access...” will be delivered to a detoxification centre in the community. An intoxicated person may be released within 24 hours from the detoxification centre if it is determined he or she will not cause harm to self or others, cause a disturbance. He or she may also be released to a “suitable and capable” person or family member who may take charge of this person (C.C.S.M. c. 190, 1988). This act looks to The Correctional Services Act C.C.S.M. c. C230 (2004) to add the defining features of an intoxicant. An Intoxicant is

...a substance that, if taken into the body, has the potential to impair or alter judgment, behaviour or the capacity to recognize reality or meet the ordinary demands of life, but does not include caffeine, nicotine or an authorized medication used in accordance with directions given by a staff member or a health professional (p.4).

Homeless individuals who are intoxicated will be taken into custody to Main Street Project at 75 Martha Street, unless charged with a crime and taken to the Winnipeg Remand Centre. Upon discharge, the Remand Centre is only bound to assure that the incarcerated, homeless individual be clothed (B. Wallace, personal communication, April 2, 2010). Under the Act, intoxicated persons are detained at Main Street Project for a maximum time frame of 24 hours in one of the 20 holding cells – detainees are medically cleared and closely monitored (Main Street Project [MSP], 2010). IPDA provides an alternative to jail, it allows a person a safe and controlled place to gain sobriety when judgment has been lost. This program keeps order in the community and has no

responsibility to rehabilitation. Main Street Project is a non-smoking environment; therefore detainees are unable to smoke until released.

Project Breakaway

The mandate of Project Brakaway is to decrease the number of homeless people using expensive emergency services, such as hospitals for primary care needs, ambulances when intoxicated, and the police officers to transfer the individual to a shelter or hospital due to calls from concerned citizens. The individuals targeted for this program are those with co-occurring disorders of mental illness, drug or alcohol addiction, and homelessness. The goal of the program is to bring the individual into a recovery or treatment centre and to decrease lengthy hospital stays that are over two months in duration in a year (Turner, 2008), which will also decrease public taxes and the WPS time and capital. The program could also affect the number of individuals facing imprisonment for substance-related crimes, or violence and aggression (Turner, 2008).

Project Breakaway is a Winnipeg Police Services` (WPS) – program initiated in 2004, it falls under the police response, and public order portfolio and received endorsement from Sam Katz for ``making cities safer`` (MacIntyre, 2009). The project operates out of a trailer on the grounds of Main Street Project, which is the program's central partner. Main Street Project offers a 24/7 detoxification unit and temporary emergency sleeping arrangements, as well as longer-term transitional housing options. Affiliated partners who work in conjunction with the WPS mental health liaison officer that coordinates mental health issues are the Salvation Army Mobile Crises Unit, the housing authority, and the newcomers community (MacIntyre, 2009), which consists of

marginalized, immigrant, refugee, and Aboriginal persons below the poverty line in the inner city (Carter, 2008).

A staff writer at the Winnipeg Free Press (2008) indicates that the number of frequent users are 38 identified persons who account for up to 1,000 emergency service calls in a year, with one client totaling 186 hospital trips in a year with a cost of \$45,000 for ambulance usage and \$119,000 in police overhead; there have been up to 300 others identified who need services (Paraskevas, 2008). The success of the program is measured by the police on number of contact calls, and monies saved. In 2007, 26 frequent users accounted for 214 hospital visits at an approximate cost of \$428,000 concomitant with 753 police calls, tallying up to a cost of \$159,903 (Paraskevas, 2008). With Project Breakaway in place in place, within three months the number of contacts with police has fallen from 364 to 44, realizing savings of \$48,000 (Paraskevas, 2008).

Winnipeg Chief of Police McCaskill reports a measurable achievement with two individuals in the program. One individual who had had a lifetime number of 736 calls to police services had no further contact with police. The other who had a lifetime number of 1,025 police-related calls decreased his contact with police 90% (Paraskevas, 2008). The numbers suggest the program is working with the reduction of service usage, however, it does not capture a person's quality of life, or if they are living safely in their own apartment or room and still accessing services. What happens to the individual when they are no longer followed, relapse?

Questions arise with respect to the long-term success of the program; a lack of reporting is a definite limitation with programs across Canada should they exist, currently there is a smoke screen veiling these initiatives. The success of this program must assume

adequate community supports are in place to address social and health service utilization and subsidized housing for those trying to “breakaway” from their transient lifestyle and the streets. Currently, there is an absence of benchmarkers and indicators that measure the success of this program and others on a Canadian scale. One barrier left unmentioned is the barrier of the landlord; many housing placements are contingent on being a non-smoker due to the potential risk of fires (Bechtal, 2010).

CentreVenture Development Corporation

With an investment of \$6.16 million, the three levels of government have partnered to revitalize the unoccupied 101-year old Bell Hotel on the corner of Main Street and Higgins Avenue (Government of Manitoba News Release, 2010). This area, considered to be part of neighbourhood 11B by the WRHA (Winnipeg Population Health and System Analysis, 2004), is a downtown core area heavily populated by homeless persons and a hub of substance and alcohol usage. A two-year construction project has transformed this hotel from a single-room occupancy structure to 42 suites of supportive housing for a chronic homeless or potentially homeless clientele. Honourable Kerri Irving-Ross, the Minister of Housing and Community Development for Manitoba, stated that this project “...can assist in decreasing emergency room visits, hospital bed utilization, and mental health symptoms, and increasing residential stability, independence and empowerment” (Government of Manitoba News Release, 2010). While valued by most political leaders, this program has been under attack by some political leaders. For example Stephen Fletcher, the Minister of State of Democratic Reform, believes that sobriety must be a requisite condition for tenancy and alcohol should not be allowed on premises. Brian Bechtal, Director of Main Street Project, finds

this viewpoint to be contentious and remarks that it “...reflects an outdated view of the homeless and how people deal with addictions” (CBC News, 2010). Irving-Ross supports Bechtal’s position by stating that tenants are able to consume alcohol. Ross McGowan, CEO of CentreVenture Development Corporation, states that “...the buildings occupants will have the same rights as any other property owner or tenant, and that includes the right to consume alcohol” (CBC News, 2010).

Each tenant is required to fill out an application, which is measured against a list of conditions and rent is based on a sliding scale. Addictions and mental health support is available on the premises for those with multiple needs (Global News, April 23, 2010). The goal of CentreVenture (2007) was to revitalize the downtown area with investments from private and public sectors or non-profit sector, as well as multiple other partnerships, like the Downtown Biz and the Exchange District BIZ. Housing is one of the social determinants of health and a basic need for survival (Bryant, Chisholm, & Crowe, 2002). Housing for the homeless would mean elevating their social class to be able to move towards improvement of other areas of their lives.

In Canada there is a move towards supportive housing initiatives for the homeless. The government has dedicated funds in initiatives such as The Homelessness Partnering Strategy (Human Resources and Skills Development Canada [HRSDC], n.d.), which takes a “housing first focus”. British Columbia has taken this approach with their program “Housing Matters” with the goal of opening 5,000 units of single room occupancies and supportive living complexes (BC Housing, 2007). In addition to programs such as CentreVenture Development, a national program called ``Housing First,” is piloting different strategies based on aggregate groups in major Canadian

centres such as Winnipeg, Toronto and Vancouver. In Winnipeg, the program has targeted homeless Aboriginal individuals (Laird, 2009; Mental Health Commission of Canada, 2009). Housing First initiatives focus first on housing and offer needed addiction and mental health services afterward. One criticism to this approach is that it is not a long term comprehensive plan, and fails to look to treat the surrounding causes to lack of affordable housing (Laird, 2009).

Adopting a long term plan much like Hamilton and their 3-year plan (City of Hamilton, 2007), or Edmonton with a 10- year plan will complement the housing first initiatives that are currently being piloted, and will also strengthen the work that is current with harm reduction strategies and shelters. Hamilton's Strategy looks to identifying those who have been in shelters over 42 days to case manage these individuals for affordable housing, accessible mental health, and addiction services (City of Hamilton, 2007). While it is not completely clear how the success of the program is measured, the following indicators will serve as a measure: emergency shelter use, housing, supports, income and employment (City of Hamilton, 2007).

The Panhandling By-Law No.6555/95

On January 26, 1995, The City of Winnipeg instituted The Panhandling By-Law, which regulates and controls the pursuits of individuals who beg or ask for money or valued objects either verbally or non-verbally with the use of a printed sign. Breaches of this act include panhandling after sunset, on transit buses, in elevators and pedestrian walkways, and from an occupant in a parked car, or one stopped at a traffic control signal, and from a vehicle being unloaded. Secondly, a 10-meter rule applies to panhandling from: the main entrance to a bank, credit union, or trust company; an

automatic teller machine; a public entrance to a hospital; a bus shelter and bus stop.

Those who transgress this By-Law incur a fine of less than \$1000 or imprisonment up to six months or even both.

The problem with this By-Law is that it fails to address the fact that many ``panhandler'' do not have legitimate identification and therefore cannot pursue traditional employment. Moreover, there is a lack of enforcement and staff to police this by-law, and it cannot be considered a long-term solution to reducing crime and homelessness, nor is there sufficient evidence to support its efficacy in regulating panhandling as it criminalizes the offence and deals not with the underlying causes, and further stigmatizes people for their socioeconomic status (Canada Research Chair in Urban Change and Adaptation [CRC], 2007). This program is designed for “cleaning up” the city rather than expending energy in treating the individual causes of homelessness.

2.2. f. Smoking Policies

Tobacco control policies may be put into practice by government action on the federal, provincial and municipal level. Levy, Chaloupka, & Gitchell (2004) identify 9 policies related to tobacco control efforts in the United States to decrease smoking rates, and ultimately tobacco related deaths. The nine policies are rated for their policy effectiveness by looking at their effects, and the limitations of each. The importance of looking to policies through this lens is to inform government leaders of the priorities of different policies on limited resources. Levy et al. use a computer simulation model *SimSmoke* to predict a policy's value and outcomes on reducing smoking rates. The computer programs predictive ability considers a multitude of factors of which includes: gender, race, ethnicity and age (p.339). Tobacco policies are prioritized based on their

magnitude in reducing smoking rates. The top 4 in order are: cigarette taxes, clean air laws, mass media campaigns, and lastly government cessation policies – which for this purpose encompasses quit lines too. It is worth mentioning that Levy's own reviews of tobacco policy documents made no mention of the effectiveness of harm reductionist approaches as a viable option.

Taxes

Taxes are a means to reduce cigarette use and garner revenues for governmental tobacco control campaigns, and may be used to recoup expenditures of rising health care costs of illness. SimSmoke calculated that a 10% increase in cigarette price will reduce the number of youth smokers (ages 18-24) by almost 7%, and the average amount smoked by more than 6% (Levy et al.). Tax increases affect low income populations, and youth who initiate smoking but do not progress on to established smoking practices (p.240). The goal of taxation is to decrease the purchasing of untaxed cigarettes via contraband, smuggling and brand switching to lower price cigarettes, these cigarettes are also higher in tar, nicotine, and tobacco and hold additional health risks (Non-Smokers' Rights Association, 2007).

Clean Indoor Air Laws

Clean indoor air laws function to reduce opportunities to smoke in public settings, public firms and workplaces, restaurants, lounges and bars. Clean air laws prohibit smoking to decrease smoke emissions (also known as environmental tobacco smoke (ETS)) that affects non-smokers – especially children, and also reduces fires, cleaning costs, and employee absenteeism (Levy et al.). Bans may either be a total ban, or partial, which includes designated smoking areas outside buildings, or a smoking room with

adequate ventilation (Levy et al). Levy et al. indicate that SimSmoke predicts an 11% smoking reduction with a strongly enforced total ban of smoking when coupled with a comprehensive media campaign. Strong smoking restrictions are reliant on public support, governmental enforcement, and community mobilization (Levy et al.). Smoking ban policies are often challenged by entertainment segments of society due to loss of income, and weak antismoking norms of the community (Lambert, 2005).

Smoke free bans are purposed to decrease second-hand smoke exposure to further decrease respiratory and coronary diseases to extend longevity (Eisner, 2006). While smoking bans face critical attack from restaurateurs, bar owners, and tavern owners, smoking bans have proven to gain public support without a loss in revenues predicted after becoming smoke free (Eisner). Eisner compiled a number of studies which show that smoke free legislations lead to decreased incidents of myocardial infarctions, adult asthma exacerbations, and sensory irritation symptoms among bartenders. Eisner adds that `` (t)hese smoke-free workplace laws have provided a ``laboratory`` for studying how such legislation affects public health`` (Eisner, 2006, p.1778).

The Non-Smokers Health Protection Act (NSPHA) of 2004 in Manitoba prohibits smoking in all indoor workplaces and enclosed public places. Bans apply to group living facilities such as personal care homes, hospitals, addiction units, palliative care units and residential shelters (NSPHA); however tobacconists are still able to test and sample their products with proper ventilation in place. Non-compliance of the ban will result in fines ranging from \$500 for a first offence to \$15,000 to third or subsequent offences for proprietors, and \$100-1,000 for individuals breaching the act (NSPHA). The NSPHA

holds the minimal standards; municipalities are able to enact bylaws which are more restrictive and limiting than the act alone.

Advertising Restrictions and Mass Media Policies

Advertising restrictions are aimed at decreasing the promotion of smoking and tobacco products. The tobacco industry's modus operandi is to increase the number of new smokers, and keep established smokers smoking with brand loyalty by circumventing policies and loopholes to vulnerable groups, like the homeless or youth (Apollonio & Malone, 2005). Policies to control advertising and promotion apply to radio, television, and print ads, youth and life-style advertising, sponsorship activities, and limitations of point of purchase advertising, and tobacco displays (Levy et al., 2004). Canada has made strides with bans on power-walls (Non-Smokers' Rights Association, 2007) which are large point of sales displays dominating store fronts, counters, and walls with product. SimSmoke predicts 4% reduction effect on prevalence rates of smoking (Levy et al.). Advertising restrictions require government mobilization and support. Subgroups affected most by these restrictions are youth with the bans on advertising during sporting events and music concerts (Non-Smokers' Rights Association, 2007). Anti-tobacco campaigns that use multimedia with billboards and print are expensive endeavours to shift social norms towards tobacco control.

Tobacco Health Warnings & Cigarette Regulations

Tobacco health warnings are a federal government sanctioned intervention requiring manufacturers to include health warning labels on the package of cigarettes, or an insert in the package (Levy et al., 2004). Levy et al. indicate this policy has limited efficacy in reducing smoking amongst adults in low-income countries which lack

understanding of associated health risks, *SimSmoke* predicts that graphic warnings have a reduction rate of up to 2% and only if coupled with another program.

Implication of Policies/ Programs for Homeless People

A government regulation on smoking creates an opportunity for the people who are homeless to turn to other avenues to smoke, like the informal or underground economy. Public space bans only push the smoker to other areas. Monetary fines are irrelevant to the homeless person who smokes and the fine is not a priority for them, nor does it hold any political authority. Bans in restaurants and other entertainment establishments are also not effective in decreasing smoking for this population as they are not using this service. If smoking offers a social outlet for this population, they will continue to smoke outside shelters, in public spaces, and when couch surfing at a friend's apartment. The tobacco industry and homeless smokers have a common interest, tobacco, and while the homeless are looking for ways and means to smoke, the Tobacco Industry (T.I.) is also growing their interest in this population. The T.I. and the homeless smokers are both working outside the retail system to meet their needs, the T.I. with their advertising propaganda and misguided charity efforts (Apollonio & Malone, 2005), and the homeless by accessing cigarettes through alternative means and being recipients of the charitable trust.

2.3. Summary

This review of the literature on homelessness and tobacco use, also addressed common health concerns and relevant socio-cultural contexts. Furthermore policies and tobacco control strategies that shape the socio-political context surrounding homeless individuals were discussed. Several important gaps and/or key points emerge through this

review of relevant evidence. It is clear that our awareness of the extent of tobacco use and related issues within the context of individuals who are homeless is limited and nascent.

The review of tobacco control strategies suggests a dearth of consideration for how these strategies shape the experiences of homeless individuals related to the tobacco use and the likelihood of tobacco reduction efforts. Poverty and limited access to healthcare are barriers to wellness, health promotion and prevention, and furthers the burden of marginalized and vulnerable populations. The homeless have compromised health related to the hardships and trauma of living on the streets, and tobacco use appears to introduce another layer of risk to their health, safety and welfare. With a paucity of research evidence concerning the reality of tobacco related illnesses among the homeless, it is evident that further study focused on homeless people and tobacco use is essential, in particular, qualitative studies that integrate an exploration of the influence of Tobacco Control strategies. The homeless are most vulnerable to policy shifts which effects control over personal space and choices, and therefore their tobacco use must be understood amongst the backdrop of their own psychosocial, environmental, and cultural context. This study will provide the opportunity to enter into a dialogue that explores the meaning of tobacco for homeless adult men in Winnipeg, and anticipates generating guidance for future steps relevant to nursing along with other health care practice and tobacco control strategies.

CHAPTER 3: THEORETICAL FRAMINGS

Three theoretical frameworks, or perspectives, are guiding this study. The study focuses on the importance of tobacco in the everyday lives of homeless adult males in Winnipeg, thus a symbolic interactionists' perspective has been chosen as a foundational perspective for investigating people's understanding of their everyday world. In addition, two theoretical lenses address specific aspects common among people who are homeless: social exchange theory and social justice standpoint. Theoretical frameworks guide development and conduct of a study along with data analysis and interpretation of results.

3.1. Symbolic Interactionism

I explored the experiences of individuals who are homeless and their tobacco use, along with the meaning they ascribe to tobacco and related interactions with others. Since symbolic interactionism focuses on how people are understood in relation to interactions with others and the meaning extrapolated through symbols or interpretation (Pruse, 1995), this theoretical perspective provided a solid foundation. In nursing, this theoretical perspective has been used to understand the symbolic meaning of family burden of living with a person who is ill (Stuart & Laraia, 2001), understanding patient care on locked acute psychiatric wards (Johansson, Skarsater, & Danielson, 2012), and discovering the health-seeking behaviors of North American Indians with persistent and severe mental illnesses (Yurkovich, Hopkins (Lattergrass), & Rieke, 2012). Symbolic interactionism was used to explain the meaning of the illness experience for each family member. Symbolic interactionism has historical roots steeped in participant observation methods and is commonly integral with ethnographic approaches (Pruse, 1995).

As a descendant of Mead, Herbert Blumer coined the term “Symbolic interactionism”, a major sociological view that is important when working with disenfranchised groups of people (Denzin, 1992). Blumer outlines the basic premises that frame this theoretical viewpoint, symbolic interactionism believes that human beings create their worlds of experience, that their actions are motivated by that which holds meaning for them, and these meanings are formed from an interplay of the person or “self” with society and its members (Denzin, 1992). The importance of this theory to the study of oppressed or marginalized persons is that it provides a narrative of a person’s identity, social structure and behaviors at a given time in history, or as Denzin (1992) states it “...speaks to those persons who occupy powerless positions in contemporary society” (p.20).

By looking through this lens, we see individuals seeking their identities and roles within a greater society by exercising rational choice and exchange in a society concerned with power, dominance, and group positioning, as a result, the person’s interactions may become “...routinized, ritualized or highly problematic” (Denzin, 1992, p.25). Specific to homeless individuals, Goffman concentrated on the social world of human beings and their interactions with each other in everyday ordinary situations of people who are homeless (Goffman & Best, 2005). Of particular interest is Goffman’s (1955) work on face-work, which focused on the ritual elements in social interaction. Goffman’s writings have also extended to the study of sacred objects and ritual interactions which speak to how people behave in public places and how rituals credit that which is socially valued (Goffman & Best, 2005). Symbolic Interactionism was an underlying foundational theory for this study of the rituals of accessing, sharing and smoking in the mainstream daily social interactions of the homeless. This study sought to

explore social conducts and codes of the street by listening to the stories of homeless individuals and observing their everyday life spaces.

3.2. Social Exchange Theory

Social exchange theory (SET) looks at the social structure and function of norms, customs, traditions, and institutions and is situated within the realm of structural functionalism (Pippert, 2007). The major assumptions of SET are that exchanges are based on free choice that is weighed against a cost-benefit ratio, that the concepts of trust and reciprocity are involved, and that over time exchange values will be balanced between partners and will be of perceived value to both parties (Pippert, 2007). Further, partnerships or friendships can be examples of social exchange theory with each member reciprocating such benefits as emotional support or personal protection.

One of the principles of SET is the voluntary exchange of resources (Horman, 1961). While the term ‘resource’ connotes tangible matter or goods, Foa and Foa (1976) describe six potential areas of exchange that go beyond that which is physically present. Based upon such, the six areas are grouped into two sub-categories: material and immaterial. Material resources are those which can be touched or viewed directly such as goods, money, or services. Immateral resources are more elusive and intangible as in status, information, or love. Pippert (2007) explains that exchange-based relationships form amongst strangers, and that items of exchange within these relationships can include cigarettes, coats, blankets, or even a person’s last dollar. Pippert also suggests that generalized exchange of goods offers a sense of solidarity and commitment to each other – essentially a makeshift family.

Social service agencies become part of the social exchange network in the everyday lives of homeless individuals. Main Street Project, an emergency shelter, offers additional hot food for the completion of voluntary tasks within the shelter, such as the cleaning and transitional set up of furniture from mats to tables (personal experience, M. Bobowski, 2010). Street Connections is a Winnipeg Regional Health Authority (WRHA) harm reduction program (2007) that uses a mobile van to deliver condoms and lubrication, safe-crack pipes and supplies, a needle exchange and basic health assessments and treatments. These services and exchanges often keep people alive and reduce morbidity levels amongst the homeless or street involved workers. Beyond the service of providing, social service agency workers are aware that street involved women and men exchange sexual acts for cigarettes, alcohol, drugs, shelter and protection (Personal Communication, S. Marshall, 2010).

The theoretical lens of SET supported an exploration of tobacco as a commodity with an exchange value that signals friendship, and a way to create connections along with obligations on the street. Tobacco is a low cost, consumable and very immediate product that has a gratifying physiological effect appealing for a population living raw and on the edge of everyday. In essence, by viewing tobacco use through an SET lens, an extended awareness of processes involved and motivations driving behaviours were sought; that understands the lived meaning of these exchanges. Understanding this economy is paramount to shaping interventions for future health policy.

3.3. Social Justice Standpoint

A social justice standpoint will support viewing tobacco use as an issue of equity and distribution. Social justice is rooted in the concept of human equality and can be described as the way human rights manifest in the daily lives of all members of society (Centre for Social Justice, 2007; WHO, 1997). Social justice means that the rights of all people, irrespective of their backgrounds, receive equal consideration (Centre for Social Justice, 2007; Health Canada, 2005; WHO, 1997). As a value, social justice focuses on identifying disparities that exist in a society, analyzing the causes and conditions, at a societal and system level, behind a disparity, and then formulates a strategy to overcome barriers (Health Canada, 2005; Pauly, 2007).

Pauly (2007, 2008) is a Canadian researcher whom has studied homelessness through a social justice standpoint. Pauley's work is important as it directs attention to the idea that homelessness and drug use add to various compounding inequities surrounding health and healthcare access. Pauly advocates for a harm reductionist approach to addictions among vulnerable populations, such as people who are street involved and homeless. Pauly maintains that prohibitionist policies cause more harm and threaten human rights and dignities to those who need the most protection. Pauly (2008) concludes that a social justice framework must be engaged to push "systemic change" (p.8) for those drug using and homeless for accessible health care services and social programming, to therefore reduce inequities.

One of the most recent literature publications that link social justice with tobacco use was published in 2007 by The National Association of County & City Health Officials (NACCHO) in the United States. NACCHO is the coordinating body of health

authorities in San Francisco that seeks health equity through a Public Health Tobacco Free Project (Clark et al., 2007). This document illustrates the importance of looking at the association between social disadvantage and alternative smoking practices taken up by the homeless in Winnipeg. A social justice stance invites us to examine the smoking practices as they are determined by the external and internal factors that surround the individual. Being without a shelter is but one of the factors that create their adverse health, and their high risk smoking practices, an examination of all social determinants of health is required. The smoking of butts and sharing cigarettes is a way the individual who is homeless makes sense of their environment with limited resources. The authors of this brief indicated that change must focus on viewing tobacco as a social injustice issue and not as an individual behavior choice. By adopting this stance, the factors that promote smoking amongst the homeless can be addressed and the community mobilized towards positive change. According to (Clark et al., 2007), one of the steps towards tackling health inequities is to work with and collaborate with communities; this research is the beginning of the change and advocacy of a community by hearing their voices and building that trust and harmony.

Adopting a social justice framework moved the study focus towards viewing inequities of tobacco use and access to healthcare among those who are homeless. By viewing Winnipeg's homeless through this lens, I sought to identify and discuss the disparities or gaps between the ideal and the reality, and how the system disrupts options within healthcare and access to goods and services (Centre for Social Justice, 2007). In addition, this lens supported identification of ways that people who are homeless work towards equity within their social context. This framework guided consideration of how

the homeless make decisions to guide and meet their needs, and how they navigate systems and networks in a society that enforces barriers and access (United Nations, 2006, 2007).

3.4. Summary

The three theoretical frameworks of symbolic interactionism, social exchange theory (SET) and social justice standpoint served as a synthesizing tool to reflect on the complex relationships of tobacco use and homelessness. The frameworks guided data analysis and interpretation of the multiple perspectives heard within the study. The frameworks allow for linkages between established theory and research to make abstractions of the importance of tobacco in the lived everyday reality of homeless males living in Winnipeg.

CHAPTER 4: METHODOLOGY

4.1. Introduction

A qualitative research approach was used, which drew on aspects of a focused ethnographic design. In this chapter I provide a rationale for the research design, which includes a description of the study site, recruitment and inclusion criteria, as well as a description of the data collection and analysis procedures. Methodological rigor and ethical considerations of the study are also discussed.

4.2. Research Design

A qualitative research approach was chosen for the strengths it brings to this study. An advantage of using this approach is how it captures multiple realities of a phenomenon for the individual, it also views the participant subjectively and holistically, and knowledge is based on social interactions, beliefs and values and culture (Fain, 1999). Qualitative research is concerned with the “discovery of meaning” rather than predictive research focused solely on cause and effect (Fain, 1999). The orientation is directed towards generating knowledge about a person in their own natural setting (Fain, 1999), which supports an in depth exploration of complex experiences. Ultimately, it provides an understanding and description of personal experiences of a phenomenon from an insiders’ viewpoint – while taking into account contextual and setting factors that relate or contribute to the phenomenon (Fain, 1999).

Consequently the downfalls of using a qualitative technique are focused on its time consuming nature of interviewing few participants (Fain, 1999). The findings are unique to those in that particular setting and therefore not generalizable; moreover there is the personal bias of the researchers that may influence the participant’s responses and

analysis (Fain, 1999). Still as Sandelowski (1993) suggests, the aim of qualitative research is not to generate generalizable evidence, rather, the aim is to generate novel and credible evidence that evokes critical thoughts about previously held assumptions. Given the novelty of the study, a qualitative approach seems most fitting to move the findings to challenge preconceived notions about homelessness and tobacco use.

4.2. a. Ethnography

Spradley (1980) states that "...knowledge of all cultures is important" (p.10) and ethnography offers a way to study a culture or people with all their complexities. Spradley explains that ethnographies put forward "...empirical data about the lives of people in specific situations. It allows us to see alternative realities and modify our culture-bound theories of human behaviour" (p.13). Culture incorporates the ideas and beliefs of a group of people, the knowledge they have of each other and the rules and behaviours that are socially ascribed to by the members (Roper & Shapira, 2000). A focused ethnography is a qualitative method of research that examines a problem with a specified population. This method can offer health professionals insight into a health situation and inform prospective intervention development based on understanding the identified population's group norms, worldview and how they live (Roper & Shapira, 2000). This method supports an exploration of the context and culture of people being studied. Ethnographic research methods are employed to gain a greater understanding of the lived experiences of individuals who are homeless and smoke tobacco.

The hallmark feature of ethnography is to conduct research within the participants' natural setting and adopting a holistic perspective – which Roper and Shapira (2000) explain that includes exploring the groups' activities beliefs, culture and

knowledge. Roper et al. indicate that the most important aspect is that the researcher becomes part of the participants' world to gain an insider's viewpoint of their culture and subcultures. Roper & Shapira (2000) further describe these multiple viewpoints as the *emic* and *etic*. The *emic* is how the participants view their world, and the *etic* is how the researcher sees the participants' world, the idea is to meld the two together to get a rich depiction of the world of interest. Interviewing is a means of gaining insight into the *emic* perspective to generate data that allows for rich descriptions. By interviewing people who are homeless in Winnipeg, we gain insights into the meaning of tobacco in their lives.

While ethnographies have been classically associated with anthropology (Roper & Shapira, 2000), this tradition of inquiring about a culture has extended to other disciplines, specifically nursing. Ethnographies give the opportunity to detail nurses' experiences with the context of nursing practice and the meaning ascribed to their work, as well as the many perspectives of patients. Areas that have been studied are death and dying in the elderly (Costello, 2001), forensic and psychiatric nursing culture within an Australian prison hospital (Cashin, Newman, Eason, Thorpe, & O'Discoll, 2010), nurses' experience with telephone triage systems (Purc-Stephenson, & Thrasher, 2010), moral distress of caring for patients with AIDS in a developing country (Harrowing & Mill, 2010), and surgical nursing care and technology within an operating room (Bull & Fitzgerald, 2006). Ethno-nursing studies and homelessness is starting to garner much attention in numerous theatres: minority women and street prostitution (Prince, 2008), experiences with soup kitchens (Miller, Creswell, & Olander, 1998), individuals with serious mental illness (Forchuk, Ward-Griffen, Csiernik, & Turner, 2006), and elderly homeless women (Cameron, 2010). The importance of exploring this method of inquiry

with nursing is its focus on the patient or participants experience with health and illness and its relation to their own environment, or social context. Ethnography gives voice to those who often are marginalized or silenced. In my thesis, the research explored how tobacco is situated within the everyday life of homeless individuals, with the intention of reflecting their voice and cultural stance.

4.2. b. Research Setting

In Winnipeg the homeless are a transient group travelling the inner city locales to meet their diverse needs; there are many agencies and facilities where the homeless place their footsteps that offer researchers insight into their lives. In my study, adult male, homeless individuals were recruited from Salvation Army's Winnipeg Booth Centre at 180 Henry Avenue, an emergency shelter and transitional housing centre. The Salvation Army shelter is part of a larger worldwide Christian organization that is dedicated to providing social services to vulnerable populations; it is open 24 hours a day / 365 days a year. The Salvation Army offers a place of safety to rest for a night or until no longer needed, it provides meals, clothing, and disaster and pandemic relief, and other services include addiction rehabilitation and vocational –work ready programs, and services to those with mental illness, the Salvation Army offers 253 beds (300 in winter) and mats on the floor in a common area (Major K. Hoeft, personal communication, December 30, 2011).The Salvation Army was chosen for its central location and because it ensured a variety of homeless viewpoints and situations to be represented with participants accessing multiple services and programs offered at this site. Interviews were conducted inside the Salvation Army day room which had a small private room that ensured confidentiality and anonymity.

Agencies that service Winnipeg homeless are located in the Point Douglas neighbourhood, classified as neighbourhood cluster number 10b by WRHA (2006). This area ranges 10.9 sq km and has a population of 41,897 (Population health and health systems analysis, 2003). The main traffic route is Main Street, and the shelter is close to the Disraeli Freeway, Higgins Avenue, and Logan Avenue which are hubs of activity for those in the area. The composition of this urban community includes: economic instability, low socioeconomic status, high levels of unemployment, low levels of education, and a lower health status with high levels of premature morbidity (Frohlich, Fransoo, & Ross, 2002).

In the vicinity are local food banks, single occupancy hotels (SRO's), soup kitchens, and Christian religious organizations, and a traditional Aboriginal spiritual centre. The Circle of Life Thunderbird House is a centre for healing and culture that provides drumming and sweat lodges and Alcoholic Anonymous groups (Thunderbird House, 2010). Near to the Thunderbird House is the Manitoba Métis Federation's main headquarters.

Health care may be accessed through the WRHA's Health Access Centre on Main Street which directly serves this neighbourhood. Health care is also available at walk in clinics on Main Street, and Mount Carmel Clinic which is less than a kilometre walk according to Google maps. An environmental scan paints the picture of this area as "skid row"; houses are derelict and boarded up or demolished, streets are littered with rubbish including discarded syringes and mouthwash bottles, and at any time of day individuals may be found sleeping or passed out on the ground, benches, or bus shelters. Abandoned wheel chairs, bicycles and grocery carts are also found on streets and alley ways. The

“drunk-tank” or IPDA – The Intoxicated Persons’ Detention Act is enacted in an off Main Street location that is attached to Main Street Project’s (MSP) emergency shelter which provides mats on the floor in a shared room for 70 individuals. The MSP is known as the “last resort” type of shelter, it is not a dry facility, and many individuals are known to be solvent and inhalant users as well as users of alcohol, however active drug and alcohol use is not permitted ((B. Bechtal, personal communication, June 18 , 2010). A major strength of this area is a dedicated group of civilians who make up the Winnipeg Biz and uphold the mandate of IPDA and keep the area safe.

4.2. c. Sampling Strategies

The recruitment of individuals for one-to-one interviews for this study used a strategy that ensured the individuals had the characteristics relevant to the study topic. Two recruitment strategies were used: purposive and snowball strategies (Roper et al, 2000). Purposive sampling includes the selection of participants based on the characteristics they hold in relation to the interest area and defined research questions, Roper et al. (2000) calls the participants “...experts in some area of interest to you” (p.78). Snowball sampling involves the participants to act as a reference or recruiter for other potential research participants who match the criteria (Roper et al, 2000, p.78). The value of these strategies were that they are convenient, cost effective, and appropriate to the research, in other words, I am getting exactly who I need for my research criteria.

Inclusion criterion for this study required participants to be adult males over the age of 18, be self-identified as homeless with no known address, and regular users of an emergency shelter in the last 30 days. Participants had to be current tobacco users with nearly-daily use. All participants were English speaking, with a stable mental status and

unimpaired cognition, and finally abstinence from using mind-altering street drugs and alcohol before the interview was also required. Eligibility criteria were not specific to ethnicity or race. Exclusion criterion included females, adolescents, non-smokers, those who are housed, and inhalant users, and those with perceptual disturbances.

4.2. d. Recruitment

I recruited 15 participants for my study over a 3 day period (September 6, 2011, September 15, 2011, and September 16, 2011), with a variance in time of day. While there were 15 sets of useable interview transcript, there was one other adult male interviewed; however, the interview was lost due to error with the recording device.

Participants were recruited by several methods: the placement of recruitment posters on main bulletin boards in the shelter advertising the research study (see Appendix B), and word of mouth, and the distribution of pocket sized postcards advertising the study were handed out and distributed to people passing by or in the lunchroom. I was situated in the lunchroom handing out postcards for an hour prior of each of the interview days, which allowed me to answer participants' questions.

Due to the transient nature of being homeless, prescheduled interviews did not work for this population; interviews were conducted in the moment as I was expecting a loss of participants or those who would not show for a scheduled interview at a later date. For the reason of sample loss, remuneration was given as an incentive during initial contact and screening, as well as at the end of interview. Wineman & Durand (1992) indicate that incentives are given at the onset of the research to compensate for effort, time and inconvenience. For the person who is homeless, participating in an interview could mean missed opportunities for shared meals at a soup kitchen, or other basic

amenities and services. A pre-packaged small snack and beverage was provided to participants at the beginning of the interview, and the incentive for participating was a \$10 gift card to Tim Horton's given at the end of the interview.

4.2.e. Data Collection

Ethnography is a dynamic process where the research is guided by pre-formulated questions, and which may change throughout the process, a process which is inductive in nature and one that is suitable for this study (Roper & Shapira, 2000). Roper and Shapira identified multiple strategies for data collection that involved interviews, field notes from observing the behavioral setting and surrounding environment, and the inspection of allied documents, and utilizing this strategy lead to “natural triangulation” (p.13) which supported the credibility of findings. In order to represent the reality of the phenomenon of smoking among the participants, multiple data sources were used to collect data to achieve a rich and trustworthy qualitative inquiry. This thesis used Roper’s techniques for ethnographic study that included open ended interviews, field notes, and a review of internal documents from the research setting. Given the anticipated likelihood of recruiting Aboriginal People as participants, prior to the commencement of data collection, I met with Dr. Michael Hart. He is a citizen of Fisher River Cree Nation, is a professor of Social Work at the University of Manitoba (Fernandez, Mackinnon & Silver, 2010), and the Canada Research Chair in Indigenous Knowledges and Social Work (University of Manitoba, 2012). Dr. Hart has a strong commitment to research and Aboriginal ways of helping, his knowledge of Aboriginal Culture was supportive and ensured that I engaged the participants in a respectful manner, he offered suggestions for

the interview questions and offered guidance on entering into research with Aboriginal people.

i. Open ended interviews. Interviews were conducted inside the Salvation Army day room which had a small private room that ensured confidentiality and anonymity. This location also supported participation amongst the homeless individuals because of going to them rather than requiring them to go outside of their daily routines. Interviews were semi structured with 5 main questions and probe questions for more information when necessary (Appendix C). The questions focused on the meaning of tobacco use within their everyday life experiences, tobacco acquisition practices, early memories, values and beliefs, health concerns, and the historical role of tobacco for the participant. Interviews were verbal and tape recorded for future transcribing and coding, and the interviews were 15 - 30 minutes in length.

ii. Field notes. Field notes served the function of recording my observations in the behavioral setting of the shelter and its surrounding environment. The notes focused on what I was seeing to make sense of the key contextual factors (Miljan, 2008) at work that influenced the social and economic world of the participants. In addition, Miljan (2008) brings to light the importance of looking at the activities of institutional structures and bodies of power that influence health care policy, she calls these “proximate influences” (p. 86), and these can include the activities of the media, courts and legislative bodies. Field notes served to record the ethos and events surrounding and impacting the homeless and their tobacco use, for example the feelings and behaviors around deaths in the area, or the H1N1 flu epidemic.

Field notes enabled me to look at factors surrounding the acquisition of tobacco, and other resources in the area. I recorded how I saw tobacco situated amongst this population, the memos captured evidence of tobacco within their setting – answering such questions as, are there cigarette butts littering the ground, non-smoking signs displayed, discarded cigarette packages or evidence of the social nature of tobacco use? Walking and driving environmental scans of the area also provided rich data of the predominant culture. Spradley (1980) emphasizes making relationships with the data in ethnographic fieldwork relating to the social situation of interest. This study referred to Roper et al.'s recommendations for recording field notes; the field noted recorded concrete observations that captured behaviors, events, and conversations that created an active dialogue between my observations and questions.

iii. Internal documents. Internal documents concentrated on the policies and procedures that direct the daily operations of the shelter and of interest are the smoking policies and restrictions, and medical management of the shelter residents, and the rules and regulations that participants abide to in the shelter. Access to the documents was in cooperation with Major Karen Hoeft who is the Assistant Executive Director, and Community Relations at the Salvation Army, Winnipeg Booth Centre.

iv. Demographics. Demographic data was collected, to support descriptions of the individuals. Demographic was gathered on participants' age, race and ethnicity, current sources of income, completed education level, duration of homelessness, and recent places of habitation (Appendix D).

4.2.f. Data Analysis

Roper & Shapira (2000) suggest a process to interpret the data which involves coding, sorting, looking at the outliers, and memoing for themes. This systematic process uncovered the realities of being both homeless and a tobacco user. A professional transcriber was used to transform the interviews to paper. The analysis involved the organizing of data for content analysis and comparisons.

i. Coding for descriptive labels. Based on many researchers, Roper et al (2000) recommend that coding be structured by applying 10 possible categorizations to compress the research interview material. These ten categories are: setting, activities, events, and relationships, general perspectives of the group members, specific perspectives of how people understand the experience or event (research topic), strategies to reach goals, process, and meanings ascribed to behaviors, and repeated phrases (Roper & Shapira, 2000, p. 95). This is a first step to analyzing data using an inductive approach.

ii. Sorting for patterns. Sorting for patterns require distinct groups to be formed of similar and dissimilar data to develop links and bonds (Roper & Shapira, 2000). Supporting researchers to ask questions of the material much like hypothesis testing of going back to observations to answer the questions. One example being, asking “if-then” questions for theme development to emerge (Roper & Shapira, p.98). This sorting allows the researcher to reflect on the data and interpret what is appearing as initial codes. While there will be questions asked of the data that arise from the experience of conducting the study, here is where SET and social justice perspectives guided analysis as well. The SET lens supported looking for evidence of social networking and exchange of tobacco, and the social justice lens supported looking for inequities and access to resources. The lens

also influenced how questions were formed to elicit information regarding acquisition practices and values and beliefs around tobacco.

iii. Outliers. Outliers refer to the cases, events, situations or settings that do not fit with the rest of the data and are dissimilar to any patterns or themes uncovered (Roper & Shapira, 2000). These outliers are still very interesting to the study and can spur future investigations; as well Roper et al state that they can be used within for comparison and contrasting.

iv. Memoing reflective remarks. Memoing is a continuous and reflective process that takes place through the data analysis process, this process however begins with data collection (Roper & Shapira, 2000). Memoing allows the researcher to think and comment on the derived data, which as Roper et al. believe will grow to a deep and meaningful understanding of the material.

4.3. Rigor

The ideal research study must be able to withstand critical appraisal and review of its strengths, weaknesses and worth in the academic and real world. Rigor is about proving the trustworthiness of one's research results, which according to Sandelowski is a central component to rigor. Sandelowski (1993) states that trustworthiness is about making the research "...practices visible" and "audible" (p.2), and the researcher should be able to confidently stand by their work that represents the worlds of others, or as Sandelowski phrases "...the essence of a phenomenon" (p.3).

This study addresses trustworthiness through multiple means. First, the credibility of this work is strengthened through the triangulation of multiple data sources: interviews, field note observations, and review of relevant documents (Roper & Shapira,

2000). Roper et al. explains that these forms of data provide a multidimensional and rich picture of the phenomenon and its complexities; together they serve as a check against each other to strengthen the validity of the findings. Interviews were the foundation of this study and greatest importance can be placed on the fifteen interviews.

Secondly, as a human researcher with my own “baggage” (Thorne, 2008), life experiences and opinions, it is paramount that peer debriefing takes place with my thesis advisor to eliminate bias (Roper & Shapira, 2000). Rigor was ensured through this process and with clarification checks (or probes) with participants during the interviews. As the researcher, I memoed through the data collection and analysis process, this uncovered potential judgments and attitudes that may have influenced interview findings. It is expected that with the above strategies in place, that enhances the trustworthiness and authenticity of study findings (Speziale & Carpenter, 2007).

The insiders’ perspective found within this study is specific to the people interviewed and observed. Sandelowski (1993) states that “...different members may have very different views of the same interpretation” (p.7), and therefore it may be said that further studies may uncover differing perspectives in other diverse environments. This is not a limitation of the study, but rather the real life experiences of a sample of individuals who are homeless in Winnipeg who use tobacco. This work set out to study a small population of individuals who smoke, and not to describe all people who are homeless and who are smoking. Thereby, filling a knowledge gap through providing insight into what tobacco means for this population, and how decisions are made around tobacco and smoking.

4.4. Ethics

Clinical settings safeguard the rights and freedoms of patients with set policies and procedures. In the research arena nurses must adhere to their own moral philosophy, and the principles of ethical treatment prescribed by Tri-Council Ethics Statement. Homeless aggregates are considered vulnerable and in some cases even incompetent, therefore it is of upmost importance to act conscientiously and with care when entering into research with this population. The literature speaks to many concerns of researching this population: coercion and underpayment (Dickert, 2009), monetary incentives and protecting free choice (Wineman & Durand, 1992), and undue inducement and exploitation (Beauchamp, Jennins, Kinney, & Levine, 2002).

This study adhered to the University of Manitoba Policy #1406 of the Ethics of Research Involving human subjects (University of Manitoba, 1999) (Appendix E). The researcher obtained free informed consent, allowed for participant withdrawal, and maintained confidential records throughout the course of the research. The researcher is a Registered Psychiatric Nurse and was prepared to mitigate any potential distress during interviews with access to emergency community referrals; there was no untoward event or distress. Withdrawal from the study was open for the duration of the interviews. Given inability to sign the consent agreement due to physical disability, verbal consent was acceptable and documented. The researcher reviewed the purpose of the study, verbally read the consent forms, and gave a copy of the consent form to the participant for their own account. Elimination of data records will follow University protocol for confidential waste. Remuneration was a nominal amount in the form of a Tim Horton's gift card; the card was presented on the end of the interview, and was not considered to be coercive as

may be kept despite discontinuation. Participants were fully informed and acknowledge that participation would in no way affect their treatment at the shelter or services received. Participant identification has been protected via the use of pseudonyms along with changes to other specific contact identifiers.

4.5. Summary

For this research it was deemed that a focused ethnographic method grounded on the principle of cultural immersion was best to study homelessness and tobacco use. This chapter gave attention to the defining attributes of ethnography, the methods of data collection that was used, and the data analysis techniques that were applied. The issues of rigor and ethical considerations of this study were explored.

CHAPTER 5: FINDINGS

5.1. Introduction

In this chapter, the voices of the participants, shelter policy content, and the observations of the researcher shed light on the world of homeless individuals who use tobacco. The findings reveal the characteristics of this group of adult males who are homeless, how tobacco plays a role in their lives, how they obtain tobacco, and their values and beliefs that surround tobacco. In addition, the findings provide a glimpse into their social and environmental context with tobacco.

5.2. Participant Demographic Descriptions

In this study, 15 homeless males agreed to be interviewed. The average age of participants was 42.4 years old with a range of 19-64 years of age. Ethnicities of the men were: 40% self-identified as Aboriginal / First Nations (n=6), 47% Caucasian (n=7), and 13% black (African Canadian; n=2). Culturally and ethnically speaking, the participants differed from many of the early smoking and homelessness studies which had a high representation of African American or black participants (Aloot et al., 1993; Connor et al., 2002; Okuyemi et al., 2006).

The highest level of education achieved by 40% of participants (n=6) was high school or equivalent. Two participants reported completing college with a computer diploma, and another individual had completed 2 years of university. One person had partially completed elementary school and defined himself as “illiterate”. Another had partially completed junior high school (grades 6-8), and the remaining 4 participants had partially completed high school.

All participants were currently residents of the Salvation Army shelter. Self-identified length of stay (LOS) in the shelter ranged between 4 days to 13 years; 3 people were new to the shelter with a stay spanning one week, 1 participant had a one month LOS, another for 1.5 months, 2 were homeless in the shelter for 4 months and 2 for 5 months. One person was homeless for a year and another at the highest end of 13 years, these participants did not stay the duration of their time at the Salvation Army. Alternate spaces habituated by some participants included: cars and vehicles, abandoned buildings, all night places of business, and hotels and motels. Hospitals and Detox centers were mentioned by one person, as well as the “drunk- tank” for two other participants. Jail was revealed to be another overnight location common to 6 participants.

Current sources of income were mainly from Social Assistance / welfare, casual temporary work and odd jobs, and from family members, relatives and friends. Two individuals were collecting Canada Pension Plan (CPP) and 3 others were receiving regular disability and workers compensation benefits. Pawning and panhandling were the sources of income for two other participants and a remaining 2 participants engaged in unspecified activities.

All of the participants were daily smokers and self-reported smoking anywhere between 10-75 cigarettes a day, which was reported by some in number of cigarettes smoked in a day and others the number of packages smoked per day. Out of the 15 participants, 1 person smoked 10 cigarettes a day, 3 smoked 15 cigarettes/day, and 2 smoked 20 cigarettes/day. Packages were another reported smoking measure with 1 person smoked a package/day, 1 person smoked 1.5 packages a day, another smoked 2 packages/day and 2 individuals smoked 3 packages a day. There were 3 participants who

were uncertain of the amount they smoked and this coincided with their method of acquisition which was sniping butts, another means of smoking was a package of tobacco for a pipe.

Health care access was a final item in the demographic questionnaire. More than half of the participants 57% (N=7) did not have a regular doctor and would access health care through various walk in clinics in the city, and 47% (N=8) of the participants had a regular doctor. Two out of the eight individuals who had a regular doctor were also under the care of specialists for advanced health conditions, and another participant admitted to “double doctoring” to fill prescriptions for benzodiazepines, and other pain relievers. Specific walk in clinics were identified: 4 Rivers, Pan Am Sports Clinic, Health Access Centre, Klinik, and Siloam Mission Health Clinic. One individual who uses walk in clinics also admits to accessing health care in jail, and through the emergency department.

5.3. Themes

The themes reveal insights from the participant voices, the shelter context and researcher observations, which reveals behavioral patterns and explores the culture of being a homeless male adult in Winnipeg who smokes. Themes focus on the reasons behind their tobacco use, different methods of acquisition of tobacco, and how tobacco is situated in their everyday lives and contexts, and their values and beliefs concerning tobacco.

5.3. a Reasons for Smoking

The reasons for smoking were a major component of the interviews with the participants, subthemes focus on their first cigarette, their early memories of smoking and their current day rationales for maintaining their smoking.

First cigarette. The first cigarette is memorable for all smokers and is a story that continues through life. The participants in this study were not born into homelessness, their early memories of their first cigarette were akin to the general public with parties and early onset drinking, peer pressure and attempts to gain social acceptance into peer groups. There were no unique differences that set this population apart from their nonhomeless cohorts; initiation of smoking was 13.8 year of age, which is actually older than the general public of youth smokers at 12.1 years of age (CTUMS, 2009), most atypical was the experience of two participants who initiated smoking at 6 years of age, and another participant who initiated smoking at reform school.

There were multiple sources of exposure and availability of cigarettes for participants to sample, absent parents opened up opportunity to steal cigarettes, and seeing parents or siblings smoke set a strong example of mimicry and learned behavior. Two participants started smoking following years of running to the store to buy tobacco for their fathers. Smoking often started while under the influence at unsupervised and underage drinking parties. Many participants spoke of developing a rebellious attitude and that their peer group influence had maintaining their smoking.

Access to tobacco was through social sources like friends or family members that moved the participants from a puff of a cigarette to smoking an entire cigarette by themselves. The participant who started at age six stole his first cigarette from his

parents, he said “I choked at first, but then I got used to it”, and claimed that he “...didn’t really care” what his parents thought of the incident.

Early memories. Following the first cigarette it was common for the participants to like the feeling a cigarette gave, and this was enough positive reinforcement to maintain their smoking. Smoking was an unknown entity prior to first use, and a tolerance developed once the thrill subsided and the coughing of inhaling lessened, participants spoke of the coughing and “getting through it”. One individual spoke of his mother catching him smoking with his sister and as punishment made them smoke more,

*My sister was a champ. She’s a trooper right. She says come on bring it on mom. You know you got nothing on me. Meanwhile I’m turning purple. F*****g puke, want to puke my guts out. Here have another one. F**k here have another. Well I guess by the time I was eighteen, twenty years old I was almost at a pack. But I was a working smoker most of my life yeah. And that’s about it. But I all, I started because of a pretty face.*

Overall educational messages that smoking was “bad” and “unhealthy” were not discussed by the participants. There was no mention of advertisements or the media playing a role in their early smoking years. Furthermore, while participants remember their parents and siblings smoking, there was no mention of early memories of sacred smoking traditions.

Current day rationales for smoking. Early memories of smoking allowed the participants a sense of commonality and ways to relate to others around them, these feelings did not dissipate once grown, in fact when homeless these men continued to regard smoking as a social experience. However, the reasons for smoking are more than a social phenomenon for the homeless male adult, smoking becomes a survival strategy. The participants share that smoking tobacco “*makes life bearable*” and that it “*fills a void, a blank*”, another participant commented that “*nothing to do, I don’t have a job,*

nothing". Some of the conversations turned to tobacco as a method to curb angry thoughts, "*it stops you from being violent*", and "*sometimes you just want to hit somebody so hard, but you just can't do it because you just get; go to jail or kicked out*".

The patho-physiological effects of tobacco dependency may not be given a formal name by the people who are homeless, but a cigarette plays numerous roles for the smoker. The most heartrending and affecting reason cited by many is that smoking is a short term reward for enduring hardship and suffering, and while first cited by Aloot et al. (1993) in their study, this continues to be salient 19 years later. Additional reasons for smoking focused on cigarettes as a coping mechanism with effects on mood regulation and stress relief – after a cigarette participants felt more relaxed and calmed. One participant shares,

Umm, me and my wife; we've been married for thirteen years, you know and umm, were going through a divorce right now and that's why I'm here, but five months ago I never used to smoke so much...but five months ago my stress level went high and my depression level was high and smoking was the only way that I could really help relax and make me settled enough.

Smoking functioned to decrease aggressive and violent feelings and tendencies. The trauma of being homeless and the reasons which lead them there was common among the participants and their smoking. One participant spoke of the rape of his daughter and how smoking butts was a means to cope. Another participant summarizes his sentiments by saying,

You, you're, you block a lot of things out and you look in reality. You know like if there's trauma in your life and other things that are dying like you know, and that's why a lot of people drink out here and use, and bum smokes or pick butts around and I guess.

To decrease boredom and loneliness and to fill a void or emptiness were additional reasons that triggered smoking, "that's why I smoke lots, I miss my kids. I

want to be with my wife". Another participant attests to this same feeling and describes that smoking helps him to cope with feeling alone,

Well I like to go with people to smoke. Ahh, I get lonely. Ahh if I'm by myself too long you know. Watching TV and all that. Then I decide to go, but ah, it doesn't matter, you go outside to have a coffee or smoke with ah two three people.

Cigarette smoking was a catalyst for socializing and networking, it speed up social interactions by creating bonds through casual conversation over a shared activity, a participant new to homelessness spoke of this,

I've talked to a worker yesterday and speaking of; I shared a smoke; ah two smokes with umm, I went home, umm, went to my house, but I couldn't get in obviously, and then I was actually leaving and ah one of the guys that lives right there, I shared a smoke with him. Two smokes. And I pretty much almost got a job just from sharing a smoke with him; someone...me personally I would recommend always smoke with someone...and right there you pretty much end up learning you could potentially learn someone's life just by just having a smoke with someone, yeah. It's a social experience and sort of thing.

The addictive qualities of cigarettes were also discussed by the participants, one person stated that it was a "bad habit and the craving itself", and he also mentioned that he was "addicted to them, the nicotine yeah", another states that the "...nicotine just mellows it out", another participant states "just because it's a habit. Habit. Bad habit. I've been doing it since I was a kid". One participant likens the craving of a cigarette to craving a piece of pie or bag of chips, "well for me it ah, cigarettes is pretty well the same thing".

Some participants shared their susceptibility to peer pressure and the "people I hang with" and that the environment promoted smoking, however these reasons were not shared by all. One participant spoke of how smoking was a survival mechanism that allowed him to survey his environment, "...I'm just like realizing what's going around

me more than if I'm not smoking or standing in that one spot", and intrinsic to this behavior is the notion of safety.

5.4. Acquisition and Economy of Tobacco Products

For the general public, tobacco products are legal and easily accessible when you have the funds to purchase. The homeless population due to lack of funds, are removed from easy access to our formal economy system, it is for this reason that their acquisition of tobacco sets up their own informal economy.

5.4.a. Acquiring Tobacco

The interviews uncovered multiple ways that homeless men acquire their cigarettes in Winnipeg: the buying of full packages from discount stores, buying individual cigarettes (loosies), sharing the same cigarettes with another, bumming and lending, and picking up butts (sniping). An informal economy operates on the streets of Winnipeg and cigarettes are a part of this economy. Each of the five methods of acquiring tobacco is described below.

Buying packs. Many participants (67% or 10 out of 15 participants) buy their cigarettes in full packages from family-run corner stores in the area, which are known for discounted products. Half of the participants who buy packs also buy loosies, either one at a time or in bundles of 3 cigarettes. The preferred brand mentioned by 5 of these smokers was the brand "Studio" which is considered by them as a cheaper cigarette both in price and quality. This discounted cigarette is described as having a "heavy smoke" or a strong potency as one individual expresses, and is a lower grade tobacco; complaints that cigarettes are loosely packed and not filled completely are common amongst these smokers. The price point on a package of budget cigarettes is \$11.02 and

\$12.76 for a premium package of brand named cigarettes like Dumarier at a national Canadian convenience store 7-11; a cigarette package contains 25 cigarettes per package (M.Bobowski, July 8, 2012). The budget brand if purchased in the inner core area may be reduced even more than a convenience store, at the time of interviews a budget brand package was \$10.00 in stores in the area of the shelter as per a participant.

While Studio cigarette brand is not a mainstream designer brand, it still maintains the Surgeon General's printed warning on the package, and the package also features graphic pictures depicting health hazards of smoking. Participants discussed buying other brands like Legends, Native, Dk's and "reserve cigarettes" which may be considered contraband, and are untaxed and from out of province. Buying a lesser brand cigarette is a conscious decision to stretch their allotted resources, which indicates a preference for more cigarettes over fewer quality cigarettes.

Another subtheme identified by the participants was the need to protect and conserve their cigarettes while living in group quarters. Hiding a full package of cigarettes is a protective mechanism that allowed their packages to last longer, and be smoked only by the owner of the package; deep pockets, backpacks and lockers in private rooms are hiding spots. Bringing out only one cigarette at a time was a regular practice to protect their cigarettes from possible moochers; however this required preplanning and a private space to pull out the one needed cigarette. One participant relates, "yeah, I make sure and pull out one smoke before I go outside, because if I pull a pack of smokes out there, there's ten people on you, they're going to swarm you." Private rooms are a definite protective mechanism against sharing, however there are monetary costs associated with the individual or shared rooms with lockers, bathroom stalls offer

temporary isolation from others to prepare a cigarette. While this subgroup faces personal decisions about selling individual cigarettes, they are still left open to those who want to share their current ignited cigarette.

Loosies. Single smokes are often associated with desperation and a lack of planning “umm, I’ll buy a pack; mostly packs, but if I’m; if I wake up in the morning and I want to have a cigarette I’ll go buy one; like a single smoke off of somebody.”

Payment for favors is rewarded with tobacco, one wheelchair bound participant asks others to buy his packs down the street for him, and he states “I give them two or three cigarettes here and there you know...they get payment one way or another”.

There is a street economy associated with the buying and selling of loosies based on a supply and demand scenario. One participant explains that he uses sales from selling loosies to support the purchase of additional cigarette packages,

Oh are you kidding? Yesterday, ahh first thing in the morning I must have made like because I don’t sell them for seventy five cents; if they’re hurting bad enough, I know they can find a buck... Man if I stick here long enough I would be called the cigarette guy... You know. Well I mean ahh, yesterday I think I made seven bucks.

A broad range of factors influences the price points of loosies: time of the day, the day of the week, and seller, for example prices may be higher with evenings, weekends and whether the seller is a store or another homeless smoker. The average price is 75 cents but may range from 40 cents to a dollar for a single cigarette.

Umm, the corner; there’s one store that charges sixty cents; there’s the [local hotel] charges seventy five cents. There’s ahh, people on the street on Sunday and Saturday night. Sometimes Friday, well late night; they will charge a dollar... A cigarette, yeah. But it’s not a regular thing these people are doing... It’s just the odd one right. But you know... Because they, they know they’re going to be partying all night so, whatever it might be or they’re on a budget... And they wanted to keep like that money that ahh you know.

Another individual speaks to the communal spirit of the tobacco street culture,

Like I've said to people many times like; umm, when they go how much like; if they go fifty cents or a dollar; depends on the day of the week. And I go; and they know I've got pennies so... I says this is all I've got and they say ahh, don't worry about it. And they just give it to me.

The loosie market is controversial and not supported by all participants, one participant discussed not wanting to inconvenience others “single smokes; not really.

No...I just don't like to bother people...yeah, I just don't like to bother people for smokes”, and the second participant did not want to be involved in anything unlawful,

I don't even; no I don't give them the pleasure of making that much money off of me you know...that's something illegal they're doing, selling smokes over the counter like that, so I don't give them the pleasure of doing that.

Sharing cigarettes. Sharing the same cigarette is a practice adopted by this population, over half (53%) of the participants engage in this practice. The sentiment is that one should smoke only cigarettes from someone known, and ideally with a friend. Desperation for nicotine causes these self regulated sharing strictures to be abandoned, and some participants will ask strangers for a “puff” or “last drag” to ensure they receive a tobacco “fix”. Alcohol use decreases the taboo of sharing. Sharing may be further delineated into the “sharer” and the “partaker”, the sharer is the person giving the cigarette, and for the purposes here the partaker is the one receiving the second drags of the initiated cigarette. Some sharers will never be partakers and will only hand off a cigarette for another, others will take on both roles, “like I'll smoke half first and then I'll just give it away, or if it's the friend that I know, like really know, then I'll take her half or his half”. The biggest reason participants would not share cigarettes is to protect one's health from potential infectious disease transmission, and while it is unclear of what was on a cigarette butt, their understanding is that it can transmit AIDS/HIV, and Hepatitis,

especially if there is “blood on somebody’s lip”. One participant states “I’m a germaphobe. You don’t touch my drink, you don’t touch my cigarette. I give you when it’s done if I give you anything”. Decisions around the sharer giving up a partially smoked cigarette seems to be arbitrary depending on how the sharer feels at that particular time, “every time I’m out in the front of the building and I’ve got a full cigarette I got people asking me to save them some. Sometimes I do, sometimes I don’t”. Giving the last drag is another practice tied into sharing, however as one participant explains, it is bad to smoke past the brand name line on a retail cigarette,

Yeah, yeah, I don’t like smoking past the brand name...but I have you know, like don’t kid yourself; I mean there’s times where I was all cracked up or something and I smoked that cigarette right until I taste the fricken, ahh fiberglass at the end... Umm, I remember hearing something about being like more dangerous to smoke it more where I guess you don’t want to smoke past the name eh...yeah. Oh yeah, there is; it’s like ahh what I heard was like you just make it ten times more trouble smoking past the band name...

The rule of only sharing a cigarette with someone known and not strangers suggests a level of discernment and concern for one’s health.

Borrowing and lending. The market for bumming a cigarette is very tentative and often met with disparaging remarks and requests are often rejected. This area of cigarette acquisition is associated with a culture of non-reciprocity, that the person borrowing lacks integrity, and is not good for payback of the cigarette, and labeled as a “mooch” or like a “bunch of flies”. Analogous to the loosie market of pulling one cigarette out at a time, patterns of smoking behaviors form to evade sharing and bumming. This conservation and safeguarding of cigarettes is to ensure that a person has enough cigarettes for themselves.

Like if ahh you’re to come up to me and or I will just come to you and ask you for a smoke and didn’t have any; and I asked you a few more times and you kept

saying no then I wouldn't share my smokes with you...but with someone else; it's just was. Like you see who doesn't have a smoke; just offer them a smoke and he does the same thing to you.

Repayment of smokes is a big issue on the street if you are the lender; a participant explains how tenuous the cigarette exchange market is when homeless,

Well, it is not a problem with ahh somebody I know, but ahh, somebody I don't know like ahh; "can you give me a cigarette, I will pay you tomorrow". Well he don't pay me tomorrow, I don't know where you were tomorrow. Where you're going to be.

The rule to lending a cigarette is ensuring that cigarette repayment is either not necessary, or that the person is good for the cigarette at a later date, which means an expected source of income or cigarettes, and finally to be visibly present in the very near future.

Sniping. The non-market economy of supplying oneself with tobacco relies on securing tobacco outside of purchasing from a retail store, or as we have discovered from another individual, sniping butts. The harvesting of butts is a complex and yielding means of obtaining tobacco for rerolling or smoking them as found, it is a free option that does not break any laws, and can be done solitarily or in the company of others, like a wife. The sniping of butts is an activity taken up by 40% of the participants, or 6/15; of this 40%, 4 individuals reroll the butts with rolling papers, or other materials found, like tinfoil from discarded cigarette packs. Rerolling may be difficult for those whose hands are injured from punching someone, or of an arthritic condition. One individual shared that his hand was "busted up" because he hit someone that week because "he was in my face". Participants describe daily routines of their search and retrieval methods of sniping butts, routines can last up to two hours with familiar established paths that include multiple high traffic stops like hotels, hospitals, colleges, police departments, city hall, as

well as, other city and industrial areas. Welfare was cited as a reason to pick butts due to insufficient funds,

... I don't believe in buying cigarettes because I'm on welfare, and smoking cigarettes costs like a package a day ten dollars a day. And I don't have ten dollars a day that's why I pick cigarette butts out of ashtrays.

Butts are collected and stored in plastic baggies or pockets and the contents may be emptied and rerolled using tobacco papers. Personal preference was a factor to whether butts were rerolled before smoking or smoked as found. Some individuals who were afraid of infectious diseases would reroll using store bought rolling papers (like “Zig Zag”) or use discarded tinfoil inserts from cigarette packages, this creativity and inventiveness of making rolling papers served as a protective mechanism for the homeless.

The search for cigarettes becomes part of their survival instinct. Those who feel vulnerable will pick butts rather than approach someone for a retail made cigarette. The sniper has made decisions around his smoking – weighing out the decision about the potential risk of rejection or violence over a dirty discarded cigarette that may be disease laden. Decisions like this return a locus of control to the individual when external factors are against them, like a lack of private space with shared sleeping spaces. One participant explains,

I don't you know, there's a lot of people that will go outside in front doors and they'll walk up to people and ask them to save them a few drags. But I don't do that... I think that's imposing on a person; personal privacy doing that.

Tobacco butt hotspots are secretly held in reserve due to high competition, and routines are abandoned during rainy days as the butts become soaked which prevents their combustion, as well as a bitter product. Participants spoke earnestly about the sense

of accomplishment in finding a good butt, which requires good judgment, shrewdness, and resourcefulness that follows experience. The rule inherent with this subgroup is to keep one's route and practice a secret, and to keep an active and watchful eye for someone's discarded cigarette as the butt still holds value to a tobacco-less person.

5.4.b. Informal Economy

An informal economy exists on the streets that involve trade and barter for tobacco, cigarettes have a street value recognized by its members. Entrance into this street economy requires an exchange of goods between two people to take place. Exchanges do not only involve money, “things” or a person’s belongings can also be tender for exchange; clothing and other tangible goods may be offered for a cigarette, not to mention items from the food bank or items “boosted” from a store – especially if money for food items have gone towards cigarettes, as one individual remarks “... but it’s like I usually just steal them you know”. The participants did not openly discuss any involvement in body work or street work in exchange for cigarettes, nor any violent means in acquiring their tobacco.

The informal economy is deregulated from a formal retail and economic market; however informal rules and codes have developed amongst the homeless members about how to acquire cigarettes. The rules of barter are specific to the exchange at hand; the rules are not written down and consist of verbal cues between the individuals. The seller (the person with the cigarettes) is the person who ultimately sets the price based on the current market value of the cigarette.

Like the traditional economic market, the informal economy has fluctuating pricing based on supply and demand and individual free enterprise. As learned in the

section on loosies, price points change depending on numerous factors, including the time of day, day of the week, and the date of the next welfare cheque. However, there are many intangible social factors that are considered upon entering into a potential exchange with another person.

First, the generosity of the seller must be taken into account, the factors that color the seller's reluctance or inclination to accept the exchange are: past experiences with the buyer of the cigarette, past history of being victimized or "taken advantage of", relationship to the buyer (close friend, stranger, family member), surroundings – does the current climate support an exchange or are there too many onlookers who may potentially "boost" or prey later, and number of cigarettes seller currently has stocked for self. This preparation does however leave them open to the sharing aspect of tobacco acquisition, sharing cigarettes could be considered as part of this street dynamic.

Secondly, a person's word on the street conveys their integrity and is considered to be part of a social street code within tobacco exchange; these types of exchange relies on the person's reputation and if they are known to be a "reciprocator", a reciprocator is known to pay back the borrowed cigarette at a later date with a cigarette in return. A poor reputation is gained by not lending and mooching cigarettes from others constantly, a person who practices mooching like this participant "I've ah I don't really buy my own cigarettes, I just get them", has the giver of the cigarette stating,

*...I'm a sucker for women yeah. The guys go f***k yourself; all you guys are mooching. They promise to pay you back; nobody pays nobody back. I only had one guy and this guy's like old school though, paid me back. The rest of them I got screwed over.*

This comment might suggest that women have a higher class status than males, and those seasoned to street life, and who are older with a lengthy homeless period, have also

garnered more respect. A different participant also shares his thoughts about women in the shelter, which differs slightly from the previous comment except for his penchant to help elderly women.

But you know what I'm not here to fricken give them away any more because everyone says they pay you back and that's such a hustle. I mean these guys got it going on. Even the ladies. I give more to the older women; the ladies, because they, I look at them and I think of my mom, I know it's like, I know they're hurting.

Cigarette exchanges are part of this social and economic market that revolves around reciprocity, a cigarette for a cigarette is an unspoken exchange and considered an equal and balanced exchange, one individual explains that for him there is a karma to his generosity, "...people will ask me and I give. You know, because they know that it will come back, maybe not from that same person, but you know". The same individual describes this exchange to be part of the bigger context of being homeless and survival, "but that's the street life. You know. That's the fast lane. You know. So be it, so".

The final aspect of the informal economy is sniping, which is an alternative within this street system that avoids any relationships to be formed with others. The solitary nature of sniping positions the person to be removed from this market, revealing information about their routes makes them vulnerable to someone coveting their route for the best butts. This population of smokers is already vulnerable with untreated mental illness, such as anxiety, and their daily routine helps decrease the anxiety, and is another reason why they avoid other people. A heightened sense of paranoia may be present among this population which furthers their need to keep to themselves with an established routine and pattern, the routine offers temporary stability and access to tobacco.

5.5. Situating Tobacco use in the Everyday Lives of Homeless Individuals

The everyday reality of living on the streets and being housed in shelters dictates how the participants feed their tobacco addiction. Three contextual influences that shape their lives and tobacco consumption are discussed: shelter rules and bylaws, the shelter structure and how they build their daily routines.

5.5.a. Shelter Rules and Bylaws

The Non-Smokers Health Protection Act (2004) is a public health policy that protects individuals' right to a clean air space. The Salvation Army responded to the enactment of The Non-Smokers Health Protection Act of 2004 by prohibiting smoking inside the building. Preceding its adoption, smoking was allowed in ventilated smoking rooms, and was not allowed in bedrooms or common areas due to fire risk and second hand smoke exposure. Prior to the designated smoke room, patrons were allowed to smoke in their rooms, in response to multiple fires and people sent to the EDs for smoke inhalation, fire retardant mattresses were trialed, but this did not prevent fires occurring in rubbish bins, on curtains, and in bathrooms.

The Salvation Army follows a philosophy of safety and welfare for all people, to accomplish this however, individual autonomy is diminished. Despite how draconian this may appear, Major Hoeft remarks that shelter living requires rules because of "volume concerns", things happen when masses congregate, and this population is already highly traumatized, and may become aggressive, especially around smoking issues. She further explains that autonomy is often wiped out for collective risk, and sometimes one value (smoking inside) must be sacrificed for a risk-benefit to occur. Fires in a shelter are a tragedy that can move all the homeless to be further marginalized without their stuff as

there are no other places for this population besides the street. Major Hoeft states that the Salvation Army is zoned as an institution and not upholding laws will result in fines or closure, smoking indoors is regarded in this penalty. Therefore, the people who are homeless and patronize the building are not afforded residency rights or tenancy rights, there is no lease agreement and they are “absolutely homeless” – and for Major Hoeft this means being on the street without any shelter. For smoking, this means that patrons of the Salvation Army are not able to light a cigarette in their room in the middle of the night, which differs remarkably from people who are housed and have rights within their own homes.

Violations of the rules results in a restriction of privileges, the status of the violator changes. They lose their autonomy and privacy, the person is removed from their private room to a common group sleeping area, and they receive a key to their locker. Major Hoeft explains that the Salvation Army has “escalating consequences” – much like that of speeding and demerit system – consequences and outcomes for repeat performances increase the restrictions until the person reaches a full ban from the premises. For example, if someone throws a butt out their private room window, than the repercussion is they lose their status on the floor, and move to a shared room and onward for another offense. The non-smoking bylaw was abided to by 14 out of 15 of the participants. While all participants smoked outside the front building’s main entrance, one participant transgressed the Bylaw when he has insomnia. On these nights, he will take a puff in the middle of the night out his window to help him go back to sleep, he was also wheelchair bound. Adherence to the rule of not smoking inside is testament to their understanding of consequences for wrongdoing. Two participants commented that the

building is open 24 hours to exit and enter, and the building did not pose a problem to their smoking. The major motive to abide the rules is that outside of jail or camping outside, there were no other shelter alternatives for them; therefore their smoking revolves around the rules.

5.5.b. Infrastructure

There are multiple concerns that have followed the enactment of the Nonsmoking Bylaw at the Salvation Army Shelter. Elevators have increased in their frequency of use, carrying passengers outside for cigarette breaks, two elevators operate for a maximum of 350 people. This wear and tear is outside of normal intended usage and poses a concern for safety and replacement (Major Karen Hoeft, 2011). The elevator was reported to be slow amongst the many floors, and it was hard for wheelchairs to maneuver in and out of the elevator, as that individual says,

oh yeah, yeah. Yeah; coming in and out all the time. Yeah. Oh it's hard to get around at all in this thing. I had a power chair and someone stole it... oh its different all together. Like this is; this is like a jail. To me it is.

The second problem lies with the opening of the locked front door, staff in charge are at risk for second and third hand smoke despite the smoke free environment. The participants however were satisfied with the ability to exit as they pleased,

... like you can go out like ah pretty much all hours of the day and then, you know so, it ah, being a non smoking inside is; doesn't affect me at all...from not having a cigarette. Yeah.

A third problem is the issue of unpatrolled and unprotected public spaces and potential for night violence. Aggression and bullying around cigarettes occurs and intensifies at night as there is no protection offered to individuals on the street during this time. The potential to be jumped or rolled for their smoke or other belongings exists. The

Winnipeg Biz street cadets patrol the area, yet there was no mention of how their presence makes the streets safer, or how it affects night smoking patterns, or if they are seen as an enemy or an ally. Another participant comments on the violence in the area over tobacco,

...a lady got stabbed for over a cigarette... Yeah. Yeah, I just heard of that one. It just, it just happened. Like I mean, I just heard about it three days ago. But apparently it happened a week or something like that... Not a lot of things are written up here in the paper and all that... There's a lot of things that go on through here that ahh, violent, not good... Yeah, people get ripped off a lot.

5.5.c. Daily Routines

Private space is limited when living in a shelter; daily routines are built around obeying of rules of this public space, and the navigation of the structure itself. The homeless participants shared how they structure their daily smoking routines while abiding to the social structures set before them.

The diverse accounts gathered from the homeless participants paint the picture that life is difficult. The homeless must go through additional steps or paces for all tasks, and waiting is a big component to achieve anything the general public can do simply with only a few steps. Daily tasks are met with barriers and challenges, the private is public and even acquiring clean clothes and bathing are a challenge. Positive change and improvement to health and quality of life are met with long waits – waiting for doctors' appointments or appointments with Social Assistance workers or potential employers, as well as openings at group homes or programs. Wait periods are broken by meals and smoking, smoking cigarettes fills the time between every task and from meal to meal. Routines are formed by individual smoking behaviors; more elaborate planning and energy is required for those who snipe.

Smoking a cigarette before and after a meal is a behavior that extends beyond the general smoking public to individuals who are homeless. Smoking surrounds meal times and is often enjoyed following satiation, however meal times at shelters follow a set schedule and many of the homeless interviewed pursue a meal time clock as part of their day – especially when meals are free. One participant confirms this by stating,

I wake up in the morning and then I'll go to the Siloam Mission for breakfast and right after the Siloam Mission I'll go picking cigarette butts out of ashtrays, because I don't have money to smoke cigarettes. And I do that usually after breakfast, lunch and supper.

Cigarettes following meals created a sense of normalcy and contentment by offering the person a consistent routine. Due to the availability of free meal options offered by numerous shelters and agencies in the area, tobacco did not play a role as an appetite suppressant.

The acquiring of cigarette butts required planning and routes were repeated throughout the day after soup kitchen meals, and while mainly a solitary act, one participant engaged in this activity with his wife,

Umm, ahhh, umm, usually umm, we leave here at seven thirty in the morning after breakfast. Umm, and I usually have a few spots that I hit. Me and the wife. You know think there might be ahh, you know butts, so. Then I'll usually hit a few places; knock off for a little bit and then we'll have coffee and then run out of any tobacco and then I'll go looking again.

Finally, since meals were often nutrition deficient, there was no mention of tobacco being used for weight loss purposes, the participants were also not sacrificing a meal to buy cigarettes.

Routines are disrupted by cold or rainy weather; snipers remark that they “won’t bother” to search for butts because “all the cigarette butts will be soaked”. Despite the best plan and personal resiliency, a change in routine during this time is just another added stressor for the person who is homeless and collects butts. Temporary day labor

jobs are difficult for the homeless as they miss meals at the shelter and lack opportunities to snipe.

5.5. d. Withdrawal and the Morning Cigarette

Cigarette dependency was a powerful driving force which directs the homeless smoker to fill their need for nicotine to avoid withdrawal symptoms. Withdrawal from tobacco is the greatest in the morning, a time of day when nicotine is lowest in the body from the last cigarette smoked in the evening. The morning cigarette was deemed to be the most important cigarette smoked in the day and became the focal point for all participants' discussion during the interviews. The importance of this cigarette confirms a strong withdrawal cycle at play throughout the night from their last cigarette prior to sleep to the morning cigarette. Securing a cigarette for the morning was of upmost importance to load the body with nicotine to avoid feeling the effects of withdrawal.

Well I smoke right today from the minute I wake up. I get a ph ph...I've been smoking since I was ten years old (how old are you now?). Sixty four... got to have that cigarette when I get up, and then I just go out all the time and smoke. Even when I am in this condition (participant was in a wheelchair)...I have to go out to smoke.

Participants were observed to be congregated outside the doors in the morning taking deep and long inhalations, some would chain-smoke more than one cigarette, and sometimes the cigarette never left their mouths – which indicate the loading of tobacco and nicotine to counter the withdrawal.

The typical day of smoking for the participants starts out the same as it does for the general population of smokers, a coffee and a cigarette in the morning, the big difference for homeless smokers was acquisition and nocturnal restlessness. Recognizing

that they may feel lousy in the morning without tobacco, the person who is homeless will secure a cigarette the evening before,

Yeah, well I usually just you know, if I can ahh you know; I get one off a buddy from the night before and I usually save it for the morning. Right, you know so. Yeah. That way I always have that morning puff when I get up in the morning.

However the plan is seldom steel proof as the reserved cigarette may be smoked in the middle of the night.

Ahh, it, it; ahh; sometimes I can't sleep if I don't have a smoke. That's, that's unreal. That I didn't know; you know what to do. But I like to ahh; to have that cigarette at least when I get up in the morning you see; the one in the morning. Sometime ahh I get up and ahh I', ok, but ahh sometime ahh I get up and I need a smoke.

Nocturnal waking was an avenue for cigarette smoking that disturbed the previous evenings planning for the morning cigarette. Sleeplessness was a trigger to smoke and many participants would go downstairs and outside to smoke a cigarette, which could be their reserve for the morning, ideally the number of cigarettes reserved should be more than one to plan for disjointed sleep and restlessness experienced in the night.

Well I like to keep one or two for the morning, like for, ahh if I wake up in the middle of the night and then I need a smoke. So I bummed two smokes off a friend and then had those and went to bed because it's easier to smoke; go to sleep after you have a cigarette... (in the morning) I got one off a friend... we shared one.

Smoking during the night was problematic for the participants due to the building layout; participants must leave the building to smoke outside where they are alone and vulnerable in an unprotected space. The draw to smoke was so strong for some of the participants that they would risk their personal safety to venture outside for the nicotine. Disjointed and restless sleep and edginess was said to be quieted with a cigarette and helped to promote sleep. Nocturnal smoking was the only time that it was reported that an

institutional rule would be broken, as previously mentioned, windows would be opened for a quick cigarette puff so to avoid travelling a slow elevator to an unknown situation outside.

For the homeless smoker who is out of cigarettes or does not buy packages, it means preplanning for the morning by obtaining the cigarette the evening before. Given that the morning cigarette is the most valued of the day, a depleted reserve from the night time smoke means that the individual must seek out people to borrow, bum or share a smoke to fill their tobacco need. When these attempts fail, the person may resort to lesser desired means of acquiring their tobacco, the sniping of butts from the ground.

While the morning cigarette was central to the lives of the participants, their smoking extended beyond this cigarette to the entire day, “when I get up until I go to bed” and “...I’ll smoke all day”. Another individual explained how a cigarette for him was associated with other items of potential addiction; coffee and alcohol, and how it served as a social aspect with his workmates when employed.

I like having a coffee and a cigarette first thing in the morning. And when I don't smoke, I do miss that. Just that one. None of the other ones or if I'm on a Friday afternoon after work; and the guys are out having a beer....I like even though I can't smoke and drink now, but I like having a smoke when I'm having a beer.

One participant summarized a typical day of smoking by stating that “if I got less stress I smoke less cigarettes”- but felt that homelessness is a constant stressor, and therefore his smoking was more frequent and heavy.

5.6. Values and Beliefs

The meaning of tobacco for the participants was explored in the interviews, which shed light on values and beliefs that shape tobacco use in their lives. The first topic is called imagining the impossible, which looks at life without tobacco. The second topic

focuses on social mores and experiences of stigma. The third topic addresses health and safety issues and how perception of how their own health status is affected by tobacco use. The fourth area describes how traditional Aboriginal tobacco use is connected with their current daily life or historically has been given a context of interpretation.

5.6.a. Imagining the Impossible

One way participants wrapped their thoughts around the importance of tobacco was to imagine their lives without it – responses were similar and centered on tobacco being “habit- forming”, “addictive” and “because I have been doing it so long it is second nature”. Shame and hardship were themes that emerged related to their tobacco use, and participants who spoke of quitting were ashamed of their dirty teeth and smelly clothes. Quitting was a desirable concept but the idea of giving up cigarettes was surreal and unachievable, one individual stated that onlookers would ask “where’s your pipe?” when he was not smoking while outside.

The sentiment among the participants who discussed cessation was that certain conditions are required for cessation to occur, they felt that to quit one must be housed and attend to other areas of their lives first, like alcoholism and be in a Detox program. One individual would give up smoking if he had visitation or custody of his asthmatic son, for him the value of cigarettes diminished when related to a human being, for him it was associated with social or familial gain. Other individuals felt they could not quit because of their social situation because the people around them would not quit, and would make their social networking circles smaller and more difficult to create, for example

...it makes it a faster process, because you’re lightheaded so you’re in the moment who you’re talking with, right. So it’s not like you’re stressed out from

anything. You're literally in the moment, so you could literally know someone within five minutes of having a cigarette.

Another individual stated that it is difficult to quit because his wife smokes, and when housed that is an activity they would engage in while sitting on the couch, when asked if there were other activities they could share outside – he said “no, we’d probably just be smoking probably in that too”.

5.6.b. Social Mores and Stigma Amongst Homeless

The idea of social capital with a homeless population of smokers holds a more raw and survivalist dimension than of a housed and nonsmoking subgroup. A homeless individual is valued by their assets, what they come into an interaction with and what they may offer to another person. How the homeless person smokes situates them socially, their acquisition method puts them into the social network or shuns and stigmatizes the person. Reciprocity is valued in this homeless culture and while a nonhomeless person may seek value in owning a cell phone with many applications, a homeless smoker is valued for their contribution in an interaction of a cigarette lighter or matches. Networking is an important feature to this social class, through the sharing of a cigarette it may be learned what agency is offering free donuts, or where to score an extra layer of clothes. Social capital for the homeless means they are defined by their ability to network, their integrity of character and their identity within the homeless community. Despite the commonality of being homeless, an individual does not immediately have access to sharing smokes with another person, nor have ease of access to information, differences exist which form stigma and a social hierarchy within this group of smokers.

Much like street drug use, smoking for the homeless is also associated with a class system that categorizes smokers according to their smoking acquisition practices.

Smokers who are purchasing packages of cigarettes from a store are at the top of the ranking and are considered the most affluent, any cigarette that is tailored made and retail are considered to be at the upper stratum. Cigarette brands also play a role in this hierarchical classification system, discounted cigarettes are less desirable than brand names like “Du Maurier” or “Players” – “Studio” brand cigarettes are considered the brand to smoke while on the street. The next level down are those who buy loosies followed by those who roll their own tobacco, bumming and borrowing are next, and at the bottom are those who pick cigarette butts.

Smoking butts was associated with the greatest stigma and dehumanization – judgments about this practice was apparent through the participants comments, “no, no, you know like if I ever find myself doing something like that I would quit smoking...I won’t go resorting to cigarette butt picking or anything like that”, and “I’d rather hurt for a cigarette than smoke a butt off the ground”. The rebuff and repulsion indicates an active value system within their subculture. The stigmatized person is dually shamed by mainstream society and the homeless subculture from which they are on the fringe. Individuals with mental illness, cognitive decline, physical or mental disabilities are vulnerable to predatory behaviors of others also trying to survive the streets, like in the case of the “gentle giant” in 2008.

The act of sniping butts evokes shame and desperation among some of the participants. When asked the question “do you pick butts?” he responded “oh yeah, yeah. I’m not perfect”, another person refers to buying cigarettes over sniping... “But when I was like in my other life before I came here”. Sniping is also linked to trauma and loss,

and internal stigmatization, one participant describes being in a bad place and needed a smoke following the news that his daughter had been raped.

...It was winter time, yeah. It's just, no, it was there, and so I picked it up and you know; and it wasn't so bad. It was off the ground it was a half, half the length of a cigarette, and it was like you know. And I'd seen other people do it...so I started doing it. You know...yeah, and then people didn't mind when I brang it to their homes. Some of the homes I stopped in. And I said this is all I've got and they accepted it. Some of them ah took the tobacco our and some of them smoked it as is.

Loss was a constant for the participants and smoking evoked a great internal struggle for the participants as they remembered past lives prior to homelessness of healthy living with families, wives and children. One individual describes the role smoking played before he was homeless,

No, I'm a health nut... You don't, you don't smoke and then take multi vitamins... And go to the gym ha ha... And then finish the gym and then go like this (simulates cough)... It was tobacco was ah, you know the growth, health growth. You don't, you don't gain anything from using tobacco.

This same individual describes his life now

Yeah. I know I will quit. Just right now, I'm just sort of like you know... I'm not sure. I know my emotions are like right up to here. Above my eyebrows. Like I know I'm full. I know I could tell you some things that would bring my tears right out.

To decrease smoking requires their external life circumstances to be different; it means they are housed; alcohol and drug free and to claim a life with routine and meaning – such as employment, and healthy living with food and exercise. One participant summarizes these points by stating, “So ah, I’m just trying to get back to reality and get back to work, yeah”.

5.6.c. Health and Safety

The theme of health and safety centered on the effect smoking has on the participants' health, and how their health beliefs have shaped their smoking behaviors.

The three topics the participants spoke about were infectious diseases, smoking despite poor health, and mood management.

Infectious diseases from sharing cigarettes were a prominent concern; there was a worry and fear that they would catch Hepatitis or AIDS, and one person was deterred by sharing with someone who had a cold. One person compared smoking butts to walking around in bare feet; an act which he states is obviously not done because he believes he would catch a "foot disease". This same participant relays that while some break the filter off to avoid mouth-to mouth placement, he says "no, no, no, I'm a germaphobe. I can't like; ah go figure. A germaphobe that smokes".

The topic of smoking despite poor health offered a variance of opinions, some participants felt it affected their health, some were in denial of the consequences on their health, and others felt it was too late to cutback or quit. Of the group who believed smoking affected their health, they spoke of how smoking decreased their breathing capacity and caused them to cough more, "...it does affect a person's health. It takes the wind away... it definitely takes away a person's wind. It takes away that air; it is, it is a detriment...it is a detriment and I know it is". Participants disclosed that their health concerns involve cancer, emphysema, heart conditions, diabetes and foot blisters and bodily ulcers. Two individuals interviewed were in wheel chairs with amputations to their legs from advanced disease conditions and undue care. Individual participants were apologetic for coughing deeply during the interviews and others had a raspy voice, which

begs if this is due to smoking or homelessness. One participant when asked about his health commented that he feels ill, "Well, ahh yeah lousy, but it's not from smoking though. It's you know, it's from being up in this kind of atmosphere right".

All participants understood the health hazards of smoking, however they continued to smoke thinking that tobacco related illnesses would not affect them. One individual reported that he was in the hospital with pneumonia and the chest x-ray indicated black spots on his lungs, he said "it's not giving me problems, except in the pocketbook". A few participants spoke of their mortality with a distancing and estrangement that they would be unscathed from their illnesses and death was not imminent, "we all have one or two goals in life. We live and then we die. It's what we do between it", and another participant stated,

...everybody is going to go sooner or later. It doesn't matter if ahh you smoke or you know and then you don't smoke because there is people that you know the cancers... people go before people that smoke. I, I, I don't know. I don't know about, but you know. But yeah, it's not good; it's not going to stop me from smoking. The hazards or what not.

Mood regulation was another subtheme running through the interviews; smoking was used as a means to control a low mood and depression. Problems with concentration and focus were revealed, and one individual described his condition stemming back to childhood with ADHD. Another person mentioned that smoking helps with his anxiety that was unrelieved by medications. One individual feels strongly that smoking is a protective mechanism that keeps people safe from committing violent acts during their rages and temper outbursts, he explained,

...like you know I was in prison, like you know when people have cigarettes they're happy and they're relaxed and they're, they're in a better mood, but they take away cigarettes, and the next thing you know everyone turns psycho and ahh you go, like you notice in jail they take away cigarettes and the murder rate goes

way up; were animals. So it's actually good for people to smoke because you become violent. So I think cigarettes stops people from being violent right. You either die of cancer or you get murdered you know.

In this vein, smoking serves as a brief and immediate action to control emotions of anger and frustration to keep self and others free of harm.

5.6.d. Traditional Aboriginal Values and Tobacco

Out of the fifteen participants there were six who self-identified as Aboriginal, and of these six participants, five spoke about memories of traditional tobacco use. Traditional ceremonial smoking was termed by all five as “smoking the peace pipe”, and their faint recollections were related to spirituality prior to becoming homeless. The participants could not recall growing up within a traditional familial context where the connection to tobacco was spiritual. Indeed for these participants a dichotomous relationship with tobacco use and misuse existed. The participants made a distinction between smoking commercial tobacco recreationally and traditional smoking; spiritual tobacco smoking was polarized with an addiction to commercial tobacco. Recreational smoking of retail cigarettes from the store and use of tobacco as an offering for the “Creator” was clearly different for these participants. In their current situation of being homeless and disadvantaged, the focus of their cigarette smoking was recreational and not ceremonial.

These participants relayed that to be involved in traditional smoking, one must be living a pure lifestyle that is devoid of other vices such as gambling, drinking, drugs, sex, and smoking retail tobacco; one participant refers to these components as “the poison world”, and states “...in the poison world when you’re having a beer there’s a craving of tobacco, the cigarette goes with the, with the beer, it’s a balance I think”. He strongly felt

that the two practices cannot be mixed. Three of the participants felt that traditional smoking requires one to adopt a healthy lifestyle of eating well, vitamin supplements, exercise - especially running, and being housed. Two of the participants stated that traditional and recreational smoking were unable to coexist together, they would not smoke traditionally if they were misusing tobacco recreationally. A return to traditional smoking means to exit the “poison world” – and for one participant this means to exit homelessness and enter detoxification programs.

Jail was one location that offered smudges and traditional ceremonies, and for those participants who were inmates they would access tobacco in this manner. One participant spoke of how he was motivated on getting a “fix” than reaching spiritual awakening,

Well, like only one I was doing time in jail you know...we went to the sharing circles you know...you pass around the peace pipe or something; you take a puff of the pipe...yeah. And that was the only time I got to have a puff of something...because they don't allow smoking in jail. When I took the one puff of the peace, peace pipe I could every week you know, once a week you know, to like ah try and find some peace you know, clear my mind and thoughts and that, well bad things that I think of you know.

All participants agreed that their current smoking behaviors were not respecting the spiritual and medicinal use of tobacco. All five participants agreed that they want to adopt a traditional relationship with tobacco following successful cessation from retail cigarettes.

5.7. Summary

The intent of this research thesis was to explore three areas of interest: to describe the behaviours surrounding tobacco use and acquisition, to describe their values and beliefs around tobacco and to describe their everyday reality or situatedness of tobacco. The fifteen participants offered rich descriptions of their daily lives which indicated very

unique patterns of use and high risk smoking patterns that range from sharing cigarettes to sniping butts. Acquisition patterns mirror available resources, and accessing the informal market reflected a survivalist coping strategy. Reasons for smoking were powerful and revealed a strong withdrawal process. Daily routines focus on acquiring tobacco to avoid withdrawal, and ensure a morning cigarette for this purpose – even if the acquisition method was stigmatized by others. The everyday reality of being homeless and a smoker is the necessity to abide to shelter rules and smoking policies. Decisions to leave the shelter at night to smoke or to break shelter rules was a product of their withdrawal and tobacco dependency, those withdrawing in the night were more likely to break the rules to smoke inside and face repercussions following transgression. As a final point, the health of the homeless participants was overall poor, but the value placed on tobacco was stronger indicating the importance tobacco plays in their world. The value and belief system of the homeless explored traditional Aboriginal smoking, and the meaning of tobacco within their culture versus recreational use.

CHAPTER 6: DISCUSSION

6.1. Introduction

Homeless individuals' everyday reality is embedded with a variety of inequities and health disparities, which includes those related to tobacco use issues. While estimated rates of tobacco use are high amongst this population, their patterns of use also compound health risks. Aloot et Al. (1993) were the first to shed light on unique patterns of use among homeless individuals. Early cessation research suggests interest in quitting when adequate supports are in place. Yet nascent insight concerning homeless individuals' use of tobacco and how it interfaces with their environment and social context, limits the relevance of tobacco control measures with this population. This qualitative thesis investigated the everyday reality of male homeless individuals living in Winnipeg with the intention of exploring their environment and social contexts relevant to tobacco use, as well as to learn how tobacco use is situated within their lived experiences.

The original research questions focused on three areas: behaviour and acquisition; values and beliefs; and the everyday situatedness of tobacco use. Since generating these questions, a panel of experts published ideas from their meeting, which outlines research needs concerning tobacco use among homeless individuals (Porter, Houston, Anderson & Maryman, 2011). Three identified research needs are addressed in the findings from this thesis: smoking patterns of the homeless, the impact of the barter system, and the impact of tobacco policies and tobacco taxes on tobacco use behavior.

The chapter begins with a discussion of research findings in relation to relevant literature, which is framed to also address the thesis research and expert panel questions

(Porter et al., 2011). This discussion covers the following topics: personal and social situatedness, environmental situatedness and contextual influences, cessation versus harm reduction, health and smoking among homeless and Aboriginal threads. Following the discussion is reflections on the utility of the three theoretical frameworks used to guide the thesis and study limitations. The final section addresses implications specific to nursing practice, education and future research for tobacco control with this population.

6.2. Personal and Social Situatedness

Reaching beyond social disadvantage, the reasons and situatedness driving their smoking preferences must be examined because they shape their behavior and may shed light on barriers to cessation. By exploring tobacco use against their reasons for smoking, their chosen acquisition method, their use of their informal economy, and their social capital, we see tobacco as a meaningful dimension that is integrated as part of their personal and social situatedness.

6.2. a. Reasons

The homeless engage in a daily struggle to meet survival needs, they wait for services and meals; complicated physical health problems are common, and many have deeply entrenched emotional and psycho-traumatic memories. The findings from this study demonstrated that homeless individuals were compelled to smoke first thing in the morning when withdrawal symptoms were at the strongest. While there is evidence of the addictive nature of nicotine, the motives for smoking are also tied to their life situation. Two reasons for smoking among the Winnipeg homeless men participants contribute to previous literature concerning homeless male smokers: psychological and emotional reasons, and socialization and networking.

Psychological and emotional. Previous research suggested that smoking was related to depression with homeless in the United States (Arnsten et al., 2004; Butler et al., 2002; Connor et al., 2002; & Okuyemi et al., 2006). The idea that smoking serves a psychological function was captured by Okuyemi et al. (2006), the homeless in their study viewed cigarettes as a reward for “enduring hardship”, which was confirmed by the findings from this study. Smoking cigarettes was a pain reliever to lesson suffering and pain. The homeless participants talked about forgetting estranged relationships, multiple losses and traumas to feel “normal”. They also voiced how a cigarette filled a “void and emptiness”, and “makes life bearable”, which suggests tobacco use may be a mechanism for escapism both physically and mentally from their problems. Finally, smoking for the study participants appears to be a psychological first aid that calmed anger and curbed violent feelings and thoughts. Smoking tobacco is a form of therapy that limits distress; it is considered a resilient coping mechanism among the participants to decrease the provocation of negative feelings and behaviors.

Socialization and networking. Patterns of solitary and group behavior preferences among homeless have been described by Pippert (2007). While there can be a variety of underlying reasons for these social positions, tobacco use appears to be one. The research of Butler et al. (2002) highlights cigarette smoking as a means to comradeship, and potential entry into an underground economy of cigarette acquisition. Okuyemi et al. (2006) confirms this early research by sharing that loneliness was a great motivator and tobacco temporarily filled that void, the Winnipeg Street Health Report (Gessler et al., 2011) also found that loneliness was a big antecedent to smoking. Observations of study participants outside the building showed them gathered around the

building smoking together. Boredom and loneliness were reasons for smoking, triggered by memories of estranged relationships and past lives, smoking with others offered temporary refuge from alienation, long waits for next meal or appointments. Strong alliances with others were built over a cigarette; participants mentioned that smoking was a means to speed up networking processes for information about jobs and service agency information. Previous research evidence and findings from this study show that socialization is connected to their tobacco use, that relationships forged are makeshift families and resources.

6.2. b. Acquisition

How homeless acquire and use tobacco was of interest to this study and also identified as an important research question by the expert panel (Porter et al., 2011). The homeless and smoking research has evolved from identifying high risk smoking practices (Aloot et al., 1993) to describing patterns of use (Butler et al., 2002), to the coining of the term “sniping” for smoking discarded cigarette butts (Okuyemi et al., 2006). This study reveals some novel findings concerning acquisition and tobacco use among the homeless male participants. Homeless individuals live with pro-smoking community norms, which support a variety of legally and illegally ways to access tobacco. Five key ways were identified by study findings; three disengaged exchange of money but required a higher degree of energy and effort (i.e., borrowing, sharing, and sniping). Not surprisingly, it appeared the method for obtaining tobacco was linked to their individual resources; less resources the greater risk taken to acquire tobacco; high resources were equated with buying discounted Studio brand cigarettes, and when resources were lower they go to alternative avenues like buying loosies and than bumming and sharing.

The participants discussed preferred routes and reasons for their acquisition of tobacco. Those with greatest resource spoke about purchasing cigarettes at a local store and one mentioned contraband from a reserve. The loosie market was one way a homeless person could create justice for themselves by generating a market share of their own; the selling of cigarettes at inflated prices can bring them extra income to put back into the market to buy even more cigarettes. Only one participant shared that he smoked cigarettes purchased from a rural reserve out of province - which meant that provincial taxes were evaded, and there was potential for him to make a little money in Winnipeg. One high risk-smoking practice mentioned by Aloot et al. (1993) was the blocking of filter vents as a means to inhale more tobacco, this one practice was not mentioned by the participants in this study, but could very well be an adopted practice. Cigarettes were augmented by other items outside of tobacco; drugs were mentioned by Aloot et al. (1993) but not a focus of this study despite its mention by a few participants in this current study.

In summary, the acquisition of tobacco among the homeless is what sets them apart from a housed population of smokers. The homeless feel powerless and helpless with many choices taken away from them in a typical day in a shelter. Decisions for eating and sleeping and other basic needs like elimination and showers follow a shelter clock; and smoking becomes one area where they are able to exercise their own choices. Consideration of acquisition is important as it is the structure that sets up their informal economy.

6.2. c. Informal Economy

For those homeless individuals who use tobacco, the acquisition and use are central in their everyday life. The addictive nature of tobacco and their inherent financial constraints supports the emergence of an associated informal economy. Porter and colleagues (2011) also recognized both the existence of an informal economy and acknowledged its relevance to tobacco control measures targeting homeless populations. Previous research provided evidence that homeless enter into an informal economy because of barriers to a regulated monetary economy (Thrasher et al., 2009). The term “shadow-work” has been applied to the unregulated work and trade of the homeless (Lee, Tyler & Wright, 2010). Venkatesh (2006) suggested for the urban poor in Chicago everything was an asset and negotiable. Venkatesh also demonstrated that relationships were the backbone of this economy market. Their commerce was framed as being “off the books” and one that creates a personal indebtedness to each other without money (Venkatesh, 2006). While these aspects are of interest, this study moved beyond to reveal greater detail specific to tobacco: bartering and exchange, protecting one’s belongings and the economy of sniping.

Bartering and exchange. The expert panel (Porter et al., 2011) specifically asked about the role of bartering and its impact on tobacco use and cessation amongst homeless individuals. Interestingly, there is no previous tobacco-related research addressing bartering strategies for tobacco acquisition. Looking outside of tobacco research literature, evidence suggests the existence of this type of informal and sometimes illicit market. For example, Lee et al. (2010) mentioned that barter may involve a multitude of behaviors and acts, ranging from trade to squeegee to scavenging to panhandling and

prostitution. The selling of loosies has been mentioned as a monetary exchange (Clegg Smith et al., 2007), and while it involves a cash exchange, it falls under the classification of “shadow-work”.

Evidence from this study indicates that an informal economy is operating on the streets of Winnipeg. The trading of favors was mentioned by the participants as a means of exchange, especially for of the men in a wheelchair who could not get to the store. The engaging of one-to-one cigarette exchange was another barter relationship, built on an honesty code and not entered with moochers. Bartering and exchange are improvised solutions outside of crime; this system suggests that participants are operating with a moral conscious in relation to others. Observations within the shelter indicate that other items are being used for exchange, like food bank items, such as a cup of instant noodles for a single cigarette.

Protection of property. Given the economic value of tobacco within the lives of these homeless males, it seems logical that emerging from their stories were strategies for protection and storage of tobacco. Understanding that storage is problematic for the homeless, the securing of tobacco becomes a survival approach guided with hypervigilance and secrecy. The safeguarding of tobacco has been a concentration of Aloot et al. (1993); this study extends their initial work by exploring how tobacco is guarded in the shelter to reduce victimization and opportunism. The homeless battle a lack of storage, potential theft and loss of personal effects, but with tobacco there is an added pressure of warding off “moochers” and avoiding the “intimidators”. The hiding of cigarettes in pockets and secretly pulling out one cigarette at a time indicates the value placed on this item, and allows for personal control of their resources. Patwary, O’Hare,

Karim, & Sarker (2012) described in their medical waste scavenging study that waste scavengers are flexible and resilient, and endorse “street capital” that is learned with interactions with street-mates and other expert scavengers (Patwary et al., 2012). The hiding and storage of tobacco is a resilient and learned protective factor that is dependent on the acquisition method and important for self-preservation.

Economy of sniping. Previous research has identified sniping as part of the smoking behaviors connected to homelessness (Aloot et al., 1993; & Okuyemi et al., 2006). This study contributes additional details of the lived experiences of homeless persons who acquire their tobacco through sniping. Going into this research we knew through Pippert’s work (2007) with road dogs and loners that a person on the street may either team up with others or take on a solitary existence; with this study we learned that the same applied to their tobacco world. Sniping is a form of economy for a destitute group of homeless smokers who do not want to borrow, bum or share cigarettes. This is a group of smokers who are left alone by others, and do not offer a strong social dynamic adding to the informal economy. Learned from the participants was the elaborate route system they take to find butts, that great secrecy is related to these routes to protect them, and that snipers do hold discerning tastes regarding the quality of their butts, for example not smoking butts that have been wet. Future research may look at patterns of sniping during winter seasons.

6.2. d. Socially Situating Tobacco and Homeless

From the homeless in this study we saw how tobacco was situated within the context of their everyday lives along with specific acquisition habits and smoking patterns. One smoking pattern of interest was collective smoking; this group activity was

an integral part of their organized social structure and sense of identity. Tobacco researchers (Poland, Frohlich, Haines, Mykhalovskiy, Rock, & Sparks, 2006)) have stressed the need to understand the social meaning of smoking in the context of peoples' everyday lives. Accordingly, the researchers state that marginalized and disadvantaged subgroups of smokers are not random phenomenon, but cluster together due to underlying social phenomenon and institutional system, a term which they refer as a "collective social practice" (p.60). This section focuses on why we should look at the social dimension of tobacco and homelessness, and moves onto the demonstration of social networks surrounding tobacco use and its benefits, how methods of acquisition influenced their social situatedness, and lastly how this research study's novel findings of a hierarchical system of smokers moves the literature forward.

Agency within social capital development among homeless populations has been discussed. Social capital was described by Wood, Giles-Corti and Bullsara (2005) to involve the formation of networks that have established norms, a formation of trust amongst its members, and mutual goals that feature positive benefits with its actions. The World Bank (2012) refers to social capital as the "glue" that holds societies or institutions together, and social networking is an essential component of the informal economy (Venkatesh, 2006), which also shapes a class system among homeless. A social class system among all homeless serves multiple purposes on the street that ultimately influences survival: emotional and moral support, recreational companionship, and sustenance and financial support (Molina, 2000). A homeless individual's informal social networking channels offer the ability to acquire that which is not offered by social services. Dordick (1996) explained in her ethnography with sheltered homeless that

respect is the cornerstone of relationships in the social order of the shelter, it ensures protections and can bring about extra benefits, it allows for the physical and social space to be positively negotiated.

Social capital is driven by the human need to have shared values, understanding and beliefs. Wood, et al. (2005) examined pet ownership as a catalyst for social capital; they found that pets served as a means for social contact and interaction that decreased loneliness. The researchers explained that people who were walking their pets formed friendships with other pet owners, the social engagement formed trust and reciprocal favor exchanges over time. A parallel may be drawn to the current research of homelessness and smoking, it seems positive social engagement is associated with smoking. Smoking facilitates contact and interaction among strangers to form bonds, networks and the building of reciprocity. Smoking was perceived to build positive social capital on the street; smoking becomes the bonding activity which serves as the glue to social support - which was evident with the participant who wanted a job and shared a cigarette with a contact person.

Findings from this study also suggest methods of acquisition influenced functioning of social position. The participants of this current research implied that methods of acquisition affected social class functioning on the street, mooching was negatively evaluated by others and identity of the moocher was low status, this also holds for snipers. The term that may be applied to this homeless social class system in Winnipeg is “categorical associational distancing” (Snow & Anderson, 1987). The term implies that we are social beings that are positively or negatively associated by the company we keep, it is desirable to have self worth and dignity – the cornerstones of a

positive identity, and the homeless go to lengths to protect this identity (Snow et al.).

Liu, Stinson, Hernandez, Shepard, and Haag (2009) studied homelessness and social class among men in a transitional shelter and found that homeless men were viewed negatively as derelicts or drunks, these views affected their masculinity and self worth; participants in this study who sniped fall into this shamed view. The idea that moochers are not reciprocal smokers supports the need for other homeless smokers to protect their own identity and property by distancing.

A class system is new to the research arena of homelessness and smoking, the formation of a pecking order around cigarettes has not yet been documented within the smoking literature. While Aloot et al. (1993) focused on unconventional smoking practices; they did not touch on how their behaviors fit into a bigger street social system. A hierarchical system has been noted with regards to the classification of drug and alcohol users in Winnipeg (Marshall, 2010); through this thesis we see a similar classification system, Winnipeg homeless with tobacco use. Categorization of homeless smokers into groups indicates identity within a homeless social class system with some tobacco practices yielding more power, authority and autonomy. Understanding the unique social stratification of this subgroup is vital for tobacco control to target programs and interventions that focus on specific issues surrounding different tobacco user groups.

This research study and the expert panel (Porter et al., 2011) both held interest in knowing the smoking patterns of homeless persons; however it is clear that such patterns only become truly meaningful when connected to their personal and social situatedness. While society may view homeless smoking as deviant, it is their response to their deprivation and a protecting mechanism that offers them a sense of community. In

summation, this study asserts that smoking with others increases their social networks which form trust, comradeship and a social norm, that how a person is situated socially is important to their safety on the street, and smoking is a relationship strategy on the street associated with mutual benefits.

6.3. Environmental Situatedness and Contextual Influences

To date, the research on homelessness and smoking has not touched on the effects of implementing a non-smoking shelter policy, nor has the literature focused on the effects of taxation of tobacco with homeless populations. The expert panel (Porter et al., 2011) holds a vested interest in how tobacco control policies and taxes impact the tobacco use behaviours of the homeless. The research described in this study has taken the first step towards identifying the effect of policies on smoking behaviours among homeless male adults in Winnipeg. This section is divided into two areas: the impact of tobacco control policies of taxation and smoke free legislations, and the influences of the shelter structural on the homeless.

6.3. a. Tobacco Control Policies

It is apparent that homeless populations are vulnerable to policy shifts, which include enactment of tobacco-related city bylaws; their smoking behaviors continue but change according to how these policies interface with their everyday lives. Based on the homeless males in this study, it appears they are not fazed by tobacco health warnings, modifications in advertising or firewalls, or of tax increases (Levy, Chaloupka, & Gitchell, 2004) – except for a possible increase in the price of loosies. The injustice with the bylaws exists when decision making leading to the legislation never included either

them or their needs in the policy formation; such consideration could circumvent policies unintentionally in posing further harm.

Taxes. SimSmoke calculated that increases in taxes decrease tobacco use, and taxes wield a big effect on underprivileged populations (Levy, et al., 2004). The expert panel (Porter et al., 2011) was interested in the impact of taxation on the tobacco use of homeless. Owing to the investment in the informal economy, government regulations such as taxation had little impact on the participants' smoking patterns. However the greatest effect was seen through the marketing tactics of the tobacco industry, as it has been demonstrated by Apollonio & Malone (2005). The tobacco industry has developed special discounted brands that comes with taxes but are more affordable to low income spenders; brands like Studio, Legends, and Natives. Interestingly, Health Canada (2010) indicates these brands pose the same risk of harmful health effects as premium cigarette brands which are priced higher and are more heavily taxed, although the Non-Smokers' Rights Association (2007) claim these cigarettes are higher in tar, nicotine and tobacco. So while the homeless are purchasing less costly cigarettes, they are also using more damaging tobacco products.

Smoke free legislation. Arangua et al. (2007) examined the receptivity among smoke free shelters and transitional centers in the United States regarding adoption of cessation programs. In general the workers in these centers were open and willing to support tobacco control efforts, and 95% of shelters were willing to participate in a cessation program. While useful, insights into homeless service provider perspectives, there is no evidence regarding the effects of smoke free bylaws in homeless shelters. As

was identified in this study, there are unintended effects on smoke free legislation in the everyday lives of homeless individuals.

Prior to the enactment of the non smoking bylaw in Winnipeg, the Salvation Army shelter allowed patrons to smoke indoors. As a clean air policy, the non smoking bylaw moved smoking to an outdoor venue to protect nonsmokers from second hand smoke and decrease room fires. The uptake of this indoor smoking ban that prohibited smoking inside of the shelter (NSPHA, 2004) has received relative acceptance with the homeless at the Salvation Army Shelter (Major Hoeft, 2011). In May 2011, the City of Winnipeg enacted the Outdoor Smoking By-Law (By-Law No. 62/2011) which stipulated smoking must be at least 8 metres from any entranceway to a building. For the shelter, this meant that enforcement officers may issue fines to individuals caught smoking at shelter doors; the threat of a fine was not a deterrent to those without money, therefore smoking continued at the shelter front entrance. Smoking at the front door is a behavior that is consistent with a Canadian study that looked at indoor smoking restrictions, Kaufman, Zhang, Bondy, Klepeis, & Ferrence (2010) found that an unintended consequence of smoking bans was the relocation of smoking to building entrances, which evidently causes smoke drifts exposing people inside to secondhand smoke.

Smoking at the front door became a façade of safety; smokers were now visible prey to moochers and intimidators. The shelter in this study upholds a no smoking indoor policy, homeless shelter patrons must exit the shelter to smoke outdoors in unprotected and unpatrolled public spaces. The Winnipeg Street Health Report (2010) indicates that 40% of the 300 homeless respondents were physically assaulted in the past year and with an average of three violent assaults. The Institute for the Prevention of Crime in Canada (Roebuck, 2008) states that some of the reasons for victimization of the homeless are

because they spend large amounts of time in public places that are high crime, they carry all their possessions on person, and they have high mental illness rates that carries a vulnerability and inability to fend aggressors away. Given the discussion around violence at night and the death of the “Gentle Giant” over a cigarette (CTV, 2008), the lack of staff supervision outside indicates that this bylaw comes with significant safety risk.

6.3. b. Shelter Structural Influences Resulting from Policy and Program Changes

There is strong public support for adopting a clean air bylaw with restrictions that limit where people may smoke tobacco; however for homeless populations such changes increase risk for violence. It is clear from this research that the homeless are marginally affected by tobacco injunctions such as taxes, but they are affected by what Miljan (2008) called “proximate influences” – the effect of the policies on the shelter and their rules.

The move to non-smoking had unintended consequences for the building and the homeless, elevators were overused becoming slow and strained from multiple trips, and staff took on the task of securing the doors – unlocking and locking after every patron.

The toll on the building was only one unanticipated result from the bylaw; homeless smokers were now leaving a controlled and patrolled environment to go outside with all their belongings for a cigarette. With smoking urges strongest at night, homeless had the added challenge of poor lighting in unpatrolled territories – going past the doors meant the risk for violence increases.

An unintended consequence of enacting the indoor non-smoking bylaw was the toll placed on the physical maintenance of the building; elevators felt the burden from the increased frequency of transporting people from upstairs rooms to smoke outside (Major Hoeft, 2011). Hoeft explained that elevator maintenance or replacement is costly, yet a

safety concern for potential evacuations, most concerning for those in wheelchairs. Many participants spoke of how the elevators were slow to operate which played on their patience and impulse control leading to indoor smoking disobedience at night. The nocturnal indoor smoking was evidence to their tobacco dependency and withdrawal, by breaking the non-smoking rule, individual privileges are decreased and the rule-breaker is penalized for not managing their tobacco withdrawal symptoms, a case where tobacco control policies have a mutual impact on the setting and the individual. The social situatedness of an individual offers more choice when managing their withdrawal, those with cigarettes are able to exit and smoke quickly, but the sniper without butts is not prepared for a trek at night.

6.4. Cessation versus Harm Reduction

The national priorities from Health Canada are to decrease smoking prevalence rates (Health Canada, 2009). While this is admirable, there might be some initial steps and considerations regarding homeless populations. The Winnipeg Street Health Report (WSHR) indicated that 78% of 300 homeless persons sampled in Winnipeg were current smokers and these individuals had not been included in Health Canada's projection. With an interest in decreasing prevalence rates in Canada, we know little about the population who has high smoking rates, and if they also hold an interest in quitting? This study adopted a unique stance, rather than asking about quitting the question posed was "can you imagine your life without tobacco? What would that be like?" What they said and the unintended consequences of legislated changes both lend themselves to adopting harm reduction supportive strategies. That may lead to cessation someday but in the short term

work towards keeping homeless individuals safe and not jeopardizing their social situatedness.

In Winnipeg, there is precedence for adopting harm reduction approaches in relation to addictions. The Winnipeg Regional Health Authority (WRHA,2007) positively supports harm reductionist programming in Winnipeg, the position is that there is great cost connected to substance use, that abstinence is unlikely for some populations, and past programs have been effective to reduce the negative health and social discrimination of the substance use (WRHA, 2007). Harm reduction strategies successfully implemented in Winnipeg are the provision of harm reduction supplies like “safer crack kits”, condom distribution, needle-exchange programs and needle drop boxes, and mobile outreach programs and sexually transmitted infection testing (Nine Circles Community Health Centre, 2012), methadone intervention and needle exchange (M.I.N.E.) (Addictions Foundation of Manitoba, 2010), Operation Red Nose (Safety Services Manitoba, 2012), and safe grads to reduce underage drinking at graduation ceremonies (M.A.D.D., 2012).

Based on current relevant homeless literature (Apollonio and Malone, 2005; Arangua, McCarthy, Moscowitz, Gilberg, & Kuo, 2007; Arnsten, Reid, Bierer, & Rigotti, 2004); Baggett & Rigotti, 2010; Connor, Cook, Herbert, Stephen, & Williams in 2002; Okuyemi et al., 2006; Shelley, Cantrell, Moon-Howard, Ramjohn, & Vandevanter, 2007; Spector, Alpert, & Karem-Hage, 2007), and the expert panel’s (Porter et al., 2011) question about the importance of cessation, we could be lead to believe that cessation is the answer to the smoking and homelessness problem; the only option is quitting. Yet what we heard from the participants was the difficulty they had managing their nicotine

withdrawal and the great importance placed on their morning cigarette. Moreover, this study reveals the integral nature tobacco plays in personal and social identities of this population, if serious about addressing harm reduction with homeless populations, than other avenues must be created for socialization that attend to the multiple benefits it holds for protection, vocational outlooks, and friendship.

By adopting a harm reductionist approach, the treatment of withdrawal symptoms is the aim along with gaining a greater understanding of this populations' relationship with tobacco. The offering of NRT at night and during cold weather conditions would decrease desperation to make their smoking safer and cleaner by decreasing high risk smoking behaviors when completely devoid of tobacco. The suggestion from this study is to implement a harm reductionist program of free nicotine replacement therapy at night that includes the "patch" to decrease withdrawal symptoms. In addition, future research should look at the various roles tobacco use plays in their lives to inform strategies related to their homelessness prior to removing smoking. The needs of the homeless are primitive and simple, yet society has not included tobacco as a basic need for the homeless despite individuals' desperation when out of tobacco. In order to even consider such paradigm shifts towards homeless being tobacco-free, policy makers, clinicians and researchers must first understand the homeless populations' relationship with tobacco, and their lived reality. The overall message for cessation to be a true reality among the homeless, we must first tackle the problems posed by poverty (Jarvis, 2004).

6.5. Health and Smoking among Homeless

From the literature on homelessness and health, it is known that the homeless are at greater risk for developing respiratory and cardiovascular conditions (Kim et al., 2008;

Lee et al., 2005; Szerlip & Szerlip, 2002), cancer (Hwang et al., 2006; Moore & Durden, 2010) and infectious diseases (Kalka-Moll et al., 2008; Peterson et al., 1999; Raoult et al., 2001; Solsona, 2001; & Woodward et al., 2000). Aloot et. al. (1993) was the first to discuss the relationship between high-risk smoking practices and infectious disease processes and years later it is still a valid concern. This research study was interested in the perception of smoking and health held by the participants. There are three main topics to discuss: some smoking methods carry more risk than others for the spread of infectious diseases; in the face of poor health they will still smoke and smoking is a mood management strategy.

Infectious disease control issues related to high risk smoking practices were first discussed by Aloot et al. (1993), the participants in this study also recognized there were risks with their sharing and resmoking of butts. While aware of potential disease spread, they believed they could catch AIDS from sharing, as well as the common cold and Hepatitis, but did not find this a deterrent to their smoking. Notable, is that while participants had an awareness and fear of diseases, they adopted a protective practice of only sharing a cigarette with people known, which indicates a form of self preservation and discernment.

The homeless participants took a very cavalier approach to their health and bodies; amputations and loss limbs were observed. Participants also reported cardiovascular and respiratory problems which are well founded in the literature (Kim et al., 2008; Lee et al., 2005; Szerlip & Szerlip, 2002). The sentiment among a few participants was the need for a legitimate reason to quit – like a diagnosis from a doctor. Even though these participants demonstrated signs of vascular health conditions and had

awareness of their poor health, there was ongoing daily smoking. However, participants were only accessing healthcare in dire circumstances which lends the thought that they may not access assistance for tobacco cessation. The literature indicated that depression was common to homeless populations, and smoking reduced their emotional distress (Butler, Okuyemi, Jean, Nazir, Ahluwalia & Resnicow, 2002; Connor, Cook, Herbert, Stephen, & Williams, 2002; & Spring, Pingitore & McChargue, 2003). This study also confirmed an active presence of depressed mood, anxiety and high levels of stress; however, smoking was also an outlet that prevented angry outbursts, which suggested that it acted as a form of behavioral self-modification.

6.6. Aboriginal Threads

With diverse values and attitudes around the acceptance of tobacco, people who are aboriginal and homeless appear to have abandoned the traditional relationship with tobacco for the recreational smoking of cigarettes. Study findings suggest that recreational smoking was a significant retreat from the trauma and stress of being homeless. Aboriginal participants made a clear distinction between their two worlds of traditional customs and spirituality with their current lifestyle of misusing tobacco. The “poison world” was equated with the misuse of tobacco and smoking recreationally. Participants who participated in “smudges” in the past made a great distinction between their two worlds of tobacco practices. The poison world was equated with the picking up of cigarette butts and recreational smoking, and the giving of tobacco to the creator was a sacred and separate practice.

Participants in this study viewed their current smoking as an addiction, which supports the descriptions of recreational tobacco use of Blondin (1990) and Health

Canada (2007). The work of Mutch (2011) found similar results which she described as a “disconnect between culture, tobacco misuse and the development of tobacco control policy” (p.89). Both Mutch and this study found that the participants referred to their smoking as a “dirty habit” and participants’ spoke of shame, guilt and stigma attached to their nontraditional smoking. Enculturation was introduced by Mutch in her study and is mirrored with this thesis’ participants with commenting about their “past life”, and the desire for healthier lifestyles and a return to traditional smoking practices. Traditional smoking was viewed as a sacred and ceremonial practice that would be adopted upon being housed, with an abstinence from alcohol and being reunited with family. This perspective indicates that the misuse of tobacco is considered to be disgraceful and dishonorable. Along with Mutch (2011), this study adds to the literature in the area of Aboriginal tobacco use in Winnipeg, and is a valuable beginning resource for researchers in clinical and nonclinical areas.

6.7. Theoretical Reflections

Three theoretical standpoints informed and guided my thesis study. Collectively the three supported this study as each brought a specific perspective to guide me, however, working with this diversity of perspective was challenging for a novice researcher. Below I briefly identify the strengths of each, which is followed by a brief reflection on the challenges of working with this diversity. In the end, I am pleased with this discussion and believe these theoretical positions interplayed to achieve a greater understanding of the backdrop and importance of smoking among the homeless adult males in Winnipeg.

6.7. a. Symbolic Interactionism

In this thesis study, I was interested in exploring the lived experience of individual male homeless people related to tobacco use. Given this intent, the inclusion of a symbolic interactionist theoretical perspective provided a clear statement about the nature of knowledge and the validity of how people make sense of their world (Goffman & Best, 2005). By incorporating this framework into tobacco control study, the voices of the homeless smoker were heard and captured a glimpse into their everyday realities. Through the interviews, it is understood that the smoker who is homeless is a product of their everyday social interactions with other individuals, which varies between the different settings they negotiate. Symbolic interactionism looks to how people draw on symbols to create meaning in their lives (Goffman & Best, 2005); the cigarette was discussed as a symbol of the stress and burdens they carry in their lives. A cigarette may become a sign of worth and wealth, and the meaning ascribed is individual – for some use is a form of escapism from the everyday stress, and for others it is a form of psychological first aide to deal with trauma. In this study of tobacco, the findings enrich our understanding of the participants in their everyday situations relevant to how they view and make sense of their tobacco use.

6.7. b. Social Exchange Theory

Social Exchange Theory (SET) focuses on the maximizing of rewards while minimizing costs; individuals are motivated by the wish to increase one's social or economic standing (Pippert, 2007). This theoretical perspective aided in examining the underground economy and social exchanges associated with tobacco use as there was an implicit belief in a street code for cigarette exchange among homeless individuals in

Winnipeg. Findings suggested at least two such informal economies: the buying and selling of loosies and evidence of the valuable economy tobacco plays in the participants lives when they discussed the means of protection or guarding their tobacco stash. Equally, one realizes the value of this source when considering the lengths some go to procure tobacco.

Social Exchange Theory is an important when trying to understand how public health and social policies affect the homeless. It was very clear that smoking is closely linked with their social context and class system. SET explains how homeless use tobacco to navigate their social and environmental locales to improve their quality of life. The homeless are unconcerned with clean air issues, second hand smoke or obeying indoor smoking laws, they circumvent policies to meet their tobacco needs, and SET provides a background to appreciate their complex world.

6.7. c. Social Justice Lens

As homeless individuals are some of the most marginalized in our society, the inclusion of a social justice lens was deemed important. Certainly within the tobacco control research community there has been acknowledgment for adoption of this theoretical lens. Greaves et al. (2009) state that when we must "... widen policy approaches to include social justice and human rights approaches"; Greaves et al.'s work in tobacco has specialized in looking at women who have substance issues and victimized by violence, Greaves et al. feels that taking a social justice approach will empower women and reduce inequalities. Such an approach is thus required to look at homeless populations who are also victimized and vulnerable.

In this study, the homeless were shaped by greater forces outside themselves, the non-smoking policies, these policies discriminated against the homeless smoker by placing their private acts under public scrutiny, their choices to smoke butts and share cigarettes were judged and demeaned. The benefit of adopting a social justice lens to this study is that we were able to look at the unintended consequences of tobacco policies on the homeless, like the risk of a violent attack when smoking outside at night and strained elevators at the shelter. It is particularly important when considering program and policy development affecting the homeless that we look at the increased disparities for this population. Green (2007) advised health care and policy to adopt a social justice framework in working with vulnerable people and communities, this framework identifies the health inequities to be related to a lack of affordable housing, unemployment, racism, classism, sexism, illiteracy. Green explained that the stress from these forms of discrimination leads to stress and stress moves a person to smoke, and for the homeless in Winnipeg, this means the adoption of high risk smoking practices, which yet again illustrates that poverty is associated with high rates of smoking which causes high rates of tobacco related illnesses.

There is a need to consider the homeless' reality and informal economy as they interface with such policies. For example, when we remove smoking areas for homeless to unprotected public places there is an increased likelihood of intimidation/harm related to this valuable economic source in their lives. The challenges of working with tobacco reduction and homelessness are the potential of zero tolerance and abstinence programs to negatively affect their social capital. Rather, harm reduction programs open opportunities to dialogue about issues surrounding homelessness to positively affect their

social determinants of health (Pauly, 2008). The benefit of adopting a social justice stance to tobacco policy is as Pauly described, “... it has the potential to illuminate underlying values and potential harms associated with the social context of drug use” (p.8).

6.7. d. Challenges of Theoretical Frameworks

The complexities of homelessness and tobacco addiction require the application of multiperspective lenses to understand all facets of the problem. The challenge of working with 3 different frameworks is finding the connection of the theories to each other to avoid interpretations being isolated. As we know from the expert panel (Porter et al., 2011), multiple perspectives have lead to the inception of the 11 recommendations. For this study, tobacco and homelessness was framed with three distinct ways of knowing, this approach has ultimately lead tobacco addiction to be rooted in broader terms to look at addiction against the contributing factors of homeless marginalization. This thesis is a living document; the research problem of tobacco and homelessness may be enlightened by theories drawn from other disciplines to engage and give new meaning and interpretations. The ideal of this research is to move from simple explanations to maximizing our understanding of the issue, the benefits of using three perspectives outweighs using one perspective that may tunnel the findings in only one direction, for instance, what may work for one person may not for another. By understanding the issue, we can than move to critically redefining the problem for workable solutions.

6.8. Limitations

The underlying intention of this study was to listen to individuals who are homeless talk about their experiences with tobacco dependence. While the study

outcomes provide novel insights, there are limitations to take into consideration. The first limitation to discuss concerns bias resulting from self-report, which is inevitable when relying on interview data. For example, the researcher noticed that at times, the participants seemed to minimize their answers to interview questions or that their accounts of previous times were disjointed. Another example is the length of time participants were able to sit through an interview; most interviews lasted 15 minutes. While one might wonder if longer interviews may have garnered more depth and breadth of their life stories, this study does reflect lived realities and experiences of individuals who are homeless. While these observations of the self-reported data in this study demonstrate a limitation, the intention of the study was to gain insight into the views and experiences of individuals who are homeless. Thus, the indicative thematic coding of the self-reported data serves this purpose.

Another commonly identified limitation with qualitative research is small sample sizes (Roper & Shapira, 2000); in this study 15 homeless adult males in Winnipeg participated during September 2011. The concern with this limitation is that findings are not generalizable to other homeless individuals, and in the case of this study to other time periods. One could wonder if differences in behaviors might have been mentioned if this study took place in winter months. Thus, it is important to remember that this study does not purport to have captured all of Winnipeg's homeless male population, and thereby generalizations are not possible. However, findings from this study provide insights to raise new questions about homeless people, tobacco dependence and related treatments.

6.9. Implications

Through connections made during this thesis study, I learned that addiction services available to the homeless focus on detoxification programs for drugs and alcohol, but do not address tobacco addictions (Bechtal, 2010; Major Hoeft, 2011). Homeless populations have adjusted their smoking behaviour due to changes in non-smoking policies in shelters; as a result tobacco control and public health also need to envision a new way to look at treating tobacco addiction among this population. Implications for future research and for clinical nursing practice are vital for this study to become a living document that holds meaning within tobacco control. Outlined below are the future directions to be addressed by tobacco control researchers and policy makers, homeless shelters, nurses, and research implications.

6.9. a. Implications for Tobacco Control Program and Policies

As is notable through the expert panel (Porter et al., 2011) report, strategies to increase the demand for tobacco cessation services for homeless individuals is emerging as a priority. However, in listening to the voices of the participants in this study, I suggest there may be more to learn about their lived reality prior to jumping into cessation strategies. Thus one strategy could be to extend our understanding by conducting a Community Tobacco Assessment in Winnipeg (along with other cities) to generate local evidence to inform public health policy and legislation. In particular, such assessments would be wise to focus on Aboriginal tobacco use within the context of homelessness populations, which the vision to guide the provision of access to culturally specific cessation support in their language and respectful of traditional sacred tobacco practices. Finally, it was encouraged by Poland et al. (2006) and clearly revealed through this study

that the social situatedness of tobacco within the lives of homeless needs to be considered when adopting tobacco control efforts and legislation.

6.9. b. Implications for Homeless Shelters Policies and Programs

A novel finding from this study was the unintended consequences of shelters implementing smoke-free policies. As was notable in the participant stories, nicotine withdrawal poses difficulties for some shelter residents. In particular, during night time hours when going outside to smoke means leaving the protection of the shelter building and into spaces that come with an increasing risk of violence. Alternately, some shelter residents decide to not risk going outside and smoke within their room in the shelter; thus, violating shelter policies and facing consequences that can eventually mean being asked to leave the shelter. Subsequently, there is benefit in considering a harm reduction strategy in homeless shelters by providing free nicotine replacement therapy at night. Such a treatment option would aid in decreasing nocturnal withdrawal symptoms and related difficult situations or behaviors. Another option for homeless shelter facilities could be replicate the healthcare bus pilot project (Daiski, 2005) in Toronto, where research evidence suggests the implementation of street health care improves quality of life and health of homeless individuals. The implementation of a nicotine dependence treatment clinic located within shelters could decrease morbidity and mortality with this population. These nicotine dependence treatment clinics could be integrated part of an onsite health clinic and operated by nursing professionals and medical residents.

6.9. c. Implications for Nursing Practice and Education

Nurses provide care to homeless populations in a variety of settings. Since homeless populations are heavy users of the health care system, awareness of how

tobacco is personally and socially situated may enhance attention to treating nicotine dependence with homeless clients. This would require expanding nurses' knowledge on the assessment and treatment of nicotine dependency and withdrawal with a particular focus on nurses working in emergency departments and psychiatric settings. Educational requirements ought to include general nicotine dependence treatment knowledge but also focus on special populations like the homeless who come with unique health concerns and social histories. Examples of courses are the Training Enhancement in Applied Cessation Counseling and Health (TEACH) based in Centre for Mental Health in Toronto or the Tobacco Free RNAO Nursing Best Practice Champions Network. Both of these courses have been offered in Winnipeg and there are anticipated future dates.

6.9. d. Implications for Future Research

Given the expert panel's (Porter et al., 2011) interest in future research and novel findings from this study, it is easy to suggest more research in the area of homelessness and tobacco. Replication study that involves homeless from different shelters would either confirm or expand our understanding of smoking behaviors and patterns among homeless individuals in Winnipeg. Further research directions would benefit from an exploration of the meaning of smoking among homeless people who are Aboriginal and their traditional and ceremonial smoking practices. Alternately, research focused on women who are homeless might reveal unique acquisition practices, especially with street workers. Do female homeless smokers use the informal economy different than male adults who are homeless? Areas to explore further concerning acquisition and informal economy could extend our insights of the culture of sniping and or greater details on how the loosie market operates. Research that would look at the social landscape of tobacco

use amongst the homeless would extend our knowledge of their situatedness and value system. Another area to consider would be interventions studies that investigate harm reduction strategies; for example, the impacts of offering free nicotine replacement therapies during nighttime hours or the uptake of an onsite nicotine dependence treatment clinic. Finally, research could look at the impact of interventions such as the Bell Hotel, to examine if the provision of homes has an impact on smoking behaviour.

6.10. Summary

From the perspective of mainstream society, homelessness and heavy tobacco use increases medical costs and use of emergency services. Problems with untreated tobacco dependency are central in itself because of the negative impact on the course of their physical condition and their functioning in the world. A lack of environmental supports, cognitive deficits, severe and persistent mental illness, lack of routines and logistic problems all intensify the need to smoke as a psychosocial intervention. Tobacco smoking extended the social capital of the homeless to expand their network for potential opportunities, friends and supports. In order to apply the recommendations listed by this study and the expert panel (Porter et al., 2011) to decrease smoking among the homeless, we must first learn more about what brings them to use smoking as a self-management strategy, and as a social and relational outlet. This thesis drew on an ethnographic approach to challenge how we understand tobacco use among this population, as learned there is more research required to shift policy to consider homelessness and tobacco use. A consensus has been reached between the expert panel and the research findings of this study that support the need for continued commitment to understand and reduce tobacco use among the homeless adult males in Winnipeg.

References

- Aloot, C. B., Vredevoe, D. L., & Brecht, M. L. (1993). Evaluation of high-risk smoking practices used by the homeless. *Cancer Nurse, 16*(2), 123-130.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.
- Anderson, J. M., Rodney, P., Reimer-Kirkham, S., Browne, A., Basu Khan, K., & Lynam, J. (2009). Inequities in health and healthcare viewed through the ethical lens of critical social justice contextual knowledge for the global priorities ahead. *Advances in Nursing Science, 32*(4), 282-294.
<http://dx.doi.org/10.1097/ANS.0b013e3181bd6955>
- Apollonio, D. E., & Malone, R. E. (2005). Marketing to the marginalised: tobacco industry targeting of the homeless and mentally ill. *Tobacco Control, 14*, 409-415. <http://dx.doi.org/10.1136/tc.2005.011890>
- Arangua, L., McCarthy, W. J., Moscowitz, R., Gilberg, L., & Kuo, T. (2007). Are homeless transitional shelters receptive environmental tobacco control interventions? *Tobacco Control, 16*, 143–144. <http://dx.doi.org/10.1136/tc.2006.018697>
- Arnsten, J. H., Reid, K., Bierer, M., & Rigotti, N. (2004). Smoking behavior and interest in quitting among homeless smokers. *Addictive Behaviors, 29*, 1155–1161.
<http://dx.doi.org/10.1016/j.addbeh.2004.03.010>

- Baggett, T. P., & Rigotti, N. A. (2010). Cigarette smoking and advice to quit in a national sample of homeless adults. *American Journal of Preventive Medicine*, 39(2), 164-172. <http://dx.doi.org/10.1016/j.amepre.2010.03.024>
- BC Housing. (2007). *Provincial Homelessness Initiative*. Retrieved from <http://www.bchousing.org/programs/homelessness>
- Beauchamp, T. L., Jennings, B., Kinney, E. D., & Levine, R. J. (2002). Pharmaceutical research involving the homeless. *J Med Philos*, 27(5), 547-564. <http://dx.doi.org/10.1076/jmep.27.5.547.10320>
- Blondin, B. (1990). Traditional use of tobacco among the Dene. *Arct Med Red*, 49(S2), 51-53.
- Bryant, T., Chisholm, S., & Crowe, C. (2002). *Housing as a Determinant of Health*. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/09_housing_e.pdf
- Bull, R., & Fitzgerald, M. (2006). Nursing in a technological environment: Nursing care in the operating room. *International Journal of Nursing Practice*, 12(1), 3-7. <http://dx.doi.org/10.1111/j.1440-172X.2006.00542.x>
- Butler, J., Okuyemi, K. S., Jean, S., Nazir, N., Ahuluwalia, J., & Resnicow, K. (2002). Smoking characteristics of a homeless population. *Substance Abuse*, 23(4), 223-231. <http://dx.doi.org/10.1023/A:1021198000377>
- CTV, (2008, September 22). Vigil held for homeless man killed over cigarette. *The Canadian Press*.
- Cameron, K. L. (2010). *Older homeless women with depression*. Manuscript submitted for publication. Retrieved from https://email.nursing.arizona.edu/Library/Cameron_Karen_Dissertation.pdf

- Campbell, M. (2008). *It's a Year-Round Problem*. Retrieved from
<http://www.siloam.ca/news/mission-news-archive/its-a-year-round-problem/>
- Canada Research Chair in Urban Change and Adaptation. (2007). Research highlights:
Legislative approaches to panhandling. Retrieved from
http://homeless.samhsa.gov/%28S%28kf3caiaaxp1xuo555qz2mu55%29%29/ResourceFiles/Location_of_Panhandling_Activity_in_Winnipeg.pdf
- Canadian Tobacco Use Monitoring Survey. (2009). *Canadian Tobacco Use Monitoring Survey (CTUMS) 2009*. Retrieved from http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2009-eng.php
- Carter, T., Polevychuk, C., & Sargent, K. (2003). *Canada Research Chair in Urban Change and Adaptation Research Highlights: Winnipeg's inner city in 2001*. Retrieved from
http://www.homelesshub.ca/ResourceFiles/WINNIPEG'S_INNER_CITY_IN_2001.pdf
- Cashin, A., Newman, C., Thorpe, A., & O'Discoll, C. (2010). An ethnographic study of forensic nursing culture in an Australian prison hospital. *Journal of Psychiatric and Mental Health Nursing*, 17, 39-45. <http://dx.doi.org/10.1111/j.1365-2850.2009.01476.x>
- Centers for Disease Control and Prevention (2007). *Emergency Preparedness and Response: Winter Weather*. Retrieved April 18, 2010, from
<http://www.bt.cdc.gov/disasters/winter/staysafe/hypothermia.asp>
- Centre for Social Justice. (2007). *Health Inequality*. Retrieved from
<http://www.socialjustice.org/index.php?page=health-inequality>

CentreVenture Development Corporation (August 4, 2007). *Revitalization of main street expected with CentreVenture's strategic purchase of Bell Hotel properties.*

Retrieved May 1, 2010, from http://www.centreventure.com/news_releases.php

City of Hamilton (2007). *Everyone has a home: A strategic plan to address homelessness.* Retrieved May 1, 2010, from
<http://www.hamilton.ca/NR/rdonlyres/8C89CD9A-3A22-4D38-9B42-C51CA9B6BCC8/0/Mar21ECS07020REPORTStrategicPlantoAddressHomelessness.pdf>

Clark, C., Forest, A., Green, E., Hofrichter, R., Phillips, C., & Valderama, C. (2007).

Incorporating principles of social justice to tobacco control. *The National Association of County and City Health Officials (NACCHO), July*, 1-4. Retrieved from

<http://www.naccho.org/topics/HPDP/tobacco/upload/TobaccoSocialJusticeIssueBrief-Final.pdf>

Clegg Smith, K., Stillman, F., Bone, L., Yancey, N., Price, E., Belin, P., & Edsall Kromm, E. (2007). Buying and selling loosies in Baltimore. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84(4), 494-507.

<http://dx.doi.org/10.1007/s11524-007-9189-z>

Cocazzo Martins, D. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing*, 25(5), 420-430. <http://dx.doi.org/10.1111/j.1525-1446.2008.00726.x>

- Connor, S., Cook, R. L., Herbert, M. I., Stephen, M., & Williams, J. I. (2002). Smoking cessation in a homeless population: There is a will, but is there a way? *J Gen Intern Med*, 17, 369-372. <http://dx.doi.org/10.1046/j.1525-1497.2002.10630.x>
- Curran, J., & Takata, R. (2009). "Situatedness," Dear Habermas: Weekly Journal of Postmodern and Critical Thought, 19 April 2009. Retrieved from <http://www.csudh.edu/dearhabermas/situate.htm>
- Currie, R. J. (2004, September). *Mental illness in Manitoba: A guide for RHA planners* (Manitoba Centre for Health Policy). University of Winnipeg: University of Manitoba.
- Currie, R. J. (2010, April). *Chronic disease in Manitoba: What are the costs?* (Manitoba Centre for Health Policy). Winnipeg, Manitoba: University of Manitoba.
- Daiski, I. (2005). The health bus: Healthcare for marginalized populations. *Policy, Politics, & Nursing Practice*, 6(1), 30-38. <http://dx.doi.org/10.1177/1527154404272610>
- Darmon, N., Coupel, J., Deheger, M., & Briand, A. (2001). Dietary inadequacies observed in homeless men visiting an emergency night shelter in Paris. *Public Health Nutrition*, 42(2), 155-161. <http://dx.doi.org/10.1079/PHN200053>
- Denzin, N. K. (1992). *Symbolic interactionism and cultural studies*. Cambridge, Massachusetts: Blackwell Publishers.
- Dordick, G. (1996). "More Than Refuge: The Social World of the Homeless Shelter.". *Journal of Contemporary Ethnography*, 24(4), 373-404. <http://dx.doi.org/10.1177/089124196024004001>

Eisner, M. D. (2006). Banning smoking in public places. *The Journal of the American Medical Association*, 286(14), 1778-1779.

<http://dx.doi.org/10.1001/jama.296.14.1778>

Environment Canada (2002). *Wind Chill Hazards*. Retrieved May 5, 2010, from

http://www.msc-smc.ec.gc.ca/education/windchill/windchill_threshold_chart_e.cfm

Fain, J. A. (1999). *Reading, understanding, and applying nursing research*. Philadelphia, PA: F.A. Davis Company.

Fernandez, L., Mackinnon, S., & Silver, J. (2010). The social determinants of health in Manitoba. *Canadian Centre for Policy Alternatives-Manitoba*. Retrieved from <http://libguides.lib.umanitoba.ca/content.php?pid=191417&sid=1605476>

Foa E.B., & Foa U.G. (1976) Resource theory of social exchange. In: Thibault J, Spence JB, Carson RC (Eds) *Contemporary Topics in Social Psychology*. General Learning Press, Morristown NJ, 99-131.

Forchuk, C., Ward-Griffen, C., Csiernik, R., & Turner, K. (2006). Surviving the tornado of mental illness: Psychiatric survivors' experiences of getting, losing, and keeping housing. *Psychiatric Services*, 57, 558-562.

<http://dx.doi.org/10.1176/appi.ps.57.4.558>

Frankl, V. E. (1984). *Man's search for meaning*. New York, NY: Washington Square Press.

Frohlich, N., Fransoo, R., & Ross, N. (2002). Health Services Use in the Winnipeg Regional Health Authority: Variations across areas in relation to health and socioeconomic status. *Health Care Management Forum, Manitoba Centre for*

- Health Policy, Winter Supplement*, 9-14. [http://dx.doi.org/10.1016/S0840-4704\(10\)60176-7](http://dx.doi.org/10.1016/S0840-4704(10)60176-7)
- Gessler, S., Maes, C., & Skelton, I. (2011). *The Winnipeg Street Health Report*. Winnipeg: The Homelessness Partnering Strategy.
- Global News, (Producer). (2010, April 23, 2010). *Prime News* [Television broadcast]. Winnipeg: Global.
- Goffman, E. (1955). On face-work; an analysis of ritual elements in social interaction.. *Psychiatry: Interpersonal and Biological Processes*, 18(3), 213-231.
- Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Doubleday & Co., Anchor Books.
- Goffman, E., & Best, J. (2005). *Interaction ritual: Essays in face to face behavior* (2 ed.). Piscataway, New Jersey: Aldine Transaction.
- Goldman, R. I., Newman, R. W., & Wilson, O. (1973). Effects of alcohol, hot drinks, or smoking on hand and foot heat loss. *Acta physiologica Scandinavica*, 87(4), 498-506. <http://dx.doi.org/10.1111/j.1748-1716.1973.tb05416.x>
- Government of Manitoba (n.d.). Cold Weather Strategy. Retrieved April 18, 2010, from http://www.gov.mb.ca/fs/allaboard/cold_weather.html
- Government of Manitoba News Release, (2010, April 23, 2010). Innovative housing initiative to promote stability, independence for the homeless. *News Media Services*. Retrieved from <http://www.gov.mb.ca/cgi-bin/press/release.pl>
- Greaves, L., Johnson, J., Bottoroff, J., Kirkland, S., Jategaonkar, N., McGowan, M., Battersby, L. (2006). What are the effects of tobacco policies on vulnerable populations? *Canadian Journal of Public Health*, 97(4), 310-315.

- Harrowing, J. N., & Mill, J. (2010). Moral distress among Ugandan nurses providing HIV care: a critical ethnography. *International Journal of Nursing Studies*, 47(6), 723-731. <http://dx.doi.org/10.1016/j.ijnurstu.2009.11.010>
- Haynes, W. G. (2000). Effects of Alcohol in the Cold. University of Iowa Hospitals and Clinics: Health Topics. Retrieved from <http://www.uihealthcare.com/topics/medicaldepartments/pharmacy/alcoholandcold/index.html>
- Hayward, L. M., Campbell, H. S., & Sutherland-Brown, C. (2007). Aboriginal users of Canadian quitlines: an exploratory analysis. *Tobacco Control*, 16(Suppl I), i60-i64. <http://dx.doi.org/10.1136/tc.2007.020115>
- Health Canada. (2005). *Building Best Practices with Community*. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/substan/_tobac-tabac/2002_pra_comm/index-eng.php
- Health Canada. (2007). *Traditional and Non-traditional Use of Tobacco*. Retrieved from <http://www.hc-sc.gc.ca/fniah-spnia/substan/tobac-tabac/index-eng.php#use>
- Health Canada, (2008). *Sleeping with a Killer: a Report from Health Canada's Tobacco Control Program*. Retrieved from <http://www.hc-sc.gc.ca/hc-ps/pubs/tobac-tabac/swk-dat/benefits-avantages08-eng.php>:
- Health Canada. (2009). *Canadian Tobacco Use Monitoring Survey (CTUMS) 2009*. Retrieved February 16, 2011, from
- Health Canada. (2009). *Federal Tobacco Control Strategy*. Retrieved December 23, 2010, from <http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/about-apropos/role/federal/strateg-eng.php>

- Health Canada. (2009). *Tobacco: Behind the Smoke*. Retrieved from <http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/fact-fait/smoke-fumee1-eng.php#cont>
- Healton, C., & Wilson, K. (2004). Reversal of misfortune: Viewing tobacco as a social justice issue. *American Journal of Public Health, 94*(2), 186-191.
<http://dx.doi.org/10.2105/AJPH.94.2.186>
- Homans, C. G. (1961). *Social Behavior: Its Elementary Forms*. New York: Harcourt, Brace & World.
- Hulchansk, D. J. (Ed.). (2004). *A New Canadian Pastime? Counting Homeless People*. Retrieved from Centre for Urban and Community Studies, University of Toronto:
<http://action.web.ca/home/housing/resources.shtml?x=66865>.
- Human Resources and Skills Development Canada. (n.d.). *The homelessness partnering strategy*. Retrieved from <http://www.hrsdc.gc.ca/eng/homelessness/index.shtml>
- Hwang, S., Wong, S. Y., & Bargh, G. J. (2006). Dyspepsia in homeless adults. *Journal of Clinical Gastroenterology, 40*(5), 416-420. <http://dx.doi.org/10.1097/00004836-200605000-00010>
- Johansson, I. M., Skarsater, I., & Danielson, E. (2012). The experience of working on a locked acute psychiatric ward. *Journal of Psychiatric and Mental Health Nursing*.
<http://dx.doi.org/10.1111/j.1365-2850.2012.01919.x>
- Jones, C. A., Perera, A., Chow, M., Ho, I., Nguyen, J., & Darachi, S. (2009). Cardiovascular disease risk among the poor and homeless – What we know so far. *Current Cardiology Reviews, 5*, 69-77. <http://dx.doi.org/10.2174/157340309787048086>

- Kalka-Moll, W. M., Lee, J. C., Faber, M., & Seifert, H. (2008). Intrafamilial outbreak of subcutaneous abscesses caused by PVL-positive methicillin-sensitive *Staphylococcus aureus*. *Journal of Infection*, 57, 278-281. <http://dx.doi.org/10.1128/JCM.00911-10>
- Kaufman, P., Zhang, B., Bondy, S. J., Klepis, N., & Ferrence, R. (2010). Not just 'a few wisps': real-time measurement of tobacco smoke at entrances to office buildings. *Tobacco Control*, 20(3), 212-218. <http://dx.doi.org/10.1136/tc.2010.041277>
- Khandor, E., & Mason, K. (2007). *The Street Health Report 2007*. Retrieved from Toronto Street Health Report:
<http://www.streethealth.ca/Downloads/SReport2007.pdf>
- Kim, D. H., Daskalakis, C., Plumb, J. D., Adams, S., Brammer, R., Orr, N., Whellan, D. J. (2008). Modifiable cardiovascular risk factors among individuals in low socioeconomic communities and homeless shelters. *Family and Community Health*, 31(4), 269-280. <http://dx.doi.org/10.1097/01.FCH.0000336090.37280.2e>
- Laird, C. (2009, September 16, 2009). Study to address Winnipeg's 'housing first' homeless strategy: Participants given housing first, then treatment. *The Uniter*. Retrieved from <http://uniter.ca/view/1253/>
- Lamb, H. R., Bachrach, L. L., & Koss, F. I. (Eds.). (1992). *Treating the homeless mentally Ill: A task force report of the American Psychiatric Association*. Washington, DC: American Psychiatric Association.
- Lambert, S. (2005, July 17). Bar owners in two prairie provinces want smoking bans deemed unconstitutional. *Canadian Press*. Retrieved from <http://archive.tobacco.org/news/202098.html>

- Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and mental illness: A population-based prevalence study. *JAMA*, 284(20), 2606-2610. <http://dx.doi.org/10.1001/jama.284.20.2606>
- Lee, B. A., Tyler, K. A., & Wright, J. D. (2010). The new homelessness revisited. *The Annual Review of Sociology*, 36(), 501-521. <http://dx.doi.org/10.1146/annurev-soc-070308-115940>
- Lee, T. C., Hanlon, J. G., Ben-David, J., Booth, G. L., Cantor, W. J., & Connelly, P. W. et al. (2005). Risk factors for cardiovascular disease in homeless adults. *Circulation*, 111, 2629-2635. <http://dx.doi.org/10.1161/CIRCULATIONAHA.104.510826>
- Levy, D. T., Chaloupka, F., & Gitchell, J. (2004). The effects of tobacco control policies on smoking rates: a tobacco control scorecard. *J Public Health Manag Pract.*, 10(4), 338-53.
- Liu, W. M., Stinson, R., Hernandez, J., Shepard, S., & Haag, S. (2009). A qualitative examination of masculinity, homelessness, and social class among men in a transitional shelter. *Psychology of Men and Masculinity*, 10(2), 131-148. <http://dx.doi.org/10.1037/a0014999>
- Long, R., Zielinski, M., Kunimoto, D., & Manfreda, J. (2002). The emergency department is a determinant point of contact of tuberculosis patients prior to diagnosis. *Int J Tuberc Lung Dis*, 6(4), 332-339.
- MacIntyre, R. A. (2009, March 19, 2009). Winnipeg Police Advisory Board 2008 Consultations Report and Recommendations (Winnipeg Police Advisory Board). Winnipeg: Winnipeg Police Service.

- Mackay, J., Erickson, M., & Shafey, O. (2006). *The tobacco atlas* (2nd ed.). Atlanta, Georgia: American Cancer Society.
- Main Street Project. (2010). IPDA. Retrieved from
<http://www.mainstreetproject.ca/ipda.htm>
- McLeon, A., & DeCoster, C. (2001, May). *Health and health care in Winnipeg* (Manitoba Centre for Health Policy and Evaluation). Winnipeg, Manitoba: University of Manitoba.
- Mental Health Commission of Canada (n.d.). *Winnipeg Research Demonstration Project: At home/ Chez Soi*. Retrieved May 5, 2010, from
<http://www.mentalhealthcommission.ca/English/Pages/WinnipegResearch.aspx>
- Miljan, L. (2008). *Public policy in Canada: An introduction* (5th ed.). Ontario, Canada: Oxford University Press.
- Miller, D. L., Creswell, J. W., & Olander, L. S. (1998). Writing and retelling multiple ethnographic tales of a soup kitchen for the homeless. *Qualitative Inquiry*, 4(4), 469-491. <http://dx.doi.org/10.1177/107780049800400404>
- Moore, C. E., & Durden, F. (2010). Head and Neck Cancer Screening in Homeless Communities: HEAL (Health Education, Assessment, and Leadership). *Journal of the National Medical Association*, 102(9), 811-816. <http://dx.doi.org/>
- Mutch, B. L. (2011). *Bringing it back: The meaning of tobacco to Manitoba's Metis peoples* (Masters Thesis). Retrieved from
http://mspace.lib.umanitoba.ca.proxy1.lib.umanitoba.ca/jspui/bitstream/1993/4426/1/mutch_bonnie.pdf

- Nine Circles Community Health Centre (2007). *Partners for positive change*. Retrieved July 24, 2010, from <http://www.ninecircles.ca/>
- Non-Smokers' Rights Association. (2007). Retrieved from http://www.nsra-adnf.ca/cms/files/pdf/Backgrounder2007_2008.pdf
- Nyamathi, A. M., Dixon, E. L., Wiley, D., Christiani, A., & Lowe, A. (2006). Hepatitis C Virus Infection Among Homeless Men Referred From a Community Clinic. *Western Journal of Nursing Research*, 17(2), 475-490.
<http://dx.doi.org/10.1046/j.1525-1497.2002.10415.x>
- Ober, K., Carlson, L., & Anderson, P. (1997). Cardiovascular risk factors in homeless adults. *J Cardiovasc Nurs*, 11(4), 50-59.
- Okuyemi, K. S., Caldwell, A. R., Thomas, J. L., Born, W., Richter, K. P., & Nollen, N. et al. (2006). Homelessness and smoking cessation: Insights from focus groups. *Nicotine & Tobacco Research*, 8(2), 287-296. <http://dx.doi.org/10.1080/14622200500494971>
- Okuyemi, K. S., Thomas, J. L., Hall, S., Nollen, N. L., Richter, K. P., Jeffries, S. K., & Ahluwalia, J. S. (2006). Smoking cessation in homeless populations: A pilot clinical trial. *Nicotine & Tobacco Research*, 8(5), 689-699. <http://dx.doi.org/10.1080/14622200600789841>
- Paraskevas, J. (2008, April 29). WEB EXTRA - Project Breakaway. Winnipeg Free Press. Retrieved from <http://proquest.umi.com.proxy1.lib.umanitoba.ca/libraries/online/proxy.php?>
- Patwary, M. A., O'Hare, W.T., H., Karim, S. A., & Sarker, M. H. (2012). The motivations of young people moving into medical waste scavenging as a street

- career. *Journal of Youth Studies*, 15(5), 591-604.
<http://dx.doi.org/10.1080/13676261.2012.665441>
- Pauly, B. (2007). Harm reduction through a social justice lens. *International Journal of Drug Policy*, 19, 4-10. <http://dx.doi.org/10.1016/j.drugpo.2007.11.005>
- Pauly, B. (2008). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, 19, 195-204. <http://dx.doi.org/10.1016/j.drugpo.2008.02.009>
- Perras, F. (2010). *Affordable housing needed for poor*. Retrieved from
http://www.winnipeg.com/comment/columnists/floyd_perras/2010/10/12/15664691.html#/comment/columnists/floyd_perras/2010/10/13/pf-15677781.html
- Peterson, L. R., & Thompson, R. B. (1999). Use of the clinical microbiology laboratory for the diagnoses and management of infectious diseases related to the oral cavity. *Infectious disease clinics of North America*, 13(4), 775-795. [http://dx.doi.org/10.1016/S0891-5520\(05\)70108-2](http://dx.doi.org/10.1016/S0891-5520(05)70108-2)
- Pippert, T. D. (2007). *Road dogs and loners: Family relationships among homeless men*. Lanham, MD: Lexington Books.
- Poland, B., Frohlich, K., Haines, R. J., Mykhalovskiy, E., Rock, M., & Sparks, R. (2006). The social context of smoking: The next frontier in tobacco control? *Tobacco Control*, 15, 59-63. <http://dx.doi.org/10.1136/tc.2004.009886>
- Porter, J., Houston, L., Anderson, R. H., & Maryman, K. (2011). Addressing tobacco use in homeless populations: Recommendations of an expert panel. *Health Promotion Practice*, 12(Suppl. 2), 144S-151S. <http://dx.doi.org/10.1177/1524839911414412>

- Prince, L. M. (2008). Resilience in African American women formerly involved in street prostitution. *The ABNF Journal*, 19(1), 31-36.
- Pruse, R. C. (1995). *Symbolic interaction and ethnographic research: Intersubjectivity and the study of human lived experience*. New York: State University of New York Press.
- Purc-Stephenson, R. J., & Thrasher, C. (2010). Nurses' experiences with telephone triage and advice: a meta-ethnography. *Journal of Advanced Nursing*, 66(3), 482-294.
<http://dx.doi.org/10.1111/j.1365-2648.2010.05275.x>
- Ramin, B., & Svoboda, T. (2009). Health of the homeless and climate change . *Journal of Urban Health*, 86(4), 654-664. <http://dx.doi.org/10.1007/s11524-009-9354-7>
- Raoult, D., Foucault, C., & Brouqui, P. (2001). Infections in the homeless. *The Lancet*, 1, 77-84. [http://dx.doi.org/10.1016/S1473-3099\(01\)00062-7](http://dx.doi.org/10.1016/S1473-3099(01)00062-7)
- Registered Psychiatric Nurses of Canada. (2010). *Code of ethics & standards of psychiatric nursing practice*. Retrieved from
http://crpnm.mb.ca/CRPNM_v2/publications/code_standards.pdf
- Rippy, J., & Baker, H. (2003). The nurse preceptor: Knowledge transfer in health care. *E-Journal of Organizational Learning and Leadership*, 2(1). Retrieved from
<http://www.leadingtoday.org/weleadinlearning/jrapr03.htm>
- Roebuck, B. (2008). Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations. Retrieved from Institute for the Prevention of Crime
www.prevention-crime.ca
- Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, California: Sage Publications, Inc.

- Sachs-Ericsson, N., Wise, E., Debroy, C. P., & Paniucki, H. B. (1999). Health problems and service utilization in the homeless. *Journal of Health Care for the Poor and Underserved, 10*(4), 443-452. <http://dx.doi.org/10.1353/hpu.2010.0717>
- Sandelowski, M. (1993). Rigor, or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1-8.
- Shaw, S. (2008). Emergency departments and urgent care in Winnipeg: Exploring data and describing users, summary. Manitoba Centre for Health Policy, University of Manitoba.
- Shelley, D., Cantrell, J., Moon-Howard, J., Ramjohn, D. Q., & Vandevanter, N. (2007). The \$5 Man: The Underground Economic Response to a Large Cigarette Tax Increase in New York City. *Am J Public Health, 97*, 1483-1488. <http://dx.doi.org/10.2105/AJPH.2005.079921>
- Snow, D., & Mulcahy, M. (2001). Space, politics, and the survival strategies of the homeless. *American Behavioral Scientist, 45*(149-169). <http://dx.doi.org/10.1177/00027640121956962>
- Snyder, L. D., & Eisner, M. D. (2004). Obstructive lung disease among the urban homeless. *Chest Journal, 125*(5), 1719-1725. <http://dx.doi.org/10.1378/chest.125.5.1719>
- Solsana, J., Cayla, J. A., Nadal, J., Bedian, M., Mata, C., & Brau, J. (2000). Screening for tuberculosis upon admission to shelters and free-meal services. *European Journal of Epidemiology, 17*, 123-128. <http://dx.doi.org/10.1023/A:1017580329538>

- Spector, A., Alpert, H. A., & Karem-Hage, M. (2007). Smoking cessation delivered by medical students is helpful to homeless population. *Academic Psychiatry, 31*(5), 402-405.
- Spradley, J. P. (1980). *Participant Observation*. Orlando, Florida: Harcourt Brace Jovanovich College Publishers.
- Statistics Canada (2007). *Weather conditions in capital and major cities*. Retrieved May 5, 2010, from <http://www40.statcan.gc.ca/l01/cst01/phys08b-eng.htm>
- Stillman, F. A., Bone, L., Avila-Tang, E., Smith, K., Yancey, N., Street, C., & Owings, K. (2007). Barriers to Smoking Cessation in inner-city African American young adults. *American Journal of Public Health, 97*(8), 1405–1408. <http://dx.doi.org/10.2105/AJPH.2006.101659>
- Stratigos, A. J., & Katsambus, A. D. (2003). Medical and cutaneous disorders associated with homelessness. *SKINmed, 2*, 168-174. <http://dx.doi.org/10.1111/j.1540-9740.2003.01881.x>
- Speziale, H. J., & Carpenter, D. (2007). *Qualitative research in nursing* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Spring, B., Pingitore, R., & McChargue, D. (2003). Reward value of cigarette smoking for comparably heavy smoking schizophrenic, depressed, and nonpatient smokers. *The American Journal of Psychiatry, 160*, 316-322.
<http://dx.doi.org/10.1176/appi.ajp.160.2.316>
- Stuart, G. W., & Laraia, M. T. (2001). *Principles and practice of psychiatric nursing* (7th ed.). St.Louis, Missouri: Mosby.

- Stuthers, R., Eschiti, V. S., & Patchell, B. (2004). Traditional indigenous healing: Part 1. *Complementary Therapies in Nursing & Midwifery*, 10, 141-149.
<http://dx.doi.org/10.1016/j.ctnm.2004.05.001>
- Szerlip, M. I., & Szerlip, H. M. (2002). Identification of cardiovascular risk factors in homeless adults. *The American Journal of the Medical Sciences*, 324(5), 243-246.
<http://dx.doi.org/10.1097/00000441-200211000-00002>
- Tanzi, V. (1999, June). Uses and abuses of estimated of the underground economy. *The Economic Journal*, 109(456), F338-347. <http://dx.doi.org/10.1111/1468-0297.00437>
- The Correctional Services Act, C.C.S.M. c. C230, 2004 Manitoba § (Government of Canada 2004).
- Thorne, S. (2008). *Interpretive Description*. Walnut Creek, California: Left Coast Press, Inc.
- Thrasher, J. F., Villalobos, V., Dorontes-Alonso, A., Arillo-Santillan, E., Cummings, K. M., O'Connor, R., & Fons, G. F. (2009). Does the availability of single cigarettes promote or inhibit cigarette consumption? Perceptions, prevalence and correlates of single cigarette use among adult Mexican smokers. *Tobacco Control*, 18, 431-437. <http://dx.doi.org/10.1136/tc.2008.029132>
- Thunderbird House. (2010). *Who we are?* Retrieved from <http://thunderbirdhouse.com/>
- The Institute for the Prevention of Crime in Canada. (n.d.).
http://www.sciencessociales.uottawa.ca/ipc/eng/documents/IPC_MR2-Eng.pdf
- The Intoxicated Persons Detention Act, C.C.S.M. c. 190, (Government of Manitoba (1988)

The Panhandling By-Law No.6555/95, H.R. Res. Cong., City of Winnipeg By-Laws (1995) (enacted).

The World Bank. (2012). Retrieved from

<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:22322420~menuPK:282528~pagePK:148956~piPK:216618~theSitePK:282511,00.html>

Tipple, G., & Speake, S. (2005). Definitions of homelessness in developing countries.

Habitat International, 29(2), 337-352. <http://dx.doi.org/10.1016/j.habitint.2003.11.002>

Tougas, G., Chen, Y., Hwang, P., Liu, M. M., & Eggleston, A. (1999). Prevalence and impact of upper gastrointestinal symptoms in the Canadian population: Findings from the DIGEST study. *American Journal of Gastroenterology*, 94(10), 2845-2854. <http://dx.doi.org/10.1111/j.1572-0241.1999.01427.x>

Turner, J. (2008, February 2, 2008). 38 street people costing millions. *Winnipeg Free Press*.

United Nations, (2006). *The international forum for social development: Social justice in an open world the role of the United Nations* (ST/ESA/305). Retrieved from United Nations Organization:

<http://www.un.org/esa/socdev/documents/ifsds/SocialJustice.pdf>

United Nations. (2007). *World Day of Social Justice*. Retrieved from
<http://www.un.org/esa/socdev/social/intldays/IntlJustice/>

Venkatesh, S. (2006). *Off the books*. Cambridge MA: Harvard University Press.

- Wineman, N. M., & Durand, E. (1992). Incentives and rewards for subjects in nursing research. *Western Journal of Nursing Research*, 14(4), 526-531. <http://dx.doi.org/10.1177/019394599201400411>
- Winnipeg Population Health and System Analysis (2004). *Winnipeg Health Region: Community Areas and Neighbourhood Clusters*. Retrieved May 5, 2010, from www.wrha.mb.ca/research/cha/files/Maps_WRHAPopulation06.pdf
- Winnipeg Regional Health Authority. (2007). *Position statement on harm reduction*. Retrieved from http://www.wrha.mb.ca/community/publichealth/cdc/files/HarmReduction_PS.pdf
- Winnipeg Regional Health Authority. (2010). Winnipeg Regional Health Authority. Community Health Assessment 2009/2010. Winnipeg MB: WRHA Research & Evaluation Unit, October 2010. Retrieved from <http://www.wrha.mb.ca/research/cha2009/files/Demographics.pdf>
- Wood, L., Giles-Corti, B., & Bulsara, M. (2005). The pet connection: Pets as a conduit for social capital? *Social Science & Medicine*, 61, 1159–1173. doi:10.1016/j.socscimed.2005.01.017
- Woodward, M., Morrison, C., & McColl, K. (2000). An investigation into factors associated with Helicobacter Pylori infection. *Journal of Clinical Epidemiology*, 53, 175-181. [http://dx.doi.org/10.1016/S0895-4356\(99\)00171-7](http://dx.doi.org/10.1016/S0895-4356(99)00171-7)
- World Health Organization. (2003). *WHO Framework Convention on Tobacco Control*. Retrieved from <http://www.who.int/fctc/en/index.html>

Wrezel, O. (2009). Respiratory infections in the homeless. *UWO Medical Journal*, 78(2), 61-65. [http://dx.doi.org/10.1016/S1473-3099\(01\)00062-7](http://dx.doi.org/10.1016/S1473-3099(01)00062-7)

Yurkovich, E. E., Hopkins (Lattergrass), I., & Rieke, S. (2012). Health-seeking behaviors of Native American Indians with persistent mental illness: Completing the circle. *Archives of Psychiatric Nursing*, 26(2), e1–e11.
<http://dx.doi.org/10.1016/j.apnu.2011.11.002>

Appendix A

Table 1. Summary of literature reviewed on homelessness and tobacco use

Study	Method and study site	Study focus and sample size	Results	Conclusion
Aloot, Vredevoe, & Brecht (1993)	Descriptive Survey; 84-item questionnaire Los Angeles, U.S.A	Evaluation of high risk smoking practices in a homeless population. Convenience sample N= 59 homeless subjects (56 men, 3 women)	Identification of 7 high risk smoking practices: Sharing same cigarette (86.4%), remaking cigarettes using discarded butts (71.2%), smoking discarded butts collected from street & ashtrays (62.7%), using other things other than tobacco (22%), blocking filter vents (23.75), and smoking discarded filters (18.7%). 93.2% of sample engaged in at least one of the smoking practices. 86.4% share cigarettes with other homeless people.	Misuse of tobacco products and alternative smoking methods increase likelihood of infectious disease transmission, & ingestion of toxic substances that potentiates hazards of cigarette smoking.
Apollonio & Malone (2007)	Systematic review of tobacco documents retrieved between December 2003 – December 2004 for time period of 1977-2001.	Describe the Tobacco Industry's goals and influences on homeless and mentally ill smokers, and the organizations to which they receive services.	Tobacco Industry has donated cigarettes to psychiatric, homeless, drug treatment facilities & women's shelters; funded homeless coalitions, volunteered at homeless shelters for presence, and supported homeless veteran groups as allies against indoor air laws.	Challenge service providers on their perceptions of client's readiness to quit. Tobacco control advocates may partner with service groups to educate and replace tobacco industry's involvement and reliance.
Arangua, McCarthy, Moskowitz, Gelberg & Kuo (2007)	Telephone survey of all long term transitional shelters in Los Angeles between March – June 2005.	Examination of long-term transitional shelters' receptivity to tobacco control interventions. 76 transitional shelters met inclusion criteria,	Cites within that 70% homeless adults are smokers; 76% of homeless persons intend to quit within 6 months. Transitional shelters which have an indoor smoking policy (75%), designated smoking areas (78%), 72% overall were receptive to tobacco control, and 95% would participate in a program.	Long term transitional housing service facilities are receptive to/ and recognize importance of intervening on high-risk smoking behaviours. Tobacco control resources must be modified to unique needs of homeless.

Study	Method and study site	Study focus and sample size	Results	Conclusion
		n= 71 participated (93.4%)		
Arnsten, Reid, Bierer & Rigotti (2004)	Structured interview; one year study (March 1996-1997); large Boston teaching hospital.	Describe smoking behaviours in a homeless population. Examine the impact of tobacco-related health problems & drug and alcohol abuse on readiness to quit & interest in counseling. N = 98 (53 outpatients, 45 hospital inpatients)	70% screened positive for depression, 43% reported an alcohol problem, 20% heroin or cocaine problem, high prevalence of medical morbidity (coronary, vascular & pulmonary diseases) & nicotine dependence. Half of sample reported health problems worsening with smoking, 33% indicated readiness to quit, 67% were not planning to quit in the next 6 months.	Self efficacy to quit smoking is higher in homeless smokers whose illness is believed to be tobacco related. Readiness to quit & interest in cessation counseling is connected to having social supports. Study recommends cessation programs to be connected to medical centres.
Butler, Okuyemi, Jean, Nazir, Ahluwalia & Resnicow (2002)	Survey Inner city health centre in a Kansas urban residential neighbourhood Data collected August and December 2000.	Examining smoking characteristics of a homeless population. Convenience sample N= 598 smokers (107 homeless, 491 nonhomeless). African American (59.4% homeless: 85.7% nonhomeless).	Homeless smokers initiate smoking at a younger age compared to nonhomeless smokers (14.2 years of age vs. 15.5), smoke more cigarettes per day (16.4 vs. 13.6), had a higher maximum number of cigarettes smoked per day (45.2 vs 22.8), and have been smoking for longer periods of time (14 years vs 11.7). Homeless smokers have higher Fagerstrom test for Nicotine Dependence (FTND) scores (4.35 vs 3.92), more likely to use recreational drugs. 66% of homeless smokers reported a depressed mood compared to 45% for the nonhomeless sample.	Homeless smokers share and borrow cigarettes from other homeless smokers, less likely to buy menthol cigarettes. Homeless smokers are more nicotine dependent and are less likely to be motivated to quit smoking. Homeless smokers know the risks of smoking and benefits of quitting, and have a moderate interest in cessation programs. Smoking practices of the homeless put them at greater risk for health concerns. Homeless lack regular healthcare and traditional cessation programs are not a fit for this population.
Connor, Cook, Herbert, Stephen, & Williams	Questionnaire 9 temporary shelter sites in city of Pittsburgh	To determine the prevalence of smoking in homeless persons, their readiness to quit,	69% of samples were current smokers and of this 37% were ready to quit smoking within the next 6 months of study. Nicotine replacement is preferred therapy (44%).	Past quit attempts are good indicator for readiness to quit, as well as availability of social supports. Cessation programs should target homeless settings they frequent, like

Study	Method and study site	Study focus and sample size	Results	Conclusion
(2002)	between November – December 1999.	and preference for smoking cessation treatment, N=236 (73% male)	Barriers to quitting included cravings (50%), stress & mood swings (44%), believing no one would support their cessation attempt (26%), and weight gain (20%).	drop in centres, soup kitchens, free care clinics, substance abuse centres and shelters.
Okuyemi, Caldwell, Thomas, Born, Richter, Nollen, Braunstein & Ahlwalia (2006)	Six -90 minute focus groups in November 2003 Six homeless service facilities in the Kansas City metropolitan area (Missouri and Kansas)	Exploration of smoking attitudes & behaviors, psychosocial and environmental influences on smoking, barriers to and interest in quitting, and preferred methods for cessation with some homeless smokers. N=62, 59% African American, (69.4% male).	Smoking prevalence is 70% among homeless smokers, 18.3 cigarettes/day on average smoked. Alternative smoking behaviours apparent. Reasons for smoking: boredom, stress, social acceptance, also combined with drugs & alcohol for a “high”. 76% reported that they planned to quit smoking in the next 6 months. Many interested in using pharmacotherapy in combination with behavioral treatments.	Intrinsic motivation to quit exists, but many psychosocial and environmental barriers are in place that makes quitting difficult. Interventions must be flexible and innovative. Smoking restrictions at homeless shelters are recommended, as well as funding smoking cessation products and programs.
Okuyemi et al. (2006)	Pilot clinical trial Kansas City area	Tested two motivational interviewing treatment approaches with nicotine replacement therapy of patches or lozenges for 8 weeks. N=46	69.6% of participants chose nicotine patches, 32% used 4 patches a week and were more likely to have quit at week 8 than those who used fewer patches (33% vs. 10.5%). Measured carbon monoxide rates show abstinence rates decreasing from 13.04% to 8.70% for the smoking-only group at week 26 follow up.	Findings are significant for future use of NRT and counselling with homeless populations. Cessation programs in underserved populations like the homeless are essential to meeting national health objectives & reducing tobacco – related health disparities.
Spector, Alpert, & Karem-Hage	pilot project of a smoking-cessation	Medical students pilot a smoking-cessation	Out of 11 enrolled subjects, six completed the protocol	Reduction in smoking frequency was significant among the homeless subjects who

Study	Method and study site	Study focus and sample size	Results	Conclusion
(2007)	outreach from January 2004 to October 2005 Michigan, U.S.A.	and tobacco education outreach for the homeless N= 11	and all decreased their smoking frequency. Average smoking rate dropped from 19 to 9 cigarettes / per day. Carbon monoxide mean level decreased from 28.0 to 20.2.	received counseling from medical students.
Bagget & Rigotti (2010)	Secondary analysis of the 2003 Health Care for the Homeless (HCH) User Survey in the U.S.A.	To report on the prevalence and predictors of current cigarette smoking, smoking cessation, and receipt of clinician advice to quit. N=966	Current smoking was 73%, lifetime quit rate among ever smokers was 9%, 54% of past year smokers were given clinician advice to quit. Current smoking related to: out-of-home placement in childhood, victimization while homeless, past-year employment, drug & alcohol use. Multiple homeless episodes had higher odds of receiving quit advice with lower odds of quitting.	Homeless people are far more likely to smoke & less likely to quit, even though more than half of smokers received quit advice in the past year. Interventions for homeless smokers must address comorbidities and vulnerabilities of this population
Shelley, Cantrell, Moon-Howard, Ramjohn, & Vandevanter (2007)	12 week pilot study of a smoking cessation intervention program including CBT + MI + pharmacotherapy. Surveys at the end of 12 weeks and 24 week follow-up. 2 sites in New York City: shelter and transitional residential treatment	To test the viability and effect of a smoking cessation intervention with sheltered homeless smokers N=58, 89.7% male 45% African American	75% of participants completed 12 week surveys (N=44), and 88% of this population completed 24 week. Smoking abstinence rates were 15.5% at 12 weeks & 13.6% at 24 weeks. Drop in cigarettes per day smoked for those who did not quit from 13.1 to 11.4. 66% of participants used pharmacotherapy to quit: 25% used Varenicline, 6.8% Bupropion, 20.5% nicotine patch, 23.6 nicotine inhaler, 13.6 nicotine gum / lozenge.	A combination of NRT with counseling that includes motivational interviewing and cognitive behavioral therapy is successful in decreasing number of cigarettes smoked and actual quit rates among homeless.
Porter, Houston, Anderson, & Maryman (2011)	Washington DC. Community-based participatory research	Homeless populations	Expert panel offers 11 suggestions for future research for tobacco use among homeless populations.	Future for policy change and initiatives will be founded on the responses to the 11 recommendations

Appendix B**Faculty of Nursing
University of Manitoba****PARTICIPANTS NEEDED FOR
RESEARCH IN Tobacco Smoking**

Looking for participants who are:

- ✓ **Male**
- ✓ **Over the age of 18**
- ✓ **Staying overnight in a shelter**
- ✓ **No fixed address**
- ✓ **Alcohol and drug free for the interview**
- ✓ **A current smoker**

We are looking for volunteers to take part in a study of tobacco smoking and homelessness.

As a participant in this study, you would be asked to: *Participate in an interview to discuss the meaning of tobacco smoking in your life.*

Your participation would involve giving 30-60 minutes of your time to talk with me.

In appreciation for your time, you will receive *a gift card for your participation.*

For more information about this study, or to volunteer for this study, please contact: *Michelle*
Faculty of Nursing

This study has been reviewed by, and received ethics clearance through, Education and Nursing Research Ethics Board, University of Manitoba.

Appendix C

Smoking Questionnaire

Thank-you for agreeing to participate in this study, I am interested in talking with you about your experiences with tobacco use. There are five questions I hope to explore with you. Please note there are no right or wrong answers only your perspectives. If you have any questions of me, at any time, please simply let me know. Do you have any questions now? If there are no further questions let's begin:

Q1. Please tell me about a typical day and how smoking is part of your day?

1. What is a typical day of smoking look like for you?
2. Which cigarette is the most important to you? Why is this one the most important or enjoyable?
If first thing in the morning, do you prepare the night before?
3. How many cigarettes do you smoke per day?
4. When do you smoke?
5. Where do you like to smoke? Are there places that are better than others?
6. Who do you smoke with?
7. Tell me what smoking a cigarette does for you? Why is this important?
8. Can you imagine your life without tobacco? What would that be like?

Q2. How do you get your tobacco/cigarettes?

1. How much money do you spend on smokes in a month?
2. How does your smoking change when you have money? Do you buy a single cigarette or "loosie" or do you buy a pack of smokes or a pack of loose tobacco and rolling papers?
3. What are the different ways you get smokes?
4. How do you plan your day around cigarettes?
5. Tell me a story about when you picked up a cigarette butt and smoked it.
6. What happens when you are out of cigarettes? How long have you gone without tobacco and what did you do?
7. Can you tell me what your life would be like if cigarettes were not part of it?

Q3. Can you tell me a story about your first cigarette?

1. Why do you think you had that first cigarette?
2. How old were you when you started smoking?
3. How long has it been since you smoked?

Q4 Now I would like to talk about your earliest memories of tobacco use and smoking

1. What are your earliest memories of tobacco being used in your home with your family?
2. How does traditional and ceremonial smoking fit into your life?
3. "Have you [your family, your tribe] used tobacco for ceremonial or spiritual purposes?"
How often does this occur?
4. What are specific ways in which you use tobacco spiritually?

Q5. Now I would like to talk to you about your health.

1. Where do you get your health information from?
2. What do you know about the hazards of smoking?
3. Do you feel your physical well-being is affected?
4. Do you anticipate health problems related to smoking? _____ yes _____ no.
5. How has smoking affected your health?
6. Does smoking effect your emotions?
7. Is stress related to smoking at all?
8. Have you ever been hospitalized on a Psychiatric ward? Did anyone give you a diagnosis?
What did they say...? Do you or anyone in your family have a mental illness?

Appendix D

Demographics

What year were you born? _____ Age: _____

What is the highest level of education you have completed?

- Did not complete Elementary School
- Did not complete Junior-high School
- Did not complete High School
- Completed High School
- College or Technical Degree/Certificate
- Undergraduate Degree
- Other _____

How long have you been homeless? _____

In the last 30 days where have you been staying overnight?

[Read List. Check all that apply]

- An emergency shelter or hostel
- A rooming/ boarding house
- Church
- A car or other vehicle
- An empty or abandoned building
- A place of business (e.g. all-night Laundromat, restaurant, etc)
- Anywhere outside (e.g. streets, parks, riverbank, bus stop, under bridges, etc)
- A hotel or motel
- Stayed with a friend or a relative
- Hospital
- Psychiatric ward in hospital
- Jail
- Detox / Addictions Centre / GB2 at HSC
- IPDA/ Drunk tank
- Other – specify: _____

SHOW
CARD

What is your current source of income?

- I have a job
- Casual temp work/odd job
- CPP disability
- Social assistance/ Welfare
- Family income
- Workers Compensation
- GST cheques
- Panhandling (asking for money in the street, Squeegee)
- Family members & Relatives/friends
- Sex trade work
- Selling/running drugs
- Boosting/theft
- Recycling (scrap metal and bottles)
- Honourariums for volunteering
- Other _____

SHOW
CARD

How would you describe yourself?

- White/Caucasian
- Latin American / Hispanic
- Black (African American/ African Canadian)
- West Asian (Persian, Arab, Afghan, Iranian, Iraqi, Turkish, etc.)
- Southeast Asian (Cambodian, Filipino, Vietnamese, etc.)
- East Asian (Chinese, Japanese, Korean, Taiwanese, Mongolian, Pacific Islander, etc.)
- South Asian (Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)
- Aboriginal/ First Nation
 - Métis
 - Inuit
 - Status Indian
 - Non-Status
- Other _____

Where do you access your health care?

- Health Access Centre
- Nine Rivers
- Emergency Department
- Regular Doctor
- Siloam Mission
- Walk in Clinics
- Don't Access Care
- In Jail

Appendix E



UNIVERSITY | Ethics
OF MANITOBA | Office of the Vice-President (Research)

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www.umanitoba.ca/research

APPROVAL CERTIFICATE

August 25, 2011

TO: Michelle Bobowski
Principal Investigator

FROM: Stan Straw, Chair 
Education/Nursing Research/Ethics Board (ENREB)

Re: Protocol #E2011:053
“Tobacco Roads: An Exploration of the Meaning and Situatedness of Smoking among Homeless Adult Males in Winnipeg”

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.
- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba Ethics of Research Involving Humans.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) in order to be in compliance with Tri-Council Guidelines.