Upstream from Vulnerable. Denial by Design.

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I was pleasantly surprised when I was asked to speak to you today about vulnerable populations and in particular because I was asked to discuss the role of advocacy with vulnerable populations.

My reaction was one of surprise because in recent years my experience has been that advocacy has become a dirty word – a dangerous word.

Why is advocacy a dirty word and activism even dirtier?

I'd like to begin by saying a few things about that question. You may all be here today, eager and prepared to hear and talk about advocacy, but in the day-to-day front line work of many nurses, social workers, outreach workers – it is frowned upon and forbidden. Many of my colleagues who are vocal, visible and speaking out on the issues of housing and homelessness do so in their spare time, or when it can be squeezed between what are deemed to be higher and more important priorities.

In recent years I have witnessed advocacy treated as a sensitive subject.

I am often asked to speak to very diverse groups about homelessness and housing. When I describe what I might speak about I sometimes mention the words advocacy and lobbying. Often there is silence. Or a quick response which may include: "***we can't do that!***" or "***that's not in our mandate***!" or "***that's not the function of our board!***" or ***"we have a committee that will have to***

go to!" or a worker says "***I've been told I can't speak about that***!" or an Executive Director might say "***that's the job of our Board, not staff***!"

I have to confess that I too became sensitive around this question of advocacy.

Not long ago, a reporter asked me "***how much of your work is activism?***" I cringed and cautiously replied (thinking of my employer): "***all of my work is nursing – you can call it what you want – but it's nursing***."

I really felt as if I was on the defensive. But why? If calling for housing, so that I don't have to treat people on the streets any longer is activism – well so be it, but it's also health promotion, healthy public policy work, a logical response to what I was seeing, and surely the decent thing to do! There's certainly a strong tradition in nursing history to do that very thing.

I tried to enlighten the reporter on examples of nursing advocacy to justify what I do.

I told her the story of babies with high lead levels. It was a nurse, playing detective (i.e. looking upstream) that identified that parts in the kettle were contaminating the water boiled for the babies'

formula. Once identified that was the end of that problem. Those kettles were taken off the market.

Was that advocacy? Activism?

I told her about the Street Nurses who were concerned about the lack of shelters, the conditions in the shelters and the impact the Norwalk Virus, TB, SARS would have – wasn't it right for them to speak out? To advocate for improved conditions through attending marches, by visiting the Coroner's office on New Year's Eve, after another TB death and another street death of a homeless person – to demand an inquest?

Was that advocacy? Activism?

I told her about the nurses that provided support and health care at Tent City – providing what can only be compared to refugee camp work. In this case the nurses were supporting civil disobedience and in some cases engaging in it by bringing in toilets, surreptiously checking the safety of the running water, and bringing houses onto private property without permission. ***Was that advocacy? Activism?***

You may wonder why I was feeling defensive or nervous about advocacy.

You may be surprised to know that I walked a tightrope in my job for a number of years. While on one hand I was receiving letters and calls from the Minister of Health congratulating me on something or other, managers were directing me to not speak out (i.e. to not tell the truth) about things I was seeing that impacted on health, to not attend certain work related events – even memorials for my patients and community members who had died.

The day that my manager told me that Adam Vaughan from CITY TV was not allowed to enter my worksite – even to wait for me to do an interview off site caused me serious concern. The day that I was forced to do a media interview in the dark in a reporter's parked car on a side street, instead of in my office, on a very innocuous subject was the day that I knew I was in serious trouble as a nurse in this province if I was to remain truthful as a nursing advocate.

When I think of advocacy I can think of 2 ways we can do that work.

First. We can work as hard as we can to ensure that people obtain entitlement to deserved resources, and we can call for additional, improved and accessible resources. This is often referred to as

consumer or individual advocacy. What will this accomplish? Well, entitlements for sure (maybe an ODSP application approved), better health, less worry and stress, hopefully, a more comfortable existence for the individual or family. Traditionally this type of advocacy is sanctioned by employers and expected by funders. However, I should caution that there is a dangerous trend to redefine who can obtain such services, who can be a client and for how long, and limits and policies are created to restrict access by clients to advocacy services. A soft description of this direction would be to call it “rationing of services”. I would call it “exclusion by design”. An example would be a decision to tell a homeless person with a health card that they should get a family doctor, instead of accessing the community health centre. Another example would be to tell that person they could only sit in the lobby for 30 minutes.

Second. We can insist and work towards systematic policy changes that impact on a greater number of people. This is often called healthy public policy work or social justice work, or work on the social determinants of health. This is the kind of advocacy most employers, managers and Boards don’t like and it is also the kind that is rarely taught in social service and health curriculum.

Both types of advocacy are necessary. Different situations necessitate different forms of advocacy. It is necessary and strategic to determine which is most useful in the circumstance.

Advocacy can be polite - relying on phone calls, letters, referrals or it can be more colourful, or “in – the face”, leaking information or film footage or pictures to a friendly reporter, holding a press conference, contacting an ombudsperson, visiting a local city councilor, or taking a “delegation” of flying squad members to the local welfare or immigration office.

Let me give you a few examples where the latter style was necessary. In fact, the latter type is increasingly necessary and that’s what I’ll primarily address today.

First example: Amanda

This is an example of using contacts, being persistent and knowing that the bureaucracy and activists do not always have to say no.

A single mom who was a woman of colour, 8 months pregnant and with 2 children was in the process of being evicted by a prominent social housing provider. Amanda contacted just about everyone

under the sun – the community legal clinic, also an eviction specialty clinic, her community health centre, several prominent anti-poverty groups, housing advocacy workers, even CITY TV and the Toronto Star. Just about everyone told her there was nothing they could do to stop the eviction. Finally a handful of University of Toronto students, (who were sleeping in Allan Gardens every Friday night protesting the shortage of shelter beds), took up her cause. At the time, I thought they didn't have much hope. They began phoning everybody again on her behalf and they organized a press conference. They contacted sympathetic media. On the day the sheriff's notice was delivered they called me and a union leader in a panic. We called media and met her outside her apartment building on the sidewalk. It was a pretty compelling scene. I thought to myself, what on earth could we do? Well, we decided to get in cars and we all went down to City Hall to Jack Layton's office and because we were there – we were a bit of a scene. Within hours and over the weekend special things happened. We were told the eviction could not be stopped – because there were legal grounds that could not be fought – and we had suspected that, but our and her bottom line position was an 8 month pregnant woman with 2 kids was not going to end up homeless and in a shelter. City Hall was able to fast track her into housing and a month later she had her baby.

Another example. Tent City.
This is an example about witnessing, speaking out, providing logistical and practical support, using whatever our expertise might be – all practical applications of advocacy.

Tent City was the largest and longest standing encampment of homeless people. It grew from a few people in tents to somewhere between 120 – 140 men and women, 14 dogs and a few cats. Over 50 shacks (no tents) including a sampling of pre-fabs and trailers, a source for running water, 6 portable toilets, a permanent shower stall, wood stoves installed in all suitable houses and portable showers.

It was the longest act of civil disobedience by homeless people in this country's history – illegally squatting on private land owned by Home Depot on Toronto's waterfront.

I tell you this story because it involved the most intense work by more than 6 core homeless agencies plus the Toronto Disaster Relief Committee. It led to concrete support of a community allowing it to survive. Its survival meant the people's survival. It had a rough ending – with the notorious and brutal eviction by a private security

company hired by Home Depot and Toronto Police. But it also had a happy ending - the win of the historic rent supplement program. 100 people are now in housing and certainly the better for it.

An example in progress: pesticide use – Lindane

Despite medical evidence that Lindane is harmful, neurotoxic and contraindicated for numerous conditions that homeless people have it continues to be used in downtown Toronto at the Harrison Baths in a delousing program operated by a joint partnership of the CCAC, City of Toronto, Queen West CHC and St. Michael's Hospital. Despite numerous requests for a meeting, for an explanation and for its' removal Lindane persists to be used. Hopefully support from the environmental movement and some other creative strategies, which I won't go into, will ensure Lindane's removal in our pesticide free lawned City.

I called my talk today "Upstream from Vulnerable – Denial by Design". I'd like you to think of this as a quaint place – you know Upstream from Vulnerable. Maybe like Mystic River or Fargo ……I'd like you to think of it as a place because we have to go there.

We've always had individuals and populations who are vulnerable. (Slides accompanied this)

I speak mostly about homeless people but within that group are people vulnerable because of age, disability, race or cultural background, status in the country, cognitive ability, etc.

To a certain extent there likely will always be vulnerable populations in our western culture.

What is distinctly different today is the purposeful and intentional collection of forces, policies and practices that create vulnerability. For example, in 1995-1996 I believe the numbers of people forced to use drop-in centres for food and to rely on emergency shelters doubled. We all saw it – people who had faced job loss, economic evictions and the welfare cuts who were suddenly homeless and who never thought they would end up there.

We have witnessed a number of practices that have worsened or created vulnerable populations:

- amalgamation
- downloading which led to social chaos
- hospital closures and mergers
- welfare rate cuts and workfare

- tighter eligibility criteria for ODSP – in fact what almost seemed to be an automatic first application denial, tighter ID criteria since September 11
- cancellation of not just the federal but also the provincial affordable housing programs
- delisting of services
- restructuring and rationing of services
- redefining of services such as the increased reliance on policing and security to deal with social issues (for eg. the lack of supportive housing for people with mental health issues – this is nicely shown in the Laura Sky movie Crisis Call)
- the recent OHIP premium which is really a regressive surtax on the middle income earners
- corporate tax cuts

This was really war waged on the majority of the population. The Harris years, the Lastman years, the Eves years, (I could name a few more but will leave that to your imagination) did a lot to stifle critical thinking, critical actions, witnessing, truth telling, and constituent advocacy – all of which I'm sure Jane Jacobs would say are essential to the health and life of a community.

In a healthy community advocacy promotes the

values of social justice and human rights – it is not penalized or prohibited – it is rewarded.

Individual and systemic advocacy are tools for social action – that's activism.

Yet advocacy can be seen as dangerous, or contrary to the interests of those in power. This is probably most exemplified by the example of Karen Silkwood who discovered health hazards at one of Kerr-McGee's nuclear materials plants. When management tried to conceal the facts, she was forced to go outside the plant to union and government officials for help.

The nurses who spoke out about the high number of pediatric cardiac deaths at a Winnipeg hospital were also brave whistleblowers. There are now numerous examples of whistle blowing clauses in health care practitioner labour contracts.

But closer to home on a simpler but perhaps more dangerous level – higher powers have silenced some of our finest workers and agencies. And it happened after Mike Harris was elected. And it was worsened because our social movements were not strong, our analysis was not strong, and our workers were fatigued. They suffered increasingly from depression, illness, other aspects of vicarious

trauma as a result of the workload they were expected to uphold, and because of the trauma they were expected to witness and stay silent about.

As a nurse with a number of years of practical and theoretical experience I know that public policy affects people's health. The injuries I see are quite simply caused or exacerbated by homelessness and for me they are almost impossible to resolve without dealing with the housing question. Yet for many people and groups who speak out for housing issues we see a labeling or a marginalization of that work.

So we must be diligent and continue to ask why is the work of health promotion or advocacy now seen as controversial? Why is there frequently a time allotment to workers determining how much of this type of work they can do? Why do organizations attempt to conceal their advocacy work or relegate it to the Board or a Board committee rather than honour and support it?

Never has it been more necessary to embrace advocacy and never has it been more critical to develop new and creative ways to do the advocacy. Although there are obviously sympathetic politicians, bureaucrats and decision makers, even they work in a milieu that is shifting towards privatization, maximum profit, costs versus life, and heavily

influenced by polls. People who are poor are increasingly marginalized and stigmatized. That translates into prejudice, hate crimes, and hate legislation.

In order to advocate for our vulnerable populations it is essential that we wake up from the political nightmare of the last 9 years and exorcize the damage that has left so many people incapacitated, including workers, including nurses. That is an enormous task that I urge you to individually or with colleagues contemplate further.

It is so important that you are each here today and at the core of what each of you do when you leave here you hold onto the belief that Canadians deserve adequate housing, employment opportunities, adequate incomes, food – more importantly that you can have something to do with making that happen.

During the next 5 weeks you will each have a chance to say to men and women knocking at your door “I’m going to vote for housing. Should I vote for you?”

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