The 'high-risk youth' label: A constructive critique

By

Alexander Clive Oliphant Makin

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In the current study I explore the 'high-risk youth' label and why and how it is applied to young people in relation to community supports and service providers. Particularly, implications of this label are examined by detailing The Centre, a youth outreach, as an alternative to conventional approaches from community supports and service providers towards meeting the health needs of young people. The Centre is a pseudonym. Using a youth engagement model as an approach to harm reduction, The Centre appointed two experienced service users in leadership positions as peers to contribute towards developing programmes and delivering services.

Collaborating with both peers at The Centre, the following research questions were explored: a) What do the peers understand as "good health"?; and, b) What do the peers identify and describe as barriers to attaining what they understand as "good health". With the use of Photovoice, a Participatory Action Research (PAR) method, the peers answer these questions by identifying and describing multiple themes through discussions of often complex and intersecting realities in regards to what they voice as their own health needs. By presenting the peers voice as captured through discussion, I provide an explanation for social exclusion from processes that define them and their needs as a fundamental determinant of health.
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A POEM

Young people labelled and cast aside
Necessitates their withdrawal into the informal
Refusing to obey hegemonic rules that are applied
Rooftops and dark alleyways become normal

Present in the shadows above and below
Subtle and overt the majority passes judgment
Produced through neglect and the status quo
Stability remains forever distant

Socially excluded and dislocated
Time is the greatest adversary
When struggling to escape internalized hatred
Strength is a necessity

Reluctantly asked for opinions and considered thoughtless
Still they negotiate and redefine dominant meanings
Forced to embody a certain coarseness
They rally against conventional teachings

Simply encouraged to fear them
Acceptance might make a difference
But it is all too easy to condemn
When underlying all evil is ignorance

Be warned as it is a mistake to pity
Such is life for the deviant
Coming together towards unique unity
Perhaps they are truly resilient
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CHAPTER ONE

INTRODUCTION

In the past, I have held several service provider positions with different community supports. These community supports included an outdoor learning centre, a needle exchange service, infection and treatment organization, and health outreach project. Within their often diverse mandates, the community supports were to meet the health needs of young people labelled 'high-risk youth'. Young people who are labelled 'high-risk youth' regularly share some or all of the following attributes: struggle with authority; suffer from mental illness; cannot identify a healthy adult in their lives; come from economically poor families; are homeless; without work; have dropped out of school; and, are involved with child welfare or the juvenile justice system (Smyth & Eaton-Erickson, 2009). Such unstable conditions are believed to increase the likelihood of young people engaging in behaviours or activities that are commonly considered unhealthy. Behaviours and activities that are commonly considered unhealthy in relation to the 'high-risk youth' label include: drug and alcohol use; smoking; being sexually active at an early age; homelessness; and, receiving tattoos outside of professional shops (Ungar, 2004). My interactions with young people labelled 'high-risk youth' was as a first level contact and service provider.

Continuing my interactions with young people labelled 'high-risk youth' as a service provider I became increasingly critical of the community supports with mandates to meet their health needs. Although each of the community supports had a unique approach towards meeting the health needs of young people, it seemed that they were always determined by service
providers alone. Indeed, besides the occasional feedback form, young people labelled 'high-risk youth' were not invited or brought into any dialogue to reflect upon and voice their own health needs. Recognizing this, I decided to further explore and critique these relationships between those labelled 'high-risk youth', community supports, and service providers, with an intention to concentrate on the voice of young people themselves.

**Contextualizing the study**

Having already begun graduate school I came across a report concentrating on Hepatitis C prevention and young people labelled 'high-risk youth'. Within the report a question was presented which asked the young people to voice what they themselves thought would enable their health needs to be met. Such a question, in and of itself, seemed to be an acknowledgment by the community supports themselves that the service providers were not meeting the health needs of these young people. When asked what would enable their health needs to be met, many of the young people requested that a place be created where they could drop in, relax, receive harm reduction services, and contribute towards programme development. In response, funding was applied for through the Public Health Agency of Canada and a specific youth outreach, The Centre, was created. The Centre is a pseudonym. I have either changed or removed all names that might identify real places in both the text and my references to assist in maintaining anonymity.

After learning about The Centre I arranged to meet with the coordinator referred to as the youth engagement worker. When I arrived, two young people in leadership positions as peers were present. Both the youth engagement worker and the peers explained the process through which young people as service users are involved within a harm reduction approach that
functions to determine and meet their own health needs. This process is known as the youth engagement model.

I met again with the youth engagement worker and the peers to discuss combining Participatory Action Research (PAR) with The Centre and its model. PAR, I explained, incorporates participants in the development of study questions and the research design. By doing so, it attempts to overcome some of the power imbalance inherent within the typical researcher and participant relationship. The youth engagement worker and peers felt that PAR paralleled The Centre and its model that involves young people as service users in determining and meeting their own health needs. Together, the peers and I then collaborated to develop study questions and a research design that would contribute towards programme development at The Centre.

**Purpose**

I begin the current study by asking why and how the 'high-risk youth' label is applied to young people in relation to community supports and service providers. More particularly, I explore the implications of this label for young people by detailing The Centre, a youth outreach, as an alternative to conventional approaches from community supports and service providers towards meeting their health needs. Using a youth engagement model as a harm reduction approach, The Centre appointed two young people who are service users into leadership positions as peers to contribute towards programme development. Collaborating with both peers at The Centre, the following research questions were established:

1. What do the peers understand as "good health"?
2. What do the peers identify and describe as barriers to attaining what they understand as "good health"?

Answers to the above research questions are necessary for determining what young people labelled 'high-risk youth', such as the peers, voice as their needs in relation to community supports and service providers through which a dominant notion of "good health" is constructed. Using the PAR method, Photovoice, whereby photographs are taken for reflection and discussion, further depth is added to what both peers voice regarding understanding, identification, and description of their own health needs.

**Rationale**

Community supports deliver multiple services through service providers, such as I was, designed to meet the health needs of young people labelled 'high-risk youth'. Arguably, however, young people labelled 'high-risk youth' are not so much in need of community supports and service providers as their provision is typically and currently constituted. Rather, it may be that community supports, service providers, and society itself should better understand what young people labelled 'high-risk youth' believe themselves to need in order to take control of attaining their own "good health". As a general principle in support of this approach, it is clear that all young people labelled 'high-risk youth' are members of society and have come to exist, just as I have, from their interactions with it. Considered a social problem, rarely are community supports and service providers critiqued as the potential issues of concern. Within the current study, it is my intention to enable the voice of young people labelled 'high-risk youth' to be shared regarding how they understand, identify, and describe their own health needs, thereby constituting a critique of community supports, service providers, and society itself.
Building the case

Underlying the 'high-risk youth' label there are assumptions that all of the young people onto who it is applied were abused and come from poor households. Rather than abuse or poverty, Alexander (2001) suggests that the common precursor amongst young people labelled 'high-risk youth' is a loss of social integration into culture and community, characterized by exclusion. In this study, the inclusion of young people labelled 'high-risk youth' is prioritized as they voice what they determine to be their own health needs. The health needs determined by the young people often counter what community supports and service providers conventionally associate with those labelled 'high-risk youth' and use to inform how they are approached. As indicated by the young people who are participants in the study, there are many interesting and regularly opposing perspectives regarding how "good health" is understood and what related barriers are identified and described by them compared with approaches from community supports and service providers. By presenting these opposing perspectives, I advocate for a fundamental shift whereby the inclusion of young people labelled 'high-risk youth' is actualized in regards to both determining and meeting what they understand, identify, and describe as their own health needs. Enabling young people to share their voice regarding what they understand, identify, and describe as their own health needs is the necessary antecedent for a dialogue that may contribute towards such a fundamental shift.
CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Introduction

Providing a theoretical foundation for later analysis, in the chapter I present my conceptual framework to the argument that young people labelled 'high-risk youth' should be included in determining and meeting their own health needs. The 'high-risk youth' label is applied to young people deemed deviant by educational, medical, and legal community supports. Subjecting these young people to a variety of corrective attempts, together such community supports constitute what is the conventional and comprehensive response towards deviance. Positioned between an examination of dominant social norms and deviance, this chapter uses Foucauldian critical theory to explore further the comprehensive response that through exclusionary processes produce deviant young people labelled 'high-risk youth', their subsequent resistance, and hence potential for harm reduction as a compassionate and politicized alternative. Finally, I present the research site, The Centre, whose youth engagement model as a harm reduction approach provides an opportunity for collaborative social research that further advocates for the inclusion of young people deemed deviant in determining and meeting their own health needs. Based on literature reviewed for the current study, I have organized the chapter into five interrelated and intersecting subsections: a) Labelling the deviant; b) Forming a comprehensive response; c) Recognizing a social product; d) Appropriation of the harm reduction movement; and, e) The Centre.
Labelling the deviant

In *Discipline and Punish* (1977) Foucault describes how contemporary society emerged as a system of disciplinary power replacing sovereign rule that operated locally on individual bodies. For Foucault (1978), disciplinary power, acting directly on individual bodies, is present and discursive, coming from all levels. Disciplinary power is not inherently repressive, however, but productive, creating the dominant social norms to which individual bodies are trained to conform (Foucault, 1978). Conformity with dominant social norms is achieved when individual bodies have been trained to an extent of docility. According to Foucault (1977), "docile" bodies are obedient and, have economic utility by virtue of contributing as healthy and productive bodies; or if not, may be analyzed, subjected, shaped, transformed, and improved (p. 138). The "deviant", conversely represents a refusal towards docility, departing from dominant social norms and is thereby considered unhealthy (Dollimore, 1986, p. 179).

Foucault (1977) discusses how there is an inherent desire to know the deviant in relation to docile bodies. In response, conceptual boxes are constructed into which the deviant is placed and labelled within expansive categories of pathological knowledge constituting what Foucault (1977) describes as a "case" (p. 191). The 'high-risk youth' label is one example of a case, applied to young people who because of their departure from dominant social norms, are deemed different, apart, worth fearing, and ultimately unhealthy. As a case, the 'high-risk youth' label provides detailed records or fields of documentation for constant comparison with docile bodies (Foucault, 1977). Consisting of records and documentation, this information is present within what Foucault (1977) refers to as three "disciplinary institutions" or community supports including the educational, medical, and legal (Foucault, 1977, p. 183). Each of these community supports has its unique structure as practices and service providers, but is responsible for
regulating dominant social norms and responding to deviance. It is within each of the community supports where discipline may be performed to create docile bodies while deviant young people labelled 'high-risk youth' are identified, monitored, and corrected.

**Educational community supports.** Consisting primarily of schools, educational community supports, Illich (1970) believes, are the first and most important organized exposure where young people encounter dominant norms. Illich (1970) explains how modern schools, comprised of various service providers including educational assistants, teachers, guidance counsellors, and principals, originated during the industrial revolution and are modeled after factories in both aesthetics and operation.

When entering schools, young people have all sorts of different personalities, interests, and backgrounds, but are released with an expectation that they must all be the same, conforming with dominant social norms as docile bodies (Gatto, 2010). Similarly, Willis (1977) explains that schools were assigned the responsibility of reproducing labour power and economic utility by subjecting young people to a mandatory indoctrination process. This indoctrination process in schools contributes significantly to the training of docile bodies functioning through what Illich (1970) describes as custodial care, the overt and hidden curriculum with regard to teaching and learning, and social processes of sorting and selecting.

Custodial care refers to how young people must attend school for an extended period of compulsory and involuntary confinement (Illich, 1970). During this period young people have their movements, thoughts, actions, and time, controlled through the systematization of daily life (Gatto, 2010). The apparent necessity for control derives from the construction of adolescents as a danger to themselves, others, and society in its entirety (Gatto, 2010; Lesko, 2001; Willis,
1977). It is within schools, and the attendant processes of teaching and learning, that young people, occupying a supposedly dangerous irrational state of human growth as adolescents, are restricted to those experiences considered most important for becoming socially manageable and obedient; in short docile bodies.

Regarding the curriculum, Illich (1970) discusses teaching and learning as both overt in its ordinary sense while also consisting of an influential hidden component. The overt curriculum consists of a prepackaged compilation of teaching disciplines such as Mathematics, Science, English Literature, Social Sciences, and the Arts (Gatto, 2010). Understanding the double meaning of the word "discipline", it is teaching disciplines such as these that in essence act to regulate and control young people. While responsibility for educating young people as critical thinkers is assumed, because learning about oneself, others, and nature is dependent on a prepackaged process, the overt curriculum, with its teaching disciplines instead function to create docile bodies (Foucault, 1977; Illich, 1970). Freire (1970) describes the overt curriculum as analogous to a banking concept of education that "attempts to control thinking and action", whereby young people, assumed empty, are transformed simply into receiving vessels (p. 77).

Conversely, the hidden curriculum is more typically embedded in the "casual" processes of schooling, such as bells signaling particular movements, bathroom passes to control bodies, and standardized school day length regarding attendance time ignoring the particular social and cultural circumstances of young people (Illich, 1970). Beneath the surface of these associations are moral instructions regarding appropriate conduct for young people separating rights from wrongs and learning to accept the teacher as expert. As Gatto (2010) explains, the hidden curriculum simply trains habits that are consistent with conformity and young people becoming docile bodies.
Pairing the overt and hidden curriculum together, Illich (1970) proposes how such constructs teach the need to be taught and implies that only learning that occurs within schools is valid. This is accompanied by the idea that schools enable all young people to attain equal outcomes. Consequently, as Willis (1977) demonstrates, when equal outcomes are not attained, young people perceive failure in terms only of their own shortcomings; leaving the perception that schools never fail young people. Instead, young people when in schools may only fail themselves. Once this lesson is learned, Illich (1970) argues, young people "lose their incentive to grow in independence" (p. 47). After young people have had their minds formed by curricular instruction, both the overt and hidden curriculum, they become conditioned to institutional and the planning of every sort as docile bodies (Foucault, 1977; Gatto, 2010).

Finally, with regard to, the processes of sorting and selecting, schools organize young people at the very least by assigning them to specific grade levels in accordance with their age and their corresponding ability (Illich, 1970). At each grade level young people are constantly assessed using both informal observation and formal examination on the basis of arbitrary standards (Gatto, 2010; Willis, 1977). These standards are used to separate young people into "ability" categories dependent on whether they are below, meet, or surpass the conduct necessary for becoming docile bodies (Illich, 1970).

Young people who conform with the processes of custodial care, teaching and learning, and sorting and selecting, receive good grades, staff support, and simply feel as though they fit in and are considered to be both normal and healthy (Illich, 1970). Those who do not conform to these processes, however, are identified as deviant. As a particular label attached to the deviant, 'high-risk youth' are nonconforming young people considered potentially incapable of completing high school education (Ungar, 2004; Wishart, Taylor, & Shultz, 2006). Not
performing within grade level standards, disrupting classroom activity, having previous histories of dropping out, or regular absenteeism, are all characteristics associated with the 'high-risk youth' label in schools (Ungar, 2004).

Once identified as 'high-risk youth', young people are closely monitored and subjected to a variety of corrective attempts from schools. Each of these corrective attempts functions to devalue young people labelled 'high-risk youth' portraying them as unintelligent, troublemakers, and unhealthy (Gatto, 2010; Wishart et al. 2006). Corrective attempts might include minor deprivations and humiliations, planned contact with parents or guardians, additional instruction, placement into alternative classroom or school settings, and suspension (Gatto, 2010; Illich, 1970). Ungar (2004) explains how only as a last resort are young people labelled 'high-risk youth' expelled from schools entirely. This is because, as Foucault (1977) explains, when removed from disciplinary institutions or community supports including schools, the deviant may no longer be subjected to corrective attempts thought necessary for conformity. While the conformity of young people as docile bodies is the primary objective, not all may be allowed to succeed in schools. Failure is thereby created in school, establishing a hierarchy of identity and assigning social positions to young people that have considerable influence on their future, often reinforcing inequalities (Gatto, 2010; Willis, 1977). For Illich (1970), schools thereby officially and successfully "combine prejudice with discrimination" (p. 11).

**Medical community supports.** Consisting of hospitals, clinics, and social services, medical community supports contribute to the construction and maintenance of health. Health, Foucault (1973) explains, is closely related to dominant social norms and docile bodies regarding
the importance of economic utility. Beyond minimum measures of economic utility, however, constructions of health by medical community supports become subjective.

For Foucault (1973), medical supports, designating normal healthy docile bodies as distinct from abnormal and unhealthy ones, consider those who do not meet minimum measures of economic utility to be deviant. As described by Foucault (1973), the deviant is considered a "double burden" (p. 20). This is because they are unable to provide for themselves and others, and require a corrective attempt in the form of treatment from medical community supports.

Historically the prescription and provision of treatment for the deviant has been conducted within hospitals (Mills, 1997). Increasingly, however, treatment has shifted to clinics, including pharmacies, street health centres and other social services and community supports (Foucault, 1973). This has given rise to service providers such as pharmacists and community health nurses. Depending on how the deviant departs from minimum measures of health then, it could be pharmacists, nurses, and doctors within various medical community supports that identify, prescribe, and organize treatment (Foucault, 1973).

According to Foucault (1973), organization of treatment is embedded within a medical esotericism that identifies signs, considered both objective and true, from the knowledgeable service provider down towards an ignorant and unhealthy deviant. Various signs are used within medical supports to identify and label deviant young people as 'high-risk youth'. For instance, the 'high-risk youth' label may be applied if young people physically harm themselves, are homeless and hungry, have mental health issues, including depression or anxiety, seek to have tattoos or piercings done outside of professional shops, share needles and other drug use equipment, and engage in substance use and abuse (Ungar, 2004). With regards to substance use and abuse, addiction is also regularly associated with the 'high-risk youth' label.
It is not uncommon for medical community supports to require that young people cease any and all behaviours connected with the 'high-risk youth' label before they may be recipient of a treatment response (Maté, 2008). Provision of prescription pills, counselling, referrals for social assistance or housing, and hospitalization accompanied by combinations of such services as treatment plans, are all attempts employed to correct the behaviour of young people labelled 'high-risk youth' (Ungar, 2004).

**Legal community supports.** Police departments, juvenile detention centres, and prisons, are legal community supports functioning to construct and maintain a measure of what constitutes the law abiding and thereby conforming citizen. Obedience to the law is mandated and conveyed as normal, healthy, and an antecedent for docile bodies. Mandated obedience, Foucault (1977) explains, maintains economic utility and functions to diminish deviance.

Within legal supports, the deviant is disobedient, considered a hindrance to both their own economic utility and that of others by refusing docility and modeling disruptive conduct. This disruptive conduct directly opposes the law and is thus subjected to corrective attempts (Dollimore, 1986; Foucault, 1977). In an attempt to correct the deviant, legal community supports respond by removing them from everyday contexts for detention. Though this response further disables economic utility of the deviant, it is seen as necessary to conform them as docile bodies and inhibit their influence on others.

Young people are labelled 'high-risk youth' within legal community supports because they disobey conformity established by the law, engaging in theft, violence, and buying, selling, or using drugs and related equipment (Ungar, 2004). As deviant, these young people represent the potential for ongoing disobedient and disruptive conduct affecting their own economic utility.
and that of others. Identifying, monitoring, and attempting to correct deviance amongst young people then is an important responsibility for legal community supports (Foucault, 1977). Specifically, it is the police, parole officers, and judges as service providers within legal community supports that have this responsibility.

For those labelled 'high-risk youth', legal community supports and their affiliated service providers attempt to correct them by enforcing a period of community service or imprisonment within juvenile detention centres (Ungar, 2004). Accompanying such corrective attempts, Foucault (1977) explains, is an ongoing reminder that if the deviant continues to disobey, extended periods of imprisonment await. This reminder, in and of itself, is a component of the attempt to correct the deviant.

**Forming a comprehensive response**

Together, educational, medical, and legal community supports with their different structures as practices and service providers, form a comprehensive response to disciplining docile bodies while identifying, monitoring, and correcting deviant young people labelled 'high-risk youth'. Fundamental to this comprehensive response is what Foucault (1977) describes as the "normalizing gaze" (p. 184).

Using the panopticon as an analogy, Foucault (1977) elaborates on the normalizing gaze. In the panopticon, the cells are built surrounding a large central tower. From the central tower, prison guards are capable of looking and observing each inmate. Each inmate from their cell knows they may be observed, but is unable to determine if and when prison guards are looking upon them. This process itself is described by Foucault (1977) as "the gaze", from the prison guards in their position of power downwards to inmates (p. 195). Judgment, inherent within the
gaze, is internalized by inmates who normalize their conduct thereby conforming to meet prison
guard expectations (Foucault, 1977). Foucault (1977) continues to discuss how an internalized
normalizing gaze creates docile bodies by demanding continuous regulation of the self and
others.

Educational, medical, and legal community supports are "minute social observatories"
functioning to invoke the normalizing gaze (Foucault, 1977, p. 211). In particular, the
normalizing gaze is invoked by service providers who act as "observers" within their respective
community supports (Foucault, 1977, p. 207). Service providers in positions as educational
assistants, teachers, guidance counsellors, principals, nurses, doctors, police, and parole officers,
to name a few, are all observers. Psychologists and social workers may also be observers, who
despite medical origins can specialize within educational or legal supports. Regardless of their
association with educational, medical, and legal community supports, these service providers
represent strategical agents and functionaries recipient of an "institutional ideology" embedded
within community supports (Franklin, 1990, p. 17).

Institutional ideology, Franklin (1990) explains, exists within a variety of "prescription
technologies" that have considerable social and political implications for the practice of service
providers as professionals (p. 17). Prescription technologies reduce the positions of service
providers to discrete, systematized, and regimented stages using language that appears objective,
but is actually thoroughly valenced discrimination (Franklin, 1990). Referencing prescriptive
technologies, Menzies (2005) argues that educational, medical, and legal community supports
which are commonly thought to require nurturing or caring service providers, have been reduced
to preset checklists. These preset checklists do not allow the original thinking amongst service
providers that is needed for genuine and compassionate understanding. As a result, it is difficult for service providers to disassociate from their roles as observers.

Franklin (1990) describes how service providers begin to perceive being externally controlled as normal and necessary. The result is a "culture of compliance" where capacity for critical thought amongst service providers becomes diminished, unable to imagine acting in any way beyond that assigned for them (Franklin, 1990, p 19). Although service providers may be caring adults with good intentions, not only is it difficult for them to envisage other ways of performing their roles, but the culture of compliance also requires that they too conform as observers (Foucault, 1977; Franklin, 1990).

Willis (1977), for instance, describes how service providers who do not conform are also perceived in relation to the deviant. Service providers then are expected to internalize dominant norms and the gaze they invoke, monitor each other, and conduct themselves in accordance with their respective educational, legal, or medical supports. It is only after service providers have internalized dominant social norms themselves, Foucault (1977) explains, that they may accept their responsibility for judging conduct based on what "does not measure up to the rule" (p. 179).

Judgment of conduct by service providers, Foucault (1977) explains, is itself "essentially corrective" (p. 179). Circumscribed further within their responsibility to judge is a system of reward and punishment (Foucault, 1977). This system is established to correct and transform the deviant, including young people labelled 'high-risk youth', into docile bodies. While internalization of dominant social norms is rewarded by praise from service providers and general social acceptance, punishment often consists of exclusion (Foucault, 1977). Willis (1977) identifies how a system of reward and punishment maintains the authority of service providers only when consent is given by those who are subjected to it. It is on the basis of exchange then,
When young people labelled 'high-risk youth' do not conform with dominant social norms they are considered to be disobeying and objecting against the authority of service providers. In response, these young people are relayed upwards to service providers within each of the educational, medical, and legal community supports. Those in positions as service providers, Foucault (1977) explains, are hierarchically ordered within their supports, each having progressively more authority to discipline the deviant. As an example, when teachers, nurses, or parole officers are unable to respond by correcting the deviant 'high-risk youth', they are sent to the next service providers in their respective community supports including principals, doctors, and judges. Education, medical, and legal community supports, Foucault (1977) describes, are also arranged hierarchically with increasing capacity to influence conformity by punishing the deviant. For instance, when young people labelled 'high-risk youth' do not conform within schools they experience a mandatory referral to either medical or legal community supports (Ungar, 2004). Ungar (2004) explains how it is not uncommon for these young people to be passed both within and across educational, medical, and legal community supports depending on how they depart from dominant social norms.

As young people labelled 'high-risk youth' are passed within and across educational, medical, and legal community supports, they often become surrounded by groups of service providers, allowing for "an intense, continuous supervision" (Foucault, 1977 p. 174). Surrounding the deviant with groups of service providers, Foucault (1977) explains, is a further attempt to correct the deviant, for instance young people labelled 'high-risk youth'. Conceived outside the subjective experiences of young people labelled 'high-risk youth' and exercised on
them, such corrective attempts are often generic (Ungar, 2004). In this context, generic refers to a corrective attempt that does not approach young people labelled 'high-risk youth' as individually unique, instead viewing them as the same. Young people labelled 'high-risk youth' are thereby approached objectively, imposing upon them a strict definition of what their health needs are that is synonymous with dominant social norms. Judgment is passed and assumptions are made through which supports stigmatize, stereotype, and most importantly, exclude young people labelled 'high-risk youth', all in an attempt to correct them.

For some young people labelled 'high-risk youth' being stigmatized, stereotyped, and excluded by community supports is serious enough to instigate change on their behalf towards conforming with dominant norms as docile bodies. Not all young people, however, accept this. Rather, it is not uncommon for young people to choose, whenever possible, avoidance, further resisting community supports, the authority of service providers, and conformity with dominant social norms. According to Willis (1977), resistant young people simply say no to dominant social norms and oppressive power. These young people, Ungar (2004) suggests, see such supports for what they are, part of a comprehensive response that devalues their unique experiences, opinions, and contributions towards determining their own health needs through processes which negatively define and label them as unhealthy.

**Recognizing a social product**

There are assumptions underlying a comprehensive response from educational, medical, and legal community supports attempting to correct those young people deemed deviant and labelled 'high-risk youth'. Such assumptions predominantly include the belief that the young people were all abused and come from poor households (Ungar, 2004). Instead of abuse or
poverty, Alexander (2001) suggests that the common precursor amongst young people labelled 'high-risk youth' is "dislocation" from society (p. 12). By dislocation, Alexander (2001) refers to the loss of social integration into culture and community. Dislocation from society often results in a sense of isolation, powerlessness, and most importantly social exclusion (Alexander, 2001). According to Alexander (2001), only "chronically and severely dislocated people are vulnerable to addiction," and other commonly considered unhealthy behaviours and activities associated with the 'high-risk youth' label (p. 12).

Dupont (1997) explains how vast social and economic changes have transformed former community relationships bringing about the exclusion from society of some young people. Some young people have indeed, lost their primary emotional attachment with nurturing adults regardless of whether they were abused or come from loving and financially stable homes (Alexander, 2001; Dupont, 1997). As young people become less connected to adults, they rely more on each other. Neufeld and Maté (2005) describe this process as "peer orientation" (p. 7).

Ungar (2004) explains how young people were never meant to bring one another to maturity and act as a focus of orientation by providing primary nurturing, modeling, cue giving or mentoring. When this happens, Willis (1977) describes how young people deemed deviant, through collective and group negotiation, develop alternative identity constructions in response to feelings of justice for their social exclusion. Young people and their alternative identity constructions form distinct "counter cultures" characterized by withdrawal into informal locations, "just beyond reach of the rule" (Willis, 1977, p. 23). It is within distinct counter cultures that alternative identity constructions are both accepted and further refined by young people as a means to overcome their social exclusion (Ungar, 2004; Willis, 1977).
Young people deemed deviant for behaviours and activities associated with the 'high-risk youth' label, including drug and alcohol use, smoking, receiving tattoos outside of professional shops, early sexual activity, and homelessness, have argued that these significantly contribute to their alternative identity constructions (Ungar, 2004). Such behaviours and activities, Ungar (2004) explains, are closely connected with attaining mental health, providing a sense of meaning, belonging, support, attachment, purpose, opportunities for participation in social action, recreation, pleasure, financial stability, personal confidence, and even basic necessities such as food and shelter. In short, these behaviours and activities, contribute towards alternative identity constructions, providing young people labelled 'high-risk youth' with inclusion and everything else they are deprived of through their exclusion from society.

Instead of recognizing the necessity for understanding and compassion, the ways young people bolster their mental health and empowerment through alternative identity constructions only enhance their exclusion from society, being deemed as deviant, and labelled 'high-risk youth'. For instance, from educational, medical, and legal community supports it is conveyed that they are stupid and "not going anywhere", incapable of making healthy decisions, and a danger to themselves and others (Ungar, 2004). In response, young people labelled 'high-risk youth' adopt negative conceptions of themselves as secondary, inadequate, and incapable of being accepted (Ungar, 2004). As explained by Ungar (2004), such perspectives which correspond to social exclusion and being deemed deviant and labelled 'high-risk youth', deny young people healthy and positive definitions of selfhood.

Discussing labelling theory, Becker (1974) explains that deviance is a consequence of being classified as the deviant. The deviant, then, is produced when those classified as such come to take on traits conforming not with dominant social norms, but their negative label designations
(Becker, 1974; Foucault, 1977). In support of labelling theory, Ungar (2004) explains when young people are labelled 'high-risk youth' for their alternative identity constructions, they further engage in behaviours and activities associated with being classified as the deviant. This, for instance, may result in a romanticization and spiteful engagement in what are commonly considered unhealthy behaviours and activities such as drug and alcohol use, smoking, early sexual activity, tattoos, and living on the street as homeless (Ungar, 2004).

Production of the deviant through social exclusion, Foucault (1977) explains, is necessary for three reasons. First, the deviant is produced to be continuously compared against dominant norms, justifying the condemnation of any departure and thereby reaffirming what is considered "normal" (Foucault, 1977, p. 303). Second, the deviant is produced because only a limited number of opportunities and resources are available in society. Opportunities and resources, Mills (1997) argues, are conveyed as accessible to all if only they conform to dominant social norms. The deviant is produced, Mills (1997) describes, to rationalize social inequality, explaining why some have seemingly unlimited resource access, while others none. Lastly, the deviant is produced to meet the current economic paradigm requirement of inefficiency. All of the educational, medical, and legal community supports that approach the deviant young people labelled 'high-risk youth' together form an industry which creates countless jobs through service provider positions (Wotherspoon & Schissel, 2001). Unfortunately, the more young people there are labelled 'high-risk youth', the larger the economic need becomes for community supports and service providers to approach them (Wotherspoon & Schissel, 2001). Given these reasons, it becomes evident that young people labelled 'high-risk youth' are a symptom of an inherent social requirement to produce the deviant.
Although production of the deviant is a social requirement, Foucault (1977) explains how community supports and service providers must not allow any deviance to remain uncontested. This is because the deviant, when uncontested, represents a significant menace in their resistance to conform with dominant social norms. By resisting conformity with dominant social norms, the deviant is viewed capable of inducing further nonconformity amongst what would otherwise be docile bodies (Foucault, 1977).

Foucault (1977) describes how frustration emerges on behalf of educational, medical, and legal community supports and their respective service providers, unable to comprehend why anyone would not conduct themselves in accordance with dominant social norms. Frustration may result in educational, medical, and legal community supports blaming the deviant. Rarely then, do community supports examine how the deviant might be produced and recognize any contribution they might have in the process. This is because, doing so would mean admitting incompetence on behalf of educational, medical, and legal community supports and thereby warrant significant critique (Foucault, 1977). It is therefore both far easier and safer to blame the deviant and search for and identify another corrective attempt. Just recently the harm reduction movement has been identified and subsequently appropriated by community supports as one such attempt to correct young people labelled 'high-risk youth'.

Appropriation of the harm reduction movement

Harm reduction emerged as a grassroots movement both from and for the deviant, in particular drug users (Keane, 2003). The harm reduction movement was founded by an ideology that prioritized drug users as participants and leaders in designing and delivering programs intended to meet their own health needs (Roe, 2005). Resembling a social and political advance,
the harm reduction movement confronted, exposed, delegitimized, and dismantled the ideology of community supports as exclusive towards drug users (Marlatt, 1998; Roe, 2005).

Assuming a nonjudgmental stance whereby deviant behaviours and activities were considered to be neither right nor wrong, the harm reduction movement sought to remove all judgment between drug users, community supports, and service providers, in favour of establishing authentic relationships based on compassion, trust, acceptance, and mutual respect. Establishing authentic relationships and asking inclusive questions, it was thought, would help bring drug users into a dialogue so that they could voice their own health needs. Such inclusive questions included: What happened?; What is your experience?; How do you perceive your life?, What would benefit you?; What do you determine to be your health needs?; and, How do you want to go about meeting them? (Maté, 2008; Roe, 2005). When asked these questions, some health needs of drug users, related to and extending beyond substance abuse, were determined, including the controlled provision of substances and related materials, education about safe drug and sexual practices, general counselling, legal guidance, shelter, and food (Maté, 2008). In response, the harm reduction movement expanded to include those deemed deviant beyond simply drug users. Those incorporated by the expansion of the harm reduction movement were generally known as service users.

Since its humble emergence, however, the harm reduction movement has been appropriated and subsumed within a conglomerate of educational, medical, and legal community supports described by Roe (2005) as the "public health machine" (p. 243). This public health machine and appropriation of the harm reduction movement represents an extension for controlling service users deemed deviant for refusing corrective attempts from educational, medical, and legal community supports. Appropriation of the harm reduction movement, for
Moffatt (1999), represents a shift from control through overt or coercive power to more seductive techniques that elicit conformity by providing the deviant with agency. It is through the provision of agency, Roe (2005) explains, that the appropriated harm reduction movement functions to "reach the unreachable" (p. 246).

Dean (1999) provides a basis for understanding the appropriated harm reduction movement as a "technology of agency" to reach the deviant (p. 168). As a technology of agency, it establishes specific community supports including 'high-risk youth' centres, safe injection sites, and needle exchanges. These specific community supports convey service users as equal participants and contributors towards determining and meeting their own health needs. Although young people are able to choose whether or not they access such specific community supports, upon doing so service users subject themselves to supervision and control as their participation is reduced to mere "tokenism" (Paterson & Panessa, 2008, p. 24).

Tokenism, as a subtle form of social exclusion, implies that while the language and rhetoric of service users as equal participants is employed, they do not contribute to determining and meeting their own health needs (Paterson & Panessa, 2008; Roe, 2005). Furthermore, though solidarity between service users and providers within community supports is communicated, in reality decisions are made by the latter that is responsible for passing moral judgments based on "scientific assessments of good and bad behaviour" (Roe, 2005, p. 248). Reverting to the exclusive processes that privilege the objective while diminishing subjective experiences of the deviant, the appropriated harm reduction movement is similar to generic corrective attempts from educational, medical, and legal community supports (Roe, 2005). As such, the voice of service users, for instance young people labelled 'high-risk youth', continues to be ignored, seen as false, irrational, and insignificant.
Failure on behalf of the appropriated harm reduction movement to include service users demonstrates both negligence towards processes that produce them and fatalism regarding prospects for broader more structural social change. Keane (2003) argues that by failing to acknowledge the processes that produce service users as deviant and engage in social and political critique, it "avoids confronting the very things that cause the most harm" (231). Roe (2005) further explains how the appropriated harm reduction movement has therefore become just another means to "minimize risk from, and maximize control over, marginal populations", such as those young people labelled 'high-risk youth' (p. 245).

Cheung (2000) describes how the appropriated harm reduction movement avoids larger social and political issues. Instead, a more saleable emphasis on health benefits, savings of money, and material resources is adopted (Cheung, 2000; Keane, 2003). The expansion of community supports, and their oversight and authority, is thereby the immediate and viable solution, simply avoiding the injustice and inequality that they necessitate. Any assertion of initiatives that contradict such oversight and authority, for instance social or political objectives, are considered illegitimate and deviant, thereby excluded by being denied partnerships and resources, most particularly funding.

There are those, however, who continue striving to combine the appropriated harm reduction movement with the revolutionary spirit of its founding ideology. Seeing the importance of determining and meeting health needs of the deviant, as service users, on their own terms, they seek a return to the once more socially and politically active analysis embodied by the harm reduction movement (Keane, 2003; Roe, 2005). For example, politicized service providers, radical academics, student activists, and autonomous drug user unions represent a
diverse array of organizations and groups that recognize the value in reclaiming the harm reduction movement (Roe, 2005).

One endeavour in particular that has received significant acknowledgement is the adoption of peers to contribute towards programme development and service delivery by community supports (Roe, 2005). For Orme and Starkey (1999), peers represent a return to the founding ideology of the harm reduction movement by appointing experienced service users as leaders and equal participants within community supports. As such, the deviant as service user and their lived experience is repositioned as the primary force behind harm reduction programming and delivery. Indeed, mandated inclusion of peers has the potential to combine user friendly approaches and take a position removed from appropriated harm reduction, Roe (2005) explains. Peers allow for harm reduction to be reconceptualized creating fluid, informal spaces where practices can be changed and adapted accommodating the shifting health needs of service users (Allman et al. 2006).

According to Orme and Starkey (1999), the importance of peers within community supports themselves, policy development, program evaluation and research cannot be understated. Young people are described by Checkoway and Gutierrez (2006) as having many unique talents, skills, and assets as peers contributing towards health needs assessment and areas where services should be provided. Moreover, for all those deemed deviant and excluded, including young people labelled 'high-risk youth', having their opinions recognized, appreciated, and used to inform decisions is an irregular yet valuable intrinsic experience (Valente et al. 2007). Indeed, being able to share how they understand, identify, and describe their health needs, often allows feelings of ownership and empowerment (Mitchell, 2006; Wallerstein & Duran,
2006). These feelings of ownership and empowerment can significantly benefit service user confidence, especially as Mitchell (2006) explains, those labelled 'high-risk youth'.

Even though initiatives that involve young people as peers are increasingly being advocated by those critical of the appropriated harm reduction movement, several activists have warned against the potential and tendency for tokenism by community supports (Keane, 2003; Roe, 2005). As Roe (2005) suggests, this potential and tendency for tokenism by community supports must be recognized and consistently assessed.

The Centre

A specialized centre for deviant young people labelled 'high-risk youth' was recently opened. Funded by the Public Health Agency of Canada, The Centre was created in response to a report which found that young people labelled 'high-risk youth' were not accessing community organizations and services because they were afraid of consequences, exposure, and judgment. The Centre conducts its own outreach throughout educational, medical, and legal community supports. Young people might also be referred to The Centre by these different community supports, but many become aware of it and choose to access its services because they recognize a need and use their own initiative.

Created by and for young people, The Centre uses a youth engagement model as an approach to harm reduction. Young people at The Centre communicate their own health needs to a youth engagement worker. The youth engagement worker is a young person themselves, capable of relating and engaging service users. Several young people are also appointed as peers, responsible for ensuring that a valuable dialogue is present between service users and providers at The Centre.
Ungar (2004) describes how young people labelled 'high-risk youth' all have a voice regarding their own health needs, and though not necessarily silenced, they are regularly unheard. The Centre, although remaining within the appropriated harm reduction movement through its affiliation with educational, medical, and legal community supports, utilizes a youth engagement model and appoints service users as peers. In this way, the voice, opinions, and contributions of young people deemed deviant as service users at The Centre are valued in regards to both determining and meeting their own health needs. Collaborating with peers at The Centre represents an important opportunity for social research advocating and further politicizing the voice of young people whom are deemed deviant and labelled 'high-risk youth' in both determining and meeting their own health needs.
CHAPTER THREE

METHODOLOGY

Introduction

The Participatory Action Research (PAR) method Photovoice was used to investigate how service users in positions as peers at a centre for young people labeled 'high-risk youth' understand "good health" and identify and describe related barriers. Photovoice was chosen because it parallels the philosophy of The Centre and its youth engagement model reflecting peers interests in creative and artistic activism. Within this chapter, I will discuss PAR and Photovoice and explain how the peers and myself collaborated to inform both study questions and the research design. In what follows, I provide a detailed description of the methodological procedures.

Research Design

In an attempt to conduct a health study with young people labelled 'high-risk youth' I chose to use PAR. According to Baum, MacDougal, and Smith (2006), PAR is successful in examining social inequity and related health issues. I wanted to use PAR also because it prioritizes local knowledge in needs assessment through the process of reflective inquiry (Minkler, 2000; Smith, 1997).

According to Minkler (2000), reflective inquiry in PAR is directly connected to action for social change, whereby participants develop a critical awareness regarding circumstances and structural conditions that influence their lived experience. Such critical awareness, Baum et al.
(2006) explain, may lead participants to have "increased control over their lives" (p. 854). This potential for participants to have increased control over their lives, Smith (1997) states, makes PAR fundamentally about "personal and social transformation for liberation" (p. 173). PAR, as described by Smith (1997), attempts to:

1. Achieve equitable communities and social contexts.

2. Develop compassionate culture, which involves commitment amongst participants to a shared struggle and the creation of dialogue for an evolving partnership.

3. Relate historical contexts to present structures, believing that individual experiences, values and feelings are vital ways of knowing.

4. Promote collective investigation and action on what participants perceive to be their own needs.

5. Create new knowledge grounded in participant experience.

PAR is conceptualized by Olesen (1994) as a continuum of possible research designs. At one end, participants are involved at a grassroots level in all aspects of defining study questions and the research design (Olesen, 1994). This is founded on the principle that participants themselves are most capable of setting their own agendas about what needs to be researched and how (Maguire, 1987). As central in knowledge making, participants may choose to have a researchers assistance in defining study questions and the research design, but they themselves retain control. Study questions and the research design are defined by participants who share a particular issue rather than that of researchers or alleged experts (Tandon, 1981). On the other end, an agenda and participant involvement emerges from a researcher and his or her particular interests. When participant involvement emerges from a researcher and his or her particular
interests, it is they who maintain control in defining study questions and the research design (Olesen, 1994).

For the current study, participant involvement emerged as a combination between both grassroots and my particular research interests. Both instances, following Tandon (1981), intend to include action in the research design and generate a mutually educative experience where participant and researcher control is shared. Regardless of intent, however, Tandon (1981) argues that when PAR emerges from a researcher there is an inherent power imbalance. I do not deny the presence of this power imbalance, but believe, as Tandon (1981) explains, that sometimes a researcher may provide participants the "external push" necessary to begin addressing an important question or issue (p. 25). An external push can be especially useful, when participants are members of a population that is excluded from society (Tandon, 1981; Ungar, 2004).

**Paralleling a youth engagement model.** Having been informed about The Centre and its model to engage young people in the community, I arranged a meeting with a programme coordinator. When I arrived for my meeting at The Centre, a programme coordinator, referred to as the youth engagement worker, and two service users in positions of peers were present. Together, the youth engagement worker and peers gave me a tour, including all amenities and the service users artwork. On my tour, they explained the youth engagement model at The Centre and its guiding principles, whereby both peers and service users identify their own health needs. Before leaving I asked if we could meet again the following week.

Returning the following week I asked about collaborating with both peers and other service users to define several study questions and a research design. I explained that my intention was for the research to support their youth engagement model and contribute towards
health education programming at The Centre. Subsequently, I discussed PAR and how it could be used to reflect their youth engagement model and also actively address issues in the community. The youth engagement worker and both peers expressed a lot of interest, particularly with regards to addressing community issues. Both peers stated, however, that their condition to being involved in the study was that the research incorporate art in some way.

Over several weeks I went to The Centre during its Friday open hours. During these Fridays I met with the youth engagement worker and peers to define study questions and discuss the research design. Initially, we all met together, but after a while the youth engagement worker encouraged the peers to lead our meetings. This was in keeping with the youth engagement model at The Centre. All of the meetings we had were unorganized. If both peers were present, able and willing, we would have a discussion to define study questions and the research design, otherwise I would simply plan to attend the following week.

It became evident as we met and began defining the potential study questions and research design that the peers wanted to concentrate on health barriers. Concentrating on health barriers, both peers and I agreed, would help contribute ideas whereby educational programming could be improved at The Centre. In particular, the peers explained how they themselves and many other service users have had difficulty overcoming addiction and that this was a constant barrier to health. The peers, however, did not want the study questions to be concentrated only on addiction. Rather, the peers wanted to also describe how other circumstances and issues in their lives have served as health barriers.

After the research focus was decided, I asked the peers if it would be interesting for them and other service users at The Centre to explore what they understand as "good health". What the peers and other service users understand as "good health", I explained, would provide a valuable
basis for identifying and describing related barriers. Using their understanding of good health as a basis for identifying and describing related barriers I felt would also reflect both the youth engagement model at The Centre and PAR. The peers agreed that this would be interesting. Next, I began thinking of a PAR method that could be used to explore health barriers.

One PAR method with which I had become familiar earlier in my graduate studies was Photovoice. Photovoice had interested me because of its emphasis on critical reflection and capacity for participants to express their thoughts and engage the community through the artistic expression of photography. Their personal interest in art I thought would be accurately captured by Photovoice. When I presented it to both peers and the youth engagement worker they all agreed on Photovoice as the research method.

Photovoice. Since its development by Professor Caroline Wang at the University of Michigan, Photovoice has received increased attention as a PAR method in health education and needs assessment (Catalani & Minkler, 2009; Wang, 2006). Photovoice, Wang (1999) explains, is a PAR method intended for empowering members of marginalized groups to identify, represent, and enhance their community through a specific photographic technique. By entrusting cameras to individuals and enabling them as recorders in their community, it uses the immediacy of the visual image for presenting evidence and promoting an effective participatory means of sharing knowledge (Catalani & Minkler, 2009; Wang, Cash, & Powers, 2000). As described by Catalani and Minkler (2009), Photovoice offers a possibility to perceive this "world from the viewpoint of the people who lead lives that are different from those traditionally in control of the means for imagining it" (p. 10). Such a process enables participants to bring explanations, ideas, or stories about their communities and lived experiences into the assessment
process affirming perspectives of marginalized groups in society (Wang, Kun Yi, Wen Tao, & Carovano, 1998). In doing so, Photovoice confronts a basic problem of assessment in that what professionals, researchers, specialists, and outsiders think is important, may completely fail to match that of specific individuals and their communities (Wang, 2006).

**Conceptual development.** Photovoice, as an innovative research method, emerged from "health promotion principles and the theoretical literature on education for critical consciousness, feminist theory, and nontraditional approaches to documentary photography" (Wang, 1999, p. 185).

**Education for critical consciousness.** Education for critical consciousness, developed by Brazilian educator Paulo Freire, promotes improved individual and community quality of life, and policy changes aimed at achieving social equity (Wallerstein & Bernstein, 1988). Wang and Burris (1997) acknowledge that in Freirian terms, one medium that can be used to promote community reflection and reveal everyday social and political realities influencing individual lived experience, is photography. Photographs were seen by Freire (1970) as tools for understanding how messages and meanings associated with them are produced, interpreted, and reinforced. It was not unusual for Freire (1973) to capture photographs portraying what he described as "significant realities" or "coded situation-problems" for individual analysis of social relations within their community (p. 90). Photovoice takes this process of using photographs further, however, transferring responsibility for community portrayal from the educator or researcher to individuals and participants at a grassroots level.
Another Freirean contribution to the Photovoice method is the concept of "problem-posing education" (Freire, 1970, p. 83). For Freire 1970, this functions towards affirming the importance of challenging individuals to identify common themes and engage in a critical dialogue about central community issues. In Photovoice, this concept is situated within a health context whereby individuals are encouraged to critically discuss the social conditions that contribute towards or detract from their personal and community wellbeing (Wallerstein & Bernstein, 1988; Wang & Burris, 1997).

_Feminist theory._ The influence of feminist theory on the Photovoice method can be seen in several ways. As Wang (1999) describes, feminist theory has been characterized by an appreciation for the subjective experiences of marginalized individuals and groups, and recognition of that experience to be significant. Such an appreciation and recognition of subjective experience builds on the understanding that feminist theory and practice function by and with marginalized groups rather than on them (Wang & Burris, 1997). Feminist theory empowers people, honours their intelligence, and values knowledge grounded in experience (Mitchell, 2006). Photovoice, by design then, in promoting personal and community health through an educational practice that involves documentary images, draws on the feminist influence that centres on exploring issues of power, representation, and voice (Catalani & Minkler, 2009; Somekh & Lewin, 2005). Moreover, this consolidation of feminist theory and social action in predicing the Photovoice concept, generates a political commitment to determining how the lived experiences of marginalized groups relate to broader oppressive systems (Wallerstein & Duran, 2006; Wang & Burris, 1997).
Documentary photography. Documentary photography has been characterized as the social consciousness presented in visual imagery (Catalani & Minkler, 2009). As Wang and Burris (1997) concisely explain, documentary photography is a visual style that represents "the things to be said in the language of pictures" (p. 371). By providing cameras to people who might otherwise not have access to such a tool, Photovoice enables them to document and catalyze change in their communities, rather than stand as passive subjects in the images of others (Wang et al. 1998).

Main objectives of Photovoice. In an influential article by Wang and Burris (1997), Photovoice is described as having three main objectives: Enable individuals to record and reflect the concerns of their community; promote critical dialogue and knowledge about important issues; and, reach policymakers.

Underlying Photovoice is a central premise that photographs contribute to how we see ourselves, define and relate to the world, and what is perceived as significant or different (Wang, 1999). In Photovoice participants are encouraged to think critically about the factors that influence their lives (Freire, 1970; Wang & Burris, 1997). Prior to taking photographs, participants think about their lives, become critically aware of issues that affect them, and then validate experiences with help from group members (Catalani & Minkler, 2009). After participants have taken photographs and assigned meanings to them, the debriefing element of Photovoice allows further analysis, reflection, and feedback through group discussions (Wang et al. 1998). This feedback serves to initiate further understanding, dialogue, and exploration of important issues (Wang & Burris, 1997).
Strack and Magill (2004) describe how Photovoice, "founded on a philosophy of collaboration, empowerment, and creative self-expression, is a research method that promises many possibilities and opportunities" (p. 56). One regularly cited possibility that distinguishes Photovoice from many other research methods is its capacity to influence policymakers using photographs. For Wang (1999), Photovoice has people come together to define both individual and group goals and objectives, and concludes by using the photographs as a platform for creating change and engaging in further action through dialogue with policymakers. Visual images influence each one of us on a daily basis. Photovoice capitalizes on the power of photographs and uses these images to influence public policy (Mitchell, 2006). As such, photographs can capture the attention of policymakers affecting their awareness and understanding of a specific issue or reality that is quite different from their own. This increased awareness and knowledge about differing experiences may help policymakers make informed decisions that improve the lives of dislocated and excluded groups (Alexander, 2001; Wang, 2006).

**Participants and recruitment**

Within Photovoice, data collection is discussed by Wang et al. (1998) as ongoing in that it begins in the early implementation of the project and continues through to the sharing of findings as a form of social action. Once we had agreed upon Photovoice as the research method, I continued visiting The Centre during its Friday open hours to talk with the peers regarding incentives for service user participation. Both peers explained to me that service users have always received food vouchers as a participation incentive when completing a questionnaire or survey with The Centre. I thought that this was fair and certainly not uncommon in research.
involving economically marginal participants and agreed that food vouchers should be provided. Community service hours, an amount of time to be spent volunteering that is necessary to graduate high school, were also raised as an incentive because many service users required them. Food and travel compensation, I explained, would be provided at each meeting as well. The peers and I then collaborated to make a recruitment flyer that would include these participation incentives and be submitted for ethics approval (Appendix A), along with the study questions and research design.

Both of the peers and I had discussed where the best place was to have our introductory meeting. Originally, I had thought the nearby public library might help maintain participant anonymity. The peers, however, explained how many service user friends and acquaintances frequent this library and that they would therefore prefer meeting in a conference room on the second floor of the building that housed The Centre, where there was also a harm reduction distribution programme. I learned that this program regularly allowed The Centre to use their conference room and so service users were familiar with its location. Fortunately, this location had the advantage of providing a space that was not in public to meet with participants.

When ethics approval for the study was received, I began recruiting potential participants. Both peers posted flyers throughout The Centre. The youth engagement worker posted the same information on their Facebook page. Flyer information included notice that all participants would receive $15 food vouchers, community service hours, travel compensation, and free food and drinks at each meeting. It was also requested for all potential participants to attend an introductory meeting in the harm reduction distribution programme conference room. Lastly, the flyers also detailed that those eligible to participate were young people aged between 16 and 26.
This age demographic was consistent with the description of service users eligible to access The Centre.

The Canadian Tri-Council Policy Statement guidelines for research involving humans stipulates the age of research participants considered vulnerable due to their age. Generally, the standard practice is to obtain consent from parents or guardians for anyone under the age of 18 before engaging in health research (Flicker & Guta, 2008). Canadian Tri-Council Policy Statement Guidelines indicate, however, that in some situations young people who are able to understand information presented and appreciate potential consequences may be regarded as competent to provide their own consent (Tri-Council of Canada, 1998). In these situations, the researcher and participants are expected to determine the probability and magnitude of possible harms to be no greater than what they would experience under similar circumstances in their every day life (Tri-Council of Canada, 1998).

Justice, as the central principle underlying ethics review, is used to ensure vulnerable groups are not coerced into research or, without reason, excluded from studies that might benefit them (Tri-Council of Canada, 1998). For potential participants, requesting consent may be viewed as admitting to engaging in illicit behaviours through their affiliation with The Centre. In response, it was possible that youth service users could lose access to The Centre through increased supervision and monitoring by parents or guardians. Unfortunately, as Flicker and Guta (2008) explain, often those youth who are unable to obtain consent would benefit most from becoming involved in a collaborative health research process that contributes towards specific supports and resources. Furthermore, when denied opportunities to participate, the experiences of these young people and their health needs would also not be reflected in research findings. As such, young people between ages 16 and 26 interested in this research were able to
decide for themselves whether or not they chose to participate. By contrast, mandating parental or guardian consent was inconsistent with the principle of justice and might cause inadvertent harm silencing service users voices regarding their health needs (Flicker & Guta, 2008).

Once the flyers were posted, many service users expressed interest in participating. Such interest was relayed to me through the peers and youth engagement worker at The Centre. I was not sure how many young people interested in participating would actually attend the introductory meeting. Wang and Burris (1997) identify between five to ten participants as ideal for focus group discussions in a Photovoice project because they provide a variety of different perspectives. A large number of participants, Patton (2002) explains, however, can also detract from focus group discussion detail and depth.

Even though they expressed a lot of interest themselves, both peers warned that many service users may have difficulty committing to the study and might not feel comfortable sharing their experiences. This is something I was cognizant of as commitment and comfort with sharing experiences were the two main criterion in my purposive sampling process (Patton, 2002). In the end, I was pleased when two service users and both peers arrived for our introductory meeting.

During the introductory meeting, I provided a detailed letter of information sheet and oral explanation about the study (Appendix B). The details in the letter and oral explanation described the project activities, its significance, timeline, possible risks and benefits, and the voluntary nature of participation stressing freedom to withdraw at any time (Flicker & Guta, 2008; Wang & Redwood-Jones, 2001). I explained that research questions and design had been developed by both the peers and myself. The research direction itself I stressed, however, was completely open for the group to define and modify throughout (Wang & Burris, 1997).
Following explanation of the study, each individual received a written informed consent form (Appendix C). They also received a confidentiality form (Appendix D) asking them not to disclose names of other young people involved in the research or discuss any content outside the meetings. Next, I explained that they needed to sign and submit their consent and confidentiality forms at our initial focus group meeting. I told them that our initial focus group meeting would be held a week later in the same conference room. Each individual agreed, however, that they might forget their signed forms and wanted to sign and submit them then and there. I then asked everyone to think of a pseudonym for themselves and provide me with it at our initial focus group meeting. Pseudonyms would be used to maintain participant confidentiality throughout the research process. Lastly, cell phone numbers were exchanged and I asked everyone to please call or send me a text message if anything would prevent them from attending our meeting the following week.

At our initial focus group meeting, both peers had anticipated correctly as the other potential participants had expressed kindly through text message how they could not commit to the research. The peers then were the only ones present. I asked them to provide me with a pseudonym for themselves. One peer chose Harry and the other Pessimistic.

Both Harry and Pessimistic were female. Harry was 17 years old and three months pregnant when we had our initial focus group meeting. Pessimistic was 20 years old with her young daughter. They both had been involved with The Centre as peers since its inception. Ahead to receiving positions as peers at The Centre, both Harry and Pessimistic had been service users of other community supports for young people labelled 'high-risk youth' in the city. While service users of these other community supports, they were asked to contribute towards a report regarding young people labelled 'high-risk youth' and their own health needs. Since they were
asked for their contribution to this report, Harry and Pessimistic had been adamant about opening The Centre. As a result, Harry and Pessimistic both had feelings of ownership and responsibility with regards to The Centre and its programming.

**Data Sources**

Data sources in the study included focus group meetings, collaborative concept maps, photographs, interviews, and field notes.

**Focus groups.** Focus group meetings are a central component of the Photovoice research method, used to interview a purposefully sampled group rather than each person individually (McMillan & Schumacher, 2006; Wang, 1999). I also decided to use focus group meetings because they would allow participants to stimulate each other with their own perceptions and ideas, eliciting important depth, detail, nuance, vividness, and richness (Patton, 2002). According to McMillan and Schumacher (2006), to facilitate focus group meetings, the researcher should be skilled in both interviewing and group dynamics. I approached the research process as a learner, maintaining an open mind and being cautious never to assume or pass judgment. Posing initial guiding and periodic questions, I concentrated on allowing participants to carry the discussions. Regularly, I received the impression that they enjoyed my questions and genuine interest. Whenever I thought the discussion was losing focus, however, participants were asked how they would convey the topic to a service provider or community member. This type of questioning not only helped them to concentrate on central points, but it also demonstrated recognition of the value and importance of both their contributions and voice.
Patton (2002) describes how focus group meetings, like all forms of data collection, have limitations. One primary focus group limitation is the number of questions asked may be limited by response time (Patton, 2002). As a result, I was versatile regarding the number of meetings we had. If there were questions or thoughts that were not fully addressed then we would arrange to meet again and carry on the discussion. This patience added a richness to the data collected.

Each of the focus group meetings were audio recorded and transcribed verbatim. Focus group meetings were initially held in a conference room above The Centre. After some time, however, they were moved to the nearby public library. This is discussed in further detail later in the study.

Collaborative concept maps. Concept maps were originally conceived by Joseph Novak as a research tool that would allow researchers to gain insight into participant understandings of knowledge (Novak, 1990). Best defined as visual organizers, concept maps, "make use of figures, lines, arrows, and spatial configurations to show how content ideas and concepts are organized and related" (Guastello, Beasley, & Sinatra, 2000, p. 357). Specifically, collaborative concept mapping is defined as a process where two or more participants are engaged in coordinated and sustained efforts "to learn and construct knowledge" (Shen, Losh, Turner, & Gao, 2007, p. 480). During our focus group meetings, collaborative concept maps were created by participants to construct knowledge in the form of themes. For these collaborative concept maps, participants encircled and connected their points, thoughts, and ideas, allowing for several themes to emerge. Van Boxtel, Van der Linden, Roelofs, and Erkens (2002) describes how the emergence of themes through collaborative concept mapping provides a depth of insight conducive to qualitative research. This depth of insight is important as it enables the researcher
to understand participant themes and any relationships between them without inferring meaning (Van Boxtel et al. 2002).

**Photographs.** Photographs were taken by participants and provided an invaluable basis for critical reflection and discussion in both the focus group meetings and interviews (Wang & Burris, 1997).

**Interviews.** Interviews are one of the key data collection methods used in qualitative research, and are used to gather participant reports and stories, learn about their perspectives, and give them voice (DeVault & Gross, 2007). The interviews in this study occurred at the end of our research to get individual participant perspectives and review the findings. All of the interviews were unstructured, and revolved around the particular feelings and concerns of the participants during that time. I audio recorded the interviews and transcribed them verbatim. The interviews took place in a coffee shop because of its public location.

**Field notes.** I kept detailed field notes serving as a recording of all interactions, observations, activities, and my personal thoughts (Patton, 2002). Keeping detailed field notes is a necessary component to qualitative data gathering methods providing further depth to the study (Patton, 2002).

**Overview of data collection procedures**

I have divided the data collection process into six steps adapted from a discussion presented by Wang and Burris (1997) regarding Photovoice and its general research framework.
These six major steps included nine focus group meetings and two individual interviews. Focus group meetings and interviews were further supplemented by collaborative concept mapping, photography, and field notes. Data collection began January 2011 and finished in March 2011.

The peers, as participants, were provided with a fifteen dollar food voucher and bus fare at each of the focus group meetings. Food and drinks were also provided for the peers at each of the focus group meetings. Prior to beginning the meetings, the peers were reminded that they could leave at any time and withdraw entirely, having all of their data removed. The importance of maintaining confidentiality by not discussing any content outside of the focus group meetings was also consistently reiterated.

Our focus group meetings were originally held in a conference room above The Centre and then moved to the nearby public library. This shift occurred because it was increasingly more difficult to access the conference room upstairs. Both the conference room above The Centre and nearby public library meeting locations were suggested and agreed upon by the peers beforehand. Each location provided us with a conference room that was separated from the surroundings with windows. People outside each of the conference rooms could see, but not hear us.

**Step 1: Initial focus group meeting.** The initial focus group meeting was held in a conference room above The Centre and was approximately two hours long. Myself and the two peers, Harry and Pessimistic, were present. Centring on discussing their goals and reasons for participating, Harry and Pessimistic took turns writing points on a large blank piece of chart paper. I asked the following probing questions taken from Wang (1999) with regard to goal setting in Photovoice research (Appendix E):
1. Why do you want to participate in this research?

2. What goals would you like to achieve individually?

3. What goals would you like to achieve as a group?

Both Harry and Pessimistic had been involved throughout preliminary processes, contributing equally to study questions and research design. I wanted to have this discussion, however, so that they might situate themselves and develop an understanding regarding their participation in the research. The goal setting discussion was also intended for each peer to become conscious of what role they desired throughout the research as individuals and a group (Wang & Burris, 1997).

Several goals were discussed including: establish a comfortable space for sharing; identify and critically explore health needs important to them; and, collaborate in presenting Photographs and related findings within the community after the research is completed.

Following the initial focus group meeting, I asked Harry and Pessimistic when they would like to meet next and together we set a date and time.

Step 2: Exploring an understanding of "good health" focus group meeting. Opening the second focus group meeting I asked Harry and Pessimistic what they understand as "good health". This understanding, I explained, would serve as the basis for taking photographs and thinking critically about identifying and describing barriers to attaining what they understand as "good health".

The focus group meeting was held in a conference room above The Centre and was two hours long.

I asked Harry and Pessimistic a few probing questions (Appendix F):
1. What does "good health" mean to you?

2. What are some words you would use to describe feeling healthy?

3. What does your optimal level of health look like?

4. Why do you see "good health" in this way?

   Although the peers and I had agreed on discussing what they understand as "good health" as we were defining the study questions and research design, it proved difficult. In response, Harry and Pessimistic both remarked that it might be easier to think about what they understand as "poor health". Shifting towards a discussion about "poor health", Pessimistic wrote the main discussion points on several large pieces of chart paper. Following this discussion, I asked Harry and Pessimistic if they thought it would now be easier to think more about "good health". The peers both agreed and several more large pieces of chart paper were used to discuss what they understand as "good health".

   Before our discussion about what the peers understand as "good health" ended, I asked Harry and Pessimistic if they would demonstrate connections between their points, thoughts, and ideas in a collaborative concept map. I explained that a collaborative concept map might help them think critically about the relationship between their points, thoughts, and ideas (Shen et al. 2007). Collaborative concept maps, I further described, are also useful to construct knowledge in the form of themes (Shen et al. 2007). Both peers then proceeded to encircle and connect their points, thoughts, and ideas, in a collaborative concept map allowing for the emergence of several themes. These themes and relationships between would serve as a useful reference throughout the research. Ending the focus group meeting, I asked Harry and Pessimistic when they would like to get together next and we set a date and time.
Step 3: Discussing barriers to attaining "good health" focus group meeting.

Beginning our third focus group meeting, I explained that we would be identifying and discussing barriers to what the peers understand as "good health". This discussion, I further indicated, would serve to help guide their photographing of health barriers.

The focus group was held in a conference room above The Centre and was two hours long. After placing the collaborative concept map regarding what they understand as "good health" in front of them, I asked several probing questions (Appendix G):

1. What are some different things or circumstances that might be barriers to attaining what you understand as "good health"?
2. Why do you think these barriers exist?
3. Describe some instances in your lives when you might have encountered these barriers?
4. What was your response when you encountered these barriers to attaining "good health"?

By asking questions regarding what Harry and Pessimistic identify and describe as barriers to what they understand as "good health", a broad discussion was generated whereby multiple stories were shared. Storytelling, as Wang et al. (2000) discuss, is an integral part of Photovoice research, allowing for solidarity and connectedness amongst participants by hearing and possibly relating the experiences and feelings of others (Wang, 1999).

Following the discussion about barriers to what the peers understand as "good health", we discussed ways photography may be used as a means for identifying and acting on issues that are not often talked about (Freire, 1970; Wang & Burris, 1997). I asked the peers for suggestions about taking photographs depicting places, objects, scenes, and symbols that convey barriers to their understanding of "good health". Following this, I explained how they could either concentrate their photography on ideas and issues that surfaced throughout the focus group.
meetings, take pictures based on new thoughts, or simply document every day realities and let themes emerge afterwards (Wang & Burris, 1997).

Mitchell (2006) discusses how originality is a significant component of a critically explorative process. Encouraging photographic creativity within Photovoice is therefore necessary to empower participants through recognition that the research is their own work (Mitchell, 2006). In response, I made it clear any points, thoughts, and ideas developed in the meetings should serve as a guide only and that Harry and Pessimistic should feel comfortable taking photographs of whatever comes to their minds (Mitchell, 2006; Wang & Burris, 1997).

Next, we discussed photography as a form of communication in an ethical context. Ethical concerns covered were supported by Wang and Redwood-Jones (2001) and included the invasion of personal privacy and staying away from physically or emotionally dangerous situations. The importance of refraining from photographing individuals, including themselves, in ways that could be potentially identifiable or incriminating was also explicitly expressed (Patton, 2002). I stressed that they were responsible to use their own best judgment, and practice censorship as a means of protecting themselves and others (Wang & Redwood-Jones, 2001). When faces were captured they would be able to blur them out.

We moved on to discuss how the digital cameras provided on the basis of cost and time efficiency, and methodological consistency could be used. Originally, I had chosen to use disposable cameras because of uncertainty regarding the number of participants and potential cost. Harry and Pessimistic did not mind using disposable cameras, but expressed that they would like it if they could see their pictures after taking them. I discussed it with the Youth Engagement Worker and decided to purchase two digital cameras. Part of my decision was based on information that digital cameras have a much greater longevity than disposable ones. As such,
two cameras were purchased and then given to The Centre after the research was complete. This, I hoped, would benefit not only the peers, but also any service users interested in using cameras for any artwork projects or other initiatives.

As the focus group meeting ended, I asked how much time Harry and Pessimistic thought they needed for reflecting on barriers to attaining what they understand as "good health" and taking photographs. They said about two weeks would be necessary. I indicated that two weeks was fine with me and then asked if they wanted to meet once during each week for an optional follow up meeting. Follow up meetings, I said, would be used to see how their photographs were coming and transfer those they had already taken onto my computer for printing. Both peers thought this was a good idea and told me when it was convenient for them to meet the following week. We finished the focus group meeting about discussing barriers to attaining what they understand as "good health" and both peers each received one digital camera to begin taking photographs.

**Step 4: Reflection period and follow up focus group meetings.** During the reflection period, Harry and Pessimistic took photographs within their community while thinking about barriers to attaining what they understand as "good health". In the meantime, funding at The Centre was being renewed throughout this reflection period. As a consequence, it became difficult for us to meet in the conference room upstairs. The peers and I discussed an alternative for where we should meet. Even though they had mentioned earlier that some service users might be uncomfortable meeting at the nearby public library, both Harry and Pessimistic expressed that they themselves felt comfortable there.
We had arranged for a follow up meeting every week because Harry, Pessimistic, and I agreed that instead of them being optional as originally planned, it would be important to meet and discuss how their photography progressed. Both Harry and Pessimistic thought that the time required for reflection and photograph taking would be about two weeks. Initially, we planned then to meet every week, however, this time required for reflection and photograph taking was about six weeks. During the six week reflection period, we met four times as both peers were unable to attend on several occasions. As we ended each discussion, the next follow up meeting was scheduled. The four follow up meetings that occurred were also regularly rescheduled to accommodate both peers. Whenever a follow up meeting was rescheduled the peers would contact me in advance and we would arrange an alternative. Such correspondence was conducted using text messages.

At each follow up meeting, Harry and Pessimistic uploaded their photographs onto my computer. I saved and kept electronic copies of the photographs so they could be printed. When photographs were printed, I put them into two separate envelopes, one for Harry and the other Pessimistic.

Each follow up meeting was relatively unstructured and revolved around the feelings and concerns of the peers. The collaborative concept map depicting what they understand as "good health" was exhibited for reference during these meetings. Probing questions I asked included (Appendix H):

1. How are you finding the Photovoice project so far?
2. What kinds of photographs have you taken?
3. Why did you choose to take these particular photographs?
4. How might the pictures reflect barriers to attaining "good health" in your life?
**Step 5: Debriefing focus group meetings.** We had two debriefing focus group meetings because of the time necessary to view and discuss their photographs. Both debriefing focus group meetings were held at the nearby public library. These meetings were held there because access to the conference room above The Centre continued to be problematic.

The objective of the two debriefing focus group meetings was to critically discuss and analyze events and thought processes that occurred during the reflection period using photographs. Harry and Pessimistic each received their photographs in an envelope. We then used the three stage critical reflection model modified from Wang (1999) for discussing barriers to what the peers understand as "good health". This model includes: a) Selection; b) Contextualization; and, c) Codification (Wang, 1999).

**Selection of photographs.** In the selection process, both peers went through their photographs and individually chose a variety of pictures felt to most accurately represent barriers to attaining what they understand as "good health". As Wang (1999) explains, this stage is important to prepare participants for an analytic dialogue. Typically, Wang (1999) suggests that five to ten photographs are enough, but Harry and Pessimistic had taken quite a few more that they wanted to discuss in detail.

**Contextualization of photographs.** In the contextualization stage, I asked Harry and Pessimistic to think individually about several probing questions adapted from Wang et al. (2000) regarding their chosen photographs:

1. What barrier to attaining what you understand as "good health" is being portrayed in this photograph?
2. How do these images make you feel?

3. How does this photograph relate to your life and experience?

4. Why do you think that the barrier to attaining your understanding of "good health" presented in this photograph exists?

   Such questions were used by Wang et al. (2000) as a method of "root cause questioning" (p. 80). These questions intended to help identify the problem "critically discuss the roots of the situation, and develop strategies for changing it" (Wang et al. 1998, p. 80). Root cause questioning originated as a concept from Freire (1970) emphasizing the importance of identifying social patterns and analyzing their situations in order to foster change. Freire (1970) used this concept to describe how participants may be brought to a level of awareness about the structures, ideas, and practices that position them unequally in society.

   Once Harry and Pessimistic thought about how they interpreted their photographs, both presented them for discussion, telling stories about any derived meanings. This verbal debriefing allowed the participants to justify their personal viewpoints and to speak about any thoughts, ideas, or revelations that emerged throughout the week of reflection (Wang, 1999).

   Before shifting to the third and final stage, we had already met for two hours. We then set a time and planned to meet the following week. At the next meeting, we began codification, the last stage of the critical reflection process (Wang & Burris, 1997).

   **Codification of photographs.** The third stage of the critical reflection process involved codifying issues, themes, or theories that arose from photograph presentations and related discussions (Wang & Burris, 1997). Establishing commonalities within which the photographs may be codified, together both peers identified and discussed any issues and theories that
emerged in the previous stage. Once again, to construct themes, Harry and Pessimistic made a collaborative concept map depicting how their identified and described barriers to attaining what they understand as "good health" related with one another.

I then asked Harry and Pessimistic what they could potentially do in the community to address their constructed themes. The aim of this group discussion was to necessitate what Freire (1970) describes as "praxis" (p. 126). For Freire (1970), praxis refers to a dialectic of reflection and action that helps develop increased critical consciousness amongst participants. Critical consciousness or "conscientization", connects learning about social, political, and economic contradictions with identifying their causes to foster change by taking action against oppressive elements (Freire, 1970, p. 19).

In closing, we referred back to the goal setting from the initial focus group meeting. Doing so, we discussed whether the peers thought their goals had been achieved and as Wang (1999) suggests, if anything had been accomplished beyond what was originally anticipated.

As we finished the meeting, I indicated to the peers that they each would be able to keep their photographs. I then concluded saying that they would be contacted by me soon with regards to a closing interview meeting.

**Step 6: Closing interview meetings.** As the final data collection step, closing interview meetings occurred between myself and each peer while I was conducting my analysis of research findings. These closing interview meetings functioned to help guide ideas I had been formulating throughout the research process and confirm accuracy of my theoretical analysis. Closing interview meetings were approximately forty five minutes in length. I contacted Harry and Pessimistic using cell phone text messages to arrange these closing interview meetings with each
of them individually. Both took place in coffee shops. We chose the particular coffee shop because it was near The Centre and also a public location.

Following the closing interview meetings we arranged to meet again and discuss how their photographs could be used to engage both community members and reach policymakers.

Analysis

There were five sources from which data was collected and analyzed: a) Focus group meetings; b) Collaborative concept maps; c) Photographs; d) Interviews; and, e) Field notes. Both peers generated themes that were refined throughout discussions about the data. In particular, after identifying and describing themes regarding what they understand as "good health", Harry and Pessimistic actively reflected on related barriers. Photographs, as concrete evidence of this reflective process, were presented by each of the peers during the debriefing focus group meetings for discussion to further analyze common themes. A three stage process of photograph selection, contextualization, and codification presented by Wang (1999) was used to guide their analysis of barriers to attaining what they understand as "good health".

Following the analysis by the peers, I reviewed data from focus group meetings, collaborative concept maps, and field notes. I began by transcribing audio recordings from the focus group meetings. Subsequently, after several readings of the transcripts, information I wanted to include for my analysis was selected and categorized. This entailed completing an initial review of all transcripts while inserting theoretical notes that served as reminders for me to revisit relevant topics in the literature (Patton, 2002). Codes were applied to all transcripts, data summarizing, synthesizing, and sorting observations that I had made from the data (Patton, 2002). Summarizing, synthesizing, and sorting the data is known as "open coding" (Strauss,
Clusters of codes were then organized and represented with the peers' themes to create categories, in a process known as "axial coding" (Strauss, 1987). Beginning my theoretical analysis, I referred back to the literature and read about relevant subject matter. Next, I returned to reorganize and evaluate by previous categories. Once my analysis had been reorganized based on the literature, I conducted closing interview meetings with each peer to confirm accuracy of the theoretical analysis (Patton, 2002).

**Trustworthiness**

Within PAR, relevance and trustworthiness rests on the commitment to involve participants in knowledge production (Bray, Lee, Smith, & Yorks, 2000). Acknowledging the peers' lived experiences and voice in the promotion of social justice and knowledge production, Photovoice as a PAR method provided democratic processes that addressed various power imbalances. Even though Reid and Frisby (2007) explain removal of all power imbalances is impossible in PAR, I have attempted to reduce those between myself as researcher and the peers. In particular, consistent collaboration with both peers to define the study questions and research design I believe has contributed positively to addressing such imbalances.

I have provided honest and representative interpretations of the peers' voice, adopting a subjective positionality that incorporates my personal standpoint to establish ethical responsibility and trustworthiness. As such, detailed accounts of my thoughts, challenges, and observations are also included in the study. These detailed accounts exemplify my own learning and, I believe, help to supplement the study findings.

Multiple methods or triangulation was used to cross check information and further gain trustworthiness in the study (Patton, 2002; Somekh & Lewin, 2005). These multiple methods
utilized in the study include focus group meetings, collaborative concept maps, photographs, interviews, and field notes, which allowed findings to emerge through different circumstances and perspectives (Patton, 2002; Somekh & Lewin, 2005). For McMillan and Schumacher (2006), focus group meetings, collaborative concept maps, interviews, photographs, and field notes provide accurate and relatively complete records of data. Each record of data and the findings, however, were also checked with the peers during closing interviews to ensure accuracy and meaning.

All of the focus group meetings and interviews were audio recorded. Audio recordings provided accurate verbatim accounts of all the focus group meetings and interviews. This enabled me to use words and phrases from the peers whenever possible, helping maintain data accuracy and authenticity.
CHAPTER FOUR

RESULTS FOR WHAT THE PEERS UNDERSTAND AS "GOOD HEALTH"

Introduction

Together, the peers explored what they understand as "good health". Drawing from their own realities, the peers shared stories and experiences giving rise to multiple themes. In the following chapter, I will present these themes and discuss relationships between them as determined by the peers themselves.

Both peers and I spent one focus group meeting discussing what they understand as "good health". As we began the discussion, both peers suggested that it would be easier to think about what they understand as "poor health" instead, which they commented was "bad but true". In response, we shifted towards discussing what they understand as "poor health". Following this, it became easier to transition into a discussion about what they understand as "good health". When we concluded our focus group meeting, a collaborative concept map was created by the peers depicting themes for what they understand as "good health" (Figure 1. What the peers understand as "good health"). "Mental stability" was determined as primary amongst these themes. Contributing to mental stability, a variety of secondary themes were also identified and described by the peers.

In the chapter, I will present and discuss what the peers determine as mental stability. Subsequently, I will present and discuss each of the secondary themes as contributors towards mental stability with reference to my literature review and conceptual framework.
Figure 1. What the peers understand as "good health".

Mental stability

As depicted by the collaborative concept map created by the peers, mental stability was identified and described as a central theme for what Harry and Pessimistic understand as "good health". The peers discussed mental stability as "feeling in control", "having a sense of responsibility", "happiness", "being sane and comfortable", and "not anxious or depressed". In relation to mental stability, a variety of secondary themes were identified and described by the peers. Such secondary themes for Harry and Pessimistic included: "Helping others", "Positive
body image", "Having access to money", "Regular sleep", "Tattoos", "Music", "Cigarette smoking", "Alcohol and marijuana", "Healthy relationships", and "Housing."

Beyond mental stability, other commonly conceived aspects of health, particularly the physical, was not directly discussed by Harry and Pessimistic.

**Helping others.** Helping others was identified and described by Harry and Pessimistic as a contributor to mental stability and what they understand as "good health". When discussing what makes them feel healthy, Harry said, "whenever I do something that is good for someone like even giving them a cigarette". Pessimistic agreed and discussed how she felt about their leadership position as peers at The Center. "I really like it and how other young people come and look to me as an example", she explained.

Mitchell (2006) describes how having a leadership position can provide young people with feelings of ownership and empowerment. Based on regular references to The Centre as their own, both peers agreed about having developed feelings of ownership. Feelings of empowerment, I believe, were also held by the peers, contributing positively towards their confidence and independence.

I asked them both to discuss further their leadership position, particularly regarding The Centre and its youth engagement model. The peers responded by discussing their relationships with the youth engagement worker, to whom service users at The Centre, particularly Harry and Pessimistic as peers, communicate their health needs.

Alex: What do you do at The Centre? What happens there?

Pessimistic: We usually go to the youth engagement worker and say we want to do this and then we organize it, such as the henna tattoos.
Harry: Yeah. Then we also have the harm reduction side of things. The clean needles and condoms. Together we distribute those.

Pessimistic: In a way it's a health centre. It's also a youth centre.

Harry: If someone comes in and they have an issue or need something the youth usually feels comfortable right away.

Pessimistic: Yeah. They are just like this is a youth place. I think it's a great program. It's really interesting how it's run. I think it gives youth some responsibility in a sense because they run their own program. I just think that it's not like this is what we're going to do. It's more like what will be helpful? How do you want to do this? You know?

Harry and Pessimistic discuss the youth engagement model and its approach to harm reduction as unique. It is this uniqueness at The Centre, they believed, that allows them as peers and other service users to feel comfortable. The peers felt that asking the opinions of peers and other service users about their health needs is not only inherently respectful, but it also provides them with a feeling of responsibility. Feeling respected and being provided with a feeling of responsibility as they attempt to help other service users, contributed towards the mental stability of both Harry and Pessimistic.

The peers appear to have understood themselves in their leadership position as equal contributors with the youth engagement workers in regards to meeting health needs of service users. Such an understanding is important for it counters what Roe (2005) explains as a tendency for institutional tokenism in the inclusion of peers by community supports and service providers.

Beyond her leadership position at The Centre, Harry thought that having access to money was necessary to helping others.

Harry: I need money to help others. People say that you can find happiness without money, but there are a lot of people out there who are happy because they have money. Like the girl in Homeless to Harvard.

Alex: What is the girl in Homeless to Harvard about?
Harry: It's a book about a girl who was homeless. She grew up in the Bronx. Her mum died of AIDS. The way her mum was buried they cut off her head and feet and put her into a box in the ground and just like a lot of messed up stuff happened to her. I can relate to her. She would scrounge for money to pay for her books and stuff after she got into Harvard. She wrote a biography and has just sort of taken off from there. Now she has a lot of money and is happy because she is not homeless and can help those who are. She is not one of those people that is like I had a shitty life. I saw her present. When she told the story about her mum some kids were laughing and I was really choked. I mean that is not funny. I thought it was the most amazing thing of my life. I loved it.

Harry identified with the woman she described because she could relate to some of her life experiences. The woman, Harry explained, did not have any pity for herself even though life had been difficult for her. Rather, the woman was strong and did not let life circumstances define her and she was also capable of transforming herself to help others experiencing similar circumstances in their lives. She seemed able to relate to this woman because Harry too had experienced difficult circumstances in her life and had risen above them. As a result, she felt a sense of pride and accomplishment.

**Access to money.** The peers identified and described the importance of having money in relation to their mental stability and what they understand as "good health". In particular, they discussed the date they received their monthly social assistance.

Pessimistic: The first of the month is the best.

Harry: Yeah check day is the best day of the month.

Receiving monthly social assistance meant that they could then travel downtown or to other areas of the city that were otherwise not too accessible. As each month progressed, however, Harry in particular would often not have any money left: "I always run out towards the end of the month. It is difficult to budget. I have too much fun with it sometimes". Ungar (2004)
confirms this reality explaining how it can be difficult for young people who receive monthly social assistance to manage their money.

**Positive body image.** Harry described the importance of "feeling good about our bodies". "Exercise", including "yoga" and "walking", was identified by the peers as a central component of this. Harry explained, "yoga is not just for the body, but the mind as well". Both peers also discussed "absence of eating disorders", "healthy eating", and "vitamins" in relation to having what they identified and described as a positive body image. Positive body image was identified and described as a contributor to their mental stability and what they understand as "good health". Money was discussed by both peers as a necessary precursor for healthy eating and the purchase of vitamins.

Another contributor to positive body image for Pessimistic was tanning.

Pessimistic: I know this might sound silly, but tanning makes me feel mentally healthy. The Vitamin D from tanning beds. That's why I can be in the worst mood of my life and then go tanning and feel great.

Harry: But tanning isn't healthy.

Pessimistic: The question though is what makes you feel healthy and I think that in moderation they are if you don't burn. I would go outside, but if the purpose is to tan and not something else I would go to a tanning bed always because you can get a more even tan without tan lines. It's a more even tan and to get the same effects you would have to sit outside for hours. I really think that if you don't burn, which causes cancer, you will be fine.

In the discussion, Pessimistic prioritizes her mental stability over commonly held notions of what is considered "good health", particularly physical, in regards to tanning. Pessimistic acknowledges that although tanning contributes to her mental stability, only in moderation is it a healthy and safe behaviour. Anything more than this, "to the point of burning", Pessimistic further explained, would be unhealthy. Moderate engagement in what are commonly considered
unhealthy behaviours and activities to attain mental stability was a recurring subject throughout my discussions with the peers about what they understand as "good health".

**Regular Sleep.** Between "eight and twelve hours of sleep" was identified and described by both Harry and Pessimistic as a contributor to mental stability and what they understand as "good health".

**Tattoos.** The peers identified and described tattoos as significant contributors to mental stability and what they understand as "good health". "I like the symbolism and how it feels. I like how it hurts", Pessimistic said. Explaining further her ability to withstand pain, she commented, "I will never take a break halfway through or anything".

Harry: Tattooing is form of expression. When you get a tattoo it's meaningful. When you put it together with the pain and everything it's a pretty powerful feeling.

Pessimistic: Yeah it's also a control thing. You can control it. You pick where and when it happens, what, and how big. Tattoos are painful in a different sort of way. If you get it when your life sucks then you are obviously dealing with pain that you cannot control, but you can control the tattoo. If you are dealing with pain that you can't control then getting a tattoo is like going to deal with pain that you can completely control.

Harry: The tattoo is also like a part of who you are and what you believe.

Pessimistic: Yeah my tattoo could mean a million different things. When I show people they don't really get why or what it's for. Like even my best friend doesn't really know. It's like my own thing.

For the peers, tattoos contributed to their mental stability as a form of control and self expression. Tattoos were visible to others, while also providing a sense of personal power regarding the meanings they attributed to the images their tattoos depicted, but which others could not have known. Ungar (2004) elaborates how tattoos amongst young people as a form of personal expression represent deliberate attempts to define themselves because they are excluded
from society. Such deliberate attempts to define themselves, as Ungar (2004) explains, provide
longed for feelings of "belonging and attachment" (p. 6).

While receiving tattoos, pain was also discussed by the peers as it related to mental
stability. The pain while receiving tattoos was embraced because it was both a challenge to
overcome and something that could be controlled and indeed chosen. Maté (2008) explains how
the "pain pathways" in the brain are the same regardless of whether it is physical or "emotional
rejection" (p. 34). For Harry and Pessimistic, choosing physical pain appeared to be a means of
overcoming other problems in their lives that they could not control.

Pessimistic also referred to the pain and control associated with tattoos as being
"addictive". For Pessimistic, tattoos were addictive because of the pain, which she described as
"craving the steel", and also being able to feel in control. It was interesting for me to think of
addiction and control in a similar context. Typically, addiction implies an uncontrollable urge,
but for Pessimistic, it seems, having a sense of control was in itself addictive.

Asking Pessimistic to explain more about tattoos and control she said, "you pick where it
happens, when it happens, how long you're there, what it is, and where it is". Discussing this
further, Pessimistic described a situation where she made an appointment at the home of an artist
because "it was like half price" to get tattoos there. The peers continued to discuss this particular
tattoo artist and their experiences with him.

Pessimistic: I brought a friend because I didn't want him to touch me. He is very forceful.
I get anxious and would not want to be there alone.

Harry: Yeah. I have only been professional with him and he is completely perverted and
disgusting. I am very assertive so I tell him right off. Someone who is a bit more passive
going for a tattoo I feel badly for them.

Pessimistic: He booked our appointments and then messaged us saying that he was in a
bad mood and started drinking. He had like two beers before we got there. I looked at my
friend and she said that he had done her arm and foot when drunk so I was like okay. The
guy is really good at his shit. I really wanted to get the tattoo and my kid was at the babysitter so I was like okay. It sucks doing it at his place though because the tattoo chair is so old and uncomfortable. I think I am going to try someone else. I am really upset though because I want another tattoo on my side but I don't know if I trust anyone else to do it.

Both peers described how they were uncomfortable with the tattoo artist, but because he was talented chose to receive tattoos from him anyway. It was a conscious decision made by the peers to receive tattoos from this artist outside of a professional shop, one over which they felt in control.

While Harry and Pessimistic considered tattoos to be a contributor to their mental stability and what they understand as "good health", receiving them, particularly outside of professional shops, is an activity that many community supports and service providers do not condone. For instance, the community supports and service providers that produced the report which resulted in The Centre being created, considered receiving tattoos outside of professional shops to be a primary risk factor for Hepatitis C. "I know it's considered unhealthy and dangerous", Pessimistic said referring to receiving tattoos outside of professional shops, "but it is my choice. I wouldn't do it if I didn't think it was safe". Harry nodded in agreement with her.

Music. The peers identified and described music as a contributor to mental stability and what they understand as "good health". For Pessimistic, music, she said "is relaxing". Harry agreed and added that it also "takes my mind off things sometimes". When I asked what things she was referring to Harry responded and said "just anything that is negative". Music was not discussed in depth, but both Harry and Pessimistic implied that they listen to it quite often.
**Cigarette smoking.** Harry and Pessimistic identified and described cigarette smoking as a contributor to mental stability and what they understand as "good health".

Pessimistic: Smoking makes me feel mentally healthy.

Harry: Yeah it's good for our mental health.

Pessimistic: If you don't have a cigarette don't you want to kill people? You want to kill people and snap. Not having it makes you feel unhealthy.

Harry: It can be both healthy and unhealthy.

Pessimistic: I don't think smoking makes me feel unhealthy.

Harry: Not even when you're sick?

Pessimistic: The odd smoke maybe, but not usually.

Cigarette smoking was only considered unhealthy by Harry when she was sick. Otherwise, both peers explained how regular cigarette smoking was healthy and necessary for their mental stability.

Although Harry and Pessimistic understood cigarette smoking as an important contributor to mental stability, it is generally considered to be a physically unhealthy behaviour. Indeed, many community supports and service providers have mandates to address cigarette smoking as a physically unhealthy behaviour amongst young people. "Why would anyone focus on addressing cigarette smoking? What a waste", Harry said when discussing how it contributes to her mental stability. Pessimistic agreed with her and mentioned how "there are so many behaviours that are worse". The peers considered mandates to address cigarette smoking as a physically unhealthy behaviour amongst young people to be insignificant compared with other behaviours that they considered more detrimental. Being confronted about cigarette smoking by community supports and service providers was therefore considered by the peers to constitute a misuse of resources.
Alcohol and Marijuana. When discussing alcohol, Pessimistic said "just before being sloshed makes me feel unhealthy and then once I get to the point of blacking out it feels good. Then I'm great". Harry followed this comment by Pessimistic with "before I was pregnant I would drink like every day. You can guarantee it. I loved my liquor. I was looking really good and felt great. I weighed like ninety eight pounds". Both peers identified and described the consumption of copious amounts of alcohol to contribute towards their mental stability and what they understand as "good health". Harry further relates alcohol with feeling good about her body, both when drinking and more generally. The opposite of this was true for marijuana despite it being identified and described as a contributor to mental stability and what they understand as "good health".

Harry: Whenever I first began smoking weed I felt healthier than ever and then by the end I was like wow this is bad.

Pessimistic: By the end of the day or end of the high I feel just terrible.

Harry: Yeah. By the end you feel like a bag of shit.

Pessimistic: At the beginning of a high I feel great but then as it starts to go away it's like suicide.

At the beginning of their marijuana high they would feel great, but as it progressed such a feeling would slowly deteriorate. For both Harry and Pessimistic, the feeling of a deteriorating high was horrible. Despite this feeling, however, neither of the peers gave inclination that they intended to cease using marijuana.

Healthy relationships. Identifying and describing healthy relationships as a contributor towards mental stability and what they understand as "good health", Pessimistic explained, "not all of your relationships mean your boyfriend or girlfriend or partners".
Harry: Relationships are about interactions with everyone.

Pessimistic: Yeah relationships in general, whether they are with other people in the community, your doctor, or a service provider of any kind.

A variety of relationships were acknowledged by the peers. Included in the discussion about healthy relationships were "friends", "family", and more generally, "community members". When asked what characteristics were the most important to a healthy relationship, they agreed on "honesty" and "trust". Honesty and trust were specifically discussed regarding healthy relationships with partners and the importance of sex.

Harry: Sex is a really key part of a good relationship. Regular and good sex. But I am not really in a healthy relationship. There is not a lot of trust.

Pessimistic: Yeah I find honesty and trust tie into a good sexual relationship.

Harry: Sex can be either a healthy or an unhealthy thing if you are in a healthy relationship with honesty and trust. If not, it's never healthy.

Sex, Harry explained, is an important component of healthy relationships. When there is no honesty and trust, however, both peers discussed how sex in a relationship is unhealthy.

When I asked what other characteristics were important in healthy relationships, the peers said "respect", a "valuing of opinions", "feeling supported", "understanding", "no violence", and an "absence of drama". I thought the absence of drama was an interesting characteristic and asked them to discuss it further. The peers seemed to have difficulty defining drama, but I came to recognize it as closely associated with "gossip" and "bullying". Both peers perceived drama in a relationship as fundamentally negative and unwanted, thereby an absence of this contributed to healthy relationships. When not directed at them, however, Pessimistic indicated how "other people's drama was really entertaining".

Both peers discussed their interactions with community supports and service providers in the context of healthy relationships.
Pessimistic: A lot of the health services I use are cool. During my pregnancy I went to North because they were supportive. I like North. The Centre and Health are really good about not judging youth.

Harry: Going to a counsellor makes me feel healthy. If I like the counsellor. My probation officer is on my side.

For the peers, healthy relationships with community supports and service providers were present when they felt supported and understood.

**Housing.** Housing, "preferably permanent" Pessimistic said, was identified and described as a contributor to mental stability and what they understand as "good health". The peers said that "sanitary living conditions" and simply "not being homeless" were important to their concerns about housing.

**Conclusion**

Harry and Pessimistic identified and described mental stability as the primary theme in regards to what they understand as "good health". Related to mental stability as the primary theme for what they understand as "good health", the peers discussed a variety of secondary themes. These secondary themes contributed to mental stability because they generally provided the peers with feelings of responsibility, comfort, control, and a sense that they were supported and understood. Both peers regularly discussed The Centre in association with the secondary themes and such feelings.

Although some of the themes identified and described by the peers correspond with dominant social norms in that they are indicative of common notions of "good health", such as those held by community supports and service providers, there is also a clear departure. In particular, mental stability as the primary theme, not only does not incorporate physical aspects
of health, but tattoos, cigarette smoking, and alcohol and marijuana, as secondary themes, are all behaviours and activities associated with the 'high-risk youth' label. The peers, however, are certain regarding the importance of these behaviours and activities in contributing towards their mental stability and therefore what they understand as "good health". In what follows, I will move beyond what the peers understand as "good health", to present and discuss that which they identified and described as barriers to attaining such an understanding.
CHAPTER FIVE

RESULTS FOR WHAT THE PEERS IDENTIFY AND DESCRIBE AS BARRIERS TO ATTAINING WHAT THEY UNDERSTAND AS "GOOD HEALTH"

Introduction

Both peers spent several weeks taking photographs providing a basis for what they identified and described as barriers to attaining what they understand as "good health". The peers then shared their photographs discussing stories and experiences that gave rise to multiple themes. Within the chapter, I will present all of these themes and relationships between them as determined by the peers.

Two focus group meetings were held where the peers shared their photographs identifying and describing barriers to attaining what they understand as "good health". Closing these focus group meetings, the peers once again created a collaborative concept map depicting relationships between all of their themes (Figure 2. What the peers identified and described as barriers to attaining "good health"). "Mental instability" was determined as the primary theme. A variety of secondary themes were also discussed as contributors to mental instability.

In the chapter, I will begin by briefly presenting and discussing what the peers identified and described as mental instability. As contributors towards mental instability, secondary themes that the peers identified and described will then be presented and discussed with reference to my literature review and conceptual framework. Photographs, taken by both peers, will be included to complement each of these secondary themes.
Mental instability

Mental instability was identified and described by the peers as a barrier to attaining what they understand as "good health". They discussed mental instability as "feeling uncomfortable", "stressed", "unhappy", "down", "sad", and "frustrated". In relation to mental instability the peers identified and described several secondary themes including: "Depression and anxiety"; "Stigma, discrimination, and judgment"; "Community supports"; "Unhealthy relationships"; "Youth drug culture and homelessness"; and, "Drug use and addiction". All of these secondary themes were
identified and described by the peers with assistance of photographs. I have included their photographs to supplement each of the secondary themes.

**Depression and anxiety.** The photograph below generated a discussion about the theme depression and anxiety as a contributor to mental instability and barrier to attaining what they understand as "good health".

*Photograph 1.*

Harry: I am diagnosed with depression and anxiety and receive medication.

Pessimistic: I'm not, but I know it's there. I know it is. I diagnosed myself because I was going insane. I need to be on medication. I am not and need to be. I took Valium for a year just not prescribed to me. I was just like I'm going to take this because I know it helps with anxiety. It helped me and I didn't have anxiety for a long time.

Harry: I have a few friends that are bipolar. I have one that has multiple personality disorder.

Pessimistic: I would say that a lot of my friends are diagnosed with depression and anxiety or other related mental health issues.

Harry: We also work with a lot of people who have depression and anxiety or other mental health issues.
Both peers identified and described depression and anxiety as a contributor to mental instability and barrier to attaining what they understand as "good health". Though Harry had been diagnosed by service providers, Pessimistic had not been. Regardless, however, Pessimistic took it upon herself to find a solution in the form of medication.

For Harry and Pessimistic, depression and anxiety was not only an important component of how they viewed themselves and their behaviours and activities, but also how they perceived those nearest to them. As such, depression and anxiety was identified and described by both Harry and Pessimistic amongst their friends and those service users they interact with on a regular basis at The Centre. Throughout our discussions, the peers claimed that depression and anxiety, although considered abnormal and a problem, had become so prevalent in their lives that it became normal for them. It was not uncommon then for Harry and Pessimistic to use depression and anxiety when explaining not only their own behaviours and activities, but those of friends and young people with whom they worked as well. When explaining their behaviours and activities the peers would often say "it's because I have anxiety", or "they would not do that if they were not so depressed".

Ungar (2004) describes how depression and anxiety can become internalized by young people in response to being socially excluded by not meeting the "social expectations placed upon them" (p. 14). Indeed, Harry and Pessimistic had been convinced that there was something wrong and were either given explanations such as depression or anxiety or sought such explanations out for themselves. Both this notion that something was wrong with them and depression and anxiety as a corresponding explanation had become internalized by the peers thereby informing how they perceived themselves and others.
Coping with depression and anxiety was discussed by both peers with reference to the following photograph.

Photograph 2.

Regarding the photograph, Pessimistic said, "I think it symbolizes suicide and things being too much. So that rope is being too much". Describing the photograph further she explained that it represents being "stuck and like things are just closing in". Harry interpreted it more literally saying "Yeah I have a mental illness. I just have learned how to cope with it more than others. You know what I mean? Everyone always thinks about killing themselves. There is not a day or moment where people have never thought about that. You just can't tell doctors that because if you do you're all of a sudden suicidal".

Thoughts about suicide can be a result of social exclusion amongst young people and their feeling that they are not accepted by society (Ungar, 2004). Ungar (2004) discusses how these young people consistently negotiate between vulnerability and desire to be accepted with a disdain for their social exclusion.
Vulnerability and a desire to be considered normal may be identified in our discussion about the photograph. Harry expressed the desire by asking me to acknowledge and affirm for her that having thoughts about suicide were common, possibly indicating a need to be confirmed as normal. At times, I was given the impression that the peers perceived me as a representative of what was normal. Unlike their typical relationship to service providers, however, the peers appeared comfortable discussing their thoughts and personal feelings with me. I think this was because of my position as a researcher and related approach to collaborate with them throughout the research process so that their voice would be shared. Compassionate curiosity and genuine interest were also fundamental to how I approached them. For these reasons, I believe that the peers valued my opinion, and viewed me as a means to validate their experience and confirm a positive position for them in relation to what is commonly considered normal.

More often than expressing desire for acceptance, the peers held a disdain towards community supports and those they felt represented what is normal and excluded them in processes designed to meet their health needs. For instance, from this discussion, it is evident that Harry is not comfortable sharing any thoughts or feelings about killing herself with a doctor for fear of being classified as suicidal. Classification as suicidal for the peers was undoubtedly negative as they associated it with such things as "messed up", "troubled", "incompetent", "not able to be take care of yourself", and "requiring assistance". Rather than be classified and pathologized negatively, Harry, similar to Pessimistic regarding medication for depression and anxiety, had taken it upon herself to find a solution without any assistance from service providers.

Feeling uncomfortable telling community supports and service providers how they felt for fear of being further labelled, pathologized, and placed under a discriminating umbrella was
clear. Both peers had a distrust and fear of service providers that was explained further when they discussed the theme stigma, discrimination, and judgment.

**Stigma, discrimination, and judgment.** The photograph below was taken of a poster. Found on a wall at The Centre, this poster was made by Harry and she thought that it captured the theme stigma, discrimination, and judgment as a contributor to mental instability and barrier to attaining what they understand as "good health".

*Photograph 3.*

Describing when she took the photograph, Harry commented, "I think it was the day one of the people we work with was having a bad day. I think I wrote it then". In response, Pessimistic said "I like it. People think about mental illness as a terrible thing when really it's not. I think that everybody has some sort of mental illness. It's just how you cope with it. So we shouldn't discriminate". Harry agreed with her statement.

Both Harry and Pessimistic saw mental illness as something that everyone had in some form or another. For this reason, they were sympathetic and understanding towards those with
mental illness and disagreed with how so many are stigmatized, discriminated against, and subsequently judged. They once again acknowledged, however, that how someone copes with their mental illness is more important than anything.

   Harry: Everyone has a mental illness, but people need to figure their own shit out.

   Pessimistic: Yeah. Everyone needs to learn for themselves how to cope with mental illness.

   Harry and Pessimistic believed it was the responsibility of the individual to learn how they could cope with mental illness. Placing responsibility on the individual continued to be a pattern for the peers. Although Harry and Pessimistic were sympathetic towards others, because they identified themselves as young people who had a mental illness and learned how to cope with it, others should do the same. If young people, accessing The Centre could not cope with mental illness, both peers believed that it was their responsibility to learn how. For the peers, there was no excuse for young people to not cope with mental illness. Age did not matter because, they agreed, there "is no difference between young people and adults". The peers discussed age further with reference to the following photograph.

   Photograph 4.
Regarding the photograph, Harry explained how "age is a barrier to good health, but it's not supposed to be". Pessimistic agreed and discussed her experience with age as a barrier to attaining what they understand as "good health".

Pessimistic: I have had landlords patronize me. Try to take advantage of me. Tell me they could have me out in a week. I was like no that's not how it works. They thought they could just use their power against me because I was young. That happens with landlords, welfare, and doctors. When I was pregnant they were trying to get me to take medication without explaining anything to me. She was like you need this and I was like no I don't what is it? She said just put it in your mouth and breath. She wouldn't explain what it was to me. It's like you don't know better because you're 20 years older than me. It's like they don't respect or trust you.

Both peers, particularly Pessimistic, felt that they were treated differently from adults in general because of their age. Harry and Pessimistic had internalized that adults in general and service providers excluded them by often attempting to take advantage because they were young people. In response to feeling excluded from adults in general and service providers, Pessimistic did not simply relax. Rather, Pessimistic felt as though she deserved an explanation when being given medication while pregnant. She did not appreciate simply being told what to do.

Ungar (2004) explains how young people generally, but particularly those labelled 'high-risk youth', are deprived of responsibility and not treated with the same respect as adults. This is because many judge young people to be immature and incapable of being reasoned with. For the peers, feeling as though they were being discriminated against and judged by adults was not rare, but rather a regular experience. Pessimistic, for instance, explains how in her life this discrimination comes from landlords, welfare, and doctors. It is apparent that Pessimistic deems adults in general and service providers with whom she interacts on a regular basis to be guilty of perpetuating such discrimination and judgment against her.

According to the report in regards to meeting the health needs of young people labelled 'high-risk youth', judgment from adults in general and service providers is a primary reason why
young people often do not access community supports. Recognition of this resulted in The Centre being created to meet the health needs of young people without judgment and in ways that differ from many community supports and service providers, including peers and a youth engagement worker.

Discussion of the following photograph arose specifically from our conversation earlier regarding Pessimistic being told what medication to take while she was pregnant.

*Photograph 5.*

Harry had Pessimistic take the photograph when she herself was pregnant during the reflection period of the research. Describing her experience while pregnant, Harry said, "a lot of people looked at me weirdly". In support of this comment, Pessimistic explained, "I think when young people are pregnant they are looked down upon for sure. Even 20 or 21 years old. They are like you have thrown your life away". I asked if they felt young parents were viewed the same way after their children were born.

Alex: Do you think young parents are still looked down upon after the child is born?

Pessimistic: Oh yeah for sure. At Denny's the other day a family was staring at me. I said to my child something like do not spit your food out that is disgusting and I do not like it.
This lady looked at me and was thinking that I was this piece of scum. I was like my kid is in a restaurant chewing food and spitting it out. That is disgusting and I do not want her to think that that's okay. I didn't say that she was disgusting and I hate my child or anything. I just said that that is disgusting and I don't like it when you do that. Not saying that I wasn't going to feed her, but that until she can stop spitting her food I will take the plate so she gets the hint. You do not get it if that's what you are going to do with it. Food is not to be spit out all over the table. Same with crayons. If you are not going to colour on the paper I am going to take the crayons. That's the consequence. Children need to understand that there are consequences for their actions. My child will not wear a hat and mitts. So I bring them but when we leave to go outside in the winter she won't wear them. She then understands that by not wearing mittens her hands will get cold. Cause and effect.

Harry: You will pass so many people that will say oh what a terrible mother.

Pessimistic: Yeah they would be like how could she bring the child out without a hat and mitts. It's a battle that I am not willing to fight. My child is going to throw them off on the floor. So we go outside and 10 minutes down the road we have passed 10 people that are like whatever. But 10 minutes down the road she's crying because she realizes oh no my hands are cold. Then eventually she will understand that there is a reason why I tell you to do this.

The peers felt like not only were they subtly viewed negatively because they were young people and pregnant or with children, but Pessimistic also explained how her parenting style was regularly being questioned and judged. Pessimistic was confident her parenting techniques were obviously appropriate in response to the behaviour of her child and that people had no right to think otherwise. I often thought how much of this subtle judgment is actually present and how much the peers have internalized feelings of inadequacy as projected onto them by others. I think Harry and Pessimistic in many ways had become so accustomed to feeling judged that no matter where they went feeling inadequate in the eyes of others was something carried with them.

Ungar (2004) affirms how young people labelled 'high-risk youth' often internalize feelings of inadequacy, stereotypes, and negative judgments of themselves as excluded from society and projected onto them by others. For instance, during one of our focus group meetings at the public library, Harry explained how she felt that the librarian had given her a "really dirty
look" and did so because she was "young and pregnant". Harry met with me outside and I walked in with her past the librarian, but did not notice this look. Comparing this look with the normalizing gaze described by Foucault (1977), within which judgment is inherent, those at whom it is not directed are often unable to notice. She asked me if I noticed the dirty look. I honestly had not. Only after we had sat down and began our meeting did I notice how the librarian was attending to her in a particularly judgmental manner.

While sometimes the judgment is subtle, other times it is more overt. Describing an instance when the judgment was overt, Pessimistic angrily related the following example: "My doctor when I went to have my kid get her shots actually told me that I should get out of where I live and get a job. That does not have anything to do with my or my kid's health. That is from the last time he saw me. He was like you need to move out and get off welfare because that is making my child unhealthy". When I asked how they have responded to such assumptions from doctors and other service providers the following discussion was generated.

Alex: What do you do when doctors and others service providers treat you this way?

Pessimistic: I think a lot of people either flip out or avoid. I just avoid my doctor.

Harry: Yeah because you're not comfortable. You don't want to share information with someone who is judging you.

Pessimistic: My doctor is contributing to my bad health because he is a creep and I won't go see him.

Harry: I told my doctor that I was an addict and that I couldn't have any pills that were addictive, but they prescribed me Tylenol 3's and literally when I ran out of that prescription I was running around and like looking for more and then was taking them for at least four months until I got sick of it.

Pessimistic: Yeah my doctor is a creep and he would be like you're fine. You are just trying to get drugs so I have to go to Health and do it through them because they are not idiots.
Both Harry and Pessimistic discuss how, when confronted with having to go to the
doctor, they choose avoidance whenever possible. This is because they do not like being judged
and excluded regarding processes intended to meet their health needs (Ungar, 2004).

Referring to another experience at the hospital Pessimistic said, "I did not want to take
my kid to the hospital when she fell out of her playpen because I'm worried what people are
going to think. I am 22 years old. I live in the Heights. I collect welfare. I'm not in school. I'm
not doing anything with my life". Perhaps this comment from Pessimistic suggests recognition
that service providers have a right to be concerned although she considers herself an excellent
parent. Acknowledging that she is an excellent parent, given the circumstances of her life maybe
Pessimistic is not surprised about being considered unfit. Pessimistic indicates, however, that still
does not mean it is right. She further stated referring to me.

Pessimistic: Whereas and I don't mean to say this, but if you took your son in because he
tripped and fell and bashed his face then they would be like oh accidents happen and
patch your kid up so you could be on your way. I bring my kid in and they're like are you
sure she fell out of her playpen? You didn't punch her right? Sure you weren't mad?

Pessimistic uses me to acknowledge how young people are treated differently based
simply on how they look. I certainly received the impression that both Harry and Pessimistic
regularly feel that others have negative assumptions and judgments about them. Although they
also reject those service providers who hold negative attitudes, there are times when they choose
to fight them in an effort to convey accurately who they are. In the case of our research
relationship, for instance, I had to earn the right to learn from them who they are. Where such a
relationship does not exist, particularly with service providers, the peers are very cold, coarse,
and dismissive, believing that negative assumptions judgments are being held about them. Next,
I asked how they felt about negative assumptions and judgments from service providers.
Alex: How do you feel about negative assumptions and judgments from service providers?

Pessimistic: It makes me angry. Even people where I take my child, not so much the staff that I work with, but some of the home workers or secretaries and things, they see me as a person on welfare that comes in with white shoes and a Benetton coat and other new things. I think they have assumptions without really knowing. Like I called my mum before I bought these shoes because they were forty percent off and I wasn't sure. When it comes down to it if I need to borrow some money I can call my mum and she will say yes. She'll know that she was the one that told me to buy the shoes.

When I asked if they felt everyone, including themselves, was guilty of such judgment, the following conversation was generated.

Alex: Do you think that all people are guilty of judging others before knowing them?

Pessimistic: Yeah I feel like I used to be that person who would look at a situation or person and immediately pass judgment. I think what really changed my mind was when I was watching television and this mum was being charged for child abuse or neglect and the reason was because someone captured a video of her on their cellphone with her son. Her son had one of those plush backpack leash things with an animal on it and he lay down. She tried to get him used to wearing it because he didn't want to, but in a busy mall I think it's safe.

Harry: Yeah as long as you're not jerking it and making them fall.

Pessimistic: Exactly. So this woman to get her kid happy with wearing it when he would lie on the floor she would pull him. He would be like laughing and would have a blast. Well what someone saw was this kid having a bad day and saying I don't want to walk anymore pull me. The video had no sound so they couldn't hear if he was crying or laughing or anything. In the 12 seconds that they were walking down the hallway and she was pulling him and they see her glance back once and then they keep walking and he's like sprawled on the floor just having a great time. This mum though is being prosecuted because of a 12 second video. When I watched it they first showed the video and I was like that's terrible. How dare you pull your child around like that, but because you don't hear the sound you don't know the story. You don't know the whole story. Once she started talking it became clear that it was an innocent game and that's why she was losing her marbles. That day I remember thinking that you can't really judge something that you have seen for ten seconds. So since that time when I see people passing judgment just by how other people look and what they think they see, it really frustrates me.

In response to reflecting on the video and the consequences of what she described, Pessimistic discusses how she had changed to become a person who is less judgmental. I probed...
Further and thought that the peers might talk more about their own experiences of being judged or elaborate on relationships they have with service users. For Pessimistic, however, the incident she described above while watching television, was the primary example used to explain why her attitude towards passing judgment had changed.

Another theme identified and described by the peers was community supports for young people labelled 'high-risk youth'.

**Community supports.** The photograph below resulted in a discussion about the theme community supports as a contributor to mental instability and barrier to attaining what Harry and Pessimistic understand as "good health"

*Photograph 6.*

Harry: Many of the supports out there don't include youth.

Pessimistic: Yeah. It's more like this is what we see as your problem and then this is how you fix it? If it doesn't work then they think it's because you didn't do it exactly their way.

Harry: Yeah for sure. It's your fault.
Harry and Pessimistic discussed how many young people reject community supports because they exclude them. Both peers discussed community supports as not having been made with young people in mind, but instead approach their health needs as all the same. As a result, it is the perception of Harry and Pessimistic that the health needs of young people are not being met on their own terms. Instead, the health needs of young people are approached based on what community supports and their affiliated service providers think is best.

Both Harry and Pessimistic alluded to how community supports attach blame to young people who do not conform with such processes. As a result, they are further excluded from discussions and decision regarding their health needs. Many community supports assess the health needs of young people in accordance with a predetermined standard that reflects dominant conceptions of what constitutes healthy behaviours and activities (Ungar, 2004). When young people find it difficult or are unwilling to conform to this standard, they are blamed. In essence, the victim is blamed. For the peers, community supports designed to meet their health needs while excluding and attaching blame onto them, largely contributed towards their mental instability as a barrier to attaining what they understand "good health".

Pessimistic elaborated her perspective on the difference between her experience with community supports and The Centre. "I just think that at The Centre is not like this what we are going to do. It's more like what will be helpful? How do you want to do this? You know?" she said. Using The Centre as their basis for comparing community supports designed to meet the health needs of young people, Pessimistic is a proponent of its youth engagement model as a harm reduction approach. In particular, The Centre and its youth engagement model is portrayed as being inherently collaborative and approaching young people without judgment. Young people as service users are thereby not measured by The Centre in accordance with a
predetermined standard reflective of what are commonly held notion of health, but rather asked what would benefit them. Many of the community supports to which Harry and Pessimistic referred have adopted the 'high-risk youth' label in reference to them and other service users. When I asked what they thought about the 'high-risk youth' label, Pessimistic stated that it depends on the context. She began by giving the example of a particular 'high-risk youth' class at her school.

Alex: What does the 'high-risk youth' label mean to you? How would you describe it?

Pessimistic: There was a 'high-risk youth' boys class at my school. They were skipping a lot of school, had bad attendance, and had a lot of drug use in their families. Things like that. They were at risk of not getting their diplomas. That is how the teacher described it. Whether it be because they were fighting, doing drugs, or skipping school. Whatever the reason might be they were seen at risk for not completing school. I have also heard it in the context of being at risk of contracting Hep C. Like when we were doing our RAR. So anyone who had a tattoo or piercing done not in a regular shop. Anyone who has cut, used drugs, has tattoos, and used needles. Those things because there was a risk for Hep C. So I think with the term 'high-risk youth' it depends on who you're talking about. In that class I told you about those kids were at risk of not completing high school. A lot of people interviewed for the RAR though were seen at-risk of contracting Hep C.

Pessimistic discussed the 'high-risk youth' label with reference to educational and medical community supports. Referring to educational community supports, she explained how young people labelled 'high-risk youth' were placed into a remedial classroom setting. As 'high-risk youth', there was a possibility that they would not receive their diplomas because of fighting, drug use, or simply low school attendance. Within medical community supports, Pessimistic discussed Hepatitis C and the report. She identified 'high-risk youth' as young people who have used drugs, needles, received a tattoo or piercings done. As she discussed community supports, Pessimistic described many of the characteristics typically associated with the 'high-risk youth' label, but was careful to say that it depends on the young people in question.
When I asked Harry in particular what her thoughts were about the label, she stated "I think any youth is at high-risk". In response, Pessimistic said "Yeah I don't know anyone who isn't. A youth who isn't at high-risk? Yeah I don't know any". The peers believed that all young people should be considered 'high-risk youth' because, in their view, there is no basis or difference that should determine what risks there might be. Even though Pessimistic and Harry had used needles, taken different drugs, received tattoos and piercings within and outside professional shops, they saw themselves as no more a 'high-risk youth' than other young people.

Foucault (1977) discusses how labels, once attached to young people for instance, result in exclusion simply by validating different treatment so that they will conform and become like everyone else. It was this process of being pathologized and subsequently treated differently by community supports that I believe the peers were resistant to. Harry and Pessimistic viewed the label as negative and did not want it to be attached onto them by community supports designed to meet their health needs.

Discussing the 'high-risk youth' label in relation to community supports further, the peers discussed how many were "uninviting". One particular context that the peers discussed as uninviting while also incorporating the 'high-risk youth' label was the psychiatric ward.
Photograph 7.

The above photograph had been taken of the psychiatric ward entrance. Both peers had spent time in this ward as service users or patients within the last several years.

Pessimistic: Its creepy walking around there. It's like a jail. I think a lot of the time inpatients are a risk to themselves and not necessarily other people. I just think that it's a little bit weird. Please don't let visitors enter the floor. Please ensure that the door is closed firmly behind you. I guess that they would be at risk of leaving, but what kind of visitors wouldn't be approved?

Alex: What do you mean by the psychiatric ward as being similar to a jail?

Pessimistic: I think it looks a lot like jail. Then it is also a lot different. Kids that are going to jail are those who have committed crimes like assault or theft. This is usually for people who are ill and they are being treated like prisoners. My friend smoked and he was admitted into the hospital and wasn't allowed to smoke. You are trying to keep them mentally sane and you won't let this guy smoke. He is going to go insane. I get it okay if you are worried he is going to start a fire. I just think that there are certain things that people should be allowed to do.

Harry: In harm reduction you try and help young on their own terms. You don't tell them not to smoke.

Pessimistic: Exactly. I think it's totally legit if I am anorexic and I need to go to the psychiatric ward then why can't I shave my legs? It's a razor, but I'm not interested in cutting myself.

Harry: Yeah.
According to Harry and Pessimistic, once inside the psychiatric ward their rights were removed as if they were in jail. Both peers discussed jail and even the psychiatric ward as representative of the most advanced form of correction for young people labelled 'high-risk youth'. Within this form of correction, these young people believed themselves to be completely robbed of their autonomy because it is seen as the only way necessary to bring them back to normal. The treatment of patients, they described, is conducted using a language that imposes "what is best" without sufficient collaboration or involvement regarding their own health needs.

As Harry and Pessimistic viewed it, service providers on this psychiatric ward think that they are meeting the health needs of young people, but in reality they are doing the opposite. The peers explained how the psychiatric ward therefore contributes to their mental instability and is a barrier to attaining what they understand as "good health".

Despite the understanding Harry and Pessimistic sometimes show regarding the obvious reasons for community supports withholding items such as razors and even cigarettes, their view is that these are necessary for mental stability as indicative of attaining "good health". Again, Harry made the comparison between what she has seen as a service user or patient at the psychiatric ward and youth engagement model as a harm reduction approach at The Centre in reference to meeting the health needs of young people on their own terms. According to Harry, on the psychiatric ward young people are not treated on their own terms. Instead, young people are locked up, isolated, and positioned such that the care of service providers, rather than they themselves, determine their health needs. For the peers, once in the psychiatric ward young people have no input nor are they given the opportunity to contribute towards their own health needs.
The peers then moved on to discuss a plaque cabinet located in the hall by the psychiatric ward entrance.

Photograph 8.

Harry: I think this one showing the department of psychiatry is interesting, well look its empty. I don't like it. It's scary. Some of these people are depressed and this must be one of the most depressing parts of the hospital with the hallways and everything. How depressing is that? I don't care who is in the department or whatever, but that cabinet, plaque, and everything just sucks.

Pessimistic: If those are the only three plaques and everything then throw in some art or something. Have some colour in the background. It's so depressing. Do you see how unfriendly it is? There is nothing. In the children's section of the hospital there is art on the wall and it looks friendly.

Harry: No wonder people become psychotic when they are there.

Both Harry and Pessimistic discussed how desolate everything from the hallways to the plaque cabinets are near the psychiatric ward entrance and they commented upon the potential effect of this on any young people staying there. In doing so, they acknowledged the contradiction regarding how community supports intending to meet the health needs of young people, can be significantly depressing and instead contribute towards mental instability.
Harry and Pessimistic then proceeded to discuss some of the posters on the walls that they had photographed near the psychiatric ward entrance. I asked them to consider how helpful they believed the information to be on the posters for them or any other young people who are there at the psychiatric ward.

Photograph 9.

Alex: How helpful is this information on the poster for you or any other young people at the psychiatric ward?

Pessimistic: Absolutely not helpful at all. This needs to be posted in high schools. In a mall, library, and places where public go. This should not be in the hospital. You already know that you suffer from things. I just think it’s a stupid place for it to be. Okay so Southeastern Ontario District Early Intervention and Psychosis Program. If you are already in the psych ward then I'm not sure that you are allowed to call that number. The sign is telling you to get help and that you are not alone. It just seems really silly. I just don't think being told that you are not alone is really that helpful. I think that it's very useless.

Harry: Yeah don't pity yourself because you're not alone.

Pessimistic made it clear that she considers the poster to be ridiculous for a variety of reasons related to its placement near the psychiatric ward entrance. First, because young people admitted to the psychiatric ward already know they suffer from mental illness, giving them this
information inside the hospital is considered by the peers to be redundant. Second, it is the understanding of Harry and Pessimistic that patients are not even allowed to access those services while they are inpatients on the psychiatric ward. Third, the peers do not find it helpful to be told they are not alone because of how it relates to feeling sorry for oneself. Harry and Pessimistic, felt that pitying oneself was useless and a sign of weakness. For Harry in particular, whatever brought young people to the psychiatric ward, it was something with which they had to take responsibility for and overcome alone.

Thinking about what Harry and Pessimistic discussed regarding the psychiatric ward it became evident that associated service providers never asked the young people whose health needs they intended to meet what their opinions were. After our discussion about the psychiatric ward, Harry and Pessimistic presented a photograph depicting a mental health clinic. The photograph resulted in a discussion about the particular mental health clinic and its relationship to the city.

*Photograph 10.*

Pessimistic: I would like this picture a lot more if there were a line of people here or nearby. Like piling up at the Pita Grill.
Harry: If that picture was taken on a Friday night during the bar rush then that area would be surrounded.

Pessimistic: Yeah so many of them wouldn't even know that it existed. Many people in the city in general don't have clue.

The peers described how those who are deemed abnormal have to segregate themselves from the normal simply by the location of community supports such as the mental health clinic. Conversely, Harry discussed how The Centre is "downtown and right in the open". Discussing it further, Pessimistic said, "The Centre is not trying to hide away, but the mental health clinic is".

Harry and Pessimistic allude to how psychiatric wards, mental health clinics, and other community supports for young people labelled 'high-risk youth', are located in places where they are hidden away so others do not know where they exist. Pessimistic implies intent on behalf of community supports to be hidden away. As a result, these community supports and young people as service users are further excluded. Community supports represent places that not only offer treatment in their intent to meet the health needs of young people labelled 'high-risk youth', but also punishment simply by being exclusive through location.

Next, Harry and Pessimistic discussed a photograph taken of the church not far from the mental health clinic. This photograph resulted in a discussion about the police in relation to community supports.
Photograph 11.

The photograph was taken of what Harry and Pessimistic discussed as the "crackhead church". I asked them about the name.

Alex: Why is it called the crackhead church?

Pessimistic: Because that's where young people get high.

Alex: Why do you think that they would choose to get high somewhere so in the open?

Pessimistic: It's like you are hidden in plain view.

Harry: Yeah.

Pessimistic: A lot of the time the cops would come up there and because the distance from the road to the steps is long enough that we can see them coming and people can put away their shit before they get there. So by the time they get there no one is doing anything.

Harry: Yeah without a warrant they can't search you. Yeah and they can't touch you unless they're going to arrest you.

Pessimistic: It's never just a kid. It's always someone that knows the streets. I always let the cops search my bag because I would always keep my drugs on me. They can either ask to search your bag or your body, but not both unless they are going to arrest you.

Harry: Yeah.
Alex: Do you think that young people use drugs in public locations as a form of rebellion?

Pessimistic: I never thought of it that way until you said so. I think it's probably a lot of that. I think a lot of it is a big fuck you.

Harry: Yeah because I am doing it anyways.

Pessimistic: Well because most of us have been brought up being told that cops are good for one thing only. Go to the police if someone touches you inappropriately. For any other reason, go get a baseball bat. We are taught that police are these trusting people, but that's not true. So I think when I was doing dope and sitting on those church step and to know that they know that I'm doing dope and I know I'm doing dope but when they get to me they can't prove anything is satisfying.

While others might believe that they are trusting and caring people, Harry and Pessimistic have had experiences resulting in a general distrust and dislike of the police. In response, the peers would choose to position themselves in public locations where they could do something illegal in such a way that the police could not engage them.

The peers identified and described how they perceive the relationship between young people, such as themselves and the police. The police at times will choose to take action and other times not. Young people are aware of this and would choose themselves when and where to use drugs in public locations. For the young people, choosing to do drugs in public was validating for them, particularly when they believed, whether it is true or not, that the police were unable to respond.

Below, Harry and Pessimistic further explained how they perceived their relationship with the police.

Harry: Literally fourteen years ago the cops would not enter the heights.

Pessimistic: You mean ten years ago.

Harry: Yeah. Not one person would call the cops. Now if you walk past someone and give them a dirty look then its harassment or something. They call the cops on everyone. I have had the police at least fifteen times break through my door. I hate them, but my
daughter is going to know that she can go to them for help. My child is going know that she can although clearly she'll know.

Pessimistic: I will not go to a cop for help. To a point, I don't think I would send my child to a police officer for help. I would tell her to call her grandmother. My mum will get more done than a cop in this town.

Harry: Yeah.

Alex: I think it's interesting that you wouldn't go to the police for help, but that you would want your children to?

Pessimistic: I would want my kid to see police as good people. It's too bad that they are not though. It's too bad that I can't tell my kid yeah they are good people because most of them aren't. There are a few good ones.

Harry: If my child was raped or anything like that then damn right she is going to the cops. She would tell them who it was because that is just wrong. Too many girls and boys get touched out there and nothing happens.

Pessimistic: I think the police are good to go for some things. Some being the operative word and it's very few. I mean my boyfriend punched my face in a million times and I never went to the police. I was like what are they going to do. Nothing. So I would go to them if I knew of someone who was raped. Or if I was raped. Probably in that kind of a situation I would go. But I don't like the police.

The peers themselves would only seek help from the police regarding rape, otherwise they would avoid them. Too often, it was clear, they had felt invaded by the police and made to feel uncomfortable. It was also clear that they did not have respect for the police. Despite these feelings, however, Harry and Pessimistic described how they wanted their children to know that they can go to the police for help.

Even though Harry and Pessimistic were very confident in themselves and their attitudes, at times they would display a subtle insecurity regarding a desire to perceive the world as they think others do. I think wanting their children to see the police as people that they can go for help reflects this subtle insecurity and desire.
Another of the supports that Harry and Pessimistic discussed as a contributor to mental instability was "the aid", referring to the Children's Aid.

Photograph 12.

Harry: This is the issue that I'm having with the aid right now. When I was little my dad raised me. My dad is a very dangerous guy, but whatever. Whenever the aid would walk in our house they would leave and say that there is no reason for them to come back. They did that about six times. Now they are saying that they should have investigated more. Well this isn't my father's child so he shouldn't have to go through all the steps to see my kid. I feel like if I think that my father is appropriate for me right now then he is going to be that way in front of my daughter.

Pessimistic: Yeah I hate the aid.

Harry and Pessimistic both discussed a hatred for what they called the aid. For Harry in particular, this was because of an issue she was encountering with them about her father and child. The aid had a significant role in her life as a child. Now it appeared as if she felt invaded because the aid was coming back into her life and not letting her decide who could be with her daughter. This was frustrating for Harry.

Discussions about her father lead to identifying and describing another theme which was unhealthy relationships.
**Unhealthy relationships.** The peers identified and described the theme unhealthy relationships as a contributor to mental instability and barrier to attaining what they understand as "good health". For young people including Harry and Pessimistic, the presence of unhealthy relationships is explained by Ungar (2004) as a consequence of social exclusion. Regarding unhealthy relationships the photograph below generated a discussion about "family" in particular.

![Photograph 13](image.png)

*Photograph 13.*

Pessimistic: Parents and home life. Someone's upbringing can be a health barrier?

Harry: My grandmother hits me and she is the only woman I am scared of. She is crazy and throws me around.

Pessimistic: Would you hit her though.

Harry: No. I have too much respect for her.

Pessimistic: Yeah that's the same for me. You are not supposed to hit your grandmother.

Harry: You know how grandmothers are supposed to bake you cookies? My grandmother would bake cookies and then ask me to go around selling them. If I ate one then she would hit me. She is a crack dealer.
Harry had been discussing the unhealthy relationship with her grandmother so I asked them about their fathers and grandfathers.

Alex: What about fathers and grandfathers?

Pessimistic: I don't have any of those.

Harry: My father can be a bit of a goof sometimes.

Pessimistic: If your dad heard you were calling him a goof he would slit your throat.

Harry: Yeah he takes that word very seriously.

Pessimistic: Yeah considering he just got out of the pen less than six months ago.

Both peers considered the word "goof" to be derogatory, but I had only ever heard it used to describe someone who was silly. I thought that for the peers it held a stronger, more derogatory meaning, and asked them to describe further what the word goof meant.

Alex: What does goof mean?

Pessimistic: It's supposed to mean child molester, but in my life goof means cunt. It's like a very rude word to say. One of the most disrespectful words you could say to a guy, but a lot of girls are goofs too.

Harry: If you call someone a goof you are either going to get punched out by either their mum, girlfriend, or their whole family.

Pessimistic: Yeah. It's a simple word that has just become so disrespectful.

Next, I asked the peers how many of the people with whom they regularly interact would be considered by them to be a goof.

Alex: What percent of people that you interact with regularly would be considered goofs?

Pessimistic: At least fifty percent.

Harry: Yeah. I hear it every day all day.

Pessimistic: I really never said goof, but now it has become my new favourite word.
For the peers, the word goof was commonly used and had a derogatory meaning. I thought it was interesting how many people with whom they regularly interact were considered by them this way. Next, I asked them what would mean the opposite of the word goof.

Alex: What is the opposite of a goof?

Pessimistic: Someone I like, respect, and somebody I care about.

Harry: Like when you tell someone that you have mad respect for them or they are legit.

Alex: How many people that you regularly interact with would you have this respect for?

Pessimistic: Thirty percent. It's sad that I have more goofs than people I care about or acquaintances. I think my attitude might change in a couple of weeks, but right now I am in such a bad mood that I hate a lot of people.

Harry: Like if you pissed us off then you could be another goof too.

Pessimistic: Yeah. I have a lot of temporary goofs too. Most of them are temporary goofs I feel. Thirty percent are goofs that will never change. Well maybe not never.

Pessimistic discussed how she was in a bad mood and for that reason viewed more people as goofs. For Pessimistic, there was an apparent association between her mood and whether people were goofs or not. Even I, as Harry said, could be considered this way depending on their mood and my interaction with them. As such, the word could potentially be used and applied loosely to people, with whom they interacted, taking away from its most derogatory meaning. This might explain why the peers would both use and hear it being used so often. Regardless, many young people with whom the peers regularly interacted were considered by them to be goofs. As such, Harry said later how she felt goofs were "everywhere" and that "they are invading the city". I got the impression from the peers that no matter what they did, distancing themselves from goofs was nearly impossible. Having to regularly interact with people they considered goofs was a significant component of unhealthy relationships.
Related to the word goof, was what both peers identified and described once again as "drama". The following photograph generated a discussion about drama.

**Photograph 14.**

Pessimistic: Drama in my life makes me feel unhealthy.

Harry: Facebook.

Pessimistic: Yeah Facebook makes me feel unhealthy. I had forty-eight comments on my status the other day. Too bad all of the comments were calling me names and cutting me up. Yeah forty-eight. I was like, god, I am going to slit my throat or theirs.

Harry: Facebook makes me hurt people. It's so gossipy and there is a lot of bullying.

Pessimistic: I would say that there is a lot of bullying on Facebook.

Harry: It's all drama. Everything.

Pessimistic: When someone told me that Facebook was being shut down, at first I was like oh no what are we going to do but then I was like yes shut it down.

Alex: Can Facebook ever be a good thing?

Pessimistic: Rarely.

Harry: Yeah very rarely because you could have your status like I think you are absolutely retarded and then someone could respond and all of sudden you got this whole back and forth. Even little things on Facebook.
Pessimistic: Yeah people will comment on your picture and its negative.

Drama was characterized by both gossip and bullying. For the peers, Facebook in particular was associated with drama. When I asked them to discuss unhealthy relationships in which drama was present, in addition to family, they identified and described "partners" and "community members". The following photograph generated a discussion about partners.

![Photograph 15.](image)

Harry: I have been with a lot of untrustworthy guys. Every relationship that I have been in was unhealthy and it all boils down to trust. If you are not honest and fooling around with someone else then all of a sudden the other person has herpes. In my last relationship, if he was mad the only way to make him happy was to have sex or whatever. It was messed up because he was mad twenty minutes later anyways. That's why he is a goof.

Pessimistic also discussed a relationship that she was in, where there was a lot of drama in the form of "game playing" that resulted in "insecurity". This was because, similarly to Harry, "we did not have much trust in each other", Pessimistic said. Both peers had been in unhealthy relationships with partners because, rather than trust, there was a lot of drama.

The peers also discussed unhealthy relationships and the presence of drama in their interaction with community members and the aid.
Pessimistic: This girl got into a huge fight with me on the main street. She started grabbing my hair and punching me in the head in front of my daughter. I went to Tim Horton's and was walking to The Centre afterwards. I got back and everyone was like what the fuck. You were going to get an ice cap. What happened? Her kid was five and standing beside her screaming at the top of his lungs saying don't hurt my mum. And the angry person in me wanted nothing more than to beat this girls face in, but the mother in me saw that kid screaming and I couldn't even clench my fist. My body wouldn't let me. I just stood there and let her hit me. I was like, this is ridiculous. So then I called the aid. Then she wanted revenge and knew that if she called the cops or something that everyone would hate her.

Pessimistic had described a situation when she had been hit by another woman on the street. I asked Pessimistic why she called the aid, and to explain more about everyone hating her because the woman might phone the police. Pessimistic, it seems, thought that calling the aid was precautionary and would protect her against the word of this other woman.

Pessimistic: She wanted to get revenge on me but there was nothing she could do because I didn't do anything wrong. So she called the police and told them that my mum ran over her baby.

Harry: Isn't that lovely. I would lose it if someone said that my dad did something like that.

Pessimistic: Yeah. A girl throws coffee on me and I call the aid because I am afraid someone else is going to.

Harry: Even if someone is screaming at you and you go to scream back at them then all of a sudden you are the bad guy. Somebody may be calling the aid on you.

Alex: What are you thinking about? You seem a little bit out of it all of a sudden?

Harry: I was thinking about speed because now I can't do it anymore. I have a child. It's not easy. If I took a hoot or did anything someone would probably call the aid.

Harry and Pessimistic viewed community members together with the aid in relation to unhealthy relationships. Community members, they felt, were constant dangers to them as parents because they could take their children away. This was because community members were the ones who could call the aid. In response, the peers discussed being constantly weary of community members disagreeing with their parenting techniques and potentially calling the aid.
Whenever they felt threatened by a community member they described how they would call the aid first so that they could protect themselves. For the peers, the aid seemed to be abhorred and feared on one hand while also depended upon for help.

Both peers then presented photographs of what they identified and described as the theme youth drug culture and homelessness.

**Youth drug culture and homelessness.** Harry and pessimistic identified and described the theme youth drug culture and homelessness as a contributor to mental instability and barrier to attaining what they understand as "good health". The photograph below was taken of one location that Harry and Pessimistic identified and described as the youth drug culture.

![Photograph 16.](image)

Discussing the photograph, Harry said, "it's definitely a youth hang out and place to do drugs". A central characteristic of a youth hang out and place to do drugs both peers explained was the amount of graffiti on walls, floors, and ceilings. The graffiti was used, Pessimistic explained, to "make it ours". I asked them why this location was chosen by the young people.
Pessimistic: Most locations where the graffiti is are secluded. It's not in the middle of the main street. People are not putting graffiti on a house or something somewhere because that is going to get them caught. If you want to graffiti and not be looking over your shoulder every minute then you are going to find and do it in a more secluded space that is not right out in the open. I think regardless of whether or not there is graffiti on the walls the drug users are looking for the same thing. They want something that is not wide out in the open. They want somewhere that is kind of hidden.

Ungar (2004) explains how young people who are socially excluded might purposely enter the fringes of society because they feel comfortable there. I asked the peers if they thought the appeal of such a place made them feel comfortable, safe, detached, and able to do their own thing without being told what to do.

Alex: Does this kind of place make young people feel comfortable, safe, and detached from everyone and everything else?

Pessimistic: I think that it's all of those things. The kid who is going to do graffiti is definitely going to a secluded place like that. The kid who is going to go smoke crystal is also going to a place like that. Not because they want to graffiti or because it's there, but because it's secluded. I think that people who are doing illegal activity, be it drugs, graffiti, or vandalism, or any of those things, they are all looking for one thing. They are all looking for something that is not out in the open.

Foucault (1977) describes how those deemed deviant and excluded for their behaviours and activities often withdraw into informal locations, just beyond the reach of the rule or normalizing gaze. When these behaviours and activities are illegal, the deviant searches for locations that are not in the open and secluded thereby functioning to further exclude themselves from society (Foucault, 1977). Next, I asked Harry and Pessimistic if they thought young people associated feelings of ownership and more importantly inclusion with the locations that were being discussed.

Alex: Is there a sense of ownership and inclusion you get from these locations?

Harry: Yeah. Youth put their names on it. This is our walkway.

Pessimistic: Yeah.
For Harry and Pessimistic, these locations that were not in the open and secluded, and where they were able to graffiti, provided them with a sense of ownership and inclusion. Next, the following photograph depicted another secluded hangout associated with the youth drug culture of which Harry and Pessimistic held feelings of ownership and inclusion.

*Photograph 17.*

Both Harry and Pessimistic knew the place being depicted in the photograph as "cloud nine". Cloud nine is a rooftop hangout accessed by young people that would be labelled 'high-risk youth" in the city. This is a location, the peers explained, where young people come to hangout, use drugs, and do graffiti. On the other side of the buildings is the main street. When I asked what they thought about being so close to the main street, Harry responded, "yeah it's crazy. I like being on the top of those buildings. I climbed the fence to get up there. Lots of people don't know about it".

I thought that this photograph captured the relationship between young people who have been socially excluded and the rest of society. These young people were going to the rooftops, out of view, and far away so that they could feel more comfortable. For everyone else, they were
out of sight and out of mind, thereby maintaining an ignorance regarding these young people and their behaviours and activities.

From the following photograph a discussion was generated in which the youth drug culture was related to homelessness.

*Photograph 18.*

Discussing the photograph Harry said "this is a place where young people go to eat, sleep, and do their fix. There is shelter there. In the winter it's cold and in the summer there is shade". Pessimistic further explained how there is a sense of "freedom and belonging in this type of place".

Pessimistic: You can ask any homeless street kid, it doesn't matter what you wear, what you look like, where you're from. You can be a heavy metal or gangster lover, or country kid. It doesn't matter because we all share one common thing. We are all homeless. And we are probably all junkies. I think there is definitely a sense of belonging. I think in high school it's a lot like you need to wear a certain thing to fit in or to like a certain music or do certain things or whatever. When it comes to being homeless it doesn't matter where you come from or what you did before then. What matters is that we all are homeless and we really stick together.

Harry: Yeah.
Pessimistic: When you are using drugs and it sounds crazy, but it’s not judgmental. I would hang out with people when we were high that I would never have been caught dead speaking to when walking through school. But we are high, homeless, and therefore have things in common. So I think that in a place like that there is a sense of belonging and security.

It is in these hidden locations, Ungar (2004) suggests, that socially excluded young people enter not only for comfort, but also to refine their alternative identity constructions as drug users who are homeless. The peers discussed the desire amongst young people who are drug users and homeless to create an inclusive space within a world that excludes them. In particular, they discussed how young people who are both drug users and homeless look to each other for a sense of belonging and security. Willis (1977) explains how sometimes when young people come together in groups to feel a sense of belonging and security, a distinct counter culture is established. Although Harry and Pessimistic discussed the freedom, belonging, and security that such a counter culture provides, there was also a darker side as captured by the next photograph.

*Photograph 19.*

In the photograph above, one of the peers is shown kneeling beside a gutter. According to Harry, "this one resembles someone who is down. Trying to show how when someone is down
they are an easier target”. The photograph was taken at the same location as the previous photograph that captured the narrow hallway with graffiti on the walls. Harry and Pessimistic discussed a contrast between the photographs afterwards and really liked how the darker side of youth drug culture and homelessness was articulated. Discussing this contrast further, it was suggested that the person in the photograph should not have been wearing brand name clothes.

Pessimistic: In all reality, how many times when I was homeless was I told that I wasn't because I was wearing DC shoes or other nice clothes? People were like you are not really homeless and I would say that I got those at donations thanks. I always would clean my shoes too and people thought that because they were clean and new looking that I wasn't homeless. They were like three months old and I was a crystal meth freak that could not help but clean their shoes. It gave me something to do. It's like you have to look exactly like the stereotype. Live with no vanity whatsoever. Not the same with youth, we want to look the best we can. People pass youth that are homeless all the time and probably never know it. Just because you don't see them doesn't mean that they don't exist.

Harry: Yeah.

Pessimistic discussed the stereotypes of homeless drug users and related them to herself. When she was homeless and using, Pessimistic explained how she always looked nice and wore the best things she could and for that reason many people did not believe she was in such a position. As a result, many young people who are homeless are not recognized to be so. Describing this further, Pessimistic explained how, "it's not typical for a young person to sleep outside. Young people are usually staying at shelters or couch surfing. The youth shelter is good. More youth go to Ridele if they can". I asked what Ridele was.

Alex: What else can you tell me about this youth shelter?

Pessimistic: It's on Gordon Street. It will take you when you are sixteen. It's for men, women, and children.

Harry: Do you get to share a room with your boyfriend?

Pessimistic: Yeah and you can get your own bathroom too because at the back of the house there is a room and a bathroom. They put us there because we fight. They didn't
want us to keep other people awake. Then he punched my face in and held me against the wall by my throat. I was like oh I'm gonna die. I looked at his face and thought I was gonna die. He was like you're fucking lucky. I was like lucky for what? That you're a pussy and you can't kill me? Then we went downstairs and they were like did he hit you? And I was like well I am going to say no. Let me use the phone. As I was saying though, I find a lot of youth go there if they know about it because Ridele will give you four dollars a day.

Harry: Doesn't Burnier give you more than that?

Pessimistic: Yeah but they give it to you once a week.

Harry and Pessimistic discussed several shelters available in the city and the monetary support provided by each. As both peers had been homeless they were well aware of what was available for young people in their city. Pessimistic was particularly conscious of what was available in the city because she had been homeless for two years. I could not help, but think how their positions as peers at The Centre provided them an excellent venue for transferring this knowledge to other young people who might have similar experiences.

Pessimistic also discussed a relationship that she had with a partner at the time who was abusive towards her. She acknowledged that she said nothing because she did not want any service providers to get involved in her relationship. She preferred to deal with it on her own.

Both peers continued to discuss shelters in the city.

Pessimistic: The youth shelter is really good for that. Ridele gives options. They will post rooms for rent and help people fill out housing applications, but mostly it is up to you. A big thing about the shelters too is that you can only stay so long. The youth shelter is 15 days with an additional three emergency days or they can give you an additional 5 emergency days on top of that but that is discretionary. So potentially for 23 days in a month you can stay there.

Alex: What do they do to help young people get permanent housing?

Pessimistic: Permanent is not so easy, but you can always find somewhere especially when you're homeless and have access to dope realistically. If you are a drug user and I show up at your house and am like, hey, want to get high you are not going to tell me no. Then if we get high together the assumption is that if I am smoking you my dope then you are giving me your house to chill at. Not for days and days though.
Harry: Yeah it depends on the person.

Pessimistic: If I get high with you and you smoke my dope then you're not going to tell me to leave so I'm staying.

The peers discussed youth drug culture and homelessness in relation to using drugs and getting shelter. For the peers, if young people who are homeless can get drugs then temporary housing is easy to find. Permanent housing by comparison, Harry and Pessimistic acknowledge, is more difficult to acquire. When I asked further about the relationship between drug use and homelessness the peers had the following discussion.

Alex: What do you think is the relationship between drug use and homelessness for young people?

Pessimistic: Yeah it's hard to be homeless and not use.

Harry: It keeps you warm.

Pessimistic: Keeps you busy and not caring.

Harry: Yeah makes time go by faster.

Pessimistic: Yeah it does not matter what kind of drug is being used. Uppers speed up your perception of time and downers slow it down so you don't notice the time.

The peers discussed how when homeless, drug use helps overcome the situation by making them feel warm when it is cold, simply not care, and forget time. Maté (2008) explains how, no matter what, drug users want to escape spending "alone time" with their minds (p. 37). Indeed, for Harry and Pessimistic, drug use was a means to combat time, relieve stress, and help them to cope with homelessness.

I asked the peers to discuss further the relationship between drug use and homelessness amongst young people.

Alex: Are young people homeless because they are users or are they users because they are homeless?
Pessimistic: I think it happens both ways. I was homeless first and then I was like there is nothing to do but get high.

Harry: I was using before I was homeless.

Pessimistic: It comes from both. People become homeless because they use and people use because they are homeless.

Describing youth homelessness and drug culture further the following photograph was presented.

*Photograph 20.*

The photograph depicts a car park stairwell where Pessimistic often slept and used drugs when she was homeless. Referring to both herself and her partner at the time she said, "originally we found it because we were looking for somewhere enclosed to smoke drugs. We went there to smoke pot in the wintertime because it was cold. So we hot boxed it a little bit". Hot boxing is when marijuana is used in an enclosed space to increase the effect of the drug.

Next, Harry and Pessimistic discussed food in relation to youth drug culture and homelessness when the following photograph was presented.
Harry: Even Tim Horton's at the end of the night will throw out everything. There are homeless people right outside that would kill for that. At the very least, take it to a shelter or something.

Pessimistic: Yeah I used to work at McDonalds and even if I screwed up someone's order because they came back and it had tomatoes on it when they can't eat tomatoes, I would always be like well you can have that burger and I'll make you a new one so you can give it to someone else. The policy is that I have to throw it out. If you want to step outside and give it to the homeless man panning or someone else then that would be great because I have to throw it out. So you might as well take it. My boss got mad at me for not taking someone's sandwich and throwing it out. I was like what difference does it make. The one day I was like I'll just give this sandwich to the man panning outside and the manager was like you can't do that, if he got sick or something and sued it would be your fault. I doubt he is going to get sick and sue. He is hungry. There are starving young people out here.

Harry: Yeah.

Pessimistic: This is a barrier to life.

The lack of food and being homeless was identified and described by the peers as a contributor to mental instability. Both Harry and Pessimistic felt that restaurants could do more to help those whom were homeless. Harry and Pessimistic had compassion for those who were
homeless because of their own experience. Both peers then presented photographs for the theme drug use and addiction.

**Drug use and addiction.** Harry and Pessimistic identified and described the theme drug use and addiction as a contributor to mental instability and barrier to attaining what they understand as "good health". The photograph below resulted in a discussion about their initial drug use exposure.

*Photograph 22.*

Harry: When I was four my dad was getting checked before going into small court and he gave me a dime and then put it into my pocket. That was my first exposure.

Pessimistic: When I was a child my parents would be doing lines of drugs on the table. I was always told to go or whatever. When they were like go I would get up and go behind our sectional couch and listen to all of the adult conversation. They would say they were going to buy a kilo and I'd be like oh a kilo. But when I was probably about six I understood that my parents sold drugs and that was okay because that was their job. When I was about seven I found out that my parents did drugs and I was in denial for the longest time. I always knew they sold drugs and that my mum was a junkie. I always knew a lot of the shit and it never bothered me because I had everything and more. You know when Adidas splash suits first came out? I had one in every colour. In Grade 4 and 5 every morning before school I would pull out clothes and rip tags off and every day I would take those clothes off, throw them into mum's bedroom, and then go put on
another outfit after ripping that tags off those. Two brand new outfits every day. I got two or three new pairs of shoes every week. I brand new winter coat every couple of weeks. For two or three years I don't think my mum ever washed. She called the Salvation Army and said listen I have an entire bedroom full of designer clothes that you can have, but they're dirty and I am not washing them. They have all been worn once. You can either come and get them or they are going into the garbage.

Family members had provided the initial drug use exposure for both Harry and Pessimistic. Pessimistic explained how she knew that her parents were users and selling drugs. It never bothered her, however, because Pessimistic was having what she perceived to be a good childhood.

I asked them to discuss how their initial exposure influenced the ways they perceived drug use. In response, Harry said, "I didn't know it was a bad thing for a long time. I think I knew what drugs were and everything, but I just didn't know it was bad I guess. I just thought it was a normal thing. When you grow up with it you know?". Pessimistic agreed, but then also said how she was "in denial" about her parents using and selling of drugs. For Pessimistic, this denial was again related to how she perceived her childhood. Next, I asked the peers to discuss when they began using drugs themselves.

Alex: When did you begin using drugs yourselves?

Pessimistic: I was nine. I went to public school and the fry store nearby was where everyone went for lunch. My mum had to write me a note every day to say I was allowed off school property. Then she got annoyed that I was waking her up every morning to write this note so she just wrote a note saying that I was allowed to leave whenever I wanted. It was Grade 5. We used to leave every lunch and walk over to the fry store and then my mum started leaving joints on the table for my babysitter and every morning I would just take two because there were like fifteen rolled up on the table. I would take them and we would walk off of school property during recess. I would take a couple friends with me and ask them if they wanted to smoke this.

Harry: That was the school to smoke at. I went there and began smoking weed around the same time.

Pessimistic: We would also smoke cigarettes. I would just steal them and weed from my mum. Most of my friends would take like two tokes and then pass them back to me. I
think that's when I really got into it because I would just sit there and smoke half a joint to myself at nine years old.

Having begun using drugs in school, I asked them to describe further how they felt.

Alex: How did you feel when you began using drugs?

Pessimistic: I liked it.

Harry: Yeah I felt really cool. There was a fence that we could hop and go between a couple houses or whatever and smoke.

Pessimistic: Yeah the brown and yellow house.

Harry: Yeah I rocked that alley way. We would get so high there.

Both Harry and Pessimistic explained that it was in school where their initial drug use began. They did not use drugs alone by themselves at school, but would do so with other young people. Using drugs with other young people in hidden locations during school hours was enjoyable for the peers and contributed toward Harry feeling cool. Harry and Pessimistic did not use drugs by themselves, but only as part of a group outside school parameters within hidden locations. Once again, the peers referenced a counter culture. For Alexander (2001) and Neufeld and Maté (2005), such counter culture involvement represents a heightened propensity for drug use, in response to a loss of adult attachments and social exclusion.

When I asked them to discuss their relationships with teachers and staff members while they were using drugs in school, Pessimistic discussed the following situation.

Pessimistic: I went back in once and was sitting in class and kicked my desk over. The teacher said pick it up and I said I don't fucking think so; you need to pick that shit up. Those were my exact words at nine years old. I don't fucking think so. You need to pick that shit up. And she was like I think you need anger management and I was like you need to go fuck yourself. She just looked at me. She was the greatest teacher. She dealt with a lot of shit from me. I was a smart kid though. When I got to high school though it was more I didn't like what we were learning. What does y=mx+b have anything to do with my future unless I want to be a mathematician. Why would I need to know the slope of a line.
A patient teacher was excellent for Pessimistic. In high school, however, she thought that the material was irrelevant and not challenging enough. I then asked Pessimistic if she felt the same way about what was being taught in elementary school.

Alex: Did you think what you were learning in elementary school was useless also? How about challenging?

Pessimistic: Not as much. It was more in high school when it got ridiculous. So I haven't finished high school, but from Grades 9 to 11 all my friends were getting 3 or 4 credits a year while I was getting 8. I didn't do amazing but I got along fairly well. I didn't fail a class until I was in Grade 12 and I was definitely using drugs in Grade 9. You can be using drugs and be in college or have graduated. Look at half the college students in the city. Go to the bar on Friday. Guaranteed you could take the same pictures of the same students because they are there every week. Alcoholics. In high school those same students would be like you're a skid to me and I remember there were the kids who would take pills to stay up late studying for exams and then there were those of us who would be smoking bongs and be open about what we were doing. Then there were the closet smokers. They would come to the smoking section and we were all skids but these people were doing the same thing. They were just hiding away to do it and hanging out with a different crowd. A kid tried to add me to Facebook today who I hated in high school. She was a cheerleader and I was labelled a skid and she smoked and took caffeine pills.

Harry: I didn't go to high school. I was at Perry for three weeks and then overdosed out front. Then they searched my pockets and found two pills of ecstasy and a half quarter of perk. Then I went to Verge two weeks later. I called the principal a fat cow on the first day and then ran away from her so I didn't get into that school. The teachers didn't care.

Pessimistic: I went to Sanderson and when I was in Grade 11 I started doing a lot of cocaine and was getting really high at school. Then one day we stayed up really late downtown until about 3:00 a.m. getting high. Then I got really high one Sunday. The next day I was like I had to go to school and I didn't want to get on four city buses to get to Sanderson so I just went to Verge. I just enrolled in Verge. It was a couple months into school. They didn't give a shit. I was high as kite every day of my life there.

Elementary and high school were not challenging for Pessimistic. In high school, she found what was being taught to be unpractical and Pessimistic did not understand why it was important. Willis (1977) describes how some young people develop a sense of superiority over the teachers and school itself. This is not only because the material is considered irrelevant, but also those teaching are seen to not know the way of the world or anything about them as young
people because they have been in schools all their lives (Willis, 1977). Regardless, however, Pessimistic performed well even though she continued using drugs on a regular basis. Conversely, Harry did not attend high school regularly because of her drug use. Although they discussed different experiences, neither of the peers completed high school. They both described teachers as not really caring about them and their behaviours and activities.

Pessimistic explained how many drug users are completely functional. In her opinion, it is possible for someone to use drugs and still be completely functional. She explained, however, that there is a contradictory standard regarding drug use. While she was perceived negatively, so many other drug users, such as university students or young people with whom she attended high school that were bound for higher education, were seen as the opposite. A significant reason for this, Pessimistic discussed, is that while she is open about her drug use, others refuse to be. Everyone knows, Pessimistic believed, about the drinking university students, caffeine pill users, and closet cigarette smokers. In her view, these young people simply conceal their drug use and pursue paths where such behaviours and activities are overlooked. She then presented the following photograph describing drug use as it related to addiction.
For the peers, addiction was symbolized by the above photograph. Discussing her thoughts on addiction, Harry said, "after you have one, you will want more". Harry had made a poster that was in The Centre. Pessimistic quoted the poster for Harry, "a romantic is chasing their first love and the drug addict is always chasing their first high". Discussing addiction further, Harry referenced the poster saying, "the problem is that you will never get that high again. The first time you ever get high is the highest you will ever have again. And for the rest of your time doing drugs you will be forever chasing that high and you will never find it again". The peers described addiction similarly to Maté (2008), any repeated behaviour "in which a person feels compelled to persist, regardless of its negative impact" on their life and the lives of others (p. 128). It is therefore characterized by a "compulsion, impaired control, persistence, irritability, relapse and craving" (Maté, 2008, p. 129).

The peers then presented another photograph that they thought depicted addiction.
Harry: This one is my favourite because of the fact that she stuck a needle in her arm and what her tattoo says. It's kind of like rock bottom.

Pessimistic: Yeah I would like to title that picture rock bottom.

Harry: The quote on her side is perfect too. It says sometimes you need a good fall to see where you really stand.

Discussing the photograph the peers mentioned a mutual acquaintance who was an addict and had been in several fights and recently got hurt. The peers talked about her mother who was an addict as well and had spent time in prison. Both peers agreed that not everyone has to be a product of their family. They referenced a video that was recently made by The Centre describing histories and experiences of several young people who are drug users in the city, including both peers themselves.

Harry: You do not have to have to be a product of your environment.

Pessimistic: I think our video proves that. You can be coming from a typical good home or not.

Harry: Some of the people in the video had a lot of money.
Pessimistic: Yeah so take them versus us. They talked about how their families were good and how they were involved in extracurriculars and everything else. Extracurriculars? I was getting high after school since I was nine. There are people who come from the opposite of us where their parents are ministers or bank tellers and they are involved with it. I mean these parents could be completely against drugs, drinking, and whatever, but that doesn't mean that the kid won't do it.

Harry: It doesn't matter how much attention you are getting either. You could be a snobby little bitch, living in a nice house, and getting tons of attention from your parents and still go fuck up your life.

Pessimistic: Yeah it could be anything.

Harry: I know plenty of people in town whose parents are amazing and they are users.

Pessimistic: Or you can have nothing, your parents are on welfare or something, and have no desire to use drugs. I don't think it has anything to do with what you have or what your parents or family has.

I asked them what they thought was the precursor to addiction amongst young people, regardless of whether coming from a good family or not.

Alex: What do you think is the dominant factor underlying young people and addiction?

Pessimistic: Trauma of some kind. Anything from your parents being junkies and seeing that every day, to having a mental illness.

Harry: Yeah either way something happened along the line. You have to decide to do it. No one is going to make me.

Pessimistic: Yeah but I disagree with you a bit.

Harry: I put all of my drug use on me.

Pessimistic: Yeah I think it's all on you, but it can have things to do with other people outside of your control. I was definitely pushed into it. It was someone that I really trusted and looked up to. Ever since I was nine I wanted to be this girl. She was cool and I thought she was the greatest thing since sliced bread. Then I became homeless and she was homeless and we were hanging out. She said let's smoke some crystal meth and I was like okay.

Harry: I guess what I am referring to is that choice to say yes or no.
Harry and Pessimistic thought that regardless of circumstances, anyone could become an addict. Trauma of some kind was the most influential factor, but ultimately, they believed that it was a personal choice. For the peers, drug use was their own responsibility because they had made the choice to initially indulge and continue doing so.

When discussing trauma, Pessimistic referenced having parents as users and mental illness. According to Alexander (2001), having parents who are drug users and mental illness are features of dislocation, leaving these youth with a loss of integration into society and thereby leaving isolated, powerless, and most importantly excluded. Drugs alone do not make anyone into an addict, Maté (2008) argues. Young people do make a choice, but there must be a preexisting vulnerability for them to become addicted, namely trauma (Maté, 2008).

At the time of our focus group meetings, both Harry and Pessimistic had overcome their addiction. I asked them how hard it was to stop their drug use.

Alex: Was it really difficult for you both to stop using?

Harry: It wasn't that hard. I got out of rehab and relapsed again. I smoked weed and then started smoking crystal again. Then about five months before I got pregnant I just stopped. I didn't want crystal. I hated the smell of it. I got a half for my friend. We split it right down the middle like half and half. I lit mine and started puking because the smell was so disgusting. I love the high though. Before I didn't like the high but the taste and then it switched. I was pretty much able to stop everything except for alcohol.

Pessimistic: Yeah not hard. I just like had enough. I won't even say that I will never do it. I will never make it my lifestyle again, but I feel that it's different to party than to live life as a party. I think spending all your money and doing it every day and screwing up your priorities is a problem. For a while I was like that. Then I was like this is ridiculous. I don't need to do this.

Both peers explained that they had made choices to discontinue their drug use and overcome addiction. Although they explained it as easy for them, this was not necessarily the case for others they knew. The following photograph generated a discussion about addiction and suicide and why young people choose to use in the first place.
Photograph 25.

Pessimistic: I know a couple of people who have committed suicide and I know plenty who have tried. Essentially anyone who has ever been a drug addict has been trying to commit suicide. Just the act of doing drugs is committing suicide. Don't tell me that while you're getting high that that's not your road to death. You're not going to die instantly necessarily, but you know if you carry on down that road that you're going to die. That's the ultimate. If you are doing drugs then you obviously don't care a lot about yourself. I didn't give a fuck about me when I was getting high. Clearly I didn't.

Harry: I didn't give a fuck about me or anyone else. I would sit there and just not care.

Pessimistic: My friend overdosed when doing crystal meth and he was inhaling and inhaling and inhaling, turning blue, and I was like stop breathing you don't need to be a pig and suck in anymore. He kept smoking and then fell on the floor and started twitching. I was calling him a greedy fucking pig and kicking him. Yelling things like if you wake up then I am punching your teeth in.

Harry: My ex-partner and I were drinking, but I was on crystal and he was being rude to me in front of all my friends and he felt like that was a good thing to do. He went to go lie down or whatever and I stood there while he was choking on his puke because he lay down on his back.

Alex: Drugs, it seems, make you not care, but is that why you use them in the first place?

Harry: I think so in sense. When you're mad you just want to get high.

Pessimistic: Yeah. It's like I just want all this shit to stop and if I get high it will.
The peers discussed how drug use is analogous to suicide or wanting to die. When using drugs they did not care about themselves or anyone else at all. In many ways, they were more afraid to living than of dying. Maté (2008) argues how amongst young people drug use and addiction is often a means to cope with things out of their control. Harry and Pessimistic affirmed this argument when they discussed how their drug use was a means for them to simply not care at all.

Conclusion

Harry and Pessimistic identified and described mental instability as the primary theme for barriers to attaining what they understand as "good health". Related to mental instability as this primary theme, the peers identified and described a variety of secondary themes. The secondary themes contributed to mental instability because they generally provided the peers with unwanted feelings of inadequacy, not being accepted, judgment, lack of support and control, powerlessness, and most importantly social exclusion. Strategies to cope with social exclusion and overcome such unwanted feelings and attain what they understand as "good health" were captured specifically by the themes unhealthy relationships, youth drug culture and homelessness, and drug use and addiction. By contrast to all of their themes for barriers to attaining what they understand as "good health", the peers regularly referenced The Centre and its inclusive youth engagement model as a harm reduction approach.
CHAPTER SIX

CONCLUSION

Reflecting on what the peers have shared, I am reminded why the current study was undertaken to begin with. For me, the current study represents more than a contribution to the health literature, embodying a voice of two young people in regards to their own needs by presenting what they understand as "good health" and related barriers to attaining it. These young people, having been labelled 'high-risk youth', are rarely asked to share their voice regarding their own health needs. As such, they have been brave to not only do this, but also to discuss experiences and perspectives that are often not acknowledged because they are considered uncomfortable and inappropriate subject matter.

Thinking critically about the various circumstances affecting themselves and their own health needs is not easy because dominant social norms communicate an objective understanding. An objective understanding does not include the subjectivity associated with how the peers and other young people view their own health needs and is thereby largely exclusive. In the current study, the peers oppose such an objective understanding presenting a disconnect between what they understand as their own health needs with that imposed by community supports and service providers. Within this final chapter, I discuss the disconnect between what the peers understand as "good health" in relation to community supports and service providers. Next, what the peers identified and described as barriers to attaining what they understand as "good health" is discussed with reference to their ongoing exclusion from society. Finally, I discuss why bringing the peers and other young people into a dialogue regarding their own
health needs is important while referencing The Centre and its potential to overcome barriers to attaining what they understand as "good health".

**Different understandings of "good health"**

Community supports and service providers function to impose an understanding of "good health" that is conveyed and promoted as objective in keeping with dominant social norms. Such an objective understanding of "good health" is problematic because it rarely allows for debate or discussion, particularly from those whose life circumstances present a challenge and engage in commonly considered unhealthy behaviours and activities. The peers for instance, as young people labelled 'high-risk youth' because of engaging in what are commonly considered unhealthy behaviours and activities, are not asked to voice what they understand as "good health". In response, the peers are denied participation in the "social discourse that defines them" and excluded from contributing towards defining their own health needs (Ungar, 2004, p. 299).

Within the current study, this exclusion from participating in the social discourse which defines their health needs is opposed as the peers voice their own, subjective understanding of "good health", presenting a disconnect with that of community supports and service providers.

When asked to voice what they understand as "good health", the peers identified and described "mental stability" as the primary theme. Mental stability, as the primary theme for what the peers understand as "good health" represents a disconnect from that of community supports and service providers which privilege physical aspects (Maté, 2008). By comparison to mental stability, the peers did not consider physical aspects as important when asked what they understand as "good health".
Related to mental stability, several secondary themes were identified and described by the peers. Such secondary themes included: "Helping others and the centre"; "Positive body image"; "Having access to money"; "Regular sleep"; "Tattoos"; "Music"; "Cigarette smoking"; "Alcohol and marijuana"; "Healthy relationships"; and, "Housing". When the peers discussed the secondary themes they were honest about engaging in behaviours and activities that are commonly considered unhealthy such as tanning, receiving tattoos, cigarette smoking, and alcohol and marijuana use. These behaviours and activities, particularly receiving tattoos, the peers explained, provided them with feelings of control. Despite providing them with feelings of control, however, only in moderation did the peers think that the behaviours and activities contributed towards their mental stability and what they understand as "good health". Both peers acknowledged how even a moderate engagement in commonly considered unhealthy behaviours and activities was contested by community supports and service providers. This represents a disconnect between what the peers and community supports and service providers understand as "good health". Furthermore, it also functions to affirm how young people and their understanding of "good health" is rarely accepted by community supports and service providers.

Ungar (2004) explains how community supports and service providers have a choice to either add to or diminish the voice of young people regarding what they understand as "good health" and their related needs. Unfortunately, too often, community supports and service providers choose to diminish. By diminishing the voice of young people, community supports and service providers exclude and devalue them. In the current study, the peers, as young people, were able to voice what they understand as "good health". When enabled to voice what they understand as "good health", the peers did so in unique ways that make clear a disconnect between their own understanding and that of community supports and service providers. Asking
the peers what they understand as "good health" is empowering, particularly when it affects approaches undertaken towards them by community supports and service providers, such as that of The Centre. For the peers, only The Centre, with its young engagement model as a harm reduction approach, recognized that there is nothing wrong with accepting a voice which is not objective and based on dominant social norms. Consequently, The Centre has provided the peers with a sense of responsibility and inclusion. This sense of responsibility and inclusion, the peers discussed, in and of itself is fundamental regarding what they understand as "good health".

**Exclusion as a fundamental barrier to attaining "good health"**

Endeavouring to attain what they understand as "good health", the peers encountered several barriers. Their primary theme for barriers to what they understand as "good health" was identified and described as "mental instability". Mental instability was associated with several prevalent and interrelated secondary themes. Such secondary themes included: "Depression and anxiety"; "Stigma, discrimination, and judgment"; "Community supports"; "Unhealthy relationships"; "Youth drug culture and homelessness"; and, "Drug use and addiction". Exclusion from society is closely related to each one of these themes that they identified and described in relation to mental instability. By exclusion from society, Alexander (2001) refers to the loss of social integration into culture and community, resulting in a sense of isolation and powerlessness.

Exclusion from society was alluded to by the peers when they identified and described depression and anxiety as a secondary theme for barriers to attaining what they understand as "good health". Not only had the peers internalized depression and anxiety amongst themselves, but they also discussed it as being prevalent in the lives of others whom both of them interacted
with regularly. Related to depression and anxiety, the peers discussed feeling suicidal and being seriously challenged by their life circumstances, and were not comfortable going to community supports and service providers for fear of being viewed negatively and abnormal. Both peers acknowledged that having depression and anxiety was not normal, although within their lives it had become so. Their acknowledgement of this, in and of itself, makes apparent how the peers are excluded from society reflecting a desire to not be viewed negatively or abnormal.

Both peers discussed their fear of being viewed negatively or to be viewed as abnormal further regarding exclusion from society when they identified and described stigma, discrimination, and judgment as a secondary theme for barriers to attaining what they understand as "good health". In particular, the peers discussed adults in general and service providers in relation to stigma, discrimination, and judgment. From adults in general and service providers, the peers felt badly treated, disrespected, unappreciated, and rarely seen as responsible because of, for instance, their age, being pregnant, or already having children. As such, the peers felt generally excluded, misunderstood, and not accepted for who they are by adults in general and service providers. Such feelings, for Maté (2008) and Ungar (2004) are evidence of social exclusion.

Community supports were also identified and described by the peers as a secondary theme for barriers to attaining what they understand as "good health". Discussing community supports, the peers referenced how they are blamed for any unsuccessful approach. In an attempt to correct them, they felt that community supports will blame service users to induce conformity. Such blame that the peers discussed functions to do the opposite, further excluding them from accessing community supports. Regardless of how the peers responded, however, attaching blame is itself exclusionary. Both peers also discussed how community supports were located on
the fringes of society alluding to how this contributed to their feeling excluded. As Ungar (2004) explains, by positioning community supports "in the shadows" of society, young people labelled 'high-risk youth' are encouraged to "feel as though they are shadowed citizens" (p. 269).

Unhealthy relationships were identified and described as a secondary theme for barriers to attaining what the peers understand as "good health". Ungar (2004) explains how social exclusion brings about unhealthy relationships for some young people by creating circumstances that are difficult to cope with in their lives. Related to what the peers identified and described as unhealthy relationships, was a discussion about the prevalence of "goofs". The word goofs was derogatory and used to describe others whom they felt contributed towards unhealthy relationships. Closely associated to the word goofs, was "drama". Drama was characterized by gossip and bullying. "Family", "friends", "partners", and "community members" could all be goofs and were significant sources of drama in their lives from which they found it difficult to distance themselves. In response to these unhealthy relationships, the peers felt constantly watched and were on edge regarding their behaviours and activities, further contributing towards their social exclusion.

The peers identified and described the secondary theme youth drug culture and homelessness for barriers to attaining what they understand as "good health". In particular, the peers discussed how behaviours and activities associated with the 'high-risk youth' label, including homelessness, are attempts to attain what they understand as "good health" and overcome their social exclusion, by forming alternative identity constructions with other young people. With other young people, their alternative identity constructions were refined giving rise to distinct counter cultures. Counter cultures were discussed by the peers in relation to locations throughout the city that were hidden away where they can seek refuge, have a sense of
belonging, and feel both comfortable and secure. Putting graffiti on the walls of these locations was also used to symbolize their ownership and reinforce their counter cultures and related alternative identity constructions. Although such locations provided them with a positive sense of self, the peers described them as barriers to attaining what they understand as "good health" because of the association with drug use.

Drug use and addiction was a secondary theme that articulated a barrier to attaining what the peers understand as "good health". For the peers, drug use was closely related to addiction as a means to once again overcome their exclusion from society. When asked what lead them to addiction, the peers discussed early drug exposure and initial use. More specifically, however, they thought the precursor to addiction was trauma or mental illness. Trauma or mental illness, Alexander (2001) explains, are both associated with social exclusion. As described by Alexander (2001), addiction itself only takes hold in people who have suffered this throughout their lives.

When thinking about what themes the peers identified and described as barriers to attaining what they understand as "good health", it becomes apparent that social exclusion does not just happen once, but is rather an ongoing process. As an ongoing process, the peers are constantly trying to develop coping strategies to negotiate and overcome social exclusion. Such coping strategies are apparent in their regular decision to not access community supports thereby refusing to associate with adults in general and service providers because of the relationship between these interactions and depression and anxiety and stigma, discrimination, and judgment. Endeavouring to have healthy relationships can also be seen on behalf of the peers as a coping strategy, while the presence of unhealthy ones is itself a result of social exclusion. Both peers discussed forming alternative identity constructions and counter cultures to cope with social exclusion by providing a variety of positive feelings, in particular belonging. Unfortunately,
however, the belonging related to forming alternative identity constructions and counter cultures only enhances their exclusion from society because of its relationship to drug use and the addiction that subsequently followed. Given their social exclusion, coping strategies seem understandable for the peers are simply responding to ongoing processes that "make them less than fully contributing members of society" (Ungar, 2004, p. 194). Rather than recognizing this, problems are seen to reside within the peers themselves and not the community or society in which the meaning of them as a problem is constructed and maintained. It is necessary then, to fundamentally rethink how and why these young people are deemed problems to begin with and the negative implications of social exclusion as an ongoing process in their lives.

**Overcoming barriers to attaining "good health"**

As a means to overcome barriers to attaining what peers understand as "good health" they regularly discussed The Centre and its youth engagement model as a harm reduction approach. By including the peers, The Centre enables a possibility of helping its service users attain what they understand as "good health", while also receiving various harm reduction provisions including clean needles, education about safe drug use and sexual practices, general counselling, legal guidance, and food. For the peers, having community supports such as The Centre, which are inclusive, is important to help overcome barriers and attain what they understand as "good health" by enabling them to define and meet their own health needs.

Labelling young people as 'high-risk youth' and the associated derogatory language used to define them shapes how they view themselves. Rather than labelling young people as 'high-risk youth' it seems appropriate for community supports and service providers to acknowledge that the pathways these young people take to meeting their own health needs are constrained.
Indeed, these young people are denied control over the language and labels which define them, but also processes that both determine and function to meet their own health needs. Bringing them into a dialogue regarding their own health needs allows them to view themselves more positively than when participation and control is denied. This process begins with an approach that incorporates appreciation and respect for their unique knowledge and experience. A fundamental shift towards an appreciative and respectful approach, in ways similar to The Centre, as both peers suggest, might significantly help determine and enable the health needs of young people to be met.

**Recommendations for Future Research**

The study presents and discusses an aggregation of results that critique the 'high-risk youth' label and both community supports and service providers as they define and subsequently intend to meet the health needs of young people onto whom it is attached. Based on the current study, I suggest future research include the following:

1. The Participatory Action Research (PAR) method in the current study could be incorporated as policy by community supports and service providers, enabling young people to determine their own health needs.

2. Extend the participatory action research method used in the current study to other community supports and service providers that have peers and a youth engagement model as a harm reduction approach. Although such places are few and far between, conducting comparative research with young people from different social contexts would provide interesting results.
3. Conducting research with young people who are not labelled 'high-risk youth' would provide a useful basis for comparing different ways in which "good health" and related barriers are understood with that of the peers.

4. Both of the peers in the study were female. Research with males who access The Centre would provide important elaborations concerning what other young people understand as "good health" and identify and describe as related barriers.

5. My intention was to include more young people who were service users at The Centre as participants in the study. Unfortunately, some of the young people accessing its services had difficulty committing to the study. Exploring alternative strategies that might include them would provide further depth and insight to what young people understand as "good health" and identify and describe as related barriers.

**Postscript**

Silence, taken to be consent, is a euphemism used to condone inaction. In my various positions with community supports as a service provider, I had often heard this expressed when discussing young people. This is because the young people were perceived to simply accept life conditions and be passive in regards to meeting their own health needs, and thought not to need, or possibly deserve, any available programmes and services. As young people, the peers in the study are not silent and, I have learned, never were. Rather, while the peers are clearly articulate and understanding of the complex and intersecting realities in which they find themselves, their voice has too often fallen on deaf ears.

To ensure that their voice was heard, after the research itself was completed, the peers and I applied for and were awarded a grant through the local community public health
organization. We then purchased art supplies so that the peers could create a presentation incorporating both themes and photographs from the study. Several presentations were arranged throughout the city for community supports, service providers, and the public in general. All of these presentations were well received. In particular, the peers received positive feedback for their artistic presentation of photographs. Regarding their themes, it was evident that the ideas and relationships between them were not necessarily understood by all. Given the originality of their ideas and relationships between them, generating widespread understanding and subsequent change requires more exposure through the further incorporation of young people.
REFERENCES


APPENDIX A

RECRUITMENT FLYER

Youth Health Photography Project

When: Thursday, February 3, 2011
4:30 PM
Where: In the conference room upstairs from The Centre

- 15% FOOD VOUCHERS
- COMMUNITY SERVICE HOURS
- BUS FARE COMPENSATION
- FOOD AND DRINKS
APPENDIX B

LETTER OF INFORMATION

Introduction

My name is Alexander Makin and I am writing to ask if you will participate in a study about youth perceptions of health. I am doing the study as part of my Master's of Education at Queen's University. The study is called: The 'high-risk youth' label: A constructive critique. This study was granted clearance by the General Research Ethics Board for compliance with the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans, and Queen's University policies.

The purpose of the study is to explore how young people accessing The Centre understand "good health" and identify and describe barriers to attaining it. Findings from the study will be used to inform programming activities at The Centre and engage the community.

What activities does participating in the study involve?

You will be asked to meet in a group with other participants to discuss details about the study. Next, the will be asked to meet and discuss what they understand by "good health". Afterwards, you will be asked to meet in a group again to think about barriers to attaining "good health". Next, you will be given a camera to take photographs, over a one week period, that depict your views as to the barriers to attaining "good health". During that week, I will be available for you to meet with me and follow up about the photographic component. These follow up meetings will be optional for all participants. Following the week of photographing, you will return the cameras to me and I will have the photographs printed. Then all of the participants will meet with me as a group to present and discuss their photographs as they relate to health barriers. Each one of these focus group meetings will be no longer than 2 hours in duration. Several weeks later, you will be contacted by me to meet for a closing interview meeting to discuss further your views on barriers to attaining "good health". The closing interview meeting will be approximately 45 minutes in length.

What are the benefits and risks from participating in the study?

You will be able to tell stories and express opinions about your understanding of "good health" and related barriers that will help influence programme development at The Centre. You will also receive community service hours and a $15 food voucher on completion of all or part of each group meeting and the individual interview. Food and drinks will be provided at the focus group meetings and closing interview.

I do not foresee any undue risks involved in this study. If emotional distress is experienced, upon your request I will provide information on how to access support services should you feel the need to do so.
What if I change my mind and do not want to participate in the study or share my information?

Your participation is completely voluntary. You are free to withdraw from the focus group meetings, optional follow up meetings, or closing interview at any time. You do not have to answer any questions or engage in discussion that may make you feel uncomfortable. There are no negative consequences for withdrawing from the study. Focus group meetings, the optional follow up meetings, and closing interview will be audio recorded and put into text. After the data has been analyzed, I will arrange to meet about the data you have contributed. At that time, you may change or remove any statement or idea from the data. You may also ask, at any time, for any or all your data to be removed from the study.

How will participant confidentiality be protected?

The privacy of the people who participate in this study will be protected to the fullest extent possible:

- You will be asked to create a pseudonym for yourself so that none of the data contains your name.
- The audio files from the group meetings, the follow up option and interview will be destroyed in 5 years.
- No photographs that could potentially identify you or others will be used.
- All participants will be required to sign a confidentiality form regarding material discussed in the group meetings.
- Data will be kept in a locked office at Queen's University.
- My supervisor and I will be the only ones to see the raw data.
- The photographs and information given in the focus group meetings, optional follow up meetings, and closing interview meeting will be published as part of my Master's thesis, they may also be presented at academic conferences, but your identity will not be attached to any materials.

How do I consent to participate?

If you are interested in participating in this project, please read the consent form carefully, sign, date, and return it to me. You will receive a copy of the form for your own records.

What if I have additional questions about the study or my participation?

Any questions about study participation may be directed to me, Alexander Makin, directly at 3acom@queensu.ca or my supervisor, Dr. Magda Lewis, at 613-533-6000 ext. 77277 (magda.lewis@queensu.ca). Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at 613-533-6081 or chair.GREB@queensu.ca.

Thank you. Your interest in participating in this research study is greatly appreciated.

Alexander Makin
APPENDIX C

CONSENT FORM

- I have read and retained a copy of the Letter of Information and have had any questions answered to my satisfaction.
- I understand that I will be participating in the study called: The 'high-risk youth' label: A constructive critique. I understand that this means that I will be asked to attend four focus group meetings, take photographs of my lived experience as it relates to health barriers, and participate in a closing interview.
- I understand that the purpose of this study is to determine how I understand "good health" and identify and describe some of the barriers to attaining it.
- I understand that my participation will be in the form of four focus group meetings that will be 2 hours in length and a closing interview meeting for approximately 45 minutes.
- I understand that the focus group meetings, optional follow up meetings, and closing interview meeting will be audio recorded.
- I understand that the photographs I take and the information given in the focus group meetings, optional follow up meetings, and closing interview will be published as part of a Master's thesis and may be presented at conferences and published in academic journals.
- I understand that confidentiality will be protected to the fullest extent possible by appropriate storage and access of data.
- I understand that no photographs identifying myself or others will be used.
- I understand that I can withdraw from the study at any time without consequences and can ask for all or part of my data to be removed.
- I understand that any questions about study participation may be directed to Alexander Makin at 3acom@queensu.ca or his supervisor, Dr. Magda Lewis, at 613-533-6000 ext. 77277 (magda.lewis@queensu.ca).
- I understand that any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at 613-533-6081 or (greb.chair@queensu.ca).
- **Please sign one copy of this Consent Form and return to Alexander Makin. Retain the second copy for your records.**

I HAVE READ OR HAD READ TO ME AND UNDERSTAND THIS CONSENT FORM AND I AGREE TO PARTICIPATE IN THIS STUDY.

Name (please print clearly): ________________________________________
Signature: ________________________________________
Date: ________________________________________
Email or Telephone Number: ________________________________________

Please write your email or postal address at the bottom of this sheet if you wish to receive a copy of the results of this study.

Email Address: ________________________________________
Postal Address: ________________________________________
I have read and retained the Letter of Information and Consent Form concerning the study being conducted by Alexander Makin entitled: The 'high-risk youth' label: A constructive critique. As a participant in this study, I understand the nature of the research with regards to the four focus group meetings and optional follow up meetings and requirements for confidentiality. I have had all of my questions concerning the study and my role as a participant answered to my satisfaction.

Maintaining Confidentiality

I agree not to reveal in any way to any person outside of the focus groups any information described by other participants in the discussions.

Identification and Signature Indicating Agreement

Name: ________________________________

Email: ________________________________

Telephone: ________________________________

Signature: ________________________________

Should you require further information please feel free to contact me, Alexander Makin, directly at 613-217-6579 or 3acom@queensu.ca. You may also contact my supervisor, Dr. Magda Lewis, at 613-533-6000 ext. 77277 (magda.lewis@queensu.ca).

Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at 613-533-6081 or chair.GREB@queensu.ca.
APPENDIX E

INITIAL FOCUS GROUP MEETING PROBING QUESTIONS

1. Why do you want to participate in this research?

2. What goals would you like to achieve individually?

3. What goals would you like to achieve as a group?
APPENDIX F

EXPLORING AN UNDERSTANDING OF "GOOD HEALTH" FOCUS GROUP MEETING PROBING QUESTIONS

1. What does "good health" mean to you?

2. What are some words you would use to describe feeling healthy?

3. What does your optimal level of health look like?

4. Why do you see "good health" in this way?
APPENDIX G

DISCUSSING BARRIERS TO ATTAINING "GOOD HEALTH" FOCUS GROUP

MEETING PROBING QUESTIONS

1. What are some different things or circumstances that might be barriers to attaining what you understand as "good health"?

2. Why do you think these barriers exist?

3. Describe some instances in your lives when you might have encountered these barriers?

4. What was your response when you encountered these barriers to attaining "good health"?
APPENDIX H

REFLECTION PERIOD AND FOLLOW UP FOCUS GROUP MEETINGS PROBING QUESTIONS

1. How are you finding the Photovoice project so far?

2. What kinds of photographs have you taken?

3. Why did you choose to take these particular photographs?

4. How might the pictures reflect barriers to attaining "good health" in your life?
APPENDIX I

DEBRIEFING FOCUS GROUP PROBING QUESTIONS

1. What barrier to attaining what you understand as "good health" is being portrayed in this photograph?

2. How do these images make you feel?

3. How does this photograph relate to your life and experience?

4. Why do you think that the barrier to attaining your understanding of "good health" presented in this photograph exists?