UNB | Urban and Community Studies Institute

EST. 1785
UNIVERSITY OF NEW BRUNSWICK

REDUCING STIGMA TOWARDS VULNERABLE POPULATIONS: OPPORTUNITIES FOR STIGMA REDUCTION AT ROMERO HOUSE, SAINT JOHN, NEW BRUNSWICK

BY EMILY FORTE, EMILY FOX, ROBYNE WALLACE, ETHAN GAUNCE, AND DR. JULIA WOODHALL-MELNIK (SENIOR AUTHOR)

Written for Romero House Soup Kitchen Inc. to fulfill the course requirements of SOCI 4379: Engaging with Community-Based Health Organizations

Executive Summary

Stigma is defined as "a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society" (WHO, 2001). There are several types of stigma including self-stigma, social-stigma, and structural-stigma that develop when a group or individual are deemed deviant. All forms of stigma have lasting physical, social, and psychological impacts (Arboleda-Florez, 2002; Livingston et al, 2011). This paper investigates the effects of stigma and explores best practices for reducing stigma towards vulnerable populations that frequent Romero House, a soup kitchen in Saint John, New Brunswick. The authors collaborated with Romero House to determine four populations on which to focus this review. The populations focused on experience food insecurity, addictions, newcomer status, and generational poverty. An extensive review of academic literature and grey literature looked for examples of best practices that could be implemented at Romero House to reduce stigma toward these populations.

People who experience food insecurity and access social assistance programs experience stigma. Grey literature offers a few solutions for reducing the stigma toward those who access these programs. However, this review finds that there are barriers to the effective implementation of these programs. Public education which promotes empathy toward vulnerable populations is key to reducing stigma (Best, 2015). There is a large gap in literature on solutions for reducing stigma toward food insecure populations and more research needs to be conducted to improve the wellbeing of these populations.

Persons with substance use disorders tend to experience more stigma than any other vulnerable population (Best, 2015). Evidence suggests that education provided for community members who are not impacted by addictions will reduce stigma towards this vulnerable population (Kayman et al., 2015) Education interventions increase are said to reduce stigma as they increase empathy (Kayman et al., 2015). Stigma reduction improves self-image in populations that use substances (Livingston, 2011), which leads to a higher likelihood of enrollment in recovery programs (Kayman et al. 2015; Livingston et al., 2011).

Newcomers experience various forms of stigma that places them at risk of experiencing high rates of poverty. In 2016, over half of newcomer children in New Brunswick lived in poverty (Human Development Council, 2018). Stigma in the form of xenophobia has had a negative impact

on the social and economic status of newcomers and continues to promote racialized discrimination (Forstenlechner & Al-Waqfi, 2010). Best practices for reducing stigma toward newcomers include one-on-one approaches, intercultural exchanges, and educational programs focused on tolerance and acceptance (Doyle, 2017).

Individuals who experience generational poverty are at risk of experiencing neighbourhood stigma and stigma associated with welfare use (Besbris et al., 2015; Blank, 2005). Generational poverty is a serious concern within Saint John's five priority neighbourhoods and will continue to impact children's development and future opportunities (Living SJ, 2018). Three strategies for combating stigma and generational poverty are social policy development, promoting mixed-income housing, and increased education.

Based on a review of academic and grey literature surrounding stigma, vulnerable populations, and best practices, there are several recommendations for action at Romero House. Further research is needed regarding the stigma surrounding food insecurity as current best practices on reducing food insecurity stigma are inadequate and ineffective. Education within the Saint John community that shares success stories of recovery from addictions may be useful in decreasing stigma towards this vulnerable population. Finally, stigma against newcomers can be countered with one-on-one, long-term, community building approaches that bring together newcomer clients of Romero House with the larger Saint John population.

Introduction

Stigma is defined as a collection of negative and often unfair and untrue beliefs that a society or group of people assigns to another group (Arboleda-Florez, 2002). Three types of stigma are commonly discussed in academic literature (Livingstone et al., 2011; Owen et al., 2013). Social-stigma describes stereotypical images that dominant groups within society associate with a vulnerable group or groups of people (Livingston et al., 2011). Social stigma contributes to the second form of stigma, self-stigma. Those who experience self-stigma internalize social stigma and develop negative feelings toward themselves. This often results in their participation in dysfunctional and stereotypical behaviours, which reinforces the stigmatized views held by dominant groups (Livingston et al., 2011). The third type of stigma is structural stigma. Structural stigma is a form of institutional discrimination where governments, organizations and policies intentionally and unintentionally create barriers for groups experiencing stigma. This often results

in experiences of inequity and leads to further loss of socioeconomic status (Livingston et al., 2011). Research suggests that stigma can create mental distress and poor socioeconomic outcomes for vulnerable populations (Weng et al., 2018).

Stigma develops when the public's opinion of normal is threatened (Derks et al., 2008). It is common for societies to assign moral value to activities, behaviours and attributes that they believe to be normal and/or desirable. These activities, behaviours and attributes are indicators of a society's social norms. Stigma is a mechanism of social control which aims to alter the activities, behaviours and attributes of those who do not fit the norms in their societies (Arboleda-Florez, 2002). Stigma creates hardship for vulnerable populations. For example, stigmatized groups often experience barriers to accessing services, employment and stable housing (Arboleda-Florez, 2002).

Governments, private agencies and non-profits intervene to reduce stigma through educational campaigns (Livingston et al. 2011) Educational interventions challenge stigma by presenting research and facts about the experiences of stigmatized populations in accessible ways. Although generally aimed at combating social stigma, educational interventions are found to be effective in reducing self-stigma (Olsen & Sharfstein, 2014). Educational interventions, combined with cognitive behavioural therapy, improve stress management and boost self-esteem in populations who experience stigma (Olsen & Sharfstein, 2014).

This paper identifies effective practices for reducing stigma toward vulnerable populations and explores how these practices can be applied in Saint John. The groups examined are those experiencing food insecurities, persons experiencing addictions, newcomers to Saint John, and individuals experiencing intergenerational poverty.

Romero House

This paper was conceptualized in consultation with Romero House Soup Kitchen Inc. ("Romero House"). We describe our community-based approach in further detail in the methods section. Romero House is a registered charity located in Saint John, New Brunswick that provides a variety of free services to vulnerable populations in the area. Their doors opened on March 8th, 1982 and since then, they have served over two million meals to individuals in the Greater Saint John area (Romero House, n.d.). Romero House is named after a famous El Salvadorian Catholic

priest who was killed for his work with the poor. They opened as a soup kitchen at 109 Union Street in the center of Saint John to meet the growing need for food security in the city ("Soup Kitchen," 1982). Their purpose was "to provide one good hot nutritional meal seven days per week for those members of the community who were unable to obtain this for themselves" (Romero House Newsletter, 1982). Initially, Romero House provided four main services: soup kitchen meals, skills development through a crafts center and workshop, client outreach, and a clothing center (Romero House Newsletter, 1982). However, they have since expanded to offer medical services, life skills support, emergency family assistance, and a popular mobile unit, which provides services to individuals at different locations in the city. Romero House now operates out of an agency-owned building on Brunswick Drive. Romero House does not receive public funding and its only support comes from private donations and volunteers (Romero House Newsletter, 1982).

Research Methods

This paper presents findings from our review of grey and scholarly literature. The objective of the review is to investigate the applications of stigma reduction interventions, which are designed to address stigma towards vulnerable populations. In order to identify the purpose and focus of the study, we took a community-based research approach and collaborated with Romero House in Saint John, New Brunswick to determine a research question that may contribute to improving health outcomes in the populations they serve. Romero House identified stigma and misconceptions of vulnerable populations as detrimental to their health and wellbeing. This report focuses on vulnerable populations identified by Romero House as clients who are highly affected by stigma. These are those impacted by food security and poverty, individuals experiencing addiction, immigrants and newcomers, and persons experiencing generational poverty. The research team and the community organization agreed upon the need to review best practices and provide recommendations for stigma reduction to Romero House.

The initial data collection phase was informed by previous news articles and existing academic literature on Romero House. We also made informal observations while volunteering at Romero House. These observations guided the initial data collection phase. Prior to beginning our search, we consulted the Sociology and Health Science librarians at the University of New Brunswick (UNB) in Saint John. They assisted with the development of academic and grey

literature search strategies. Searches for peer reviewed research were performed online through the UNB libraries Catalogue, Scopus, Pubmed, PSYCINFO, and Google Scholar (for a fill list of search terms see Appendix A: Table of Search Keywords) and were performed by group members at various times between Jan 2019 and April 2019. A wide selection of keywords were used to identify stigma and best practices for stigma reduction in each vulnerable population. Key words were diverse and included stigma, misleading information, vulnerable populations, government funding, social welfare, food and security, substance additions, immigrants, poverty, and refugees. Grey literature consists of documents found at Romero House, web site articles, and newspaper articles posted online. Finally, research gathered from academic and grey literature on best practices to reduce stigma informed key recommendations for application at Romero House.

Literature Review and Best Practices for Stigma Reduction

Food Insecurity and Stigma Around Social Assistance Programs

Food security exists when every individual has consistent physical and economic access to "sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life" (as cited in FAO, 2006). This requires that individuals have access to income and food programs that are comprehensive. Saint John, New Brunswick struggles with poverty and food insecurity, which result from gaps in funding and legislation. Stigma plays a role in developing and maintaining these gaps (Hicks, 2018).

In 2012, 13% of Canadian households experienced food insecurity (Loopstra & Tarasuk, 2012). Food insecurity is associated with inadequate access to wealth (Sonnino, 2016). Although Canada is traditionally viewed as a wealthy nation, segments of our population continue to experience poverty, low-income and food insecurity (Tarasuk et al., 2019). Statistics Canada (2017) classifies 9.5% of population of New Brunswick as low-income. However, rates of low-income in New Brunswick vary by subgroup. For example, non-elderly, single adults experience a poverty rate of 31.5% (Statistics Canada, 2017). As a capitalist nation, Canada subscribes to a neo-liberalist ideology, which values individualism and self-sufficiency (Lazăr, et al., 2019). This results in assigning fault to the individuals who access economic and material assistance to meet basic needs.

As noted above, stigmatized individuals are often in violation of social norms. Society often views people who access social programs as 'undeserving' of support. This view produce stigma that is dehumanizing and harmful to persons who are not considered to have economic worth (Baumberg, 2016). Baumberg (2016) surveyed 2,601 people and 1,123 of these respondents received direct or indirect financial assistance from the government. He finds that 58% of respondents disagree with the statement that people are treated with respect when they make a social assistance claim. The degree to which people experience stigma is often dependent on the perception of whether an individual is deserving of support (Baumberg, 2016).

There is a lack of literature, which provides interventions for reducing stigma toward persons who access food banks and social assistance. However, there is consensus that stigma is a barrier to service access in vulnerable populations (Casas et al. 2000). Further, it is also a barrier to volunteerism in the general population (Ho & O'Donohoe, 2014), which is especially problematic for food banks and hot meal programs that often rely on donations and volunteers (Knutsen, 2016). Programs such as Operation Sharing in Ontario, Canada argue that we can reduce the stigma experienced by individuals who access food banks and meal programs by providing grocery store gift cards (Woolley, 2015). This provides people with dignity and choice, as they can shop in grocery stores; however, we lack sufficient evidence to support the ongoing viability of these types of initiatives.

People often associate homelessness with food bank use and this association creates stigma (Quan, King, & Fotheringham, 2017). However, research finds that not everyone that is food insecure experiences homelessness or requires access to additional social services (Loopstra & Tarasuk, 2019; Tarasuk et al., 2019; Quan et al., 2017). For example, many people who access food banks have families, homes, and jobs (Amador, 2014). This can be attributed to an increase in precarious work and the high cost associated with obtaining basic needs such as housing and healthy food (Hicks, 2018). To counter this, Tony Fuller et al. (2003) from the University of Guelph recommend the use of inclusive spaces for feeding all people regardless of socio-economic status. Hamilton, Ontario's Café 541 is a thriving example of this. The café uses an exchange system where patrons are able to pay extra for affordable meals. Each extra dollar paid provides the café with a button for use by anyone who comes into eat at the cafe. The buttons are not only for those experiencing homelessness. Anyone without currency for any reason can use buttons.

This would break down some of the existing barriers and reduce some of the stigma associated with food insecurity (Loopstra & Tarasuk, 2012).

Tarasuk (2001) discusses alternatives to food banks often being successful at the community level because of initiatives like Cafe 541, which are designed to foster personal empowerment through mutual support strategies. It is through these community-based initiatives that stigma is lessened and barriers between those experiencing food insecurity and those who are not are broken. Giving a sense of personal empowerment reduces a lot of the self-stigma vulnerable populations experience.

As there is a lack of peer-reviewed literature on reducing stigma associated with food banks and hot meal program use, we investigated programs and suggestions for stigma reduction from grey literature. However, the suggested stigma reduction interventions in the grey literature are not always evidence-based and may not be effective. For example, some meal programs strive to provide clients with a restaurant style dining experience. The goal is to provide clients with dignity. Although these ideas are great in theory, they run the risk of alienating clientele who feel uncomfortable in restaurant settings. Further, they accentuate the notion that it is humiliating to be viewed as poor (Tarasuk et al., 2014). Incorporating formal waiters, professional kitchen staff, and high-end décor and suggesting that clients dress up, can remove clients' sense of familiarity and safety (Tarasuk et al., 2014). This can also result in self-stigma if clients feel that they are not of the social class to partake in fine dining. Romero House successfully hosts a formal Christmas dinner each year for their clients. These dinners are well attended and operate successfully, as clients are not asked to dress up and are provided table service by regular the volunteers with who they are familiar. This may indicate that agencies should focus on the needs of their specific clientele when designing special dinners and programs.

It is important to recognize the value of social programs; however, stigma reduction does not fix the true problems faced by individuals who experience food insecurity and poverty. The best way to reduce the need to access social and food programs and hence reduce residual stigma is to provide all residents and citizens with a guaranteed annual income (Emery et al., 2013). In Saint John, a family of four requires two adults to each work full-time and earn at least $18.18 per hour to live modestly (Hicks, 2018). A guaranteed annual income would provide all people with the income needed to meet basic living needs. This is key for establishing food security according

to Emery et al. (2013) because a guaranteed income would mean less financial vulnerability for people who are forced to live from pay cheque to pay cheque. When financial stressors occur, households with lower incomes are less able to recover quickly than households with higher incomes. This is because lower income households lack budget surplus and access to assets or credit, meaning it is easier to be pushed over the threshold for food insecurity (Emery et al., 2013).

Stigma and Addiction

Persons who use substances experience a lot of social, self and systemic stigma. The World Health Organization reports that drug use is the most stigmatized health condition in the world (Best, 2015). Alcohol use disorder is the fourth most stigmatized health condition (Best, 2015). This is especially problematic as society often sanctions stigma toward persons who use substances (Best, 2015). In other words, this stigma is perceived as warranted or socially acceptable.

Sociologists argue that society stigmatizes individuals and groups who do not uphold social norms in order to sanction them into behaving normatively (Link, 2001). However, Best (2015) argues that stigma has the opposite effect on the behaviour of persons who use substances. Stigma toward those who use substances results in increased substance misuse and addiction (Best, 2015). In turn, affected persons are not inspired to seek support or treatment. This contradiction produces a divided discourse on treatment for substance use disorders.

Although addiction is classified as a mental health disorder in the DSM-V, arguments on morality and substance use continue to impact decisions on treatment (Livingston et al., 2011). For example, persons who use certain types of substances experience criminalization. However, criminalizing substance use does little to change behaviour and instead results in increased stigma and social exclusion for individuals who use illegal substances (Livingston et al., 2011). This is problematic as stigma and social exclusion are not conducive to recovery (Best, 2015; Szalavitz, 2009).

Persons who are stigmatized for their use of substances often experience multiple vulnerabilities, which include social alienation, poor physical and mental health, and lack of motivation to seek medical treatment (Best, 2015). Research finds that health care providers often display stigma toward persons who use substances (Kayman et al., 2015). Providers who do hold stigmatizing beliefs tend to think that people who use substances tend to overuse government

resources, fail to comply with treatment orders, and abuse the system by depending on it to treat self-inflicted health issues (Livingston et al., 2011). Individuals treated by providers who stigmatize them experience depression, alienation and financial difficulty (Livingston et al., 2011). Further, those who have had negative experiences with a health care provider are less likely to seek medical assistance when required (Livingston et al., 2011). This results in the delayed treatment of conditions, which is detrimental to the health of individuals who use substances and requires greater investment from the health system. According to research, stigma reduction is integral to health promotion and recovery in persons who use substances (Kayman et al., 2015).

Education is a commonly used intervention for reducing social stigma toward persons who use substances (Kayman et al., 2015). Education programs help those who encounter persons who use substances and members of the broader population to understand the root causes and motivations for substance use. Livingston et al. (2011) find that community members who viewed educational documentaries experienced a 16% reduction in measured stigma toward persons who use substances (Livingston et al., 2011). Group discussions amongst community members result in a 11% decrease in stigma (Livingstone et al., 2011). Their results also indicate that documentaries and group discussions are particularly beneficial for reducing stigma in health care workers as they encourage more empathy toward patients who use substances (Livingston et al, 2011). Positive experiences with health care workers leads to an increase in patients' self-esteem and help seeking behaviour (Livingston et al., 2011).

Social stigma leads to self-stigma for those experiencing addictions (Kayman et al., 2015). Kayman et al. (2015) find that people who use illegal drugs often do so to escape the stigmatizing reality of living with multiple vulnerabilities and substance use disorders. Harm reduction interventions are found to be the most useful in reducing self-stigma in persons who use substances (Kayman et al., 2015) One of the key principles of harm reduction is acceptance and lack of judgement (Kayman et al., 2015). Harm reduction involves a variety of interventions that are designed to improve public health and lower the risk associated with a variety of activities and behaviours. For example, wearing a seat belt while driving a car is harm reduction, as the risk of serious injury from driving is reduced. Harm reduction for substance use draws on a variety of interventions, such as counseling, education, the provision of unused injection product, managed alcohol consumption programs, supervised consumption sites, and the provision of Naloxone kits

to respond to opioid overdoses. Individuals who participate in harm reduction and are ready to change can connect with supports through harm reduction programs. Harm reduction programs do not label clients as addicts; rather, they view each person as an individual with goals and innate self-worth. Participation in harm reduction programs is associated with increases in self-esteem, more enthusiasm toward goal setting, and the desire to enter recovery (Kayman et al., 2015).

Hot meal programs or soup kitchens are in a unique position to address the social, self, and systemic stigma experienced by individuals who use substances. Hot meal programs often serve people who use substances and staff and volunteers can use their contact with this population to display acceptance and provide people with dignity (Garett, 2017). The physical layout of hot meal programs can promote social inclusion and reduce stigma. For example, Garrett (2017) finds that the service stations used to provide food to clients create unintentional and intentional physical barriers between staff and clients. These barriers contribute to social exclusion and isolation (Garrett, 2017) which are contributors to self-stigma and low recovery rates (Cole et al., 2011). Hot meal programs with minimal to no barriers create a space with a sense of community which promotes social inclusion and limits stigma (Garrett, 2017).

Hot meal programs can also provide safe spaces for people who use substances. Kayman et al. (2015) find that clients were more likely to access medical treatment through outreach medical clinics at hot meal programs than in a traditional medical environment. Similar studies also found outreach medical programs are accessible and convenient to those seeking treatment for addictions (Nuttbrock et al., 2003). Bringing these types of clinics to the environments of soup kitchens, shelters, or the streets gives those in need better access to health, harm reduction and recovery services (Nuttbrock et al., 2003). Mobile medical outreach programs are used in large cities to meet people where they are at. This typically involves the deployment of a van and medical staff which drives to areas where those experiencing substance use disorders are common located (Nuttbrock et al., 2003). Mobile programs increase patient comfort and reduce the intimidation patients often experience when interacting with medical staff in traditional medical environments (Nuttbrock et al., 2003).

Reducing stigma towards persons who use substances is beneficial for recovery from substance use. Our literature review indicates that stigmatizing and criminalizing substance use further marginalizes a population, which is already extremely vulnerable to poor health outcomes

(Kayman et al., 2015). Interventions for reducing stigma include education for community members and health care providers, harm reduction programs, and locating health and recovery programs in accessible, safe places like soup kitchens. Our review finds that decreasing stigma will increase participation in treatment for substance abuse, minimize hardships for individuals experiencing addiction, and increase access to health care. Stigma reduction is beneficial to persons experiencing addictions and to society as a whole.

Stigma and Newcomers

Saint John can expect to see an increase in immigration in the next year with the new Canadian 2020 multi-year immigration plan. Since 1990, over six million immigrants have arrived in Canada (IRCC, 2018). Approximately 2,000 newcomers to Canada came to the Greater Saint John Area between 2011 and 2016 (Statistics Canada, 2017). Immigration bolsters Canada's economy, as over half of new Canadians residents are skilled workers. New skilled workers help to fill labour gaps and market needs and contribute to overall population growth (IRCC, 2018). This is crucial for areas like Saint John who are reliant on immigration for population growth.

In 2017, Immigration, Refugees, and Citizenship Canada sponsored over 44,000 refugees (IRCC, 2018). Resettlement in this case exists for humanitarian reasons (IRCC, 2018). The IRCC sponsors refugees; however, the support that they are provided is temporary and only covers necessities, such as basic shelter, food and health services. As a result, one in five racialized families live in poverty in Canada in comparison to one in twenty non-racialized families (Canada Without Poverty, 2019).

Newcomers to Canada and Saint John face various forms of stigma and racialized discrimination that limit employment and social integration opportunities, which place them at risk for high rates of poverty. According to the Human Development Council (2018), over half of newcomer children in NB were living in poverty in 2016. A recent survey indicated that over 80% of Arab children living in New Brunswick were living in poverty, compared to the NB general poverty rate of 22.8% (See Appendix B) (Human Development Council, 2018). The stigma associated with living in poverty creates additional barriers and disadvantages for newcomers who already experience stigma associated with racial discrimination (Mental Health Commission of Canada, 2019).

Newcomers in the Greater Saint John Area face a form of cultural stigma known as xenophobia. Xenophobia is the belief that people should be feared, hated, or perceived as inferior because of their "race, colour, descent, religion or belief, national or ethnic origin" (Doyle, 2017: 4). Unfortunately, xenophobic sentiments and stigma have become increasingly popular and visible in Western countries such as Canada (Morey, 2018). Through misinformation on the economic burden of immigrants and unfounded claims of immigrant threats to national security, xenophobia has become a form of anti-immigrant rhetoric, which contributes to the lack of integration of immigrants into Canadian society. Xenophobia produces stigma by stereotyping individuals as outsiders and undocumented criminals, and places them in vulnerable and exploitable positions within the political and economic power structures of society (Morey, 2018). Cultural stigma leads to racialized discrimination which negatively affects newcomers socioeconomic and health outcomes (Forstenlechner & Al-Waqfi, 2010; Heslin, Bell, & Fletcher, 2012; Morey, 2018).

One of the best ways to reduce stigma and xenophobia against immigrants and refugees is to implement small-scale interventions that can be targeted to specific communities (Doyle, 2017). In order to overcome stigma, we must improve the integration process for immigrants in the Greater Saint John area. To combat stigma, communities must take a holistic approach to integration that focuses on mutual social interactions between newcomers and the receiving society (Doyle, 2017). Research finds that one-on-one social interactions between newcomers and members of the community have the biggest impact on reducing stigma toward newcomers (Doyle, 2017). To decrease stigma, the receiving community must be included in the integration process.

Stigma reduction and cultural integration are not quick processes. Zay (2011) argues that communities need a lot of time to foster and develop intercultural exchanges that occur in natural and healthy ways (Zay, 2011). Intercultural exchanges initiate understanding and respect between newcomers and members of the community. Rather than creating barriers between individuals, these exchanges strengthen relationships that will benefit all aspects of community life and reduce stigma towards immigrants (Doyle 2017, p. 22). Intercultural exchanges can be included in the introduction of cultural competency training for professionals, service industries, non-profit organizations, and government entities. In addition, New Brunswick's education system can introduce programs that teach young Canadians the importance of social interaction with

newcomer children (Doyle, 2017). While the New Brunswick Curriculum Framework for Early Learning and Childcare includes a focus on diversity and social responsibility, these concepts of acceptance and respect need to be continued throughout their education, with later education touching on the impacts of stigma on the lives of individuals (Ashton et al., 2010). As with many stigma reduction practices, education is an important tool for policymakers and advocates. As stated by Mutuma Ruteere, a past Special Rapporteur on contemporary forms of racism, "(e)ducation has a central role in creating new values and attitudes and provides us with important tools for addressing deep-rooted discrimination" (as cited in UN News, 2013).

All Canadians have the right to equality and the right to life without discrimination under the *Canadian Charter of Rights and Freedoms* (Government of Canada, 1982). Additionally, in 1988, Canada became the first country in the world to have a national multiculturalism law (Brosseau & Dewing, 2018). However, newcomers in Canada and Saint John have been negatively impacted by stigma in the form of xenophobia, decreased economic opportunities, and increasing health disparities (Forstenlechner & Al-Waqfi, 2010; Heslin, Bell, & Fletcher, 2012; Morey, 2018). Romero House is in a unique position to interact on a personal level with their newcomer clients on a daily or weekly basis and can help with the integration of immigrant populations. Integration can alleviate newcomer generational poverty and create a more inclusive community in Saint John. To assist newcomers with integration and to reduce stigma, Romero House should consider a small scale, community-based approach that provides newcomers and individuals from Saint John with opportunities to interact in meaningful ways. Evidence illustrates (Doyle, 2017) the need for long-term and one-on-one, personal approaches to reduce stigma toward newcomers.

Stigma and Generational Poverty

Generational poverty refers to poverty experienced by two or more successive generations of a family. The term also explains the process by which poverty is transmitted from one generation to the next (Living SJ, 2018). Common terms that are synonymous with generational poverty are the cycle of poverty and the cycle of disadvantage (O'Conell, 2016). Children caught in the cycle of poverty experience low-income from an early age, have less access to resources and have fewer opportunities for upward social mobility (O'Connell, 2016). According to UNICEF (2013), the first eight years of an individual's life are the most important to future health, social and economic outcomes. Children who are in this cycle from an early age often continue to experience poverty,

as they are not provided with the resources they need to break the cycle during developmentally critical time periods. Research finds that children who were raised in poor families grow-up to earn less income, complete fewer years of school, and are over three times as likely to be poor as adults than those who are not raised in poverty (Hardaway & McLoyd, 2009).

According to the Canadian Council on Social Development (CCSD, n.d.), one of the key factors that maintains and fosters generational poverty is social exclusion. They define social exclusion as "a lack of belonging, acceptance and recognition," and state that "people who are socially excluded are more economically and socially vulnerable, and hence they tend to have diminished life experiences" (CCSD, n.d.). Stigma surrounding poverty results in the social exclusion of persons experiencing generational poverty (Blank, 2005). The stigma associated with living in poverty influences the way that others interact with and view policies that support people living in poverty (Reutter et al., 2008). Stigma toward those living in poverty is highly detrimental to persons experiencing generational poverty as it deepens feelings of social exclusion and interferes with the development of poverty reduction policies (CCSD, n.d.).

The City of Saint John has a population of 67,575, and 15,200 of those people are living in poverty. Saint John's poverty rate is 22.5%, which is higher than both the national and provincial averages (Living SJ, 2018). In Saint John, poverty tends to be concentrated in five priority neighborhoods: Crescent Valley, Waterloo Village, The Old North End, The South End and The Lower Westside (Living SJ, 2018). Saint John residents often express stigma toward poverty as neighbourhood biases. The evidence for this is antidotal; however, individuals who live and work in Saint John are keenly aware of the differences in socioeconomic status between neighbourhoods. Individuals who live in neighbourhoods that are labelled underprivileged are at higher risk of experiencing social exclusion and neighborhood stigma (CCSD, n.d.; Besbris et al., 2015). The stigma experienced by the five priority neighbourhoods can marginalize residents and can prevent socioeconomic growth in these neighbourhoods. The migration of people out of impoverished neighbourhoods results in increased marginalization of those who cannot afford or are unwilling to leave their communities.

The literature identified three strategies for combating stigma and intergenerational poverty. The first strategy is policy development. Reutter et al. (2008) argue that policy development is one of the most effective strategies for reducing poverty and its effects. One of the

first things that policy makers must address is the complexity of applying for and receiving access to social assistance and government funded social programs (Wilton, 2004). Eligibility criteria is complex and extensive and social assistance is administered through all levels of federal, provincial, municipal, and regional governments. The application processes are complex and lengthy (Kennelly, 2017). Policy makers should consider the unique needs of persons experiencing poverty when they create social assistance programs and social programs. These programs should be accessible and easy to access so they are available for those who need them. The characteristics, composition, and culture of each neighbourhood must be accounted for when policies are developed and implemented (Blank, 2005).

While policy development is important in the process of reducing poverty and stigma, policies need to effectively address the issues surrounding generational poverty. For example, social assistance provides insufficient economic support for individuals and families. Further, recipients often experience stigma from others who believe that they should be working (Besbris et al., 2015). One policy that has been considered within the social policy framework in Canada is guaranteed annual income (GIA). Originally popularized by economist Milton Friedman (1962), GIA is a direct cash transfer from the government to individuals or families that ensures every recipient receives a basic annual income (Lammam & MacIntyre, 2015). This program, which was piloted in Manitoba in the 1970s and briefly piloted in Ontario before a change in government in 2018, would be unconditional and replace many of the current social assistance programs, which would lower administration costs. GIA may remove many of the barriers to welfare that individuals and families experience (Hum & Simpson, 2005). Unfortunately, Ontario was unable to complete their evaluation of GIA, which would have significantly contributed to the knowledge base on the efficacy of GIA as a poverty reduction intervention.

Research finds that mixed-income housing is an effective strategy for poverty and stigma reduction (Dunn, 2012). Typically, households who access rent-geared-to-income (RGI) enter provincially subsidized housing units that are clustered in areas that contain other provincially sponsored RGI units. The heavy concentration of poverty in one neighbourhood leads to stigma and discrimination (Dunn, 2012). This stigma and discrimination are detrimental to residents' health, wellbeing, access to resources, and ability to move out of poverty (Dunn, 2012). The location of RGI housing in areas that mostly contain RGI housing stock limits limits social

interactions between people living in and out of poverty (Dunn, 2012). A few policies can be adapted to address the concentration of poverty in RGI housing. First, the provincial government provides portable Housing Allowances (HAs) to some households that qualify for subsidized housing. However, limited housing stock and expensive rents continue to constrain neighbourhood choice for households that receive HAs. has provided people with housing allowances (HA) which they can use to choose their own housing; however, limited housing stock and expensive rents constrain neighbourhood choice for HA recipients. Policies that promote adequate, suitable and affordable housing in all areas of the city could be created to address problems associated with neighbourhood choice. Second, governments can participate in designing and providing mixed-income communities. In these communities, a proportion of housing units are designated for market rent and a proportion are reserved for RGI recipients. The provincial government is beginning to create mixed-income communities in New Brunswick. Mixed-income communities increase social interactions between people living in and out of poverty. They provide people living in generational poverty with contacts in new social networks that can increase access to resources, such as job-finding networks (Dunn, 2012). Mixed-income housing also directly reduces neighbourhood stigma and discrimination that people experience because of where they live (Dunn, 2012).

The third and arguably most effective strategy for reducing stigma toward people who experience generational poverty is education (Wittenauer et al., 2015). Beddoe & Keddell (2016) argue that many social workers have biased views toward people experiencing poverty. They argue that this is largely a result of exposure to Westernized values, which promote self-sufficiency and use welfare programming as a form of punitive surveillance. Hence, education for social work students should counter the individualistic, neo-liberal discourse that ignores systemic failures and instead blames individuals for their poverty (Beddoe & Keddell, 2016). Education to reduce stigma should be extended to the public (Wittenauer et al., 2015). Romero House could introduce educational training to reduce stigma toward clients and others who live in generational poverty. This may facilitate the development of meaningful interactions between volunteers and clients. Further, broader impacts from the educational training may be realized if lessons learned are transmitted from volunteers to others in their social networks.

Conclusion

An extensive survey of academic and grey literature on stigma and stigma reduction for a variety of vulnerable populations reveals the important role that community agencies, such as Romero House, can play in stigma reduction. The soup kitchen in uptown Saint John provides many services to those experiencing poverty in the area. Romero House also offers additional services, such as a clothing assistance, health care, and financial aid. One of the main approaches in the literature for reducing social stigma is to promote education that humanizes people living in poverty. This education can assist with reducing the blame that people often place on the victims of poverty. Romero House may contribute to this by offering education and training. They may choose to participate in social media education campaigns that aim to address ignorance and misinformation. These campaigns need to stress the importance of food, housing, and income security as basic human rights and address neo-liberal, victim-blaming rhetoric (Beddoe & Keddell, 2016).

This literature review indicates that educational programs that focus on exposing different groups to one another are effective in reducing stigma. It that it is critical that stigma be reduced toward people who use substances. Removing internalized stigma or self-stigma promotes recovery for those affected. Educational interventions and harm reduction programs greatly reduce self-stigma, which promotes recovery (Best, 2015; Szalavitz, 2009). Furthermore, best practices indicate that programs which organically connect the receiving community to newcomers improves social integration, reduces stigma and poverty, and improves health outcomes (Forstenlechner & Al-Waqfi, 2010; Heslin, Bell, & Fletcher, 2012; Morey, 2018). In order to be effective, Romero House should focus on small-scale, long-term, community building initiatives that take advantage of the one-on-one social interactions that can occur at the soup kitchen (Doyle, 2017). Reducing stigma toward individuals who experience poverty, generational poverty and food insecurity is critical to creating inclusive and healthy communities. This can be done through educational programs and mixed-income housing communities. Generational poverty and stigma within Saint John's priority neighbourhoods needs to be addressed through social policy reform and mixed-income housing in order to combat the continuation of poverty among Saint John's youth. GAI programs could help reduce poverty in priority neighbourhoods which would subsequently improve health outcomes and reduce stigma. As champions of these strategies,

policies, and educational opportunities, Romero House can make a positive contribution to stigma reduction for vulnerable populations in Saint John.

References

Amador, E. A. (2014). Can anyone with low income be food secure?: Mitigating food insecurity among low income households with children in the Tampa Bay Area. *Graduate Theses and Dissertations*. Retrieved from http://scholarcommons.usf.edu/etd/5170

Arboleda-Flórez J. (2002). What causes stigma? *World Psychiatry, 1*(1), 25-26. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489829/

Ashton, E., Hunt, A., Nason, P., & P. Whitty. (2010). New Brunswick curriculum framework for early learning and childcare. *Social Development, Government of New Brunswick.* Fredericton, New Brunswick: Early Childhood Centre, UNB. Retrieved from https://www2.gnb.ca/content/dam/gnb/Departments/ed/pdf/ELCC/ECHDPE/Diversityand SocialResponsibility.pdf

Baumberg, B. G. (2016). The stigma of claiming benefits: A quantitative study. *Journal of Social Policy, 45*(2), 181-199. doi: 10.1017/S0047279415000525

Beddoe, L., & Keddell, E. (2016). Informed outrage: Tackling shame and stigma in poverty education in social work. *Ethics and Social Welfare*, *10*(2), 149-162. doi.org/10.1080/17496535.2016.1159775

Besbris, M., Faber, J., Rich, P., & Sharkey, P. (2015). Effect of neighborhood stigma on economic transactions. *Proceedings of the National Academy of Sciences of the United States of America, 112*(16), 4994-4998. doi:10.1073/pnas.1414139112

Best, D. (2015). An unlikely hero? Challenging stigma through community engagement. *Drugs and Alcohol Today, 16*(1), 106-114. doi:10.1108/DAT-09-2015-0054

Blank, R. M. (2005). Poverty, policy, and place: How poverty and policies to alleviate poverty are shaped by local characteristics. *International Regional Science Review, 28*(4), 441-464. doi.org/10.1177/0160017605278999

Brosseau, L. & Dewing M. (2018). Background paper: Canadian multiculturalism 2009. *Legal and Social Affairs Division, Government of Canada*. Ottawa, Canada: Library of Parliament. Retrieved from https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/BackgroundPape rs/PDF/2009-20-e.pdf

Canadian Council on Social Development. (n.d.) Social challenges: social exclusion. *Children and Youth Crime Prevention Through Social Development*. Retrieved from https://www.ccsd.ca/resources/CrimePrevention/c_exclusion.htm

Canada Without Poverty, (2019). *Poverty and Demographics.* Retrieved from http://www.cwp-csp.ca/poverty/just-the-facts/#demo

Casas, F., Cornejo, J. M., Colton, M., & Scholte, E. (2000). Perceptions of stigmatization and satisfaction with services received, among users of social welfare services for the child and the family in 3 European regions. *Social Indicators Research, 51*(3), 287-308.

Cole, J., Logan, T. K., & Walker, R. (2011). Social exclusion, personal control, self-regulation, and stress among substance abuse treatment clients. *Drug and Alcohol Dependence, 113*(1), 13–20. https://doi.org/10.1016/j.drugalcdep.2010.06.018

Derks, B., Inzlicht, M., & Kang, S. (2008). The Neuroscience of stigma and stereotype threat. *Group Processes & Intergroup Relations, 11*(2), 163–181

Doyle, K. (2017). *Promoting best practices to prevent racism and xenophobia towards forced migrants through community building.* Jesuit Refugee Service. Retrieved from https://jrseurope.org/assets/Publications/File/JRS_Europe_igetyou_eu.pdf

Dunn, J. R. (2012). "Socially mixed" public housing development as a destigmatization strategy in Toronto's regent Park: A theoretical approach and a research agenda. *Du Bois Review: Social science research on race, 9*(1), 87-105.

Emery, J. H., Fleisch, V. C., & McIntyre, L. (2013). How a guaranteed annual income could put food banks out of business, 6. doi:1919-1138 SPP research papers.

Food and Agriculture Organization (FAO). (2006). Policy brief: Food security. *FAO Agriculture and Development Economics Division. United Nations.* Retrieved from http://www.fao.org/fileadmin/templates/faoitaly/documents/pdf/pdf_Food_Security_Cocept_Note.pdf

Forstenlechner, I., & Al-Waqfi, M. (2010). "A job interview for Mo, but none for Mohammed". *Personnel Review, 39*(6), 767-784. doi:10.1108/00483481011075602.

Friedman, Milton (1962). *Capitalism and freedom.* University of Chicago Press.

Fuller, T., Connell, D., Farkhouh, M., Savage, J., & Whittaker, R. (2003). Social and economic inclusion initiative: Closing the distance in Elgin County. Final Report. *School of Environmental Design and Rural Development.* https://www.swpublichealth.ca/sites/default/files/file-attachments/basic-page/2003_social_and_economic_inclusion_initiative_-_closing_the_distance_in_elgin_county.pdf

Garrett, L. E., Spreitzer, G. M., & Bacevice, P. A. (2017). Co-constructing a sense of community at work: The emergence of community in coworking spaces. *Organization Studies, 38*(6), 821–842.

Government of Canada. (1982). Canadian Charter of Rights and Freedoms. Retrieved at https://laws-lois.justice.gc.ca/eng/const/page-15.html

Hardaway, C., & McLoyd, V. (2009). Escaping poverty and securing middle class status: How race and socioeconomic status shape mobility prospects for African Americans during the transition to adulthood. *Journal of Youth and Adolescence, 38*(2), 242-56. doi:10.1007/s10964-008-9354-z

Heslin, P., Bell, M., & Fletcher, P. (2012). The devil without and within: A conceptual model of social cognitive processes whereby discrimination leads stigmatized minorities to become discouraged workers. *Journal of Organizational Behavior, 33*(6), 840-862. doi:10.1002/job.1795

Hicks, N. (2018) Saint John living wage report 2018. *Human Development Council & Canadian Centre for Policy Alternatives.* http://livingwagecanada.ca/files/3315/3136/9516/SJLivingWageFinal2018.pdf

Ho, M., & O'Donohoe, S. (2014) "Volunteer stereotypes, stigma, and relational identity projects." *European Journal of Marketing, 48,* 5/6, pp.854-877, https://doi.org/10.1108/EJM-11-2011-0637

Hum, D., & Simpson, W. (2005). The Cost of Eliminating Poverty in Canada: Basic Income with an Income Test Twist. *University of Manitoba*. Retrieved at http://home.cc.umanitoba.ca/~simpson/3360%20papers/BI%20ms%20Dec%2015%2003.pdf

Human Development Council. (2018). *A Reboot for Poverty Reduction. 2018 Child Poverty Report Card New Brunswick.* Retrieved from https://campaign2000.ca/wp-content/uploads/2018/11/NewBrunswickChildPovertyReportCardNov2018.pdf.

Immigration, Refugees and Citizenship Canada (IRCC). (2018). *2018 Annual Report to Parliament on Immigration.* Retrieved from https://www.canada.ca/content/dam/ircc/migration/ircc/english/pdf/pub/annual-report-2018.pdf

Kayman, D.J., Gorden C, Rosenblum, & Magura, S. (2015). A Port in a Storm: Client perceptions of substance abuse treatment outreach in a soup kitchen. Journal of social work practices. 5(4), 3-23.

Kennelly, C. (2017). Universal basic income guarantee: the next 'big' thing in Canadian social policy. *Canadian Association of Social Workers*. Retrieved from https://www.casw-acts.ca/sites/casw-acts.ca/files/attachements/universal_basic_income_guarantee_-the_next_big_thing_in_canadian_social_policy_0.pdf

Knutsen, W. (2016). The non-profit sector is dead, long live the non-profit sector! *Voluntas, 27*(4), 1562-1584. doi: 10.1007/s11266-016-9696-1

Lammam, C. & H. MacIntyre. (2015). The practical challenges of creating a guaranteed annual income in Canada. *Fraser Institute*. Retrieved at https://www.fraserinstitute.org/sites/default/files/practical-challenges-of-creating-a-guaranteed-annual-income-in-canada.pdf

Lazăr, F., Mihai, A., Gaba, D., Ciocănel, A., Rentea, G., & Munch, S. (2019). Romanian social workers facing the challenges of neo-liberalism. *European Journal of Social Work, 22*(2), 326–337. https://doi.org/10.1080/13691457.2018.1540405

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–385.

Living SJ. (2018). Poverty 101: Looking for answers. https://www.unb.ca/saintjohn/_assets/documents/promise/poverty101.pdf

Livingston, J.D., Milne, T., Fang, M., & Amari, E. (2011). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. Society for the Study of Addiction. 107, 39-50.
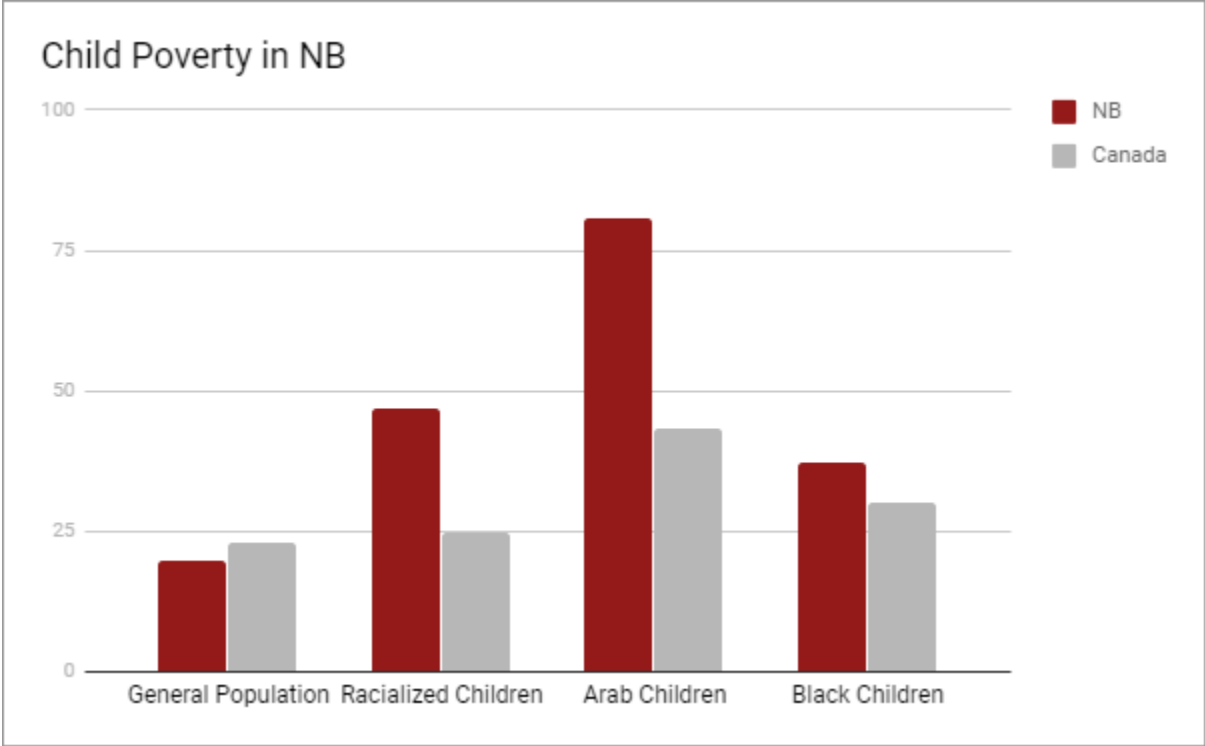
Loopstra, R., & Tarasuk, V. (2012). The relationship between food banks and household food insecurity among low-income Toronto families. *Canadian Public Policy, 38*(4), 497–514. https://doi.org/10.3138/CPP.38.4.497

Mental Health Commission of Canada. (2019). *Immigrant, refugee, ethnocultural and racialized populations and the social determinants of health: A review of 2016 Census data.* Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/2019-03/irer_report_mar_2019_eng.pdf

Morey, B. (2018). Mechanisms by which anti-immigrant stigma exacerbates racial/ethnic health disparities. *American Journal of Public Health, 108*(4), 460-463. doi:10.2105/AJPH.2017.304266

Nuttbrock, L. & Rosenblum, A. & Magura, S. & McQuistion, H. (2003). Broadening Perspectives on Mobile Medical Outreach to Homeless People. *Journal of Health Care for the Poor and Underserved 14*(1), 5-16. Johns Hopkins University Press.

O'Connell, J. (2016). *Our window of opportunity: It's time to end child poverty in Canada. 2016 Child Poverty Report Card*. Human Development Council. Retrieved from http://0104.nccdn.net/1_5/024/06f/2a3/2016-NB-Child-Povert-Report-Card.pdf

Olsen, Y., & Sharfstein, J. M. (2014). Confronting the stigma of opioid use disorder - and its treatment. *Journal of the American Medical Association, 311*(14), 1393–4. https://doi.org/10.1001/jama.2014.2147

Owen, J., Thomas, L., & Rodolfa, E. (2013). Stigma for Seeking Therapy: Self-Stigma, Social Stigma, and Therapeutic Processes. The Counseling Psychologist, 41(6), 857–880.

Quan, A., King, A., & E. Fotheringham. (2017). Hunger report 2017: The rising cost of house and its impact on hunger in Ontario. *Ontario Association of Food Banks.* Retrieved from https://oafb.ca/wp-content/uploads/2017/11/Hunger-Report-2017.pdf

Reutter, L., Veenstra, G., Stewart, M., Raphael, D., Love, R., Makwarimba, E., & McMurray, S. (2008). Public attributions for poverty in Canada. *Canadian Review of Sociology/Revue Canadienne De Sociologie, 43*(1), 1-22. doi:10.1111/j.1755-618X.2006.tb00852.x

Romero House. (n.d.). In Facebook [Business Page: About]. Retrieved on March 4th, 2019, from https://www.facebook.com/pg/romerohousesoupkitchen/about/?ref=page_internal

Romero House Inc. (1982). *Romero House Newsletter*.

Sonnino, R. (2016). The new geography of food security: exploring the potential of urban food strategies. *Geographical Journal, 182*(2), 190–200.

Soup Kitchen. (1982, April 13). *The Evening Times-Globe.*

Statistics Canada. (2017). *Focus on Geography Series, 2016 Census.* Statistics Canada Catalogue no. 98-404-X2016001. Ottawa, Ontario. Data products, 2016 Census. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-pr-eng.cfm?Lang=Eng&GK=PR&GC=13&TOPIC=7

Szalavitz, M. (2009). Drugs in Portugal: did criminalization work? *Time*. 1-3

Tarasuk, V. 2001). Household food insecurity with hunger is associated with women's food intakes, health and household circumstances. *Journal of Nutrition, 131*(10): 2670-76.

Tarasuk, V., Andrée-Anne Fafard St-Germain, & Loopstra, R. (2019). The relationship between food banks and food insecurity: Insights from Canada. *Voluntas*, 1-12. doi:http://dx.doi.org/10.1007/s11266-019-00092-w

Tarasuk, V., Mitchell, A., Dachner, N., & PROOF. (2014). *Household food insecurity in Canada, 2012*. PROOF, Research to Identify Policy Options to Reduce Food Insecurity.

UN News. (2013, June 14). *Quality education can help prevent racism and xenophobia*. Retrieved from https://news.un.org/en/story/2013/06/442302-quality-education-can-help-prevent-racism-and-xenophobia-un-expert

UNICEF. (2013). *The formative years: UNICEF's work on measuring early childhood development*. Retrieved from https://www.unicef.org/earlychildhood/files/Brochure_-_The_Formative_Years.pdf

Weng, S. S., & Clark, P. G. (2018). Working with homeless populations to increase access to services: A social service providers' perspective through the lens of stereotyping and stigma. *Journal of Progressive Human Services, 29*(1), 81–101.

Wilton, R. (2004). Putting policy into practice? Poverty and people with serious mental illness. *Social Science & Medicine, 58*(1), 25-39.

Wittenauer, J., Ludwick, R., Baughman, K., & Fishbein, R. (2015). Surveying the hidden attitudes of hospital nurses' towards poverty. *Journal of Clinical Nursing, 24*(15-16), 2184-2191.

Woolley, E. (2015). Are grovery cards a better approach than food banks in solving food insecurity? *Canadian Observatory on Homelessness/Homeless Hub: York University.* Retrieved from https://www.homelesshub.ca/blog/are-grocery-cards-better-approach-food-banks-solving-food-insecurity

World Health Organization. (2001). *The World Health Report 2011: Mental Health: New Understanding, New Hope.* Geneva, Switzerland: World Health Organization. Retrieved from https://www.who.int/whr/2001/en/whr01_en.pdf?ua=1.

Zay, D. (2011). A cooperative school model to promote intercultural dialogue between citizens-to-be. *Policy Futures in Education, 9*(1), 96-103. doi:10.2304/pfie.2011.9.1.96

Appendix A: Key Search Terms

Key Search Term	Secondary Search Term
stigma	anti-stigma, best practices, intervention, soup kitchen, stigma, stigma reduction, vulnerable populations
food security	assistance claims, Canadian health, federal funding, food security, food insecurity, non-profits, nutrition, provincial funding social programs,
addictions	drug addiction, recovery, substance abuse, substance disorder, intervention
immigrants	Canadian immigration, community initiatives, education, immigrants, misconceptions of immigration, myths of immigration, newcomers, racism and stigma, refugees, xenophobia
generational poverty	cycle of poverty, generational poverty, constant poverty, intergenerational poverty, social exclusion

Appendix B: Child Poverty in New Brunswick

Child Poverty in NB

(Human Development Council, 2018)