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Health in the Tenderloin: A Resident-Guided Study of Substance Use, Treatment, and Housing.

Author
Chang, Jamie Suki

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HEALTH IN THE TENDERLOIN
A RESIDENT-GUIDED STUDY OF SUBSTANCE USE, TREATMENT, AND HOUSING

by

Jamie Chang

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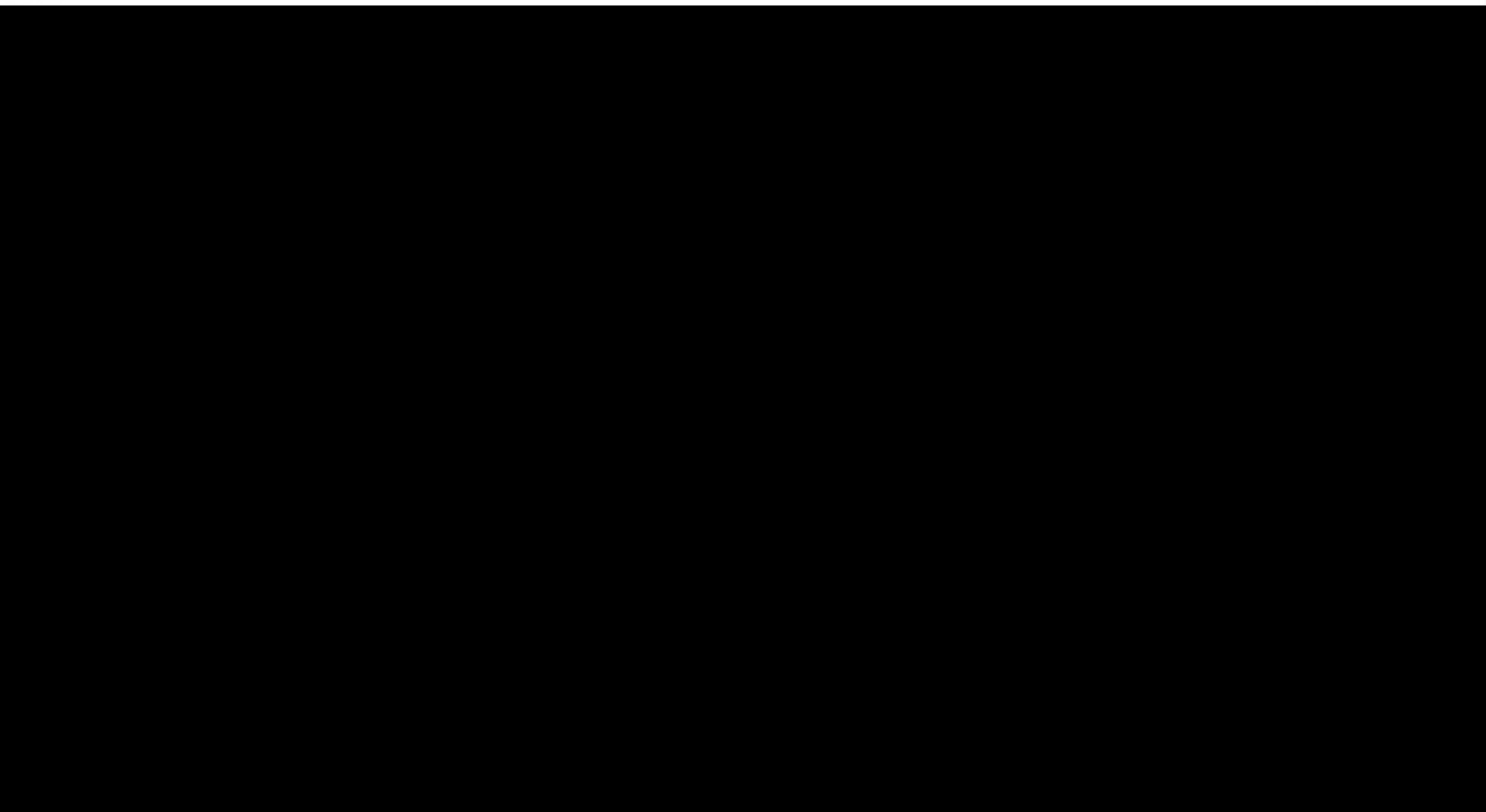

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Health in the Tenderloin
A Participant-Guided Study of Substance Use, Treatment, and Housing
By Jamie Chang

Abstract: Understanding the relationship between health and places is critical for the successful delivery of community-based health services. This is particularly true in places that are considered "risky", where the social or physical environments can increase harm, such as the Tenderloin neighborhood of San Francisco, California. In this study, I examine the relationship between places and health in the Tenderloin from a sociological perspective. I conceptualize places and health not as self-contained concepts suspended in time; rather, they are constructed and contested. They have active histories, and the two concepts shape one another.

The purpose this dissertation is to describe how historic and modern struggles among groups and individuals for resources, power, identity, and control, are directly linked to the built physical and social constructs that affect everyday health in today's Tenderloin neighborhood. Because of my dual role as sociologist and program evaluator in a community-based program located in the Tenderloin, my goal was to provide sociological and substantive contributions that can be used by both researchers and people providing health services in communities. These goals motivated all aspects of the study design, data collection, and analysis. For example, as I describe in Chapter I, I developed the docent tour method, a place-based qualitative method. I designed the docent tour to examine places in a way that is broad and participant-guided, but also systematic and targeted to key sites and concepts relevant to health.

The dissertation begins with a brief social history of the race-, class-, and gender-based development of Uptown Tenderloin as a stigmatized neighborhood. In Chapter II, I show how today's Tenderloin (Uptown Tenderloin) is closely linked to San Francisco's former so-called "zone of deviance" - Barbary Coast (Downtown Tenderloin). Then in Chapter III, I situate modern-day Uptown Tenderloin, which is known as a "containment zone", within this historical context. Using the data collected I from docent tour interviews (N=20), I describe four defining features of the Tenderloin as a modern containment zone: the concentration of the drug market; the concentration of risks; heightened policing and surveillance; and social and physical stratification. These factors have glaring similarities to the historical "zone of deviance" I describe in Chapter II. In Chapter IV, I explore how the containment zone's social and physical contexts shape relationships between residents living in Tenderloin hotels. I argue that this context results in "calculated associations" - women routinely described having to manage or balance the opportunities versus the risks relationships presented. Using social, physical and emotional boundaries were one way relationships were managed. Finally, I conclude with several contributions of the dissertation to sociology theory and methods, as well as substantive implications for community-based health services delivery. For example, I present the clock gear model, a theoretical model I developed to conceptualize health and places as the contested, historic concepts they are. I also argue that the findings of the dissertation bolster and nuance the theories of social conditions as a fundamental cause of disease and illness.

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Chapter I: Introduction and Approach

A. Purpose of Project: Examining Health and Place

> "A child's zip code should never determine her destiny; but today, the neighborhood she grows up in impacts her odds of graduating high school, her health outcomes, and her lifetime economic opportunities."
>
> (US Department of Housing and Urban Development 2013)

Sociologists and anthropologists have long been compelled by how places (or environments, settings, neighborhoods, communities) shape life, and more recently, how places are important for understanding health. Places set the stage for our life events, actions, and interactions to unfold, including those that benefit or harm health. The significance of places to health is crystal clear to both the clients and workers of community-based organizations in San Francisco's Tenderloin neighborhood. I have worked as an on-site program evaluator for one, a substance use and mental health treatment program, for five years. The program is called the Treatment And Supportive Housing program (TASH, SAMHSA TI-020680, see Section C.3, Page 18). It is geared toward formerly homeless people and operates on harm reduction principles. A client of the program, Bonnie (pseudonym), wrote the following poem for the treatment program's quarterly magazine. As she communicated her experiences as a woman addicted to substances in the Tenderloin, she stressed the importance of places (emphasis added):

> We know what is stagnate, confused, and disrupts out life
> Whether relationships, habits, or behaviors or fears. We know.
> Sometimes we don't have the discipline, willingness or power to stop.
> But we are the only ones responsible for our life.
> When we are sane and continue to do things that are unhealthy and unproductive
> We must do more than just know.
> *We must have a genuine love for change.*
> *And that does not mean changing one behavior, fear, habit, or relationship for another.*
> *It means removing ourselves from people, places, and things*
> *That hold absolutely no access to growth.*

A common notion in substance use treatment is that a person with substance use issues or addictions must personally desire change intensely to develop the discipline to maintain recovery. Much of the treatment curriculum, therefore, in all types of programs ranging from residential treatment, to Alcoholics or Narcotics Anonymous (NA/AA), to harm reduction models, focus on the individual cultivating motivation, discipline, and coping skills (Drake et al 2004). But Bonnie points out another possibility – that for people who struggle with substance use issues, it is not just the knowledge or willpower that enables recovery from drugs or alcohol – it is removing oneself from "people, places, and things", or *altering one's environment*.

It was clear to everyone working at the TASH program that the environment was a key factor shaping people's substance use, recovery, and treatment experiences. Since I began working in the Tenderloin, I've observed that for many residents, especially those involved in drugs or alcohol, every day is a delicate balancing act between safeties and risks of the neighborhood. Thousands of people live out much of their lives, in some cases for years and decades, largely within this tiny, one-square kilometer space. The tenuous balance between health and illness occur with the Tenderloin as its backdrop.

The relationship between place and health is particularly salient in the Tenderloin, San Francisco's most infamous neighborhood. The Tenderloin, sometimes called *The TL*, has been designated with different meanings. Most are stigmatized. The neighborhood's stigma has a long legacy – as I explore in Chapter II, the name itself is an undercutting reference to the deviance, policing and stigma that historically characterized this small urban landscape. Bordered by Chinatown, the Financial District, Cathedral Hill and Market Street, this region, which was originally called Saint Ann's Valley, was dubbed "the Tenderloin" in the late 1800's based on its resemblance to the red light district of Manhattan with the same name. The New York City

police department called the district the Tenderloin because the officers who worked the neighborhood were said to be able to afford the tenderloin, the most expensive cut of beef, by demanding bribes from people involved in illegal activity[1]. In the early twentieth century, San Francisco's Tenderloin had social and economic conditions (illegal economies, crime, bribery) that were parallel to its Manhattan namesake. The neighborhood name indicated not location (SoMa), geography (Pacific Heights), or purpose (the Mission); rather, it signified policing, surveillance and corruption.

Today, the Tenderloin is still San Francisco's most stigmatized neighborhood, and it is a deeply contested space. It is not an official San Francisco district, but the neighborhood is the poorest in San Francisco and the heart of the low-income housing in the city. Recurrent images and stories, or "strong tropes" (Appadurai 1988), of crime, gang violence, drugs, addiction, homelessness, and mental illness have defined the Tenderloin. Over the last several years, I've read everything I could find about this unofficial and imaginary neighborhood, from newspaper articles, academic publications, and historical documents. According to source after source, the Tenderloin is rough, menacing section of an otherwise enchanting city. It is frequently characterized as a problem space - one of drugs, violence, crime, sex work, and homelessness. It is the subject/object of endless news stories and academics, the bane of law enforcement and health care, and the butt of many jokes. (A favorite, by Dave Chappelle: "I went to that Tenderloin. Nothing tender about that motha fucker!") Incredibly, particularly given its premier location, the TL is one of the few neighborhoods that have resisted the powerful forces of gentrification and development that have engulfed much of the San Francisco (consider the transformation of the Haight, Mission, Hayes Valleys, SOMA over the last two decades), largely

[1] There are many speculations about how the name originated, but this is the most agreed-upon theory.

due to the organized political efforts of residents and community advocates. It is a place where changing casts of people and groups have struggled fiercely over resources, power, identity, and ownership, a battle that continues.

When I began this project, it quickly became apparent to me that my dissertation topic is significant and controversial in San Francisco today – the struggle for health and housing in an era of massive wealth disparities and gentrification. For example, in early November 2013, the San Francisco Board of Supervisors narrowly approved legislation to close public parks between midnight and 5AM, a measure that criminalizes sleeping in parks and targets people who are homeless. Meanwhile, there is a dearth of housing options, even for San Francisco's "middle class"[2]. As San Francisco's second Gold Rush is well underway, primarily driven by the technology industry, the city has the least affordable housing in the United States. Long-time San Francisco residents are concerned how huge income disparities have affected housing options for the non-wealthy. Housing is one of the important platforms through which the identity and ownership of neighborhoods is struggled for. According to a recent article from the New York Times:

> "San Francisco has the least affordable housing in the nation, with just 14 percent of homes accessible to middle-class buyers, said Jed Kolko, chief economist at the real estate website Trulia. The median rent is also the highest in the country, at $3,250 a month for a two-bedroom apartment."
>
> (Goode and Miller 2013)

Along the margins of the Tenderloin, buildings, stores and spaces are being redeveloped or constructed for wealthier residents. In the context of these pressures, it seems the Tenderloin's low-income community, though well organized, will face an uphill battle in the decades ahead.

The goal of this dissertation is to describe how historic and current struggles among

[2] The median household income is about $70,000 in San Francisco (San Francisco Planning Department 2011), 33% higher than the United States median household income of $52,762 (US Census 2013).

different groups and individuals for resources, power, identity, and control in the Tenderloin, are directly linked to the built physical and social constructs that affect health today. In this study, I conceptualize places and health not as self-evident, neat concepts suspended in time, rather as ongoing, constructed, and contested. They have histories that are alive and active within them. Because of my dual role as sociologist and program evaluator in a community-based program, the three aims of the dissertation are:

1) To conceptualize places and health as historical, constructed, and contested concepts that affect one another.
2) To examine health in the Tenderloin neighborhood through the involvement and guidance of those with the greatest expertise – its residents.
3) To offer ways for place and health to be understood and addressed by researchers and community-based health programs (like the substance use treatment program I work for.)

These aims motivated all aspects of the study design, research collection, and analysis. The primary health areas I examine are drug and alcohol use, treatment and recovery, and homelessness because these are the central issues that have dominated the media, policy and academic narrative about the Tenderloin. However, health areas are often related and most people I interviewed for this project had multiple co-occurring health concerns (physical, mental, substance use). I pay special attention to *community-based substance use treatment* and other types of place-based health delivery because of the opportunities and challenges of these models. Community-based models are increasingly[3] relied upon for health delivery in places like the TL to increase access to marginalized populations, but place-based health has a number of unresolved questions: how do places affect health and health delivery, and vice versa? How do

[3] The Affordable Care Act, for example, will fund an expansion of place-based services through its community-first choice option, which increases federal reimbursements for community-based services to people who would otherwise be institutionalized.

we measure the effects of these broad concepts? Where is health located – in the environment or the individual? What is a health care organization's role in marginalized communities like the Tenderloin? How do environments shape the relationship between providers and clients? These are some of the questions I examine through the dissertation.

B. Nested Chapters

To approach a broad, complex relationship like the one between places and health, it is necessary to explore this relationship through multiple layers and lenses. I present the findings on place and health in a nested fashion. Each chapter addresses a different conceptual layer, and concludes with a brief discussion about how places shape health delivery and health, especially drug and alcohol use. In Chapter II, I provide a social history of the Tenderloin with the purpose of excavating the construction of the neighborhood's reputation, function, and identity. There is a direct line connecting key historical social/political/economic dynamics based on race, class, and gender, to development of the Tenderloin into as a policed, stigmatized neighborhood. Using academic articles, as well as historical accounts, documents, and maps, I provide a selected overview of the Tenderloin, from the days when it was called Saint Ann's Valley up to its diverse social composition today. I focus on how the neighborhood was used, and the factors that made up its function and identity. Significant to this discussion are the so-called deviance industries that fueled San Francisco's early cultural and economic development, the physical constructs of the neighborhood (especially the many hotel-style buildings), and several national policies and trends that shaped the face of American cities over the decades.

In Chapter III, I describe the relationship between the Tenderloin's history and the "containment zone" concept that has characterized the neighborhood today. Politicians, the

media, and its residents have referred to the Tenderloin as a containment zone – a place where activities unwanted in other neighborhoods are permitted, contained and policed. Based on the docent tour interviews I conducted between 2010 and 2012, I discuss four central features of the containment zone: first, the Tenderloin is a central meeting place for a larger drug market. Both drug dealers and consumers "commute" from other parts of San Francisco and the Bay Area into the Tenderloin to transact drugs. Second, poverty and the risks of the larger drug marketplace are transferred and concentrated in the Tenderloin. I argue this outcome is the result of an ongoing historical process involving multiple people and groups contesting over power, resources and identity in Tenderloin. Third, the parallel practices of extensive policing and surveillance (formal and informal) are intensified in the Tenderloin. Forth, the containment zone is a space Tenderloin residents are physically or symbolically tethered to. I show several examples of participants being "stuck" in the neighborhood, a place-based form of social stratification.

In Chapter IV, I discuss social relationships in the Tenderloin, focusing on how the containment zone explored in Chapter III affects interactions and networks among women living in Tenderloin hotels. I found that women only had a few people they called "friends", people they could unconditionally trust. However, in almost all cases, women had much more wide-ranging social support networks – a larger group of people they relied on for support ranging from emotional to informational to financial. Yet I also show the women constantly recognized the risks of even peripheral relationships. The circumstances of relationships in hotels could change on a dime due to incarceration, death, conflict, and a slew of other common instabilities - abrupt and dramatic losses linked to the intersection of drug use and poverty. As a result, relationships for women living in Tenderloin hotels were characterized by what I call *calculated*

associations – the potential for social support was routinely weighed against the potential for risk or loss. Women used boundaries to manage relationships and protect themselves from risk.

In Chapter V, I offer several contributions of this dissertation to sociology theory and methods, as well as substantive implications on community-based health services delivery. I introduce the *clock gear model*, a new framework for conceptualizing the relationship between health and place as the contested, dialectical, and historic outcome of struggles between groups and people. I also argue that this model provides a conceptual basis for examining places as one of the social conditions that are fundamental causes of disease and illness. Building on the work of fundamental cause theorists (Link and Phelan 1995), social stratification theorists (Grusky, Manwai and Szelényi 1994), and risk environment theorists (Rhodes 2002), I show how the Tenderloin social environment increases susceptibility and vulnerability to risk through the mechanism of inequality, which harms the health of residents in multiple ways. I then review the *docent tour method*, a new place-based, participant-guided walking interview I designed for studying health and places. Finally, I present some of the major substantive implications this dissertation offers to community-based programs and substance use treatment.

This project is situated in multiple theoretical perspectives and research areas. Place has been examined in different ways by health researchers. The primary approaches for examining places can be categorized as positivist, structuralist, humanist/interactionist, and post-structuralist/modernist (Gelser and Kearns 2002). These are broad categories for the purpose of explaining trends, but most place research is multi-theoretical (Gelser and Kerns 2002). Because "place" represents a broad array of histories, actions, objects and ideas, and moreover since theories can overlap and build upon one another, place research frequently applies a combination of theories. Each of the chapters addresses a different conceptual focus and level of analysis of

the Tenderloin, and therefore requires different theoretical lenses. Chapters II and III are broadly situated in classic and contemporary sociology *theories of place* (ex. Simmel 1909; Gieryn 2000), which conceptualize physical spaces – their boundaries, contents and identities – as built and used by people within power relations, and therefore symbolic of these people and activities. They are also based in *theories of communities* (Collins 2010) a postmodern framework that contextualizes "communities" as political, global, and contested. Chapter IV borrows and builds on *social network theories* to examine the relationships and interactions between formerly homeless women in the Tenderloin.

C. Methods

1. The Docent Tour Method

A major motivation for the dissertation was to examine how community-based health organizations like the TASH program can address the ways places affect clients' lives. To address this question, I developed the *docent tour method* out of necessity. Everyone who worked in the TASH program knew that the Tenderloin environment was a major factor affecting the health of TASH participants. And we knew that the environment was often a barrier to people's participation in the drug and alcohol treatment program. We needed to understand and characterize the environment because it was clear from our observations that the environment was a weighty factor that affected the outcomes and success of the program. This topic was discussed in several staff meetings. Data about places had to come directly from the participants since they were the only ones who understood these environmental effects. And since as a sociologist I conceptualized places and health as broad, contested concepts, it was important to me that the methods capture an array of place-based points of view, ideally from as

many people as possible. How can a broad inventory of concepts as nuanced as placed and health be studied in a manner targeted to the needs and questions of community-based organizations?

I researched the available methods that would meet the following demands: place-based, prioritizing the guidance and perspectives of an array of residents; systematic and targeted. I was drawn to three approaches in particular. The first was grounded-theory-based interviews, the second was ethnographic methods, and the third was community-based participatory research (CBPR) (Hergenrather et al. 2009; Minkler and Wallerstein 2010). As I considered each method, it was clear that they each had relative advantages that were useful to address my research questions. Based on these advantages, which I explain below, I developed *the docent tour method* - a photographed walking interview of salient places in the neighborhood that is planned with and guided by residents. It is structured by an interview guide, and the same conceptual spaces are targeted in each interview.

When one thinks of qualitative place-based methods, what often comes to mind is ethnography. A staple of social science research stemming from the Chicago School, ethnography is broadly characterized methodologically by fieldwork and participant observation. Ethnographic methods situate the researcher in environments, communities and places, thus are place-based in design. Modern ethnographic methods are diverse and include sub-types that vary tremendously in theoretical and methodological position. Some are deductive (data collected is based on a pre-existing analytic framework); others are inductive (ideas emerge from the data). Ethnographers can position themselves in various degrees of membership within examined communities – sometimes, the researcher is a distant outside observer; other times, she is working from an insider membership role. The researcher also has the responsibility of claiming and maintaining her degree of objectivity or subjectivity as a researcher in the community. For

these and other reasons, ethnographic methods, though invaluable in health research, have been subject to concerns over the consistency and credibility of claims (reliability and validity), as well as questions as to whether these claims can be applied to other environmental contexts (Savage 2000).

Semi-structured interviews that are analyzed using grounded theory (Strauss and Corbin, 1997) provide frameworks for examining places while addressing concerns over the consistency and interpretability of ethnographies. And because of its symbolic interactionist, constructivist roots, grounded theory provides a theoretical and methodological framework that emphasizes the social constructedness of the data gathered (Charmaz 2006). As the name suggests, semi-structured interviews provide structure to data collection through the use of an interview guide tailored to the topic of interest. That interviews are structured is valuable for organizing data along relevant topics.

Community-based participatory research (Minkler and Wallerstein 2010), or CPPR, is a research approach that is popular in public health. It is typically used by non-profit organizations involved in the delivery or implementation of services in communities, better known as community-based organizations. Although CBPR can use ethnographic methods for research, one way the approach itself is distinct from ethnography is that it emphasizes advocacy, versus neutrality and objectivity, in its design. The core principles of CBPR are that research is participatory, with the participant (the person affected by the research, program, or intervention) involved in all stages of data planning, collection and analysis. It is cooperative in that the researcher and participant are tasked to contribute equally. It is a co-learning process that involves both system development (improving services) and local capacity building

(empowering the community). Finally, CBPR emphasizes collecting data that is translatable and useful in communities (Israel et al 1998).

Community-based participatory research is, however, more of a research orientation than a specific methodology (Minkler and Wallerstein 2010). Methodologies have been developed which are inspired by the CBPR design, including Photovoice (Wang and Burris 1994), the go-along method (Kusenbach 2003), and participatory-photo mapping method (Dennis et al 2009). Photovoice, which is rooted in feminist theory, involves using photographs taken by participants as prompts for in-depth discussions. It was intended to amplify the voices and standpoints of people who are marginalized, and allow these standpoints to drive the research discussion. But it is not place-based, in that the researcher is not physically exploring places or neighborhoods. Over the last ten years, walking interviews like the go-along method (Kusenbach 2003; Carpiano 2009), which wherein the researcher undergoes place-based explorations with residents, have gained popularly. In an empirical study comparing walking interviews to sedentary interviews (Evans and Jones 2011), walking interviews were better for eliciting specific, place-based stories, memories, and perceptions. The authors also point out that such data came up more naturally, unprompted, in the course of conversation. In the go-along method, interviews are usually conducted on-foot with the purpose of exploring the participant's everyday routines and realities, although it is feasible for alternate setups to be more advantageous (ex. ride along with police officers in cars).

The *docent tour* is drawn from these methods. In summary, the docent tour is a place-based audiotaped and photographed walking interview that is designed so that expert docent participants (residents of the Tenderloin) guide the researcher on systematic tours of key spaces of interest. The spaces of interest in this specific project were selected based on those most

germane to low-or-no-income people in substance use treatment – *their homes*, *the "streets"*, *the substance use treatment programs*, and a *neighborhood safe space* or comfort zone. The docent tour shares key features of ethnography in that it is place-based, observational, and relies on participant-informants to excavate key dynamics and concepts. The docent tour, however, is also rooted in grounded theory (Strauss and Corbin 1997; Charmaz 2006), which emphasizes a more structured, systematic approach to data analysis and constructivist theoretical underpinnings. The structure of the docent tour comes from systematically interviewing multiple participants on the same themes and by targeting the same conceptual spaces. Through grounded theory, the docent tour is intended to capture the richness and nuance of social life, and to examine both the social and physical constructions of the neighborhood. A final feature of the docent tour is that the walking interview is planned by, in addition to guided by, the participant. This emphasis on participant involvement in research planning and data collection is drawn from CBPR methods that emphasize the importance of resident participation, buy-in, and expertise in community-based health interventions and delivery.

It is termed a docent tour to underscore features of the method: first, in this method, participants are positioned as authorities with privileged knowledge about specific environments. Much like docents in museums or gardens, "docent participants" are experts of their neighborhoods, communities, and experiences. As docents, they take the lead in several aspects of the research process such as data collection planning and guiding the walking tour, and selecting what objects and places should be photographed. (In other walking interviews like the go-along method, destinations and routes of the interviews are either determined by the participant or the researcher, depending on how structured it is intended to be.) The docent term also underscores the situated perspectives that are both acknowledged and addressed by this

method. All research is at risk of misrepresenting participants, and research that takes place in marginalized communities must take this risk especially seriously. The docent tour attempts to shift the power balance in the research dynamic by 1) heightening participants' influence and directive, and 2) making the "outsider" status of the researcher both an explicit acknowledgment and methodological entrée point — participants teach me their knowledge. The methodological emphasis on participant involvement in planning and data collection improves the power disparity in the relationship between researchers and participants, and should also increase the relevance of research to participants' lives.

The term "tour" is intended to underscore the systematic, place-based, and comprehensive nature of the method. The systematic but flexible design – visiting predetermined conceptual spaces using routes determined by the docents – allows the data collected to be analyzed both inductively and deductively. The term tour should not be confused with "tourism". Unlike tourism which can often be scripted and relatively superficial engagements with a place, and where detached voyeurism is to some degree a central feature, a critical component of the docent tour method is that the participant and the researcher are both parties who are invested in health well being of the neighborhood.

2. Methodological Stages

In practice, the docent tour is structured into three stages (Figure 1.1):

Stage 1 – Warm-up interview: The participant and I begin with a warm-up interview. It is audiotaped, based on a semi-structured interview guide, and is conducted in a safe space of the participant's choice (typically in their housing units.) The warm-up interview focuses on gathering information on: women's experiences with homelessness, permanent supportive

housing, substance use, recovery and treatment; their perspectives of harm reduction, and their experiences with how substance use creates different types of harm (health, economic, social, etc.); and identifying local places meaningful to substance use, treatment, and recovery. This part of the interview is important because it helps build rapport with the participant, and it provides the background information needed to analytically situate the walking tour.

During this stage, the participant and I plan the walking tour, mapping out the locations to be visited. To structure the tour, I typically suggest we target three specific locations – the housing buildings, any relevant substance use treatment programs, and a safe space of the participant's choice. These locations are targeted because they are aspects of the women's environments that are relevant to my research question (substance use and harm reduction practices). Although I do suggest the broad categories of target locations, the decisions about where to go are ultimately determined by the docent participant – she selects the route and destinations of the walking interview. Safe spaces are of particular interest in order to combat the tendency to characterize environments only through risks or harms, overlooking the security and safety environments can provide. By examining the comforts, securities, and resources of communities, the docent tour can be used to explore how environments can also protect and empower residents.

Stage 2 - Guided tour: After the warm-up interview, the docent participant guides me on a walking 'tour' of her environment. It is audiotaped and photographed. The questions I ask are based on a memorized semi-structured interview guide focused on her experiences with substance use, treatment or recovery in specific places. The route is loosely structured and we frequently make unscheduled stops along the way. Typically, we tour the housing facilities then walk between two and twelve blocks to the TASH program or other substance use treatment

program. We then walk to a place she identifies as a "safe space". Some places women have guided our walk to include local churches, community support and health organizations, liquor stores, coffee shops, the public library, and parks. By systematically walking with docent participants from their homes, to the community-based programs, and to safe spaces, I can map out women's routes and passageways through the Tenderloin. I can also observe and discuss the health risks with the participant along the way, as well as the aspects of the environment that facilitate security, safety and health.

Stage 3 - Wind-down interview: At the end of the docent tour, a wind-down interview is conducted in a private area of the safe space. It is also audiotaped and semi-structured by an interview guide. The wind-down interview focuses on reviewing, discussing and clarifying the concepts mentioned and photographs taken during the guided tour. The docent participant and I conclude the interview with a discussion about strategies women have used to manage substance use and health in Tenderloin.

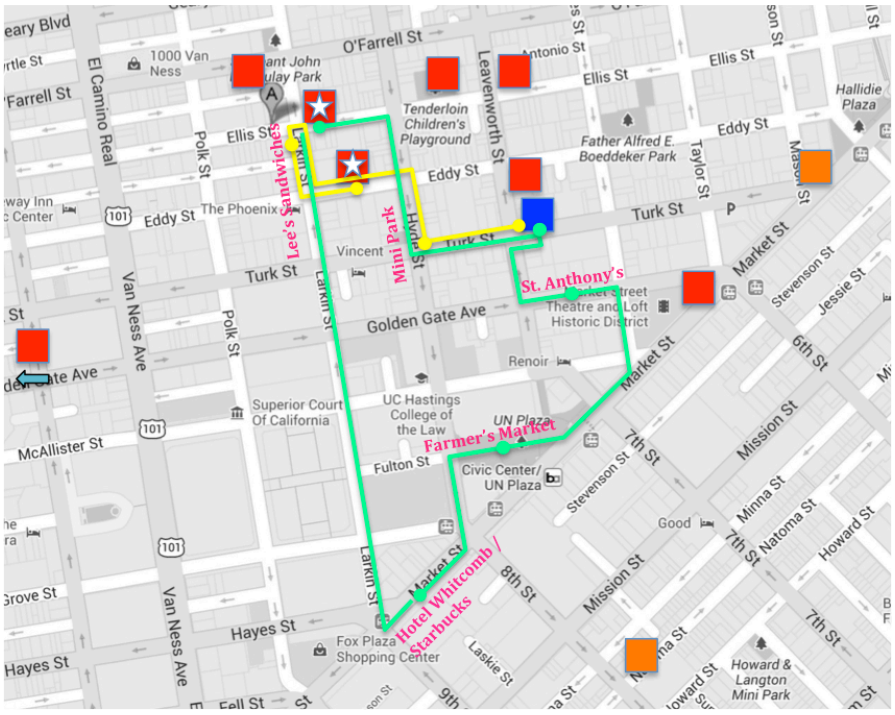


Figure 1.1 – Docent Tour Map Example

The mapped walking paths of two docent tour interviews (Erin in Yellow, Ruth in Green). The star indicates the starting points, and the dots along the path indicate key places visited.

All hotel sites of study participants are mapped here. Red are CHP buildings; orange are non-CHP buildings; blue is the most recent location of the TASH program.

Photographs are taken throughout the docent tour, but unlike methods like Photovoice (Wang and Burris 1997), I, not the participant, take photographs. The participant, however, identifies what should be photographed, and why it is meaningful to her substance use experiences. This is strategic for my specific project. The Tenderloin is a neighborhood with elevated privacy risks. Given the nature of my research subject (drug and alcohol use) I predicted that related photographs would contain sensitive content, such as illegal activity. Particularly due to my dual role as a researcher and evaluator, I wanted to include participant-driven photographs while remaining cautious of the risks to participants or other Tenderloin residents. Taking photographs myself enables me to control the content of photos for the privacy and security of the participant and community (for instance, no photos of people's faces or illegal activities). This was a difficult methodological decision, however, made based on the sensitivity of my research topic and my experiences working in the Tenderloin. For other research contexts, it may be more appropriate for the docent participants to take photos themselves.

Following the docent tour, I document field observations, map the walking route (marking the barriers and facilitators along the way), and catalog and memo each photograph. I also send handwritten thank you letters to each of the docent participants, updating them on the progress of the research study and early findings. Being surveyed, assessed, intake-ed, and examined were regular but dreaded activities that often left Tenderloin residents feeling intrusively gazed upon. And to add insult to injury, research participants rarely or never saw the outcome or benefit of the avalanche of interviews and surveys they were subjected to. Therefore any material published using the docent tour data is sent to the research participants for their records and feedback. Having done evaluation work in the Tenderloin – a community wary of

research – this ongoing availability, contact and communication is part of the research process, an effort to keep docent participants informed on the study progress and to open opportunities for feedback.

3. Site, Data Collection, Participant Demographics, and Conceptual Analysis Procedure

I conducted docent tour interviews with women living in the Tenderloin (N=20) between 2010 and 2012. I also conducted participant-observation between 2009 to 2013 in the local streets, homes and businesses of the Tenderloin, and have documented field notes on community-based health organizations I have visited, including Community Housing Partnership, Treatment And Supportive Housing, Hospitality House, BAART Health Care (methadone clinic), Glide Memorial Church and Foundation, Saint Anthony's Foundation, and Saint Boniface Catholic Church.

I recruited formerly homeless women living in permanent supportive housing in San Francisco who have histories of chronic substance use. Most of the participants (95%) live in hotel-style buildings primarily within the Civic Center/Downtown area of San Francisco operated by housing organizations like Community Housing Partnership (CHP), Tenderloin Neighborhood Development Corporation, Tenderloin Housing Clinic, and Mercy Housing. Although the buildings operated by the housing program are mixed-gender, participants in the project are all women. All tenants were chronically homeless before entering the housing programs, which use a harm-reduction-based 'housing first' model. Housing first can be thought of as a structural harm reduction intervention geared for tackling homelessness. It is based on the principle that individuals with major substance use issues or co-occurring disorders require stable housing to focus on recovery goals. Thus, in housing first programs, housing is not denied based

on substance use issues, and sobriety or abstinence from alcohol and drugs is not required for housing. Instead, residents are paying tenants with rights (residents pay 1/3 of income for rent), are permanently housed and are often long-term tenants. The housing programs are usually "supportive housing", meaning they provide both housing and supportive services.

One of the services offered is the now closed TASH program, a voluntary substance use treatment program that is based in harm reduction principles. This was the primary site for recruiting participants into the study. The TASH program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA, grant #TI-020680), operated through Community Housing Partnership's clinical team, and is free-of-cost to anyone who lives in permanent supportive housing. Since it opened in 2008, it has had two locations – between 2008 to 2012, it was located on Market Street at 7th Street. After the lease ended on that location, the program was moved to Turk Street at Leavenworth Street from 2012 to its closing date in October 2013. The Clinical Services Director of CHP, a licensed clinical social worker, managed the TASH program with a team of three treatment coordinators. I have been a consultant on-site evaluator for the TASH program since its inception through the contracted evaluation firm, Davis Y. Ja and Associates. Like CHP, the TASH also uses a harm-reduction approach and is a non-abstinence-based program. Clients who attend treatment are not required to be sober or abstinent from drugs and alcohol; rather, all clients, regardless of their usage status, are welcomed to participate in treatment. The goal is to provide easy access to support and care for clients who have "failed" or been denied from substance use treatment in the past due to inability or lack of willingness to stay abstinent. Instead of focusing solely on abstinence from drugs and alcohol, TASH goals are centered on empowering clients, improving quality of life and reducing the harm of substance use. A few examples of services and care offered include: daily group

treatment on topics such as drug and alcohol education, symptom management, coping skills, and healthy relationships; one-on-one treatment for clients in isolation; peer mentorship and aftercare opportunities; alcohol- and drug-free social activities; and crisis intervention.

I recruited women primarily by posting study flyers and making announcements at community meetings, but also though snowball sampling. All women had long term experiences with substance use, and most had co-occurring mental health, physical health, and substance use issues. More than half (N=12) of the participants had undergone the 6-month harm-reduction-based treatment at the TASH program for substance use issues. The other 8 participants had major substance use histories but not currently undergoing any type of treatment. The average age was 47 years old (range = 32-60). Thirteen participants self-identified as African American (65%), six as White (30%), and one as Asian American (5%). Ten participants were single (50%), and ten were partnered or married (50%).

On average, the docent tour interviews lasted 2.5 hours. Typically about half of the interview was conducted indoors, about half outdoors while walking. A certified transcriptionist transcribed the interviews verbatim and removed all identifying characteristics in the transcripts. I analyzed the transcribed data using the grounded theory method (Strauss and Corbin 1990) in Atlas.ti. It was through the grounded theory method that I could organize the richness and vast possibilities of the interview data and field notes into the concepts most germane to the participant's experiences. The audio and transcribed data was analyzed according to the following structure:

1. First, I listened to all the interview audio files as I reviewed the interview transcripts. Based on this first pass through the data, I documented memos on broad theoretical/substantive topics based on initial interpretations. I used a standard database program (Excel) to organize these memos into broad thematic categories. The original thematic categories included: theories of place; theories of identity; features of the Tenderloin environment; relationships and social

networks; environment and identity; place implications for health (treatment); cross-category themes; and other.

2. I then coded all the interviews and field notes in Atlas.ti. In a process of open coding, I flagged segments (segments, versus line-by-line or word-by-word, to provide context upon analysis) of the interview with existing codes. I also expanded, refined, and organized the codes into the broader thematic categories. This process was facilitated using Atlas.ti "code family" function. The code list was reviewed, discussed, and revised with advisors who have expertise in qualitative health research.
3. Finally, I listened to the audio files a second time while examining the coded material in Atlas.ti. Based on this second pass through the data, memos were drafted for each docent tour participant summarizing their life course with specific attention to their circumstances around substance use, housing and treatment. The code list was also reexamined and refined during the second-pass analysis.

This method was used to excavate and organize the health and place themes in the data, which are presented primarily in Chapters III-V.

Chapter II: A Social History of the Tenderloin

A. Overview

My favorite metaphor for the historical social construction of places is the "miracle of the road" by classic place sociologist, Georg Simmel. Through this metaphor, Simmel (1997/1903) argued that humans are prone to the division and separation of space. Without it, we are lost, disoriented, unsure where to go. Through this miracle, as he calls it, human beings create the very pathways and structures that frame, contain, and limit our existences. Eventually, boundaries and structures are institutionalized. They are given names, formed into roads, which are paved into streets and avenues. Buildings for home, work, recreation, and government are raised.

The road is both a social and physical product formed from people's movement, and over time, it comes to direct movement (Tonkiss 2005). When Simmel's metaphor is applied to the Tenderloin, I imagine: the first humans to step foot in what we now call the Tenderloin, trail blazed paths over the sand dunes, hundreds or maybe thousands of years ago when the setting was a spring-fed lake near the shoreline of the peninsula we now call San Francisco. After generations of seasonal use, some paths were used more, some less. Over time, the paths traveled frequently were trampled and embedded into the landscape, creating the human passageways, divisions and boundaries of the surrounding space. As new people encountered these constructed boundaries, they were folded into the way human geographies and societies were perceived and organized.

The division and arrangement of places goes far beyond physical functions. As places are used and developed, as they structure human activity, they also come to function as symbols and objects of social meaning. People struggle over power in places, and they come to represent

prevailing powers. Objects and arrangements of place, therefore, are representations of the struggle over power. In the Tenderloin, for example, social hierarchies and difference are built into, sustained, reinforced and negotiated every day in liquor stores, under every hazy street lamp, through each littered sidewalk and broken window, in each hotel. Each setting contains messages, some overt and some subtle, of social categories. Who is welcome here? Who is not? What are the moral expectations, and who is setting them? What is the worth of its residents, what kinds of power do they possess, what kinds are absent? These meanings can facilitate social interaction, engagement and collective action; they can also foster isolation and estrangement. A collection of these meanings can facilitate a sense of security and frame people's memories; people become attached to places and form strong bonds to them, as is certainly the case in the Tenderloin. In these ways, places have constructed meanings that have tangible affects on our perceptions, behaviors, and health (Gieryn 2000).

The creation of boundaries, structures, objects, and ideas in places are products of, and therefore indicative of, social histories and power dynamics. The social construction of places is also a process that is ongoing. Places have meanings that evolve over time, but at the same time, they contain meanings that are so deeply institutionalized that they remain inert. When examining the social construction of places, sociologists have suggested the relevance of both the evolving and inert features of place.

This chapter provides a brief historical review of the processes by which Saint Ann's Valley – named after the grandmother of Jesus Christ, the patron saint of Women – transformed into the Tenderloin, a neighborhood whose name and legacy is inspired and permeated by stigma. I discuss the origins and development of Uptown Tenderloin, from the days when it was called Saint Ann's Valley up to its diverse social composition today. I focus on how the

neighborhood was used throughout the decades, and the factors that made up its function and identity. Significant to this discussion are the "deviance" industries that fueled San Francisco's early cultural and economic development, the built spaces of the neighborhood (especially the many hotel-style buildings), and the national and local polices and trends that shaped the face of American cities over the decades. Throughout the overview, I emphasize that the social construction of the Tenderloin has been driven by race, gender, and class dynamics.

In this section, I rely primarily on early historic and journalistic accounts of Saint Ann's Valley and its counterpart vice district up the hill, the now dissolved infamous Barbary Coast[4]. Most documents were acquired through the San Francisco Public Library, the San Francisco History Center, Bay Area newspaper archives and online resources. Four historical literatures I rely on for subsections B – C.3 are: Herbert Asbury's (1933) *The Barbary Coast*, a third-hand historical review of the period between 1850 and 1920; Colonel Albert Evan's (1873) "A la California, Sketch of Life in the Golden State", a firsthand account of San Francisco in the 1871-2; Frank Soul, John H. Gihon, James Nisbet (1855) *The Annals of San Francisco*, the first published history of San Francisco; and the final report of the Tenderloin Ethnographic Research Project (1978), a historical review and ethnographic report sponsored by the still existing Tenderloin-based community organization, Hospitality House. I also relied on two non-academic web-based data resources: oldsf.com, an interactive photo history of San Francisco buildings (based on San Francisco Public Library photo archives), and upfromthedeep.com, a photo history blog by TL resident Mark Ellinger, which contains the most complete history of the TL architecture I have found.

[4] This is an abbreviated history with several limitations. As I mentioned earlier, it was alarming to me how few documents I could find about the Tenderloin. Those I did find typically contained the voice and authority of the White, male author, and reflected this social position in different ways depending on the historical period. I could find shamefully few – virtually zero – documents authored by members of marginalized groups of early San Francisco. I take these power dynamics and missing perspectives into account when interpreting these histories.

B. Race, Class and Gender Relations of San Francisco, circa 1849 – 1870

The modern Tenderloin's roots can be traced directly back to the beginning of San Francisco's American history. In this subsection, I describe how three social conditions of the city's burgeoning were profoundly relevant to the metamorphosis of Saint Ann's Valley, a residential district, into the stigmatized Tenderloin: the rapid, enormous injection of both people and wealth following the Gold Rush; the vastly disproportionate male-to-female population ratio; and the racially hierarchical economic and social disparities.

Descriptions of Saint Ann's Valley, in the pre-Gold Rush days when San Francisco was a village called Yerba Buena, are idyllic. Much of the sandy, wind-swept peninsula lacked fresh water. Small streams, however, flowed through what are now the Downtown, Civic Center, and Tenderloin neighborhoods, making these regions ideal for settlement by Spanish missionaries. Early accounts paint dreamy scenes of native flora, and gardens that flourished when the rich soil beneath the rolling sand dunes was cultivated. One stream emptied forming a lake where Market and Powell sit today, and stories abound of Yerba Buena residents taking respite, skinny dipping, and picking wild blackberries on its shore.

This tranquil scene would not endure. Within a few decades, the tiny peninsula underwent a dramatic transformation from quiet missionary village to the 8th largest city in the United States. In 1846, California was annexed by the United States during the Mexican-American War, bringing the nation one step closer to fulfilling the dream of Manifest Destiny. Yerba Buena's proximity to the still and deep bay made it an ideal docking point for the booming maritime commerce and travel industry. The city was soon renamed (rebranded) San Francisco – the port city by the glittering bay and American gateway to the Pacific.

The adventurous and hopeful throughout the continent began westbound migrations by covered wagon or ship, some ending their journeys in San Francisco. Among the early settlers included a group of Mormons, who in the face of religious and social persecution on the East, set sail from New York City on a ship chartered by Sam Brannan, arriving in San Francisco through Cape Horn. When it was discovered that that rivers flowing into the San Francisco Bay contained, of all precious things, gold, Brannan, who ran several newspaper businesses including the city's first newspaper, the *California Star*, publicized the discovery broadly. The news spread throughout the United States and even overseas. One can imagine the fantasies of gold being sifted right out of mountain water. The population trickle into San Francisco turned into an avalanche, and the city would never be the same. In 1846, the population was less than a thousand; by 1849, the number jumped to 25,000. By 1869, US Census estimated San Francisco contained a resident population of 150,000 people who were most densely settled into the northeastern corner of the small city.

There were large wealth disparities following the Gold Rush, and San Francisco's economy was turbulent during this period of rapid change. For the vast majority of forty-niners, gold-clad fantasies were quickly disenchanted, as most did not find the fortune they expected. Despite the bust, there they were in San Francisco, a brand new city in an undeveloped, virtually lawless land, where municipalities lacked the infrastructure and resources needed to sustain the mounting population. The demand for food, housing, and clothing far outweighed supply. The result was dramatic wealth disparity and inflation. Those who struck gold, profited from the gold rush economy, or arrived in San Francisco wealthy possessed the resources to build elaborate homes in Nob and Russian Hills and Pacific Heights. For miners, laborers, and migrants, however, housing typically took the form of wooden tenements, built from harvested redwood or

assembled from ready-made structures shipped from China. Tenement units and other housing for the masses were exceptionally crowded, dubiously constructed (prone to collapse and fire), and often squalid. Moreover, in true San Francisco form, rents were high:

> "To sleep in a bunk or cot cost as high as fifteen dollars a night, although none had either springs or mattresses. Very few private rooms were available . . . Enterprising landlords also rented sleeping-space on tables, benches, and other articles of furniture at from two to ten dollars for eight hours. One man is said to have realized fifty dollars a night from the rental of a dozen rickety old rocking-chairs. Another placed wide redwood plants on saw-horses and sold the right to sleep for three dollars, the occupant to furnish his own bedding. In all of these flimsy places roamed millions of flies, lice and other noxious bugs and insects, besides the huge gray rats, which almost immediately began to infest the waterfront and muddy streets."
>
> (Asbury 1933, Pg. 13)

The cost of food was also extortionate. Agriculture was growing throughout California, yet the supply was still not adequate to meet demand. In San Francisco, basic items like bread, apples and cheese demanded up to ten times their cost in New York[5] (Asbury 1933).

Along with the economic disparity resulting from the Gold Rush, San Francisco was also characterized by massive gender population disparity. Due to the social/economic circumstances of westward migrations, for decades San Francisco was predominantly male, as was the case for many early settlements on the frontier. The disparity was most acute following the first frenzied Gold Rush migration – in 1849, there were only 1000 women in San Francisco, compared to 25,000 men. In 1860, even after thousands of women of all social classes migrated to San Francisco, the sex ratio remained disproportionate, with 1.5 men for every one female (Shumsky and Springer 1981).

[5] Good cooks and chefs were also scarce. A favorite account from Asbury (1933) is of a legendary woman named Mary Ellen Pleasant, who was of Haitian decent and famously known as Mammy Pleasant (yikes). Her cooking skills were exceptional, and she charged a base rate of $500/month (about $14,600/month today) for cooking services only. It was even stipulated in her contract that she was required to do no cleaning. She was also involved in civil rights and devoted much of the fortune she amassed to abolitionist movements.

As a port city connecting South America and Asia to the United States, by US standards, San Francisco was racially and ethnically diverse from the onset, but race and ethnicity were also the basis of social hierarchies. Immigrants from Russia, Ireland, Spain, Italy, Mexico[6], China and other Asian nations (as well as migrants throughout the United States) forged their lives and identities alongside one another, and social hostilities sometimes spilled into violence. Political, economic and social power was concentrated with the wealthy, upper class white citizenry. Other groups had social and economic rankings that loosely followed the skin color spectrum, with "[white] Americans at the top, then the English and Germans, the French, the Italians, the Hispanics, the Chinese, the blacks and at the very bottom the Indians" (Maldetto 2013). People of color were often clustered into ethnic enclaves, most notably the Chinese into Chinatown. They also worked the most laborious and low-status jobs in the city, such as laundry, shipyard labor, and construction. The earliest historical documents of San Francisco reflect this social hierarchy:

> "The foreign population were generally an orderly, obedient and useful class of the community. The Chinese might here perhaps form an exception. They are an exclusive race, and mingle but little save with their own people . . . They, as well as most of the foreign races, generally dwelt together in particular localities, which gave these quarters a distinctive appearance from the rest of the town. The Chinese and the free negroes, of whom there was now a goodly sprinkling, were "the hewers of wood and the drawers of water" of the place; and performed washing and women's business, and such menial offices as American white males would scorn to do for any remuneration. The "greasers," [Mexicans] too, who are verily "of the earth, earthy," helped the celestials [Chinese] and the black fellows, or infernals, in their dirty work."
>
> (Soul, Gihon, and Nisbet 1855)

The race relations of this era exacerbated gender disparities in non-white neighborhoods. Social conventions and local ordinances prohibited men of color from interacting with white women, restricting the possibility for Asian, Black, Latino and Native American men to have

[6] "Immigrants" is something of a misnomer for Mexican-Californians, since the State of California itself was Mexican territory until 1846.

relationships with or marry women outside their own racial and ethnic group. Therefore, although the gender disparity affected all social groups and classes, it was far more pronounced in communities of color. For example, in 1880 (just before the Chinese Exclusion Act), the US Census estimated approximately 100,000 Chinese men living in San Francisco, but less than 5000 Chinese women – at least a 20:1 gender ratio (Shumsky and Springer 1981).

C. Two Tenderloins: The Stigmatization of Places, circa 1870 – 1917

In these demographic, political and economic conditions – the swollen economy, the boom/bust hazard of gold mining, the gender population disparity, racial hierarchies and hostilities, and the absence of established laws and government – the people of San Francisco developed vital informal economies based on gambling, prostitution and black markets. These activities were common throughout the city, but had a centralized hub - the Barbary Coast, an entire neighborhood devoted to entertainment, sex, gambling, drugs and alcohol. In this section, I describe the race- and class-based development of Barbary Coast, San Francisco's first "zone of deviance". I compare the neighborhood to Saint Ann's Valley, the counterpart neighborhood down the hill where illegal economies were also practiced, but less stigmatized. I then show how Saint Ann's Valley transformed into what we today know as Uptown Tenderloin following the demise of the Barbary Coast in 1917.

1. Downtown Tenderloin, the Barbary Coast

> "Ever city on earth has its special sink of vice, crime and degradation, its running ulcer or moral cancer, which it would fain hide from the gaze of mankind. London has its St. Giles, New York its Five Points, and each of the other Atlantic and Western Cities its peculiar plague spot and curse; it is even asserted that there are certain localities in Chicago where vice prevails to a greater extent, and life, virtue and property are less secure than in others. San Franciscans will not yield the palm of superiority to anything to be found elsewhere in the world. Speak of the deeper depth, the lower hell, the maelstrom

> of vice and iniquity-from whence those who once fairly enter escape no more forever-and they will point triumphantly to the *Barbary Coast*, strewn from end to end with the wrecks of humanity, and challenge you to match it anywhere outside of the lake of fire and brimstone."
>
> (Evans 1873)

By day, the Barbary Coast was a maritime district with ship supply stores, boarding houses, and entertainment targeted to sailors. By night, the neighborhood transformed into what was San Francisco's so-called sinkhole and underbelly, where prostitution, gambling, drugs, alcohol, music, and dancing (though technically illegal) were widely and openly conducted. It was San Francisco's own Sodom and Gomorrah, first and original Tenderloin – a place where police were offered enough bribes to easily afford them the choice cut of meat.

The Barbary Coast is portrayed as an X-rated adult underworld of yesteryear[7], but it had integral social and economic functions. Sex, gambling, and substances were more than respite and recreation – they were economies that were indispensable to the survival of early San Franciscans. Gold mining, the primary legitimate economy, was intimately connected to gambling. Those who struck gold gambled to extend their fortunes; those returning from the gold mines empty-handed gambled for the chance to change their fate. Prostitution was also linked to the Gold Rush and gambling. Females, who were scarce, were hired to work in gambling establishments as entertainers or companions to attract male clients. Like gambling, prostitution was a contentious moral and political issue, and officially illegal in most Western cities. Yet the laws were rarely enforced, partly because sex work was accepted as necessary amid wide gender population disparities.

[7] The subtitle of Asbury's *The Barbary Coast* (1933) is "An unflinching account of the sink-hold of depravity and vice that once made San Francisco's underworld the most dangerous spot in America".

What is key about Barbary Coast is that its formation, function, and stigmatization were spurred the economic, gender, and racial dynamics of late 19th century San Francisco. Barbary Coast was not a planned neighborhood. Located where the corners of North Beach, the Financial District and Chinatown meet today, Barbary Coast's emergence at this specific location (Figure 2.1) was linked to its proximity to Chinatown, a neighborhood that represented the farthest margins of early San Francisco society. Following the 1844 Treaty of Wanghia, which permitted immigration between China and the US, thousands of Chinese immigrants, primarily from Guangdong province and almost entirely male, made their sojourns to San Francisco (Bowen and Bowen 2008). Though considerable in numbers, making up a sizable portion of the San Francisco population, the Chinese were considered alien and strange to the white San Francisco establishment. They were also perceived as economic and social problems. Social hostility toward the Chinese erupted into interpersonal conflict and violence. Eventually, discrimination against the Chinese was institutionalized into the legal system. In 1882, the US government passed the Chinese Exclusion Act, the first anti-immigration legislation in the country's history. The new law was detrimental to the Chinese community in San Francisco – it heightened social stigma against Chinese (and other Asian Americans), limited economic opportunities, and exacerbated social stress in the increasingly stratified Chinatown communities.

The racial dynamic between white and Chinese San Franciscans was key to the development of the Barbary Coast's identity as a stigmatized deviant space (Shumsky and Springer 1981). In a city where gambling, prostitution and black markets were widespread, the nucleus of these activities emerged alongside the city's marginalized communities. Barbary Coast overlapped with Chinatown, but was situated closer to Pacific and Montgomery Avenues, a vital transportation artery that connected the ports of San Francisco to the downtown business

district. Everyday San Franciscans traveling through the thoroughfare, from upper class Nob Hill residents to port and railway laborers, had one foot in the conventional and the other in marginality. This precise geographic position, born out of race and class relations, created the conditions of possibility for the industries of Barbary Coast to originate and flourish. The city routinely turned a blind eye to the strange and isolated Chinese ghetto. Nestled safely by its side, the illegal activities of Barbary Coast could be openly practiced. Barbary Coast was San Francisco's first stigmatized, centralized "vice" or "deviance" district, drawing in locals and travelers (again, almost entirely male) with possibilities of gambling, entertainment, sex, drugs, and alcohol.

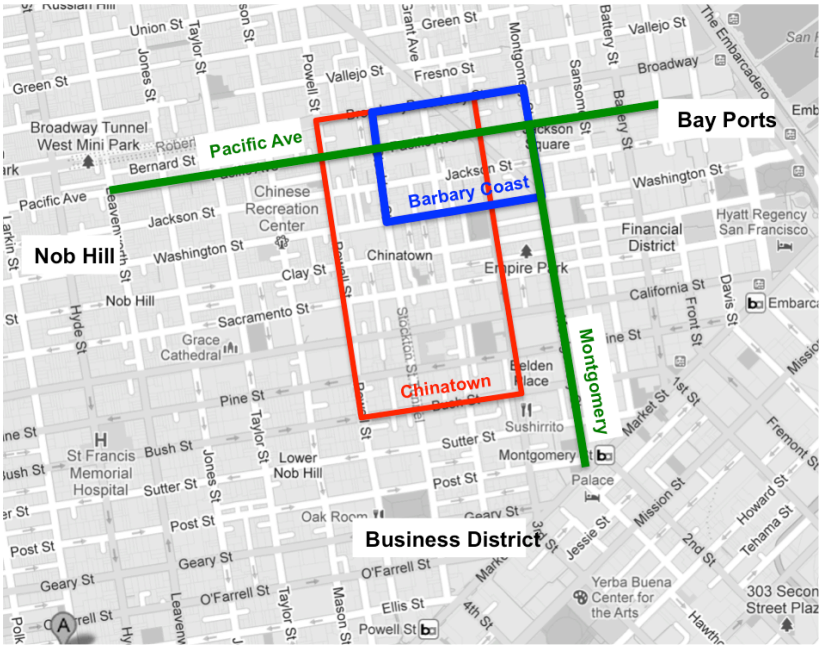


Figure 2.1 – Social / Geographic Development of Barbary Coast.

Approximate outline of Barbary Coast (blue), overlapping Chinatown (red) and the port commercial district. Pacific Avenue and Montgomery Avenue, which ran through Barbary Coast, were main thoroughfares between work, commercial and residential neighborhoods.

Although Barbary Coast was the capital of deviance in San Francisco, it is key to recognize that gambling and prostitution were common throughout the city during this period. Because of the vast gender, social and economic disparities, people from all social backgrounds engaged in different forms of betting and sex work. However, the industries themselves were diverse, reflecting deeply pronounced existing race, class, and gender hierarchies. Prostitution

occurred in a variety of settings (opium dives and dens, parlor houses, cribs, dancehalls, bars, melodeons, music halls, etc.) and social/economic arrangements between brothel owners, sex workers and clients ranged considerably based on social position. As I explain further below, in privileged quarters of society like Saint Ann's Valley, prostitutes were more often highly desirable parlor socialites who possessed social status and were often well compensated for their work. In Barbary Coast, however, firsthand accounts paint a far more stigmatized, negative, *and racialized* portrait of sex work. There is no data on the racial profile of prostitution during this period, but multiple historical accounts suggest that sex workers in Barbary Coast and its neighboring Chinatown were disproportionately women of color, compared to other neighborhoods. For example, in an early participant-observation-like account of an evening in the Barbary Coast, Colonel Albert Evans describes his encounters with women of color in a dancehall prostitution establishment:

> "Half a dozen men, or overgrown boys, are sitting or lying on the floor in various stages of inebriety, but they are unnoticed by the other occupants of the place. Every time a man takes a partner for the dance he pays fifty cents, half of which goes to the establishment and half to the girl, and at the close of each dance he generally takes her to the bar and treats her. We notice with thankfulness that the females appear to be almost all of foreign birth, the exceptions being Spanish-Americans, with occasionally an Indian girl, who has been raised as a servant in some family in San Francisco, but, Indian-like, prefers a life of idleness, vice and degradation to one of comfort and honest labor."
>
> (Evans 1873)

The historical documents suggest that it was not uncommon for women of color to practice prostitution in Barbary Coast. Also, sex cost less, work settings were risky and less attractive, and women had less power (Shumsky and Springer 1981, Light 1974, Asbury 1933). Most notoriously within the Chinese community, prostitution was often a form of sexual slavery. In the decades following the Gold Rush, Chinese females were so scarce in the western United States that young women were sent by ship from China to San Francisco by the boatloads. For

the young women (girls), the move to America was typically out of economic or social desperation. Some were sold by their families; others made the voyage on the basis of indentured servitude. They were often overtly treated as human commodities. The historical accounts describe the Pacific sex trade using language that explicitly mirrors the Atlantic slave trade[8]. According to Asbury then Evans, of the period around 1870:

> "The girls were shipped to San Francisco in batches of from three to a hundred and, once there, were either placed in dives operated by their masters or offered for sale in the open market. Dealers and owners of cribs and parlor houses were notified when a consignment had arrived, and those who were interested assembled at an appointed place, usually a cellar or other chamber which offered comparative safety from the prying eyes of white men, and particularly of white women who operated the Chinatown missions and waged unceasing warfare against the slavers. When the sale began, the girls were brought in one by one to the block. They were stripped, punched, and prodded and in some cases examined by Chinese physicians who had, more likely than not, been bribed to warrant them sound in wind and limb."
>
> (Asbury 1933, Pg. 179)

> "These poor creatures are all slaves, bought with a price in China, and imported by degraded men of their own race, who, despite our laws, contrive to hold them to a life-long servitude, which is a thousand times more hopeless and terrible than the negro slavery of Louisiana or Cuba could ever be. They have been reared to a life of shame from infancy, and have not a single trace of the native modesty of women left. They are, as we have said, mere children in point of intellect, having no education whatever, and no experience of the world outside of the narrow alleys in which they have always lived, and the emigrant ship in which they were brought over to this country."
>
> (Evans 1873)

For decades, illegal economies were the primary industries of the Barbary Coast. Sex workers were persistently under threat of fines or imprisonment by police patrolling the neighborhood, who occasionally raided dens and arrested women. Yet given the demand for the deviance industries, the risks were little deterrent. Bouncers guarded doors and prevented police

[8] The prostitution contracts stipulated that in exchange for the trip to America, the girl would work X years as a prostitute, and that if she were ever sick during this period of time, extra time would be added to her contract. In Asbury's example, one day of illness could amount to two extra weeks of servitude, making it impossible "earn" freedom. This trap in the contract would not be noticed by women, however, since most were illiterate.

from entering establishments, and sex work, gambling, and substance use went on unconcealed. Red lanterns signaled brothel locations (thus the phrase "red light district"). Women who did not have the safety of a den, dancehall or parlor solicited clients on the streets.

It was around this period, in the late 19th to early 20th century, that Barbary Coast developed the savory nickname, *Downtown Tenderloin*. The nickname was based on the concentration of many illicit activities (gambling, drugs, alcohol, dancing) into one space, but without question, the unequal race and class relations of early San Francisco was a factor that fueled Barbary Coast's stigmatized reputation.

2. Saint Ann's Valley

While overt gambling and sex work was occurring in Barbary Coast, illegal industries, especially prostitution, were practiced differently downhill in Saint Ann's Valley. Saint Ann's Valley began as a residential district situated just southwest of the city's nucleus. As the city developed (Market Street was paved at the foot of Saint Ann's Valley, City Hall was erected on Polk and MacAllister where U.C. Hastings sits today) its nucleus grew, expanding into and eventually encasing the Saint Ann neighborhood. Even at the turn of the century, the neighborhood was valuable real estate, situated between the city's primary government and business districts. By the late nineteenth century, because of its premier location, Saint Ann's Valley was designated and used as San Francisco's "legitimate" entertainment district (versus the illegitimacy of Barbary Coast), offering music, shows, and theater.

Prostitution occurred throughout San Francisco, but was most concentrated in Barbary Coast and Saint Ann, the two heavily trafficked entertainment neighborhoods closest to downtown. In Saint Ann's Valley, as in many other San Francisco neighborhoods, the sex

industry was alive and well, but it was decidedly less policed and stigmatized than in Barbary despite being practiced overtly. The stigma of prostitution in Saint Ann was so relaxed that established madams routinely flaunted socialite workers outside the parlor house. Tessie Wall, one of San Francisco's most infamous madams, had a parlor in the heart of Saint Ann, on the corner of Ellis and Larkin. She paraded her "company girls" on Market Street on Sunday afternoons, donned in elegant attire, down the so-called "Pathway to Propinquity". Suited up in the most glamorous and stylish fashions, the women were walking advertisements for the brothel and symbols of style, glamour, and social power. Especially since the neighborhood was designated as an entertainment district, the Saint Ann sex workers were socialites who were, in some regards, admired by the community. Wall and her sex workers formed close ties to the San Francisco Police Department, even marching in their annual police ball. Sex work in Saint Ann, though certainly frowned upon by some, did not face the same degree of stigma or policing as Barbary Coast and Chinatown prostitutes.

Race and class inequalities in the neighborhoods explain the disparity in the criminalization and stigmatization of sex work. The women of Saint Ann had greater social status and resources to protect themselves from the criminalization of sex work. Though Saint Ann was not elite-society like Nob Hill or Pacific Heights, it was a primary White middle-income neighborhood, and considerably more elegant and comfortable than the crowded, seedy living conditions prevalent throughout much of the city. Race relations in San Francisco have never fit the strict black/white paradigm, in part because of the dense coexistence of racial and ethnic groups, and in part because of the widespread economic disparity, in which poverty that affected a large number of whites as well as people of color. Nevertheless, it is evident from photographs and historic accounts that race was a key factor that shaped the social acceptance of

sex work in the Saint Ann's Valley. According to Asbury (1933), Tessie Wall's workers "all of whom were young, blond, and plump" charged higher prices and, as a rule, Saint Ann's working girls were "more handsomer and more accomplished". The Saint Ann workers also earned more wages compared to Barbary Coast. Asbury (1933, Pg. 242) describes this disparity with the utmost age sensitivity:

> "Prices in cribs and cow yards, over a long period of years, ranged from twenty-five cents to a dollar, while the inmates of parlor houses [more typical of Saint Ann] received from two to ten dollars for favors. Very young and handsome girls were sometimes paid as much as twenty dollars for entertaining visitors for a half-hour or so, as were a few older women who made up in skill and simulated passion what they lacked in youth and beauty."

Compared to the conditions of Barbary Coast, the residents of Saint Ann's Valley had more spacious, less crowded homes or apartments. Even as the neighborhood was being transformed into an entertainment district, most property lots contained simple two or three story buildings built for families and businesses, alongside a smattering of grander churches, hotels, and theaters interspersed as the neighborhood approached Market Street (Figure 2.2). This architectural and organizational structure was conducive for controlling discreet activities, such as prostitution and gambling. It also enabled an alternate way to advertise sex work - placing ads for "massage" services in newspapers like the San Francisco Examiner and Chronicle. The newspaper advertising strategy allowed sex workers to live outside their worksite - a potential client would contact the Madam, the worker would then travel to meet the client at the brothel (TERP 1979). Thus while Saint Ann was known for sex work, solicitation and advertisement rarely occurred overtly in broad daylight. Also, with the earning potential of a thousand dollars a month, and free of racial stratification, Saint Ann's women could live where they chose. The lifestyles and social mobility of Saint Ann's sex workers were in stark contrast to the Barbary Coast women.

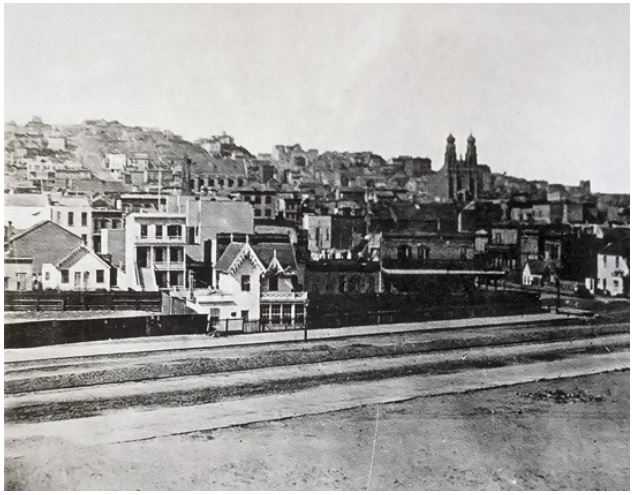


Figure 2.2 – Architectural Composition of Saint Ann's Valley, 1860's.
1864: View of Taylor Street toward Nob Hill from Turk Street. Architecture consisted primarily of two and three story wood residential units.
1865: View of Mason Street (the heart of Saint Ann's Valley) from the unpaved Market Street.

3. Transformation of Saint Ann's Valley to Uptown Tenderloin

Three forces of history unfolded that indelibly fused the histories of Barbary Coast and Saint Ann's Valley, and formed Saint Ann's identity as "Uptown Tenderloin", a stigmatized place: 1) the strengthening power of moral crusades at the turn of the century, 2) the 1906 earthquake, fire, and reconstruction, and 3) the gradual zoning, constriction, policing, and demise of Barbary Coast. The turn of the century was a critical period in the history of American cities as forces of industrialization and modernization competed for the identity of urban spaces. National church-organized social movements known as "moral crusades" were among the powerful voices in the struggle. Moral crusaders organized meetings, rallies and protests to crack down on hedonistic activities occurring in cities, like prostitution, drinking, and gambling. San Francisco's salacious Barbary Coast was a target of the moral crusaders, and thus at the center of a national struggle over political, cultural and moral identity.

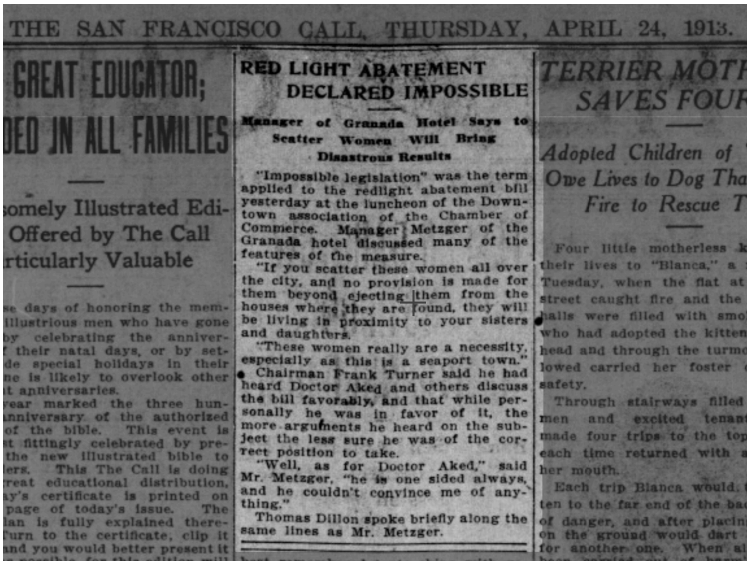
The moral crusader's efforts were focused in Barbary Coast for more than the redemption of ungodly souls. Between the gambling, prostitution and black market, Barbary Coast was also known to San Franciscans as the nucleus of crime, violence, and diseases. It was the notorious target location for the "shanghaied"[9] labor market, and was regarded as a hotbed of sexual transmitted diseases. From the crusaders' perspective, the region and people of Barbary Coast were not only morally depraved, but also a threat to San Francisco's safety, public health and reputation.

The 1906 earthquake and fire, which moral crusaders claimed was retribution from an angry god, devastated San Francisco. The fire following the great quake leveled Barbary Coast, along with modern day Chinatown, Northbeach, South of Market, Nob and Russian Hills. As the smoke lifted, city planners faced increased pressure to address the Barbary Coast dilemma. The long delayed U.S. Panama Canal construction finally was well underway, which shortened the voyage from the East Coast from 6 to 2 months, made the city accessible to Europeans for the first time. Planners knew the canal would release a floodgate of economic possibilities for San Francisco. There would soon be tourists and investors from Europe, new settlers from throughout the Americas, and global attention on the western port city.

In this historical moment, when the promise of attracting investors and tourists was acute, city officials grew concerned about the reputation of Barbary Coast. Yet prostitution, gambling and the black markets were not easy for San Francisco to shed. They were central functions in the city's economy and symbolic of its open, tolerant culture. City officials were pressed with the

[9] In a time of maritime labor shortages due to workers abandoning ship, shanghaiing was a common practice of forced conscription into ship work. Intoxicated men's signatures were forged by traffickers; they were then placed on boats ready to set sail. Upon gaining consciousness, victims would discover they were en route to god knows where. Barbary Coast's name itself is directly linked to the shanghai: the Berbers (or Barbary) people were pirates famous for shanghaiing people for the slave trade in the North African region of the Mediterranean known as Barbary Coast.

dilemma: as San Francisco's frontier past was left behind for a future as a world-class metropolis, how should the city's original economic foundations, the so-called vice industries, be addressed? It was San Francisco's tolerant, permissive culture that attracted settlers, tourism, and entrepreneurship, but these factors of progress threatened the city's future. These social controversies were actively debated, as evident in the following article from the San Francisco Call reporting reactions to the California Red-Light Abatement policy (Figure 2.3):



THE SAN FRANCISCO CALL, THURSDAY, APRIL 24, 1913.

GREAT EDUCATOR;
DED IN ALL FAMILIES

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Offered by The Call
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illustrious men who have gone
by celebrating the anniver-
their natal days, or by set-
de special holidays in their
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RED LIGHT ABATEMENT DECLARED IMPOSSIBLE

Manager of Granada Hotel Says to Scatter Women Will Bring Disastrous Results

"Impossible legislation" was the term applied to the redlight abatement bill yesterday at the luncheon of the Downtown association of the Chamber of Commerce. Manager Metzger of the Granada hotel discussed many of the features of the measure.

"If you scatter these women all over the city, and no provision is made for them beyond ejecting them from the houses where they are found, they will be living in proximity to your sisters and daughters.

"These women really are a necessity, especially as this is a seaport town."

Chairman Frank Turner said he had heard Doctor Aked and others discuss the bill favorably, and that while personally he was in favor of it, the more arguments he heard on the subject the less sure he was of the correct position to take.

"Well, as for Doctor Aked," said Mr. Metzger, "he is one sided always, and he couldn't convince me of anything."

Thomas Dillon spoke briefly along the same lines as Mr. Metzger.

TERRIER MOTH
SAVES FOUR

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Figure 2.3 –Red Light Abatement Debate, *San Francisco Call*, April 24, 1913.

Title: Red Light Abatement Declared Impossible
Two perspectives:
"If you scatter these women all over the city, and no provision is made or them beyond ejecting them from the houses where they are found, they will be found living in proximity to your sisters and daughters."
AND
"These women really are a necessity, especially as this is a seaport town."

As a massive post-quake reconstruction effort went underway, San Franciscans were determined to rebuild the ashes into a world-class, modern city, and in this process, made the response to the Barbary Coast question clear. The two competing demands – the economic/social utility of the deviance industries, and the crusaders, investors, developers, and tourists demand for a safe, wholesome environment – were balanced through a process of *regulating and bounding* gambling and prostitution. Gambling was permitted – it was legal and regulated through licenses. Only specific gambling establishments could obtain licenses, the most common being banking games where bets are placed against the house (such as blackjack) versus other players, as is the case with games like poker.

Prostitution, though technically illegal, would be permitted only within specified zones in and around Chinatown and Barbary Coast, which effectively sanctioned prostitution by limiting the work to a bounded space that was routinely policed. The exact boundaries of the zone were published by the San Francisco Health Commission (Figure 2.4):

> Commercial Street from the westerly line of Kearny Street to the easterly line of Grant Avenue; Jackson Street from the westerly line of Kearny Street to the easterly line of Grant Avenue; Pacific Street from the easterly line of Montgomery Street to the westerly line of Front Street; … the north side of Jackson Street between Kearny and Grant Avenue north to Pacific Street; Washington Place . . . from the north side of Washington Street between Kearny and Grant Avenue north to Jackson Street.
>
> (Shumsky and Springer 1981)

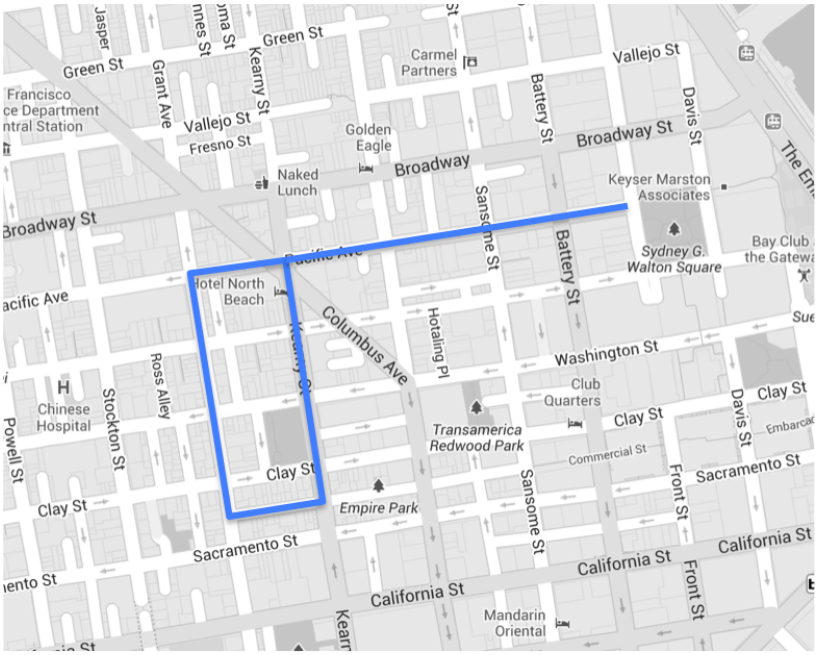


Figure 2.4 - The Official Zone of Prostitution, 1911.

Of note, the stated zone fell neatly within the overlapping regions of Barbary Coast and Chinatown.

The space where thousands of sex workers were clustered was officially zoned and policed. On Valentine's Day 1911, the policies "for the Prevention of Venereal Diseases" were enacted. This controversial early public health effort was developed by a prominent physician, chief of staff at Mt. Zion Hospital Julius Rosenstirn, as a compromise between moral crusaders working to abolish Barbary Coast, and the stakeholders invested in its continuation. It officially stated that prostitutes were not to be permitted to live outside the specified zone, and that the

women were to undergo twice-weekly pelvic examinations for gonorrhea, chlamydia, syphilis and other diseases. Women who passed the exams received cards with their photograph and medical history from the Department of Public Health, validating they were free of diseases (Sides 2006, Shumsky and Springer 1981, Asbury 1933). According to Asbury:

> "No woman was permitted to enter a brothel without a medical certificate, and all harlots were required to report at the clinic every fourth day for medical inspection, which included a blood test. For this they paid fifty cents, but their treatment in case of disease was free. Each prostitute received a booklet containing her photograph and a record of her examinations, and if she failed to produce this identification upon demand of a policeman or member of clinic staff, she was liable to arrest for vagrancy."
>
> (Asbury 1933, Pg 275)

By allowing prostitution and gambling to remain open for business within these regulated spaces, the city concentrated the risk, violence, and crime into predetermined neighborhoods. This strategy of policing, controlling, and inspecting women, at times violently, enabled the remainder of San Francisco's increasingly gentile citizenry to have a sense of safety (and morality authority), while preserving the option to visit the vice district if so desired.

The zoning and policing escalated in 1911 after the election of James Rolph[10], a mayor who understood the political potential of allying with established religious organizations. Under his administration, city police controlled and gradually squeezed the places where deviant activities were permitted. In February 1912, under mounting pressure from organized moral crusaders who now had an ally in the mayoral office, the city police announced to the newspapers:

> "1. All dance-halls and resorts patronized by women in Montgomery Avenue west of Kearny Street, and on both sides of Kearny Street, to be abolished.
> 2. Barkers[11] in front of dance-halls in Pacific Street to be done away with and glaring electric signs forbidden.
> 3. No new saloon licenses to be issued until the number has been reduced to 1,500.

[10] After San Francisco, he would go on to be the Governor of California from 1931 until his death in 1934.
[11] Men paid to solicit interest in events or establishments.

4. Raids to be made against the blind pigs[12]."

(Asbury 1933, Pg. 300)

A year later in February 1913, the crackdown continued as the police announced:

> "No female shall be employed to sell or solicit the sale of liquor in any premises where liquor is sold at retail to which female visitors or patrons are allowed admittance. Further resolved, that no women patrons or women employees shall be permitted in any saloon in the said district."
>
> (TERP 1979)

The new ordinances called for the constriction and regulation of the deviance zone. The designated space where activities were permitted was narrowed, the legal distribution of alcohol was limited, and the candid advertising of sex work was criminalized. The explicit targets of police were the female workers (versus the brothel owners/managers or clients), who were arrested and jailed if found in violation of the policies.

For a few years, the zoning of deviance seemed effective at balancing the city's competing social and economic demands, but in an era of heightening national conservatism, political hostility toward Barbary Coast continued to bubble under the surface. A change in California law would be the final blow to Barbary Coast, as it was known. In 1913, the California government passed the Redlight Abatement Law, which was legally challenged but eventually upheld by the California Supreme Court in 1917. It declared prostitution as a public nuisance and allowed affected property owners to sue brothels for financial compensation (Shumsky and Springer 1981). The Redlight Abatement Law represented an important shift because it raised the possibility for brothel owners, in addition to sex workers, to be targets of not-in-my-backyard nuisance lawsuits.

The city government and police authorities under Mayor Rolph used the Redlight Abatement Law as an opportunity to finally crack down on Barbary Coast. In early 1917, the city

[12] Establishments that sell alcohol illegally.

conducted two thorough raids of Barbary Coast. The entire boundary of the prescribed deviance zone was blockaded, and the San Francisco Police raided brothels one by one. Some women were tipped off about the raids and escaped in advance, but those who didn't flee were arrested and imprisoned. Two thousand women were forced to abandon their homes, leaving Barbary Coast deserted and unrecognizable within the space of a few hours (TERP 1979; Shumsky and Springer 1981). Saint Ann's brothels were also raided on the same day (including Tessie Wall's), but since prostitution operated under more concealed conditions, only two hundred women were displaced.

The 1917 raids effectively decimated Barbary Coast as the center of deviance. The scenario is hard to imagine, but what was the playground of San Francisco was within days an inner city ghost town[13]. Shumsky and Springer (1981) have shown through municipal and police records, however, that the morality raids against Barbary Coast did *not* put a halt to prostitution. Instead, the crackdown sent prostitution underground and diffused it throughout San Francisco. One special neighborhood had the social and structural conditions ripe for concealing prostitution – Saint Ann's Valley (Figure 2.5).

[13] Shortly after the raids, some deviance work was reestablished in Barbary Coast (consider the modern day strip clubs on North Beach's Broadway), but never close to the extent is existed before.

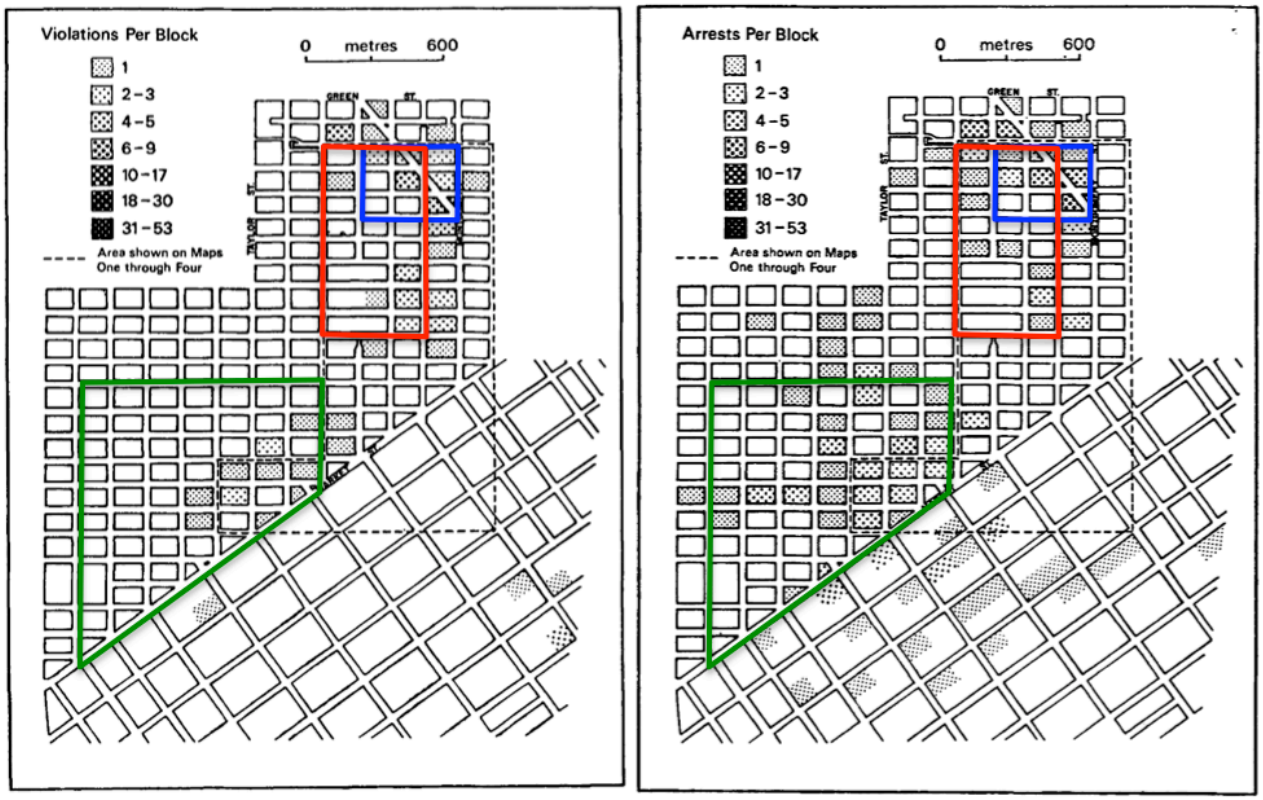


Figure 6. Locations of alleged violations of the Red Light Abatement Law in San Francisco, 14 June to 7 September 1917. Source: Edwin E. Grant, *San Francisco Affidavit, September 8, 1917* (Broadside, San Francisco 1917).

Figure 7. Addresses at which arrests were made under 40 US Stat Ch. 15, Sec. 13 Source: US District Court, Northern District of California, San Francisco, *Criminal Case Files, 1918–1919* National Archives and Records Center, San Bruno, California.

Figure 2.5 – Movement of Sex Work from Barbary Coast/Chinatown to Saint Ann's Valley, 1917-1919.

These maps are copied from Shumsky and Springer (1981) with colored borders added. The images are poor quality, but they help demonstrate the diffusion of prostitution from Chinatown (blue) and Barbary Coast (red) into Saint Ann's Valley (green). The first map (left) shows Red Light Abatement violations cited just before the 1917 Morality Raids. The second map (right) shows the number of arrests per block a few years following the raids in 1919. Arrests were spread through varied settings, and appear intensified particularly in the Saint Ann's Valley area.

As Downtown Tenderloin - Barbary Coast - was policed and constricted following the 1906 quake, the Saint Ann's Valley neighborhood had a different fate. It was entirely leveled by the great earthquake and fire, and city planners resolved that the neighborhood, adjacent to the central business district, was far too valuable to remain for residential use. Ornate theaters and stages, concert halls, restaurants, and grand luxury hotels were assigned to devastated lots to promote tourism and business. The city also passed tighter regulations on reconstruction, requiring that buildings be constructed from fireproof materials, like granite or brick. The new

ordinance escalated the cost of construction, and prevented many average-income Saint Ann dwellers from restoring property on their lots. Many relocated. Wealthier property owners who could afford to reconstruct erected taller buildings that promised to yield more rent income in the premier real estate location.

Brick by brick, Saint Ann's Valley was transformed into a neighborhood where residential spaces were comprised primarily of hotel and boarding house buildings (Figure 2.6). The sex industry in Saint Ann was strengthened through the neighborhood's newfound designation as an entertainment district. Though some brothels were displaced, many were rebuilt on an even grander scale than ever. For example, following the 1906 fire, Tessie Wall reconstructed an even larger and stronger three-story terracotta brothel on the same plot on O'Farrell Street (where the downtown Hilton stands today), and even opened a second location a few blocks over on Larkin Street.

Figure 2.6 – Uptown Tenderloin Architecture Pre- and Post- 1906 earthquake.

Uptown Tenderloin's Eddy at Leavenworth, following the 1906 earthquake and fire.

Same intersection today. Brick and granite structures up to seven stories tall, mostly for use as residential hotels, gradually replaced three story wood buildings.

The 1917 criminalization, crackdown and ultimate demise of deviance in Barbary Coast infused Saint Ann's Valley with thousands of sex workers virtually overnight. There were few other neighborhoods where the Barbary Coast businesses and women could go, and Saint Ann with its towering boarding houses and entertainment venues had the housing opportunities and cultural pulse to receive the influx. Shortly following the 1917 crackdowns, dozens of brothels and parlors were discreetly set up throughout Saint Ann and its panhandle, the 6th Street Corridor[14]. Saint Ann became the new and more mainstream deviance zone. Indeed, it was around this period (early 1900's) that the region was no longer locally referred to as Saint Ann's Valley – it became known, as it remains today, *as Uptown Tenderloin*. At this historical nexus, the identities (and futures) of Barbary Coast and Saint Ann were traded. Barbary Coast was destined to become the bridge-and-tunnel entertainment districts of North Beach, while Saint Ann became the densely populated, deviant, policed Tenderloin.

D. Fortification of Uptown Tenderloin, circa 1917 – 1970's

When Uptown Tenderloin was infused with illegal economies of Barbary Coast in 1917, the neighborhood began its legacy as its own deviance zone. Soon after, alcohol distribution and consumption was criminalized during Prohibition (1920-1933). With its new function as an entertainment district where illegal economies survived, Uptown Tenderloin became the lively heart of the black market alcohol industries. Speakeasies in the Tenderloin thrived, contributing to the consensus that Prohibition failed in San Francisco, and further fortifying the neighborhood's identity as the new deviance space. During the Roaring 1920's and even through

[14] Brothels also reemerged in the Barbary Coast, but not close to the pre-raid numbers. By the 1930's, the name Barbary Coast entirely dissolved.

the Great Depression, Uptown TL was energized by the tourism and capital brought into the fashionable entertainment district by vaudeville and jazz, which were beloved in San Francisco.

The Tenderloin was the spirited heart and soul of the rising world-class city, and the architecture of the era reflected this youthful idealism. Dozens of hotels with grand marbled and gold-gilded lobbies, but small living quarters and shared bathrooms, were constructed throughout the Tenderloin, allowing landlords to entice visitors and tourists with elegant impressions, while maximizing the occupancy and profitability of each building. Several of these hotels would become today's SROs, important architectural spaces in the neighborhood. Over the decades, as San Francisco's economy ebbed and flowed, the hotels provided housing options for tourists and residents (Figure 2.7).

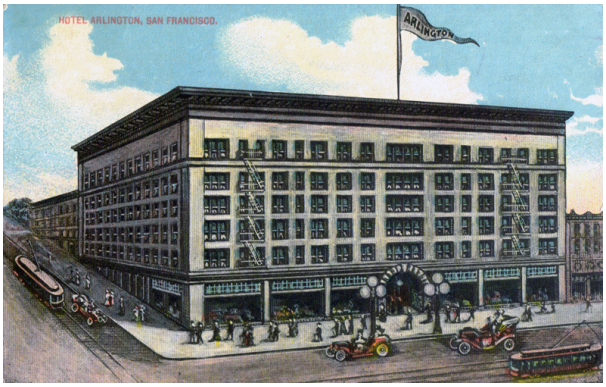


Figure 2.7 – Arlington Hotel, 1907 and Today.

Arlington Hotel, on Ellis at Leavenworth, was one of the first hotels built after the 1906 earthquake. Postcard from 1906 (top right), and 1907 (top left).
Today, the Arlington Hotel (bottom right) offers 148 SRO units and is operated by Mercy Housing on the housing first model.

And indeed, the Tenderloin's economy did wax and wane. The positive synergy of the entertainment district combined with illegal economies that drew in urban adventure seekers began to diminish as stage entertainment, the Tenderloin's primary legitimate industry, gave way to motion pictures in the 1930's. With fewer shows and affluent patrons, the neighborhood began to lose its footing as a national destination for music and theater. The local brothels, bars, dance-halls, lounges, burlesque halls, strip clubs, gambling and entertainment venues that were fueled by the entertainment heyday had to find different audiences. Military servicemen stationed in the Bay Area by the thousands during the 1940's filled this void. During World War II, as a major commercial and military port, sailors, servicemen, shipyard and port workers passing through San Francisco found lodging and entertainment in the TL. The Tenderloin continued to cater to tourists and servicemen through the Korean War (1950-1953).

In the postwar era, three national social migrations shaped the demographics of the Tenderloin – the "Great Migration" of African Americans from the south to urban spaces in the West (Tolnay 2003), the mass exodus of white Americans from cities into suburbs known as "White Flight" (Frey 1979), and the settlement of Southeast Asian refugees into the Tenderloin following the Vietnam War. Terrible social and economic conditions for blacks in the south – spurred on by occupational segregation, discrimination in housing and land ownership, and hostile, violent racial conflicts – led thousands of African Americans to move to Northern cities, such as New York, Chicago, and Philadelphia, for job and life opportunities during the first Great Migration (1910-1930). As the country ramped up for World War II, the Pacific-facing ports of San Francisco, Oakland and Los Angeles were bursting with unionized shipyard work, propelling the second Great Migration (1941-1970's) of blacks to the west coast. According to US Census data, in 1940, less than one percent of San Francisco's resident population was black.

By 1960, the city had 75,000 Black residents, or about 10% of its population, who built communities primarily centered around the Western Addition and Fillmore districts. Black communities, which relied heavily on wartime union jobs, were economically stressed when the jobs evaporated during a brief era of peace. Due to housing discrimination, in the Tenderloin, like in many other American "inner cities", the boarding-home-style hotels were among the few low-income, short-term housing options available for many African Americans who were economically and socially marginalized[15].

In the same postwar period, much of the Tenderloin's white middle and working class residential population moved to the suburbs, in sync with the national pattern of white exoduses from cities. The G.I. Bill, or the "Serviceman's Readjustment Act," enabled young veterans of war, who had returned from the fight of their lives, to obtain low-interest loans to buy their own homes. Many elected to move to the newly devised American suburbs. "White Flight", which is partly explained by whites aversion to the increasing black settlement in American cities (Frey 1979), lead to vacancies that increasingly stressed the Tenderloin's hotel and entertainment industries. Moreover, in an era of peace, businesses in the Tenderloin could no longer rely upon the wartime flow of visitors and tourists.

Vacancies in the Tenderloin hotels were high until the 1970's, when following the wars in the South Pacific, hundreds of thousands of Southeast Asians were granted entry into the United States as refugees beginning through the Interagency Task Force on Indochina Refugees. After 1975, Vietnamese, Laotians, Cambodians began to arrive in the Bay Area, hundreds of whom were directed to settle in the Tenderloin public housing and hotels. The neighborhood hotels, which were originally constructed to maximize the number of guests, had small units, and

[15] The city's first public housing projects were built to cheaply house wartime workers and were segregated until 1954 (Banks v San Francisco Housing Authority). Potrero Terraces housing projects were built in 1941 for Hunter's Point shipyard workers, about 40% of residents were black.

often lacked a private bathroom or kitchen. They were not conducive for families or long-term occupancy. Yet these hotels were rapidly utilized because they were the only low-income housing available in San Francisco.

Another social and political shift that affected the Tenderloin was deinstitutionalization and lack of adequate community mental health housing and supportive systems. The decades-long process of releasing people with mental illnesses from state hospitals was gradual and it is hard to determine what happened to the people released, but it is evident that many became homeless and ended up in places like the Tenderloin. Beginning in the 1950's, and escalating in the 1960's and again in the 80's through social movements and a series of mental health legislations, there was a national process of deinstitutionalization of psychiatric facilities. In 1954, there were over half a million people living in large state-run mental institutions; by 1996, this number reduced to 61,722, with 120 hospitals closed during this forty-two year period (Geller 2000). Homeless is frequently cited a major unintended consequence of deinstitutionalization, an issue that was exacerbated because the proposed community alternatives to institutions were not available or inadequate to care for released patients (Susnick and Belcher 1995). Estimates of mental health issues among the homeless are higher than in the general population and usually range between 30-50% (Krieg 2001). Although homelessness is a rural and urban concern, homeless people have more commonly moved to cities. Today, it is estimated that about 91 percent of homeless people, about 680,000 individuals, live in cities (National Coalition for the Homeless 2009). Today, about half the homeless individuals in San Francisco live in District 6 (Uptown Tenderloin) and 37% of those surveyed reported major mental health issues (San Francisco Homelessness Count and Survey 2013).

These social factors and migrations transformed the Tenderloin into a space characterized by race, class, and health-based inequalities. From the 1950's onward, no longer a trendy entertainment district, the Tenderloin was a neighborhood largely settled by the very poor in San Francisco who had few other housing options in the city. For decades, these issues were (and continue to be) exacerbated by slumlords and dysfunctions with public housing. There were insufficient low income and public housing spaces for the high demand. In the TL, public housing facilities available were sorely neglected, having to do with reimbursements being allocated based on the number of people housed, not on the basis of *adequate* housing. Following the Kerner Commission report and the Fair Housing Act (1968), as well as influential academic work underscoring the gross disparities in the quality of housing (Massey 1990; Wilson 1987), a national effort was underway to de-concentrate poverty in the United States. Programs that link benefits to an individual (Section 8, now called Housing Choice Voucher, or HCV) instead of buildings (public housing) were created, but researchers suggest de-concentration efforts were inconsistent and never meaningfully prioritized (Galser 2013)[16].

The SRO hotels in the Tenderloin provided affordable housing options for people who were poor, but these spaces did not offer the same housing rights and protection as units with proper leases. Poor residents of hotels were under persistent risk of losing housing, exacerbating the homelessness issue in San Francisco during the 1970's and 80's. Estimates suggest San Francisco's homeless population peaked around the late 1980's and early 1990's. Homeless estimates (particularly early estimates) are notoriously unreliable, but according to one estimate

[16] Galser (2013) makes an important caveat in the beginning of his paper: "At the outset I should make it clear that the deconcentration of poverty has never been a major, consistently pursued goal of federal housing policy, nor have HUD programs or administrative rules been comprehensively and systematically oriented toward achieving this goal. Indeed, the federal effort at poverty deconcentration could be described as token, fragmented, and reluctant. Scattered-site public housing was rarely adopted by the local housing authorities that manage public housing and HCV programs, and often only under the impetus of a court order. This initiative never represented more than a tiny share of public housing units nationwide"

from the Centers for Disease Control (1991), 6,000 to upwards of 18,000 homeless individuals lived in San Francisco in 1990.

During this era of instability in the Tenderloin (postwar – 1975), a countervailing force to urban blight began to emerge and organize. People in the Tenderloin community saw firsthand the life-altering effects of housing uncertainty, economic isolation, and architectural decay – poverty, homelessness, and illness. Religious groups started the first community-based health/support organizations in the Tenderloin. Father Alfred Boeddeker, a Franciscan Friar, opened Saint Anthony's church dining hall in 1950, and was the first to serve free hot meals to the scores of poor Tenderloin residents on such a scale. St. Anthony's was followed in the 1960's by Glide Memorial United Methodist Church's food program[17]. Daily, for decades, the hungry people of San Francisco have lined up, wrapped single-filed around the corners of the Tenderloin, counting on these charitable organizations for a warm meal.

Health and support groups like these were pivotal to protecting the low-income community in the Tenderloin and catalyzing early community organization. The neighborhood gradually developed a character as a place where, to some extent, poverty and difference were understood and accepted. People marginalized elsewhere could find housing, support, resources, and potentially even community. It is worthy to note, for example, that San Francisco's queer communities convened in the Tenderloin even before the Castro and Haight Ashbury blossomed in the 1967 Summer of Love[18]. The Compton's Cafeteria riot of 1966, an important political, historical event of police brutality against the transgender community, took place in the heart of the TL at Taylor and Turk.

[17] Now known as Daily Free Meals. Both meal programs are still in operation today and expanding due to increased demand for free food and other supportive services.

[18] The first brothel in the country known to offer male prostitutes was famously opened after the great quake in Uptown TL, on Mason Street (Asbury 1933).

The low-income resident population in the TL began to re-establish from all walks of life, centralized in the SRO hotels. Without proper leases, however, the residents of the Tenderloin hotels had little power to ensure the stability or condition of their housing. Landlords were known to increase room prices dramatically without notice. SRO hotels, which had become the de facto home for many of San Francisco's very poor, were being converted back into tourist lodgings. Evictions were common, as was homelessness. Moreover, by the 1980's, San Francisco underwent a boom in development. The Tenderloin, which just decades prior was the neglected scourge of the city, regained interest from developers.

In reaction, the low-income residents began to organize to fend off development, eviction, and other factors of gentrification. Tenderloin community has focused much of its organizing effort on housing issues. Throughout the 1980's, battles over rent control and hotel conversions were waged between organized tenants, landlords, developers, and city officials (Shaw 1998). Through the 1970's and 80's, activism and organizing became engrained into the Tenderloin neighborhood (Waters and Hudson 1998). As I discuss in the next chapter, most recently, housing organizers and residents have advocated for the social justice, health, and economic importance of providing *adequate, permanent, low-income* housing options in San Francisco, the most expensive city in the United States.

E. Conclusion: Implications for Health

At times, the social history of the Tenderloin I discuss in this chapter seems detached from a modern concept of health. How can the Gold Rush or the 1906 earthquake be relevant to the health of San Francisco citizens today? Yet as I demonstrate in this chapter, there is a direct line between historic events like these and the development of the Tenderloin as a stigmatized

social environment characterized by deviance. This history raises three implications for understanding health in the Tenderloin that I preview here and discuss further in Chapter V.

First, excavating the history of the Tenderloin nuances the stigma of the neighborhood, stigma being an understudied factor I argue shapes the health of Tenderloin residents. It was important for me as a health researcher to understand this history because I have repeatedly found that the Tenderloin is indeed characterized in negative, stigmatized ways. As I discussed in the introduction, the widespread perception I have encountered is that the neighborhood is bad, dangerous, or unhealthy, as are Tenderloin residents by association. If taken out of context, it is easy to assume these features are natural or simply the way things are. But, is it evident the factors that drive the Tenderloin's long history of stigma are rooted in the social history of the neighborhood, which can largely be explained through the race, class, and gender power relations of different historical eras. The neighborhood's very origins were related to the criminalization, zoning, policing, and crackdown of poorer, more colored sex work and gambling from Barbary Coast, and race and class relations continued to drive the persistence of poverty and risk in the Tenderloin over the decades (Great Migration, White Fight, Southeast Asian refugees, etc.). Stigma does not emerge in a vacuum, and understanding the Tenderloin's history puts stigma in the context of the race, class, and gender inequalities, and at times blatant discrimination. Acknowledging this may help unravel the many potential harms of stigma.

Second, this analysis underscores the historically dialectical relationship between places and health. Built physical places, which have considerable inertia, shape health. The SRO hotels, for example, which were built for an entirely different function a hundred years ago, have been the site where the health activities take place for poor San Francisco residents for decades. They were not constructed with modern health needs in mind, yet today they house people with the

greatest, most complex health demands like people on disability and the formerly homeless. Yet places are also mutable, as health in turn shapes places. For example, many people in the hotels manage addictions to drugs or alcohol, which alters the social dynamics, activities and functions of the hotels, which I explore further in Chapter IV.

Third, the stark parallel between the historic Barbary Coast and the modern Tenderloin cannot be ignored. As I demonstrated in this chapter, the neighborhoods are historically linked, as the demise of Barbary Coast spurred the development of Uptown Tenderloin. They are both types of deviance zones that contain illegal economies that are criminalized, monitored, and policed. Barbary Coast was then the "zone of prostitution"; today, as I explore in-depth in Chapter III, Uptown Tenderloin is known as a "containment zone" for homelessness, crime, and the illegal drug economy. Barbary Coast had prescribed boundaries that were zoned and policed. Similarly, the Tenderloin has a police department dedicated entirely to policing its boundaries. The policing and stigma cannot be divorced from race, class, and gender inequalities in both neighborhoods. This may be an opportunity to learn from historical examples to inform and guide our modern health policies and interventions[19].

In the next chapter, I examine today's Uptown Tenderloin situated in this historical context. The social history discussed in this chapter sets the stage for understanding the Tenderloin as both a contested community and containment zone.

[19] Ex. In the case of Barbary Coast, the diffusion of deviance through policing and criminalization did not eradicate prostitution or gambling in San Francisco. Instead, it shifted to other neighborhoods. That is, the policing and criminalization as sole strategies for addressing illegal economies was not entirely effective.

Chapter III: The Political Uptown Tenderloin Community

A. Overview

Sociologists have long grappled with the concept of community. For decades, the term suggested a location, an idealized place that was often homogenous, comprised of like-minded members, and bound by commonalities such as family, religion or culture. In George Hillery's (1955) analysis of ninety-four concepts of community, he identified the following characteristic elements: geographic area, self-sufficiency, kinship, consciousness of kind, common lifestyles, and various intensive types of social interactions. Talcott Parson's (1968) notion of community involved a common sense of identity, basing the notion of community in "value commitments" instead of geographic regions. Robert Nisbet (1966) defined community as containing a high degree of personal intimacy, emotional depth, moral commitment, social cohesion, and continuity in time.

More modern definitions of community, however are more dynamic than these earlier idealized conceptualizations. Communities are social constructs, rather than natural orders, which develop over time. They can be local or global, with real and virtual meeting spaces (Rheingold 1993). Communities themselves can be nested – communities exist within communities. They can have boundaries, symbolic or physical, which are blurry and fluid rather than concrete. These modern notions of community emphasize their diverse, contested features, but also recognize that communities are tied together by some sense of connection (Bruhn 2011).

One definition of community has especially resonated for me. The first American Sociological Association's Annual Meeting I attended as an ASA Minority Fellow was in 2009, held in the city where I was born, San Francisco. The conference theme was "The New Politics

of Community", and I had to opportunity to hear the then ASA President, Patricia Hill Collins, speak about communities during the presidential address and when she met with the Minority Fellows privately. She argued that today, the community concept is taken for granted, like some kind of affirmative societal given. But it is in fact a *contested concept*. Communities are political constructs where power is exercised. They contain different types of knowledges and experiences, both elite and common. They therefore also contain diverse, sometimes contradictory meanings, emotions, and social practices. At the same time, although communities are contested spaces, they can compel people into action. They are tools and catalysts for organizing and wielding power, and they are sites where politics are exercised (Collins 2010).

As I sat in the audience at the Hilton hotel, just three blocks from the drug treatment program where I worked, this contradictory, political construction of community had the Tenderloin written all over it. "The Tenderloin Community" is a concept that is frequently evoked when the neighborhood is discussed within service organizations or social movements. I've heard this term used by housing organizations, health and advocacy organizations (ex. Glide Memorial Church, Saint Anthony's), schools (ex. Tenderloin Community School), by journalists and academics writing about the Tenderloin, etc. Yet the Tenderloin "community" has contradictory meanings depending on the actors and issues at stake: it is something that is unified and vibrant; it needs protecting; others need to be protected from it; it needs help to be "healthy"; it is fragmented; it is organized. In reality, "community" in the Tenderloin indicates conflicting entities, actions, intentions, and goals.

In this chapter, I borrow from the conceptualization of community as a political space because it acknowledges the positive aspects and potentials of community (support, shared goals), but it balances these with the certainty that communities are dynamic and contested

political arenas. In communities, ideas and resources are competed for and claimed by multiple stakeholders. The Tenderloin today is the second most densely populated neighborhood in San Francisco with 25,000 men, women and children living within a single square kilometer. With its political history and current population density, the Tenderloin is the political site of diverse, contested ideals and stakeholders that exist both within and outside of its imaginary boundaries.

In the first half of this chapter, I describe several sub-communities in the Tenderloin. It is by no means a comprehensive list. The purpose of presenting a selected snapshot is three-fold. First is to stress the immense diversity of backgrounds, ideas, and interests that compete for resources, identity, space, and opportunity in the Tenderloin. Understanding this diversity helps to dispel the common perception and stigma that the Tenderloin is a uniformly bad, scary neighborhood. Second, it underscores that micro groups possess different interests and degrees of political power. Third is to stress that the participants I worked with for this project, formerly homeless women who were living in supportive housing, represent a small percentage of Tenderloin residents today. They are nested within, and interact across, multiple types of communities. With 25,000 individuals sharing the same streets and buildings, it is important to describe how the participants of this study fit into the broader Tenderloin landscape. To begin, I discuss the Tenderloin's borders, which I argue are real yet simultaneously imagined and elastic. I then describe the demographics of the sub-community of the Tenderloin most relevant to this project – the resident population. I also briefly introduce the jigsaw of other major sub-communities that utilize this space, including the government buildings, technology companies, arts and theater, community-based organizations, and the many surrounding businesses. These many sub-communities are all stakeholders competing for the modern Tenderloin's function and identity.

In the second half of the chapter, I explore the most memorable and defining feature of the neighborhood's identity – the drug marketplace. Beginning in this subchapter, I rely heavily on quotes and data from the ethnography, participant observation, and the walking interviews I conducted with the docent participants from 2010 to 2012. As I refer to the women recruited for this project, I have chosen to call them "docents" as well as "participants" to accentuate their expert status in the neighborhood – this recognition is a pivotal aspect of the docent tour method. Based on grounded theory analysis of the twenty docent tour interviews, I argue, as others have before me, that the Tenderloin can be characterized as a *containment zone*. This containment zone bears some notable resemblances to the historical, circumscribed, policed San Francisco deviance district of Barbary Coast ("Downtown Tenderloin") I discussed in Chapter II. But the Uptown Tenderloin containment zone today is distinct. I organize the interrelated features of the modern containment zone into four categories. *First, the Tenderloin is a central meeting place for a larger drug market.* Both drug dealers and consumers "commute" from other parts of San Francisco and the Bay Area into the Tenderloin to transact drugs. *Second, the Tenderloin is a neighborhood that concentrates poverty and the risks of the larger drug marketplace*. This is the result of a historical process: competing groups, including housing organizations, federal and local housing agencies, neighborhood associations, and private property owners, have for decades competed over the use and identity of the Tenderloin. *The third aspect of the containment zone is the practice of intense policing and surveillance* (formal and informal). Residents do not move freely around the Tenderloin. Streets, stores, and homes are monitored and policed in ways comparable to being institutionalized. *Forth and finally, the containment zone is a space residents are physically or symbolically tethered to*, particularly if they are involved in drugs. Participants repeatedly described being "stuck" in the neighborhood.

Sociologists have discussed mobility in terms of class, but less so in terms of physical spaces. These four manmade conditions of the containment zone are deeply interrelated, and have direct implications for the health of its residents, which I review in the conclusion.

B. Modern Uptown Tenderloin: A Contested Community

1. Real and Imagined Boundaries

Despite its notoriety, the Tenderloin has never formally been designated as a San Francisco district. It is not officially a neighborhood, district, or anything really. By most unofficial indications, like Google maps, it is a subsection of the larger Downtown/Civic Center district, which extends several blocks further west, north and east. As I studied old documents and maps of the city, I found that geographically, the Tenderloin's recognized borders have expanded over the years since it was first described as Saint Ann's Valley (Figure 3.1). These changing neighborhood borders underscore the mutability and social construction of places.

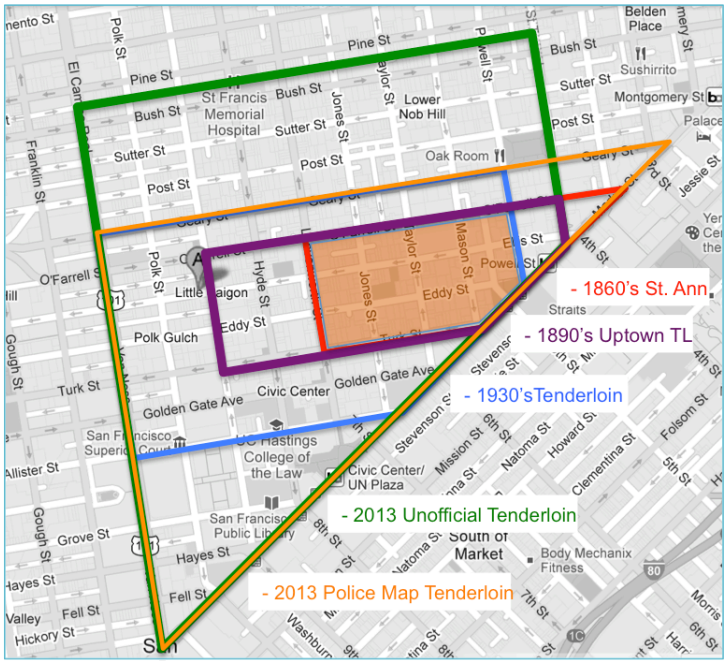


Figure 3.1 – Changing Borders of the Tenderloin

From when it was a neighborhood called Saint Ann in red (sfmuseum.org, Ellinger 2013), to an early entertainment district in purple (Asbury 1933), to reconstruction following the earthquake in blue, to today's designation in green, the name "Tenderloin" has grown to encompass much of the Downtown/Civic Center neighborhood. The SF police maps cut off the Tenderloin designation at Geary Street, in orange.

The changing boundaries and unofficial status make the TL a challenging place to study. Defining boundaries is a common methodological problem in neighborhood research (Small and Newman 2001). In official surveys and censuses, the TL demographic data is tied in with the larger Downtown and Civic Center district, limiting our ability to apply this data to the Tenderloin section[20]. Given that the longstanding historical connection between the concept of the Tenderloin and the police, the best indicator of the exact modern boundaries of the TL may be San Francisco police maps (SFPD 2013). The Tenderloin division of the San Francisco Police Department is devoted to the small square kilometer section outlined in orange below. To stress how policed this tiny neighborhood is, consider the size of the police designations for the Tenderloin compared to the other police districts (Figure 3.2):

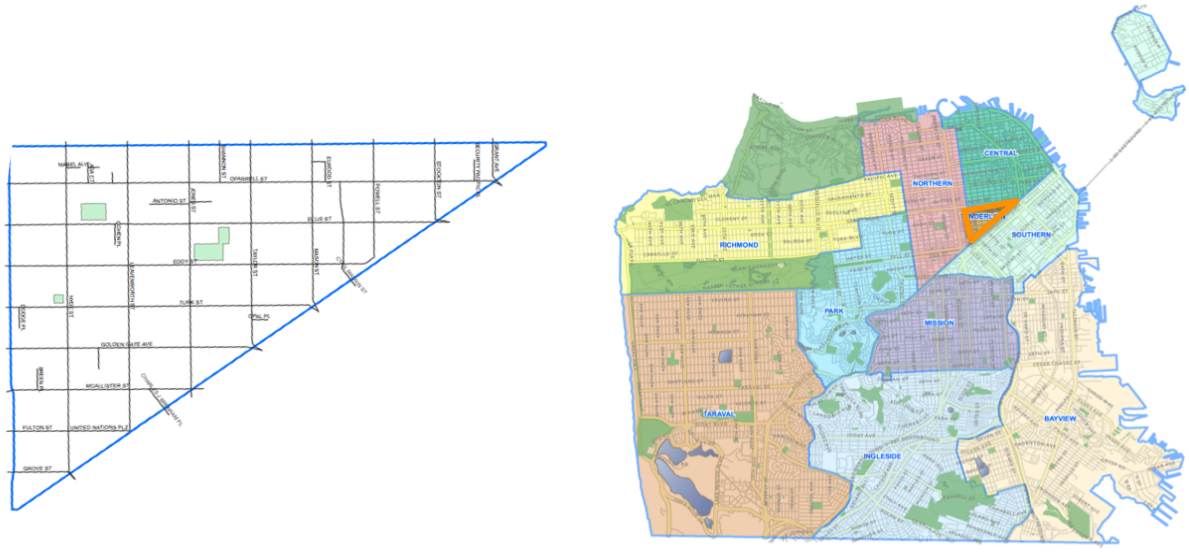


Figure 3.2 - SFPD Division Maps

(Left) Tenderloin District Police Map
About 1 square kilometer

(Right) SF Police Station Maps
Consider the size of the Tenderloin District (dark orange) compared to the Taraval District (light orange).

[20] San Francisco's other poorest neighborhood – Hunter's Point – is also not considered an official district. Rather, much like the TL is a section of Downtown/Civic Center, Hunter's Point is designated a segment of the larger Bayview neighborhood. What does the unofficial status of these poor neighborhoods say about the identity and acknowledgement of these communities?

2. Tenderloin Demographics and Spatial Utilization by Residents

Bearing in mind that these demographics are drawn from the entire Downtown / Civic Center district, which extends further north and west beyond the recognized Tenderloin boundaries, consider these figures from the San Francisco Planning Department (2011) based on the US Census Bureau 2005-2009 American Community Survey: the median household income was $24,491 (barely a third of the average in San Francisco, $70,000). One out of four people live under the federal poverty line[21]. Only four percent of homes are owner-occupied in the TL, meaning virtually no residents own the homes they live in. Forty-one percent of residents have a high school education or less, and forty-one percent are first-generation immigrants to the United States. These numbers are skewed higher because they are generalized from the entire downtown neighborhood and do not include the undocumented residents of the TL. Nonetheless, the Tenderloin (along with the Hunter's Point) is the poorest neighborhood in San Francisco.

The residential population was mostly male (61%) and racially/ethnically diverse, with 10% reporting black, 28% Asian, 18% Latino, 15% multi-racial and 1% Native American (San Francisco Planning Department 2011). Although it is a space where people of different racial/ethnic backgrounds live side-by-side, a report developed by Urban Solutions (2004) showed that the neighborhood has unequal racial/ethnic settlement patterns. By overlaying race/ethnicity data collected from the 2000 US Census onto a map of the Tenderloin, the authors of the report show, block by block, that the residents of color (Black, Asian/Pacific Islander, and Latino) tended to reside in the far more densely populated, more rundown, older central spaces. Whites, on the other hand, lived throughout the TL, but predominantly in the more spacious

[21] The Federal Poverty line (2013): below $23,550 for family of four; $11,490 for a single adult), however, has little applicability to standard or quality of life in San Francisco, which demands much higher income to support basic living expenses.

exterior margins (Figure 3.3). This settlement pattern is due to the architectural landscape of the Tenderloin – the central space contains most of the area's single resident occupancy (SRO) hotels and low-income housing, whereas more expensive residences with fewer units comprise the margins. The historical factors I discussed in Chapter II, such as housing discrimination and the directed settlement of Southeast Asian refugees through the Indochinese Refugee Task Force, also explain clustered racial and ethnic settlement patterns. The data suggests that though racially and ethnically diverse, the Tenderloin is also somewhat segregated, with a disproportionate number of low-income residents of color living in tightly occupied, poorer living conditions.

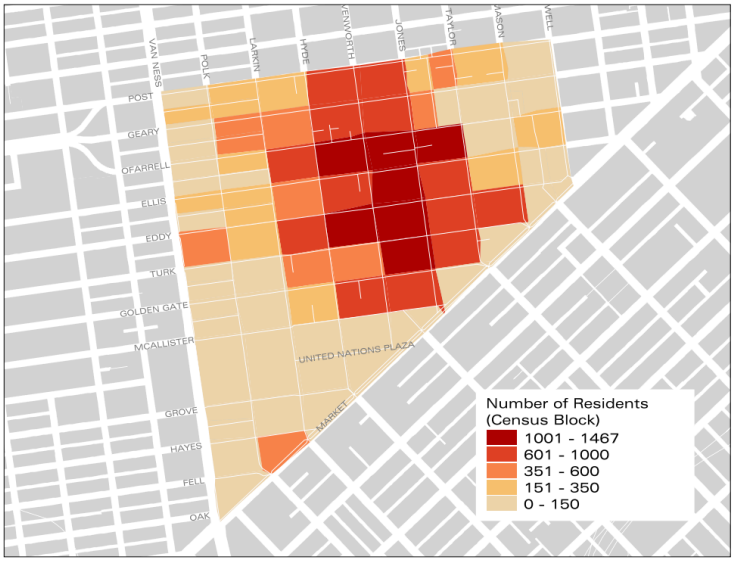


Figure 3.3 – TL Residential Ethnic and Racial Distribution.

Left: Population density of the Tenderloin based on 2000 US Census data (Urban Solutions 2004).

Below: Race/Ethnic settlement patterns based on 2000 US Census data (Urban Solutions 2004). Clockwise starting from the top left: Asian/Pacific Islander, black, Latino, and white on the bottom left.

3. A Jigsawed Use and Identity

The Urban Solutions report begins to suggest the first, most basic concept to convey about the Modern Tenderloin - that it is an intensely populated, diverse, loosely segregated space. In researching its diverse makeup, I came across one depiction of the TL's "micro-neighborhoods" (Figure 3.4). It resembles a jigsaw puzzle, with each distinct micro-neighborhood mashing into one another.

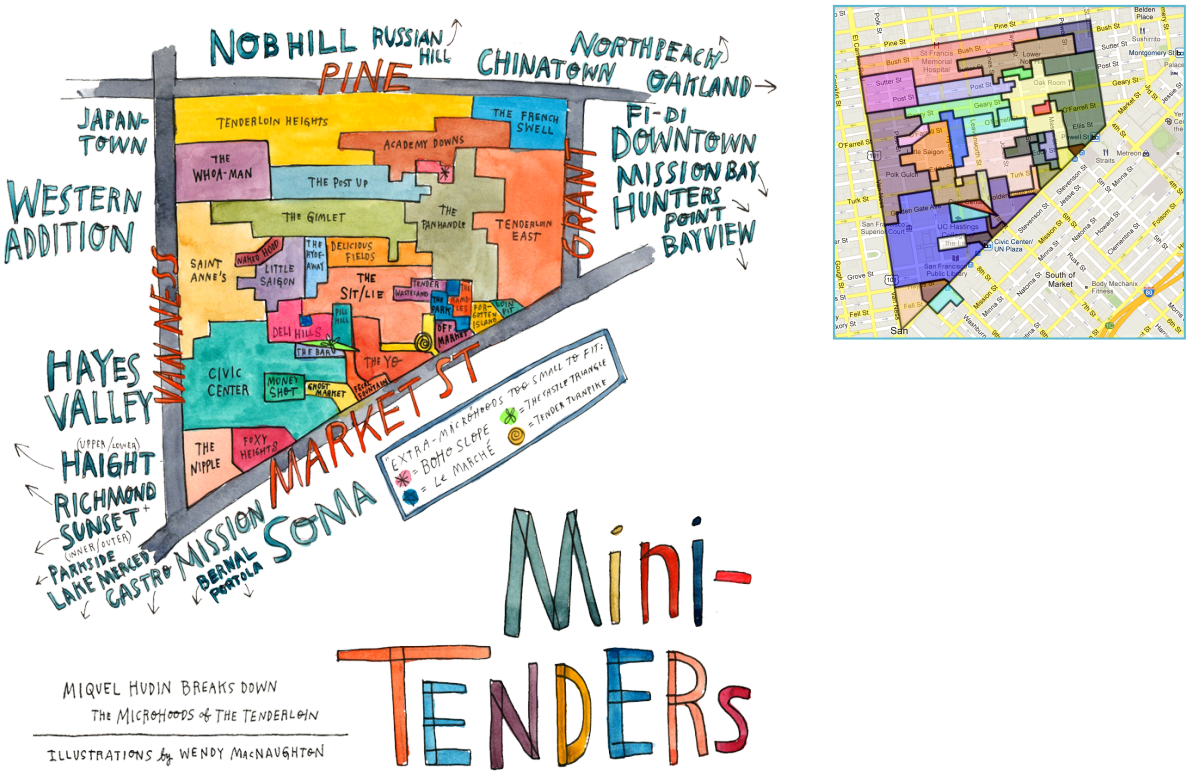


Figure 3.4 – Tenderloin Microneighborhoods.
Artist Wendy MacNaughton's rendition of the Tenderloin microneighborhoods published in *The Bold Italic* (2013) (left). It seems to be based on one group of residents' conception of Tenderloin micro-neighborhoods or "microhoods", which they published on google maps (icon on the right).

The names and boundaries of the micro-neighborhoods in the map above are invented (some rather crudely). But based on the docent tour interviews and ethnography I have done, the characterization of the Tenderloin as an intensely mixed-use space fits residents' own representation. Within five minutes, I can stand in front of the Renaissance-styled City Hall, walk three blocks north up Larkin to the heart of the Southeast Asian business community, then two blocks east into what is known as San Francisco's skid row on Turk Street.

The Tenderloin conjures images of poverty, drugs, or crime. These are the scary mental images about the neighborhood that seem to resonate in people's memories. But in fact, the Tenderloin is an extremely mixed-use space that contains an array of diverse stakeholders

representing many facets of society. Some live in the Tenderloin, like the residents I discussed above. Others come to the Tenderloin for work or recreation. Below I discuss some of the important sub-communities that make up the jigsawed space. Each group represents a community, yet they are also each part of the symbolic "Tenderloin Community" in its broad sense. In everyday circumstances, they also compete amongst themselves for their place in the neighborhood.

One distinctive piece of the jigsaw is composed of the government buildings like City Hall, the State and District courthouses, the Civic Center Public Library, and U.C. Hastings Law School, and the thousands of mostly white-collar professionals working in them. These symbols of power and authority, which occupy the whole of the southwestern corner, are major presences rarely included in popular imaginaries of the Tenderloin.

Over the last five years, city planners have used tax incentives to attract technology companies into the Tenderloin, most notably Twitter[22]. Most of these companies are situated along the southern border of Market Street, the "mid-Market" area that is increasingly an extension of the technology-laden South of Market (SOMA) neighborhood. Some in the Tenderloin view these companies as potential benefactors that will support business, local revitalization, and social welfare efforts to the neighborhood. To others, they are threats to the low-income residents of the Tenderloin and indications of relentless income and power inequalities that spur gentrification.

Another piece of the Tenderloin jigsaw is made up of the many organizations and economies based on art, culture, and entertainment. On the western end, the Tenderloin is home to grand theaters, such as the Orpheum Theater constructed (1926) and the Curran Theater

[22] Twitter is expected to save 22 million dollars in taxes over 6 years in the Tenderloin, the largest tax break offered to a company in the State of California.

(1922), constructed in the TL's glory days. Other large performance venues are located within the Tenderloin's margins like the Herbst and the Warfield stages. The Asian Art Museum, the San Francisco Symphony, the San Francisco Ballet, and Opera House are situated on its western margin. The TL is also home to the American Conservatory Theater (A.C.T) along with a number of smaller stages, such as the Cutting Ball Theater and EXIT Theater. Recently, the city has invested in the art and theater identity of the Tenderloin as another strategy "revitalize" the neighborhood. This effort is most recently demonstrated by a project called 950 Center for Art and Education, currently under construction on the corner of Market Street and Turk Street, which will house projects by Youth Speaks, the All Stars Project and other theater organizations.

Over the last ten or so years, the Tenderloin has regained popularity among locals and tourists, particularly since the area has undergone revitalization (or development or gentrification, depending on who you ask.) The "Heart of the City" farmer's market and at least half a dozen food trucks set up weekly in UN Plaza. Dozens of trendy (pricey) bars and restaurants have emerged (ex. Bourbon and Branch, Farmer Browns, Chamber's Bar, Tradition etc.), and alongside the TL's old seedy dives (ex. Geary Club, 21 Club). With a dense concentration of Southeast Asian residents, the Tenderloin is also the known oasis of the city's best Vietnamese, Burmese, and Thai cuisine particularly in the sub-space centered on Larkin Street dubbed Little Saigon.

Finally, non-profit and for-profit community support, welfare or advocacy organizations are a major presence in the Tenderloin. In this chapter, I focus on the housing organizations that have played a crucial role in delivering and bolstering the safety net for low-income and no-income San Franciscans in the Tenderloin. Housing organizations like Community Housing Partnership, Tenderloin Neighborhood Development Corporation, Mercy Housing, and Glide

Housing provide permanent, affordable housing to people who were chronically homeless, and have worked for decades to reverse housing instability that has come to define the TL. Over the last 15 years, permanent, supportive housing (versus short-term or transitional) has been the favored model to provide housing to people who were, sometimes for decades, in the revolving paddle wheel between the streets and temporary housing circumstances. As I describe below, these housing organizations have worked with private, local, state, and federal organizations to purchase, renovate, and/or manage the SRO hotels for use in permanent supportive housing. They have also constructed several affordable housing buildings from the ground-up.

Housing organizations are just one sliver of the large, complex, interdependent yet highly fragmented network of social support and health organizations used by people in the Tenderloin. Since Father Alfred Boeddeker opened Saint Anthony's dining hall in 1950, community-based support organizations have been a core presence in the TL and today provide the food, shelter, clothing, health care, child care, respite, recreation, job training, counseling, education, and the social, religious, legal, and employment services sorely needed by the community. As I have shown in Chapter II, before these organizations, these services have historically not been available to residents in the Tenderloin. Each community-based organization is a plank on the makeshift "bridge", supporting survival and perhaps even a way "out" of poverty, but the pathway is unpromising and rickety nonetheless (Figure 3.5).

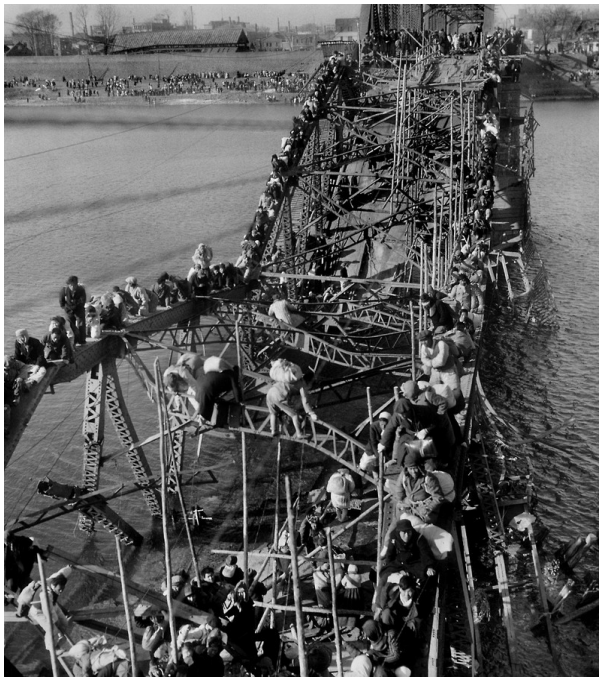


Figure 3.5 – Makeshift Bridge Metaphor.

Koreans escaping Pyongyang, using a bombed makeshift bridge to cross the across the Taedong River in 1950

When thinking about the hundreds of social services organizations in the Tenderloin, this haunting image comes to mind. Each organization is a beam on the bridge out of poverty, but the system is unstable and the route perilous.

To demonstrate just how widespread and critical these services are to the Tenderloin community, below is *an abbreviated* list of the social support organizations mentioned by the participants of the study:

- **A Place for Women**, a local female-only transitional and emergency housing
- **Alcoholic Anonymous / Narcotics Anonymous**, national/international 12-step, peer-based (non-professional) substance use treatment programs.
- **Asian American Recovery Services**, a local mental health and substance use services targeted to Asian populations
- **BAART Programs**, local methadone maintenance, drug treatment services, rehabilitation programs based in the Tenderloin.
- **Black Coalition on AIDS**, a local advocacy, education, and harm reduction organization for the HIV+ *black population*.
- **City Impact**, a health and wellness center, community organizing located in the Tenderloin.
- **Compass Family Services**, a local organization providing shelter, housing, children's resources.
- **Epiphany Center**, a local organization providing substance use treatment, residential recovery programs, in-home health services, children's services.
- **Food Runners**, a local organization providing at-home free food delivery service
- **Glide Memorial Church and Foundation**, a local church and community-based organization providing housing, meals, medical care, clothing, furniture, rehabilitation services, and senior services in the Tenderloin
- **Haight Ashbury Free Clinics**, a local clinic, part of the Department of Public Health, providing health care services, mental health, substance use treatment.

- **Hamilton Family Center**, a local, transitional, emergency, interim and permanent supportive housing program; children and youth services
- **Headstart**, a national childhood school readiness program.
- **Homeless Prenatal Program**, a local organization providing prenatal services for homeless families
- **Hospitality House**, a local, Tenderloin-based support organization providing shelter, drop-in center, an employment program and a community arts studio.
- **Iris Center**, a local organization providing women's counseling and recovery services
- **Lutheran Social Services**, a national organization operated in the Tenderloin providing case management and money management for people in supportive housing.
- **Meals of Wheels**, a national free food delivery service.
- **Project Homeless Connect**, a local, City-sponsored program that provides monthly "one-stop" drop-in resource for homeless people.
- **Saint Anthony's Foundation**, a local church and community-based organization providing shelter, housing, meals, medical care, clothing, furniture, rehabilitation services, and senior services
- **Saint Vincent de Paul**, a national/international organization operated in the Tenderloin providing shelter and social support services.
- **Salvation Army**, a national/international organization providing food, resources, social support, substance use treatment
- **San Francisco Food Bank**, a national but locally run organization that collects and redistributes food for free or low cost.
- **Seneca Community-Based Services**, a state program providing case management, probation, therapeutic, transitional age youth, and wraparound services.
- **Shelter Plus Care**, a federal program providing case management, money management, residential treatment, mental health services, crisis intervention, vocational training.
- **Smart Recovery**, a national non-12-step (non-AA) community-based substance use treatment
- **Tenderloin Housing Clinic**, a local organization providing housing, legal and supportive services
- **Tenderloin Neighborhood Development Corporation**, a local organization providing affordable housing and supportive housing services.
- **Tom Waddell Health Center**, a local organization, part of the Department of Public Health, providing health care services.
- **Walden House Inc**, local residential substance use and mental health treatment facilities, and multi-service facilities.

C. The Containment Zone

In this subsection, I explore the dynamic processes and characteristics that have resulted in the drug market that has made the modern Tenderloin notorious. To situate this discussion, I

argue, as many San Franciscans have, that the Tenderloin is a *containment zone*: a place where people who are marginalized or stigmatized – the disabled, extremely poor, homeless, mentally ill, people with criminal histories, people involved in illegal economies - live freely in theory, but exist in policed, monitored, and controlled conditions. The "Patron Saint of the Tenderloin", Reverend Glenda Hope, a Presbyterian minister who has advocated for the Tenderloin for 35 years, recently described the containment zone concept in an interview with a reporter:

> "Some years ago, one of our city officials said that the Tenderloin is a containment area. And I think what that meant is that behavior would be contained in the Tenderloin that would not be allowed, for instance, in the Marina or Pacific Heights or places like that. Drugs are sold very openly on the streets here. Homeless people sleep on our streets, which is not their shame - it's ours. Some for-profit hotel owners aren't allowed to maintain conditions that do not measure up to the city's codes, health codes, fire codes, other kinds of safety codes. And we've been a part of going into those buildings and bringing in city officials and pointing out these violations. These behaviors cannot be contained, and poor people made to live here while slumlords make a lot of money. So this has to be challenged."
>
> (KQED News, September 25, 2013)

Reverend Hope provides a good basic explanation of the containment zone concept, as a place where behavior or activities unwanted elsewhere are contained under the assumption that if such activities are controlled in the TL, they won't bleed into other neighborhoods. But based on the grounded theory analysis of twenty docent interviews, I argue that the containment zone has four other salient characteristics, which are highly interdependent. *First*, the Tenderloin is a central meeting place for a drug market that extends far beyond the Tenderloin's borders. *Second,* the Tenderloin is a neighborhood where poverty is concentrated, as well as the risks of the larger drug marketplace. *Third,* the parallel practice of extensive policing and surveillance (formal and informal) are acute in the Tenderloin. *Forth,* the containment zone is a space where residents are physically, economically and symbolically tethered/stuck.

The politics of the containment zone highlight the complexity of communities. The "Tenderloin Community" is commonly stated and evoked, but as Collins (2010) described, I will show that the Tenderloin Community is in fact an ongoing, politicized community where multiple groups possessing varying degrees of power struggle for access, resources, freedom and identity. Over decades, this process resulted in a space that contains commonalities and contradictions.

1. The Tenderloin as a Central Meeting Place of the Drug Market

The first characteristic of the Tenderloin containment zone is the widespread, unconcealed drug market. On my four-block walk up the southern stretch of Hyde Street from the Civic Center BART station to the TASH program, many of the street dealers are unmistakable. The illicit drug marketplace of the Tenderloin is diverse, with different types and scales of dealers. The street dealing landscape is a mash-up of dealers with different histories, clients, and specializations. Generations of dealers, old and young, of different races, ethnicities, and backgrounds work in close proximity to one another, on different scales of operation, specializing in different menus of substances. There are a number of gangs, which are often racially/ethnically defined, operating on a larger scale, but there are also middle-sized and individual setups. Drugs are sold overtly on the streets, but selling and exchanging also occurs less formally in hotels among friends, neighbors, or acquaintances. A confidential informant (July 2013) pointed out that there has been a rise in female street dealers, a tactical move by gangs and other operations because male police officers are not permitted to body search females suspected of selling drugs.

The primary way I have identified dealers, however, is not through sophisticated detective work. When I, or almost anyone for that matter, walk up Hyde to work, I am routinely targeted by drug dealers through *blatant, undisguised, and overt* advertising. This aspect of the Tenderloin drug market is frankly jarring and unlike anything I have experienced elsewhere in San Francisco. The drug market is what everyone who comes to the Tenderloin remembers, what resonates in people's minds. Everyday as I walk up the hill to work, dealers recite their inventory to me and other passers-by in muffled but explicit calls.

Part of the reason for overt advertising is each dealer specializes in a different type or menu of drugs, and this menu changes based on what is available. Walking up Leavenworth Street, I hear "oxy" and "methadone" chanted most routinely - presumably the area is a spot for opiate pain killers. One docent Ruth, a 48-year-old white woman whose story I explore in-depth in Chapter IV, said of the dealers in front of her apartment:

> Ruth: In front of Family Building, most of the crack dealers are Honduran or whatever. They're not Mexican. They call them Mexican. That's what they call them. But they're not Mexican really. Everybody knows that those are the ones that sell crack, you know? . . . And then on Ellis, like right before you get to Glide's, they have an area on that part of town, and those are all Black . . . They have different territories. But it's not like in L.A. and stuff, where you hear about somebody can't go on somebody else's turf. It's not like that out there [in the Tenderloin]. Like, Hyde, they got a lot of drug dealers on Hyde, and it's mostly the Mexicans, but a black person can go stand between two Mexicans and sell, and they're not going to say nothing. They're not going to tell him to get out or nothing like that.
>
> Jamie: It's not as much turf-driven, maybe?
>
> Ruth: Right. Yeah. I think everybody's just out trying to make their little money and, you know, yeah. But I know that there are certain people that kind of, sort of, run it, you know? And they like, pay them taxes so to speak.

The sheer quantity and brashness of drug dealers accentuates how widespread and accepted drugs sales are in the Tenderloin. Several times over the years, I have witnessed police officers make arrests, often undercover in plain-clothes, but these efforts have apparently done little to deter the open drug marketplace. According to several docent tour participants and other

Tenderloin residents I interviewed, the street dealers remain bold, and the drug market (and related violence) in the Tenderloin seems to have intensified, particularly since the Tenderloin Police Department has undergone a 30% cut in staff due to the recession.

Part of the reason why the Tenderloin drug market exists on such a scale is that for those who need to buy drugs, regardless of background, the Tenderloin is *the* destination. When I began working on the Turk and Leavenworth Streets intersection, looking conspicuously like a community advocate in my housing sweatshirt and ID badge, I thought surely dealers would never promote their drugs to me. And yet when I walk up Hyde toward Turk street, I am routinely approached and offered drugs. I quickly learned there is *no target audience* in this market. The Tenderloin drug market is not just serving the addicts, mentally ill or homeless – it draws customers from all walks of life throughout San Francisco and the Bay Area. This was captured in several interviews I conducted. As an example, in one walking interview, the docent pointed out a nervous, preppy, very young (late teens or early twenties) white male, wearing a pale pink button up shirt, khakis, and topsider shoes. He was buying drugs from an older black man dressed in jeans and a denim jacket. The entire transaction was short, less than ten seconds, but not the slightest bit discrete - we watched as the two men greeted one another, murmured a price, and exchanged a folded bill for something dropped into the young man's hand. The docent, Erin, a 42-year-old black woman who has lived in the Tenderloin for 5 years (whose story I also explore in Chapter IV), pulled on my sleeve and commented:

> Erin: See? See? It [the drug dealer] takes all types.
> Jamie: Yeah, so true.
> Erin: And you'd think he [the patron] was just going to an office. He probably *is* on his way to the office!

Just as many people who buy drugs in the TL are not from the area, the many of the street drug dealers are also not residents of the Tenderloin. They are "commuter" drug dealers. The

street drug dealers use the neighborhood to work and set up shop, not to live. They are visitors to the neighborhood like the government professionals, law students, business workers, and nightlife seekers. According to several docents, including Erin, the larger scale drug dealers are known to commute into the Tenderloin from the East Bay:

> Jamie: Could you talk to me a little bit about what you think of as substance use triggers in the Tenderloin?
> Erin: The fact that the police drive by here every single day. They see the same amount of dealers out here every day. These boys be out here drinking beer, [the police] know they don't live here, and they allow it.
> Jamie: They don't live in the neighborhood? The dealers?
> Erin: Hell no. All these boys right here-- some of these boys right here live past Divisadero. The ones that come at night, they all live in Oakland.

That the Tenderloin is the jobsite for commuter drug dealers is not a new concern. In a 2006 article by the San Francisco Study Center, the author quotes an interview with the former Tenderloin Police District Captain, Kathryn Brown:

> " 'The Tenderloin is known around the Bay Area as drug trafficking turf,' Brown said. It attracts an increasing raft of 'commuter' dealers from Oakland and Richmond. She cited the hot spots: Market Street, U.N. Plaza, and most Lower Eddy street corners. Dealers commute to TL because the consequences of arrest 'are minimal here,' Brown said, a point that has been a consistent theme at her monthly police meetings. 'They get arrested and are out the next day.' Drug arrests, 25% of the TL total, were 2,224 in 2005, up 5.8% in a year. 'Almost as soon as officers leave the station, they are making arrests,' Brown said. 'I don't know how it's possible to make any more.' Every officer averages about 34 drug arrests a year. Brown's idea to clean up the scene is to clean up the addicts."
>
> (Carter 2006)

The Bay Area drug market is sophisticated and boundless, but through this finding I emphasize that the market*place* has distinct boundaries – the Tenderloin. Like a desert trade post, where people from hundreds of miles around gather to exchange their goods, the Tenderloin serves a similar function for the illegal drug market in the Bay Area.

2. Transferred, Concentrated Poverty and Risk

The second characteristic of the containment zone is that, with the commuter dealers and buyers, the Tenderloin is also the site or container of San Francisco and the greater Bay Area's *poverty and risk*. The poverty in the Tenderloin ranges from chronic to acute homelessness, to the formerly homeless in hotels, to the marginally housed low-income resident population. Risks in the Tenderloin have an intense range, from the stress of living with drugs, to the social and economic effects of drugs, to the health effects, the crime and violence, the homelessness, and more. These are not perfectly overlapping categories, but they are highly related. For example, one study suggests that crime is not necessarily related to drug use, rather to measures of concentration of poverty, suggesting that it is the relationship between drugs and environmental inequalities that spur crime (Valdez, Kaplan, and Curtis 2007).

There has been much academic exploration of the relationship between poverty and substance use, which examines whether poverty (or other SES) cause substance use, or vice versa (Kaestner 1999, Boardman et al 2001). This dissertation cannot answer the question of which came first in the Tenderloin, drugs or poverty. But I do show that in the Tenderloin, the relationship between the drug marketplace, drug use, and inequality is not causal in a linear way. Rather, it is multi-faceted and dynamic, involving the actions and counteractions of different individuals and groups in the space under specific historic circumstances. In this sub-section, I argue *first* that risk has indeed been concentrated in the Tenderloin, exposing its residents to drastically disproportionate violence, crime, and other potential risks compared to other neighborhoods. *Second*, this has been the result of a historical process involving multiple stakeholder groups, including housing organizations, federal and local housing agencies, neighborhood associations, developers and private property owners, competing over resources

and interests. *Third*, this concentration of risk is increasingly intensified as housing becomes a more contentious issue in San Francisco.

Throughout this dissertation, I try to present a balanced portrait of the Tenderloin as a very diverse, jigsawed space, toward unraveling the "bad neighborhood" stigma that often entirely dominates the narrative and perception about the space. However, the elevated risks in the Tenderloin, compared to other San Francisco neighborhoods, are palpable and undeniable. Twice walking through the Tenderloin I have witnessed the immediate bloody aftermath of drug-related gang shootings. The docents I spoke to all had stressful and violence experiences in the neighborhood, and worried about gunshots at night. Muggings and property theft were also common concerns. At the TASH program, staff were advised to walk to housing sites for outreach in pairs after one female staff was assaulted while walking to one of the hotels. The Tenderloin is widely cited as San Francisco's most dangerous neighborhood, and the SFPD has reported it is where seven out of ten of the city's violent crimes occur. A recent report by Tenderloin Housing Clinic and the Central City SRO Collaborative (2011) showed that Turk Street (where the TASH program is located) has violent crime rate that is thirty-five times (35x) the citywide rate. Crime figures over a long-term period are difficult to find, but the following snapshot of violent crimes in SF over a two-week period illustrates the concentration of reported violence in this neighborhood (Figure 3.6):

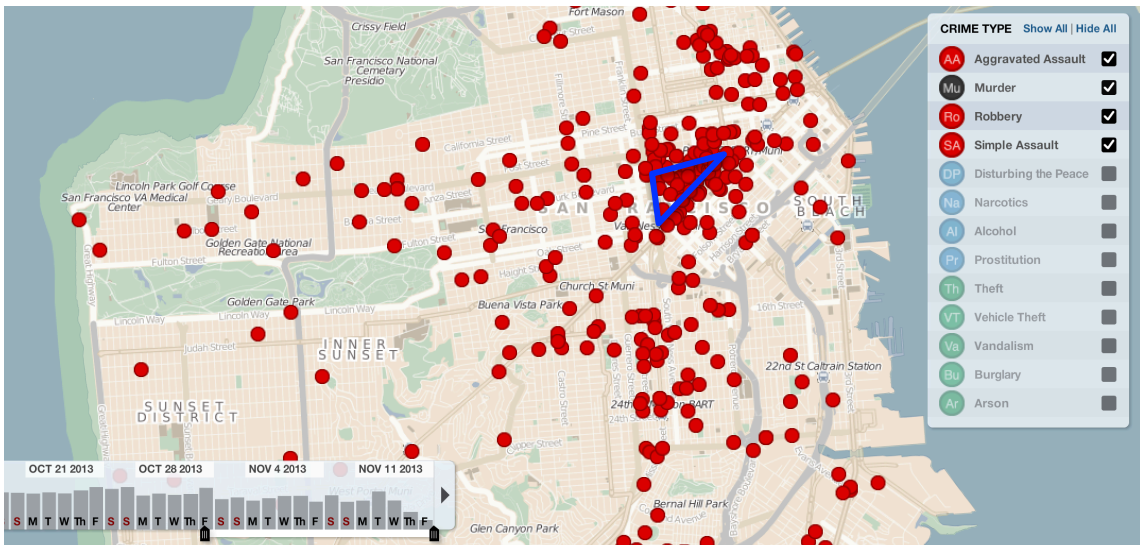


Figure 3.6 – The Concentration of Violent Crimes In and Around the Tenderloin.
A snapshot from San Francisco Crimespotting (2013) of reported *violent* crimes over a two-week period, October 25 - Nov 8, 2013.

According to the SFPD (2013), the TL contains the highest concentration of parolees in San Francisco. This is in part because the hotels are among the few places that will provide affordable housing to people with criminal records who cannot find jobs, but also because the Tenderloin is home to parole/probation transition programs, meaning that San Francisco inmates are often sent directly to the Tenderloin upon being released. The Tenderloin does indeed contain a high concentration of San Francisco's extreme poor, marginalized, and physically and mentally disabled, many of whom live primarily in the hotels. Some are people unwelcome and unable to obtain housing in other neighborhoods. A rather disconcerting fact, for example, is that the Tenderloin contains the highest concentration of registered sex offenders in San Francisco (City-Data 2013).

The question is, why is poverty and risk so densely concentrated in this space? The residents of the Tenderloin are low-income, and systematically exposed to the most acute risks in the city through the ways the neighborhood is used – as a meeting place for drug dealers and

buyers, as a place where the homeless gather to survive, as the dropping ground for released inmates. This concentration of poverty and risk in the TL cannot be understood without examining the neighborhood's political history in the context of a national housing, mental health, and homelessness crisis. In the previous chapter, I described how the Tenderloin became the site of organized community activism, largely because the neighborhood was home to so many homeless, low-income, and politically marginalized people whose lives were persistently threatened by slumlords and the forces of gentrification. A major focus of neighborhood advocacy was providing housing for homeless populations. Through public and private, local and federal efforts, over the years, thousands of people who were homeless in the shelters and streets of San Francisco have been moved into permanent, affordable supportive housing.

Importantly, a meaningful number of the formerly homeless people now living in permanent housing in the Tenderloin had or have major substance use histories. This is a key aspect of the harm reduction *housing first model*, in which housing is provided regardless of active substance use. Housing first is promoted on the basis of human and tenant rights, but also because it is effective at reducing the costs of chronic homelessness, improving quality of life, and improving health of homeless people (Gulcur, Stefancic, Shinn et al 2003; Tsemberis, Gulcur, and Nakae 2004). This underscores that while some of the Tenderloin's risk is transferred to the Tenderloin from other places through the drug trade, a considerable fraction of neighborhood's resident hotel population is also involved in drug economies and/or drug use and addiction. With the dense concentration of these hotels in the same neighborhood, and a large population of residents needing substances on routine daily basis, the neighborhood harbors a regular consumer group for the drug trade. Indeed, drug use was prevalent in all of the hotels I visited.

What is key, however, is that the supportive housing and services for the homeless are concentrated within and around the Tenderloin for political, social and economic reasons - the result of decades of struggle over resources between groups with different degrees of power. Regardless of the type of program, its management or funding stream, be it state, local, or federal, private or non-profit, the majority of low-income housing is located in the neighborhood. For example, SF Housing Authority public housing is scattered, but disproportionately located in San Francisco's poorer neighborhoods, like the Tenderloin, Western Addition, and Hunter's Point (Figure 3.7). The Tenderloin area contains five public housing facilities targeted to families and seniors, with several more near its borders. The SF Department of Public Health's Direct Access to Housing program offers permanent supportive housing, almost entirely served through SRO Hotels in the Tenderloin. Community Housing Partnership, Mercy Housing, Tenderloin Housing Clinic, and Tenderloin Neighborhood Development Corporation operate the majority of their affordable housing buildings in the Tenderloin. Although there have been efforts to de-concentrate and dispel poverty, for example through the Section 8 program, the scenario today is that the most extreme forms of poverty has remained densely and disproportionately concentrated in the Tenderloin. In San Francisco, Section 8/HCV vouchers have been historically far too inadequate to even put a dent in demand and today docents report that it is impossible to obtain HCV in the city. Indeed, the housing authority currently reports on their website (November 2013) that the waiting list for HVC vouchers is long and they are no longer accepting applicants.

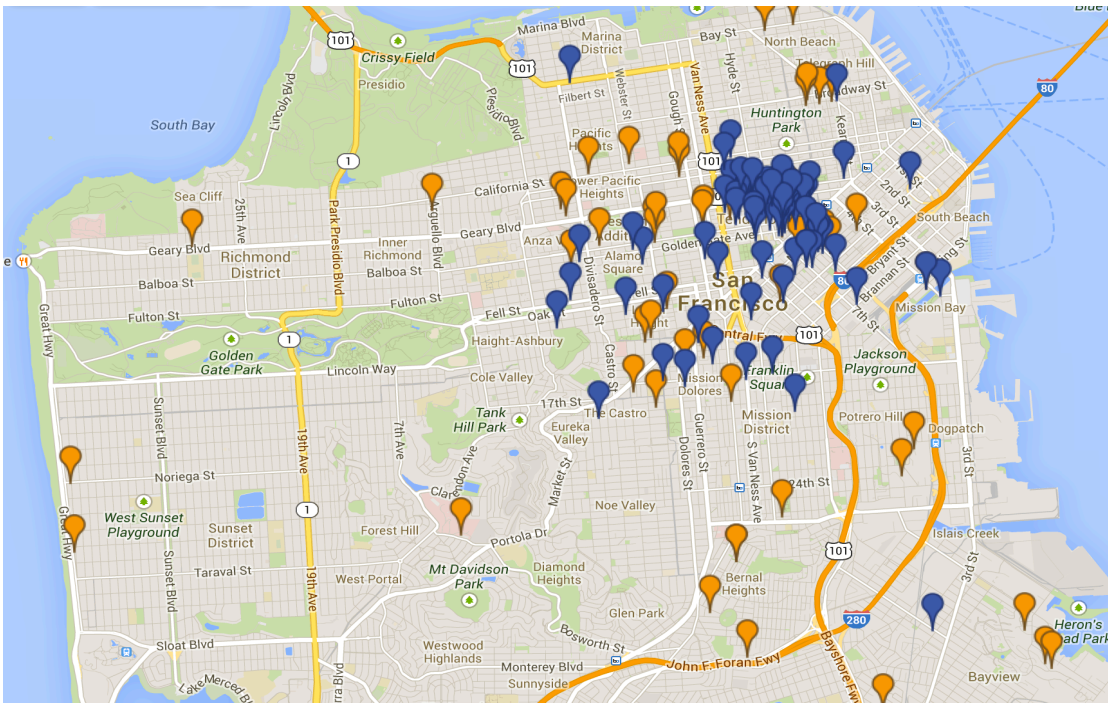


Figure 3.7 – Map of Low-income housing in San Francisco.

I created a map of the major low-income housing sites in San Francisco. (This is an incomplete list. There are dozens of housing organizations, large and small and provide housing services, and may buildings are operated based on collaborations between two or more agencies. As far as I know, there is no complete list of low-income housing in San Francisco.) The orange-colored markers indicate housing operated primarily through the San Francisco Housing Authority. The blue-colored markers indicate buildings operated by the major housing organizations in San Francisco, including: Tenderloin Housing Clinic, Mercy Housing, Tenderloin Neighborhood Development Corporation, Community Housing Partnership, and several smaller organizations. Although low-income housing is scattered through much of the city, it is widely concentrated in and around the Tenderloin neighborhood.

The majority of facilities operated by these housing organizations are located in the Tenderloin for reasons related to the neighborhood architecture and power relations/struggles between groups. First, in many cases, the housing organizations took over existing SRO facilities that were sorely in need better management. They purchased and remodeled former SRO facilities and converted temporary residences into permanent housing, or they were contracted to manage and provide services for hotels owned by others. This pattern was (and is) partly due to the inertia of architecture - the SRO hotels provided *a* space in a time when almost *no* space was

allocated for the homeless and very poor. Second, the organizations providing housing were not only housing and homelessness advocates but also *community* advocates. They organized to create and maintain a stable, healthy low-income TL neighborhood for its residents, who were for decades neglected, displaced, and marginalized by slumlords and the forces of gentrification.

Third, housing and community advocates have long recognized the importance of building new affordable housing in other San Francisco neighborhoods in order to reverse the concentration of poverty in the Tenderloin. However, when new sites outside of the Tenderloin have been considered for permanent supportive or affordable housing, such projects have routinely been met with severe resistance from potential neighborhoods through neighborhood associations. NIMBY (not in my back yard) battles are waged against proposed housing sites, with safety and property value commonly cited as concerns. Since implementation of US housing projects are decentralized to the city level, city officials and developers must contend with constituencies to decide where to allocate housing. Community Housing Partnership, a major advocate for building outside of the Tenderloin, has only recently been successful at operating affordable housing sites outside of the Tenderloin. The first milestone, the Senior Building (pseudonym) in the Western Addition neighborhood, was constructed ground-up and opened in 2009. Although the lot had been vacant for two years, and previously used as a home for homeless mothers, the building was initially met with contention from vocal neighborhood associations. In a New York Times report describes some of the widespread perceptions about the development:

> "Dariush Kayhan, director of homeless policy in the mayor's office, remembers the 'charged' meetings when Senior Building was proposed more than five years ago. The building was named for [NAME], a frugal and unassuming German refugee who left $6 million to be used for the poor and needy of San Francisco. Residents voiced 'support for senior housing all the way to concern that we were going to decrease home values and the safety of the neighborhood,' Mr. Kayhan said."

(Elinson 2010)

The second space, Youth Building (pseudonym), is currently being converted from a vacant boutique tourist hotel to be used as housing for 24 homeless young adults. It is located in the Marina District on Lombard Street, and this space in particular was met with active contestation from the neighborhood associations. Over the last three years, I have heard stories from the staff at Community Housing Partnership about heated neighborhood meetings over the building. These accounts were echoed in reporting on the issue:

> "Currently, residents of the affluent Marina district are vociferously opposing converting the Inn and Suites into transitional housing for 18- to 24-year-olds who have left the foster care system. 'No one wouldn't support the good work they do with these kids,' Lori Brooke, president of the Cow Hollow Association, said of the conversion plan. 'This particular project and this particular building have not been thought out, and they haven't taken into consideration the impact both economically and otherwise on the neighborhood.'"
>
> (Elinson 2010)

This neighborhood resistance was effective to the extent that construction on Youth Building was stalled for over a year. Finally in 2011, CHP obtained the approval they needed to proceed with development, and the building will begin serving homeless youth in 2014.

It is important to keep the battle over housing in the context of ongoing migrations into the city. Despite major efforts toward housing homeless in San Francisco, progress has been stymied by persistent homelessness emerging in the city and the relentless threat of gentrification (which I discussed in Chapter II) on the housing stability of poor San Franciscans. Homelessness is generated by the high cost of housing in San Francisco, but homeless and marginalized people are also drawn to the city, particularly the Tenderloin, because of the possibility of resources and opportunities. The most current homeless count, which suggests homeless populations have remained relatively stable (around 6,500 homeless in 2004, similar estimates today), is indicative of this trend. Homeless populations have not waivered in almost ten years (2004-2013), despite

the City records that show over *18,000 people* have "left" the streets or shelter system during the same period through:

- Care Not Cash program (4,018 homeless placed in housing[23], City program),
- Direct Access to Housing (3,000 people housed, City program)
- Housing First Master Lease and Local Operating Subsidy (2,666 people housed, operated by non-profits like CHP)
- Shelter Plus Care (1,022 people housed, Federal Program)
- Veterans Affairs Supportive Housing Program (VASH, 440 veterans housed)
- Homeward Bound program (7,123 homeless people returned to their home with friends or family outside San Francisco, a city program to re-divert the streams of homeless people).

(Human Services Agency of San Francisco 2013)

Most of the docents I interviewed came to the Tenderloin from different cities in the Bay Area or California upon becoming homeless; others were from other neighborhoods in San Francisco. In a national context, it is critical to recognize that San Francisco (as well as other cities like Seattle and Los Angeles) have developed reputations for being places that can offer a better quality of life for the poor[24]. According to Erika, a 36-year-old black woman who has lived in San Francisco her entire life, most recently in the Tenderloin:

> Erika: Some people come down here and get real fucked up and get stuck within these 4 or 5 blocks this little mile radius, this little Tenderloin patch you know. When people run away, and they can't find their family members, this is the first place they come and look for them at because they know they touch down here. They know. Whether they coming from out of state, this place is famous. If you know

[23] Though, controversially, shelter beds (which are not permanent at all) count as "housing" in the Care Not Cash program.

[24] The centralization of risk into the Tenderloin is not just citywide, it remarkably transcends State boundaries. Recently, the City of San Francisco filed a class action lawsuit against the State of Nevada for sending newly discharged psychiatric patients (mostly residents of Nevada) on a one-way bus ticket to San Francisco with just snacks and a few days worth of medication. The City has documented this practice known as "patient dumping" since 2008. In the news release (September 10, 2013), City Attorney Dennis Herrera stated:
"What the defendants [state-run Rawson Neal Hospital] have been doing for years is horribly wrong on two levels: it cruelly victimizes a defenseless population, and punishes jurisdictions for providing health and human services that others won't provide."
I could find no exact records where these abandoned psychiatric patients are today, but the lawsuit states that the City provided both healthcare services and shelter to the homeless psychiatric patients, a sure indication that some found themselves in the Tenderloin.

> that your folks are kind of lost and on drugs, 9 times out of 10, if they in Frisco this is where they're at. And this area is a lot of people's comfort zone because you can eat a lot of places, get free this, free that it's you know.

This sub-section underscores the complex circumstances housing and community advocacy organizations face as they work to reduce the risks poor San Franciscans are exposed to. They are advocates for the low income Tenderloin community, and fight for the rights of tenants to stay in the neighborhood in the face of gentrification. They are simultaneously advocates of the de-concentration of poverty, which entails another type of battle against neighborhood associations. Housing organizations have worked to reduce homelessness, yet the political struggles along the way have resulted in a concentration of the formerly homeless in the Tenderloin neighborhood. Moreover, housing programs and support organizations in the TL are tasked to address much larger problems of homelessness, mental health, and substance use than contained or originated within the space itself. They are left to address not just the neighborhood's homelessness and health concerns, but the city's, the Bay Areas, and as Erika suggests, the extent is even national.

3. Surveillance and Policing

The next components of the containment zone are surveillance and policing. These factors of control and regulation are related but distinct concepts that are intense, weighty presences in the Tenderloin. In the ethnography and docent interviews, I found that policing was practiced by different people and groups, and conducted on multiple levels. The Tenderloin is not a neighborhood where one moves about freely. To organize the analysis below, I conceptualize *surveillance* as the act and practice of watching and monitoring, while *policing* is the practice of regulation. They are related, interdependent concepts: policing requires surveillance strategies, while surveillance itself can cause regulation. For example, in Foucault's (1975) famous example

of the panopticon architectural construction of prisons, the perception of being watched affects prisoner's consciousness and behavior, creating regulation and discipline, even when there is no physical enforcement.

The Tenderloin Police Department (TPD) is an obvious place to begin a discussion on policing. In this section, I show that the police have a complex, contradictory presence in the Tenderloin. Earlier in the chapter (see Figure 3.2, Page 8), I showed that the TPD polices the city's smallest district, about one square kilometer. They have the unenviable, bewildering task of combating the large drug market funneled onto the neighborhood's streets. First I explore the complex relationship between the police and the neighborhood - residents are at times in conflict with police, but this is balanced by recognition that policing is necessary to combat the harmful aspects of the drug market. Many residents have had personal experiences with police and prisons. They want to live in a crime- and violence-free neighborhood, but are concerned about widespread criminalization and profiling of drug use/sales. Second, the police presence in the Tenderloin is sizable, but has been inconsistent over the years, particularly since the recession began in 2008. Staffing ratios at TPD are alarmingly low given the ongoing, highly acute nature of crime and violence in the neighborhood. The Tenderloin community-at-large, who have organized repeatedly around this issue, argue that the low level of staffing would not be acceptable in other police districts, reflecting the low political priority of San Francisco's poorest neighborhood. I also explore how policing and surveillance are not only functions of the police, but how these concepts trickle down to structure many social worlds in the Tenderloin, focusing on the hotels as a sub-site of policing and surveillance strategies.

To begin, I emphasize that the docents had a hybrid of experiences with police, and thus their perceptions about the police and crime institutions were mixed. Several docents reported

alarming experiences of being profiled and harassed by police. For example, Erika, the 36-year-old black woman I introduced above, was recently stopped and frisked by police while carrying oxycotin (a popular street prescription) and cannabis. Erika moved to the Tenderloin into permanent supportive housing at age 23 when she developed serious health issues. (She is one of the few examples of younger women living in the hotels, though this number seems to be increasing.) She has medical prescriptions for both oxycotin and cannabis, which she uses to manage chronic pain from kidney failure, osteoarthritis, and ongoing dialysis, but she did not have her prescription paperwork with her on the day she was stopped and frisked by police. She was in disbelief when she was arrested for drug sales and incarcerated for three nights until she was bailed out:

> Erika: These were just some asshole cops. I gave them my [cannabis] card and they slammed their hand on my leg . . . I was just shaking, like, "Oh my gosh! Am I going to jail? This is fucking movie." You know what I'm saying? I haven't been in jail since I was like 18 years old . . . Yeah, I had the weed stashed and they went in my underwear talking about "You got crack on you". "I got no fucking crack on me." . . . I felt violated. And she's [female officer] looking all over my private and all this and they're not finding nothing. Where's the big white rock? Everything I had on me [oxycotin, cannabis] is in my name . . . I had to call on my doctors to get this approved saying I was on this. I mean they did me wrong. It was like a movie. They had me just – I'm cuffed up.

She took her case to court and was charged with drug possession, but the drug sales charges were dropped. The circumstances of Erika's circumstances arrest were certainly not uncommon. In just the month of August 2013, consider the concentration of the 277 narcotics-related police reports in San Francisco, according to police records (Crimespotting 2013). The Tenderloin is precisely the nucleus where narcotics-related police reports occur (Figure 3.8):

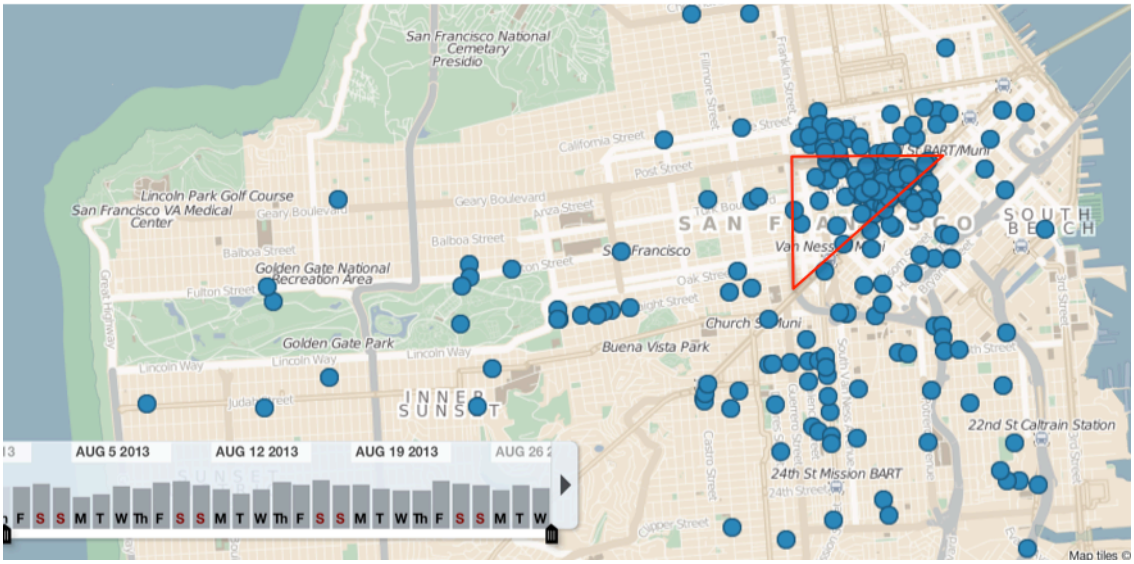


Figure 3.8 – The Concentration of Narcotics Reports In and Around the Tenderloin.
A snapshot from San Francisco Crimespotting (2013) of narcotics-related reports over a one-month period, August 1-31 2013.

The docents routinely described a high degree of mistrust, ambivalence, and frustration with the TPD due to these kinds of negative personal experiences with both surveillance and policing. Yet this mistrust and dislike was often balanced by a firm recognition that some degree of police presence was necessary in efforts to keep the streets safer from the drug dealers, and the violence and harms they brought into the neighborhood. Many of the residents, even those who used drugs, intently wished to live a neighborhood free of street drug dealers. According to Beth, a 54-year-old white woman, the TPD once had a stronger foot presence in the Tenderloin, which was effective at reducing the number of dealers around her building:

> Beth: The only time [the dealers] run and hide is when the police come. They're like cockroaches, they run and then they come back. Get rid of them, the drug dealers out there. I mean the police need to be more out there because when the police are around they're gone. [The police] started standing out there for a while and that worked. But I don't know why, now they just got some hotel cop . . . But the police need to be more – they're aware of it and they just haven't done enough. I don't know what they're working on now. I've heard they've been taking pictures of people, of people buying and people selling. And I don't know what they're going to do with that.

Beth's experiences are substantiated by documented trends in police and drug dealing activity. In a recent article, Tenderloin community activist and reporter Randy Shaw argues that efforts by SF Police Chief George Gascon in 2009 to end the containment zone by increasing the number of police officers in the TL were thwarted when the force was gradually reduced between 2009-2013, from 101 officers to 69 officers today. He writes, emphasizing as I do in the subsection above, that the Tenderloin bears the cost and risk in a way disproportionate to other San Francisco neighborhoods:

> "This staffing reduction returned Tenderloin drug dealing to prior levels, reducing expenses for public defenders and jail staff. This cost savings was borne by Tenderloin residents, whose quality of life worsened as drug dealers returned. Nobody needs to ask whether residents of the Richmond, Sunset, Pacific Heights, or [Jeff] Adachi's home neighborhood of St. Francis Wood would ever have to accept drug dealers on sidewalks in order to avoid increased public defender or jail staff costs; the answer is obvious."
>
> (Shaw 2013)

The Tenderloin resident community has broadly supported an increased police presence on the Tenderloin streets to stand as a deterrent for violence and crime. In May 2013, over 1500 signatures of Tenderloin residents were collected to petition the police department to increase the number of officers. According to the latest reports I have seen, the TPD intends to increase staffing by 6 officers this year.

In addition to the intense but inconsistent police presence on the Tenderloin streets, other forms of surveillance and policing are common. One docent, for example, pointed out the many surveillance cameras aimed in our direction during the walking interview. In 2012, I tallied over twenty visible surveillance cameras on the four-block route between the Civic Center BART station and the TASH program. Some are installed by the State, in daunting shiny bubble domes affixed to posts on the many government buildings. Others spy the entranceways of private restaurants, hotels, apartments and businesses.

The docents' hotels, their very homes, were among the most conspicuous sites of surveillance. Many hotels have private security. The front door is usually locked and there is a front desk clerk who is the literal "gatekeeper" for the building, allowing people in and watching who goes out, including residents. For guests and staff like me to enter buildings, we must produce identification and document our visit on a sign-in sheet. Most hotels have a long "do not allow entry" list based on tenant requests or past incidences. Thus, in addition to the cameras and police on the outside, tenants are also monitored on the inside, most often by the staff and other residents of the buildings. Much like the dynamic with police, this type of surveillance has risks and benefits. One docent, Danielle, a 53-year-old black woman, described how the building surveillance strategies are important for deterring drug activity in front of the hotels:

> Jamie: So many people sell right in front of your building.
>
> Danielle: Right in front of it. But when the cops was there, they come out and they make a move. Like the one dealer [pointing across the street], they go up there and then they can leave and make a move. We see everything on [the hotel surveillance] camera. Everything they're doing out there we see it right on camera, especially if they're in front of our building. And you know [desk clerk], she'll go out there, she'll holler or they'll just call the police and they'll move.

Yet other docents suggested that this type of protection is not without cost. I asked Erin, who was actively using drugs, what it's like to be watched this way, and she responded that it stresses trust and social relationships, a topic I take up in the next chapter:

> Erin: It affects your self-esteem . . . the first time you go outside the building [to buy drugs], you might as well guarantee Tenant Services [support staff] know. Desk clerk know. Apartment building know. You know what I mean? So sometimes, even if you go away from here, like, you don't go right outside to get it, right? Some big-mouth motherfucker that's seen you down the street will be like, "Oh girl, I could see you down there." You know? It's like, shit, chill out. You know? So it's this-- it's almost like there's no rules of confidentiality.
>
> Jamie: Do you think that affects your relationship with staff?
>
> Erin: Yeah. Let's see. I'm going to give you an example, and I'm just going to put it out there. Like, the lead desk clerk right now? Those of us that he knows buys dope, he don't talk to us respectfully, you know what I'm saying? Just don't get a twist,

> that you gon' talk to me crazy just because I smoke dope. Because that don't make me scandalous. That don't mean that I'm a thief or anything like that. That just means I've got a drug habit. You know what I mean? You don't talk to me crazy. I ain't with all that.

The severity of policing and surveillance limits the freedom of Tenderloin residents. These factors are intense to the degree that several docents have described living in the Tenderloin as analogous to their experiences in institutions like prisons.

4. Tethered to the Tenderloin

Sociologists of place have argued that we are all, to some extent, connected and bonded to the places we live (Gieryn 2000). I argue for very poor in San Francisco's TL, however, this connection is more than a sentimental, historic, or emotional bond. Through various types of constraints, both symbolic and physical, docents described being tethered to, stuck in, and bound to the Tenderloin neighborhood, the final characteristic of the containment zone.

As I showed in sub-section C.2 above, the Tenderloin is where much of San Francisco's affordable housing programs are concentrated. For the poor, it is one of the few neighborhoods that can provide relatively stable housing on low income, such as the approximate $800.00/month received by people on disability. Docents, therefore, are geographically stratified as a result of their economic stratification. For example, one participant, Sonny, a 54-year-old Asian woman, is on disability and enrolled in the federal program called Shelter Plus Care. When I asked her if she considered leaving the TL one day, she responded:

> Jamie: [Do you ever think of getting] out of places where there's lots of access to drugs?
> Sonny: I would love to, but I don't want to lose my Shelter Plus Care. I almost had a place in Pacifica, but I couldn't go there because it's out of the county . . . I'm on this waiting list for Shelter Plus Care. I'm number one on the list, but my criminal background makes it kind of hard for me to find a place, I guess. I should appeal it, so next time I get a chance to, I will appeal it. But I do-- I would like to move out of this building. I have a lot of bad experiences here.

Shelter Plus Care is a U.S. Housing and Urban Development program based that provides rent assistance and supportive services to homeless people with major disabilities. The services are distributed through the City agencies, thus for her to move, Sonny must find a city that offers Shelter Plus Care, and then reapply for eligibility, a processes that involves a wait list. Since she qualifies in San Francisco, she's inclined to stay, and the Tenderloin is her only option. Sonny is stuck in the Tenderloin. Stuck is the precise word Abby, a 31-year-old white woman, uses to describe her situation as a mother in the TL:

> Abby: I'm kind of used to this neighborhood, so it doesn't really bother me, but you know, as [my daughter] gets older, I don't want her to grow up in this neighborhood. But I mean, the nicer neighborhoods, I couldn't even dream of affording a place, so I guess I'm kind of stuck here.
> Jamie : Is that how you feel?
> Abby: Yeah. Unless I win the lottery.

In other circumstances, people were stuck for physical reasons – participants who were seriously disabled and had limited physical mobility experienced hardship maneuvering different spaces, even the buildings they lived in. Some hotels used for affordable housing are very old and notoriously neglected, in part because of the issues with Housing Authority reimbursements and slumlords I discussed above. For example, Molly is a 60-year-old black woman who is paralyzed and dependent on her wheelchair for mobility. The hotel she lived in was built in 1906. It was one of the first hotels constructed after the great earthquake. I am no building inspector, but it was apparent that the hotel was unsuitable for people with disabilities, particularly people using wheelchairs. She showed me what she had to endure to go to her room. She, like all tenants, had no key to the front door, and we waited to be buzzed into the building. She was then raised onto the elevator platform, which was about five steps up, on a steel lift that was only operable by another person, who we had to find and again wait for. Once on the platform, we waited for another few minutes for the elevator. When it arrived and the doors finally opened, the

elevator was dangerously small, no wider than 36” x 36”. Molly, who like many residents used a wheelchair, could barely fit inside. After we squeezed into the tiny space, she told me she was once stuck in the elevator when the power went out one day. She also described a terrible situation that occurred a month earlier, when she was stuck in her room for over a week due to another elevator failure:

> *[Elevator arrives, doors open.]*
> Molly: You see, I need to put my [wheelchair] footrest up. It’s that tiny. To me, it's the size of a large coffin.
> Jamie: I cannot believe how small this is. It doesn't seem right for people who need larger chairs.
> Molly: What's crazy about it is a month and a half ago, it was out for eight days. Completely out.
> Jamie: How did you get to your room?
> Molly: I didn't. I didn't go in my room. Actually . . . when the elevator went out, a friend of mine gave me his room on the second floor because it took an hour to go down the stairs, going down the stairs one at a time on my butt. So hard coming back up . . . I have a lawyer looking at this issue right now. We've been working on this for awhile. I'm in a room on the sixth floor. This is the highest floor they have. There are no facilities for disabled people on this floor. On any of them. So if the fire was to break out anywhere out here, I'd literally have to run through the fire to get through that, because there's no fire escape on the back of the building.
> Jamie: There's no fire escape?
> Molly: There's one in the front. There's not one in the back, except that one (___) on both sides, and we have this one with people living in there.

Molly, who is seriously physically disabled, finds it not only challenging but also exceptionally dangerous to navigate her building in her wheelchair. As a result of these multiple barriers, she rarely leaves her room and building. Her life in the Tenderloin is deeply constricted.

Other tethers were related to substance use. For docents who were addicted to substances, the Tenderloin was the only feasible place to obtain a regular dose. Above, I discussed how people who are addicted to drugs rely on the regularity of the illicit drug market of the Tenderloin due to a physical need for substances because withdrawal, a complex psycho-physiologic process, is painful and distressful for drug users. To avoid undergoing regular

withdrawal symptoms, people need access to their substances. Ruth, a 48-year-old white woman, is on methadone maintenance and described her daily connection to the methadone clinic as a "ball and chain" (emphasis added):

> Ruth: I go right here on Turk to the BAART Clinic. [In the Tenderloin.]
> Jamie: … How often?
> Ruth: Every day. I go every day, and I'm on 180 mg, which is a medium dose, I guess.
> Jamie: … And what does it feel like to be sick [withdrawing from opiates], as you say?
> Ruth: You have-- you can't get up. Your bones hurt real bad. It's kind of like the flu, you know? You can't get up. You're throwing up. Your stomach burns. You have no energy. You're dizzy. You barely could walk . . . you could even feel your heart rate changing, your (___s/l vitals) changing. People actually-- I guess you could die from it.
> Jamie: . . . Do you think about reducing one day?
> Ruth: Yeah. Actually, I've been thinking a lot about it, because *I feel like I'm tied to this city with a ball and chain*.

Because the residents of the Tenderloin hotels are poor and often with health issues, though theoretically free, thousands are tangibly stuck and stratified to the extent that almost entire lives are lived out on the few blocks surrounding the hotels.

D. Conclusion: Implications for Health

The factors of the containment zone have several implications for health in the Tenderloin, which I discuss further in Chapter V. First, many of the themes in this chapter have revolved around how the neighborhood itself, through the mechanisms of poverty and marginalization, exposes its residents to an inordinately high degree of risk that can harm health. TL residents are subjected to more crime, violence, drugs, and gangs in their daily lives, and they simultaneously have fewer resources and opportunities to protect themselves from these harms. Moreover, since the same places that contain risk are the only viable spaces to live, residents cannot escape. That is, being poor in San Francisco too often means exposure to a high degree of risk, without a pathway out. This formula is directly linked increased illness and harm, as I've

shown through various examples. This chapter therefore bolsters the theory that poverty itself is a fundamental cause of disease (Link and Phelan 1995). And since people of color occupy the Tenderloin hotels in numbers disproportionate to whites (Figure 3.3), it also supports the theory that racial segregation is a fundamental cause of race-based health disparities (Williams and Collins 2001).

Second, high exposure to risk in specific neighborhoods problematizes the advantages of community-based health promotion. Although the potential benefits of place-based health delivery, especially in increasing access to health, are embraced by harm reduction and other community-based public health programs, this chapter has shown that contested notions such as "place" and "community" also presents challenges. The advantages and disadvantages of place are unique to the specific settings and interventions, but since community-based programs are often operationalized in the places with great need, relevant places can contain formidable barriers to successfully promoting health. The TASH program, for example, is on Turk Street, the street with the greatest need *and* thirty-five times (35x) the violent crime rate compared to the rest of SF. Several docents reported that this location exposes them to harm, and avoided the area when possible. In this case, being located in the heart of drug activity did not seem to increase access to treatment. Other research has suggested that factors such as neighborhood disadvantage are linked to attrition from substance use treatment programs (Jacobsen 2004). I do not argue that community-based programs should not deliver health in neighborhoods with elevated risk, rather I stress that optimizing location is important for the successful delivery of community-based health. As I discuss further in Chapter V, for community-based programs to increase access and health delivery, the social dynamics of precise locations in neighborhoods must be examined and taken into consideration as sites are selected.

In the next chapter, I explore how the social environment of the containment zone shapes the personal relationships, interactions and social networks among women living in the Tenderloin hotels. The women I interviewed had only a few people they called "friends", those they could unconditionally trust. However, in almost all cases, women had much more wide-ranging social support networks – a larger group of people they relied on for support ranging from emotional to informational to financial. Yet there were risks to having social support systems that the women constantly recognized. As a result, relationships for women living in Tenderloin hotels were characterized by what I call *calculated associations* – the multiple ongoing interactions and social supports, which were buffered by varying strategies of self-protection.

Chapter IV: Social Networks Among Women Living in Hotels

A. Overview

There have been many studies examining the social networks of people who are or were homeless, especially in the fields of social work, geography and sociology. One study (Rowe and Wolch 1990) described the social networks of women living in homeless encampments. The authors theorized that the women lack what they call time-space continuity, or the stability provided by a regular place to come home to. Women made up for this absence through heavy reliance on peer social networks (ex. spouses/partners; neighbors in encampments) and home networks (the people with homes who provide a supportive role, ex. social workers, people offering change, etc.). This study underscores the profound way places (or lack of a stable place) shape relationships, and vice versa. The authors, however, do not mention of the role addictions and mental health issues may play on these networks. In a more recent study of formerly homeless people with co-occurring issues (Hawkins and Abrams 2007), the authors emphasize that while concept of "social network" seems positive, for people with mental health and substance use issues, social connections can also be problematic. Social networks can make strenuous demands on people, create conflict, or influence relapse. The authors show that for the homeless, social networks were small, with each participant averaging just two social ties. They suggest networks were small because of factors like death, emotional boundaries (withdrawal or pushing others away), and also because any existing friends or family were often stressed on their own. That is, social networks were small, fragmented, and characterized by frequent, abrupt, and dramatic changes.

In this section, I discuss social relationships between women in the Tenderloin hotels, focusing on how the containment zone explored in Chapter III affects interactions and networks. Like Hawkins and Abrams, I found that women do indeed have only a few people they called "friends". Friends were the people they could unconditionally trust. However, in almost all cases, women had more wide-ranging social support networks – a larger group of people they relied on for support ranging from emotional to informational to financial. Having a large group of people that provided support was at times literally the difference between life/death or illness/health, especially since all the women I interviewed were managing multiple health issues.

Yet the women also routinely described the risks of social interactions and relationships. There were financial, emotional, and personal risks involved with social networks, particularly since the circumstances of relationships could change on a dime due to incarceration, death, interpersonal conflict, and a slew of other abrupt and dramatic changes linked to the intersection of drug use and poverty. As a result, relationships for women living in Tenderloin hotels were characterized by what I call *calculated associations* – multiple ongoing interactions, interdependencies, and social supports, which were buffered by varying degrees of boundaries toward self-protection. This relationship dynamic is important to understand because it affects several aspects of health and health delivery. In the conclusion, I discuss how calculated associations impact substance use treatment in particular, wherein "therapeutic relationships" between members of the community are paramount to successful outcomes.

In this chapter, I stress the dialectical relationship between physical (built) spaces and social interactions. People build and shape places, and places frame the social activities that occur around them, in turn shaping people. Places, which are real, imaginary, and symbolic, represent and frame social circumstances. The Tenderloin Safe Passage Program (Figure 1

below), a public safety program for children, provides an explicit, visible metaphor of this dynamic. It is a physical boundary - in 2012, community advocates painted a "yellow brick road", a safe way home, for the 3,500 children who navigate the drug-saturated streets of the TL everyday. It is striking, visible evidence of how the neighborhood is sectioned off, protected, and limiting for most of its residents.

Figure 4.1 - Tenderloin Safe Passage Program.

Implemented in 2012 for Tenderloin children navigating the neighborhood. The yellow brick road is painted onto eleven city blocks. It includes "safe place" compasses pointing to the safe businesses and organizations in the community that children can enter if they are in danger or threatened.

The Yellow Brick Road is a visible physical boundary, but it is also social. It was created to represent a social barrier between children and the people who could harm them, and a community of volunteers in a protective role monitors it. It would not exist if not for the social dynamics fostered by the Tenderloin containment zone. The Yellow Brick Road was designed for children, but it is conceptually similar to other (not as obvious) boundaries that profoundly structure in the lives of hotel residents, both in their buildings and their neighborhood.

I argue that much like the Yellow Brick Road, the hotel residents construct boundaries and mental maps with the purpose of balancing the potential opportunities and harms of the neighborhood. For the residents, the borders and boundaries of the Tenderloin were imagined but as real as can be in practice. Again and again, as the docents and I walked through their hotels and neighborhood, it was crystal clear what spaces were available and unavailable for their use.

These mental maps were constructed for physical and social reasons, and they provide a tool for residents to balance the potential opportunities and harm of the neighborhood. Throughout the ensuing discussion, I stress that the Tenderloin containment zone (concentrated risk, stratification, surveillance) amplifies the function and need for these elevated, acute boundaries.

B. Extended Exemplar: Erin and Ruth

The containment zone created dynamics of both conflict and support, which resulted in calculated associations. Women knew that being alone in the Tenderloin could be difficult and dangerous. They needed support systems and allies. The most common word the docents used to refer to these support systems was "associates". These associations were explicitly *not* friendships, however, because they were balanced by the recognition that due to the instability and criminalization of homelessness and drug use, bonds and relationships could evaporate without warning. Disability, physical illnesses, mental health issues, addictions, incarceration and death from chronic illnesses or acute circumstances, like injury or overdose from drugs or alcohol, were circumstances that bonded individuals together and simultaneously created a need for boundaries. Therefore, hotel residents balanced needing support systems with a deep recognition that these systems were fragile and unstable. Creating associations with neighbors that had strong emotional, social, or physical boundaries was one common way women managed this balance.

To illustrate how these contrasting but parallel dynamics unfold, I present the interviews with two docents, Erin and Ruth, who I recruited in July and August 2012. This extended exemplar provides a descriptive framework for the analysis on calculated associations. I interviewed the docents separately at different time points not knowing they were acquaintances

and neighbors, and by chance, I had the opportunity to observe the two women interact. I wrote the exemplar below based on the data I gathered (ethnography and participant observation field notes, docent tour interview transcripts), but it is primarily based on the walking interviews through the Tenderloin with Erin and Ruth. I also hope it demonstrates the complexity and richness of data that is obtained by place-based methods like the docent tour, as the concepts below would not have been observed without them.

1. First Week of August, 2012

On an exceptionally warm San Francisco summer, I threw on my backpack and speed walked down the hall of the TASH program, which was located on 280 Turk Street, above Hospitality House. As I turned the corner, the woman I was rushing to meet, Erin, a 42-year-old black woman, was fanning her face with a brochure at the top of the humid staircase. She was wearing a colorful yellow sundress and canary sandals, her hair slicked back into a tight ponytail. I was surprised to see her at TASH – we originally arranged to meet at her hotel. She said she was restless at home and felt up for the Coping Skills group discussion that morning.

We decided to walk the ten blocks back to her apartment together to conduct the interview. As we set off, I learned that I encountered Erin at a sensitive point in her life. She told me that just yesterday, she was informed her seven-year-old daughter, Lily (pseudonym), would be given up for adoption. Erin would lose all of parental rights to her only child. Lily was born with fetal alcohol syndrome, and Child Protective Services (CPS) took her about a year ago citing substance use as a factor in their separation.

Erin was a person with a somewhat aloof air, and firmness in her tone. But when she spoke of her daughter, she grew emotional. Her voice cracked, and she choked with every few words, speaking through both anger and sadness. Erin continued her account about Lily during our walk through the Tenderloin. She described the miserable long, lonely nights – alone in her small apartment, surrounded by Lily's clothes and toys, with distant fantasies of reunification tormenting her. If she is to get Lily back one day, or to even have the chance of visitation with her, Erin must deal with all her pains and make major changes. However, Erin is in a Catch 22 – she uses substances to cope with and ease her pain, yet in this deeply painful time, it is the primary behavior she is tasked to change.

Erin has a dual diagnosis (chronic history of substance use and a bipolar disorder). She is also poor with less than a high school education, few job skills, and no employment prospects. She grew up with parents she calls alcoholics. At the age of thirteen, Erin began using substances – first alcohol directly from her father's liquor cabinet, then prescription pain pills, later methamphetamines, and now crack-cocaine (or some combination of these). She has not been able to work in several years and lives off

disability payments she receives, about $800 per month. On this small income, Erin told me the Tenderloin offers her the only housing she can afford. To be in San Francisco where her daughter goes to school, Erin had two options from the Housing Authority – Tenderloin hotel housing and the Sunnydale Projects in Visitation Valley. She elected for the Tenderloin because after all, drugs riddle both neighborhoods – why not chose the one with more access to jobs, opportunities, and resources? Indeed the Tenderloin has become home to dozens, if not hundreds, of social service organizations and programs, like the TASH program where we met.

It was a Wednesday, farmer's market day. It was the first week of the month, meaning locals still had money from paychecks, monthly entitlements or allowances. These conditions combined to create an atmosphere brimming with energy. Erin and I walked by elderly Asian women, many who are undocumented, gathered in groups on the perimeter of the farmer's market to sell jumbled groceries hidden in suitcases. Peddlers on Leavenworth Street spread out the items they gathered – DVDs, clothes, snacks, toys, plastic containers, and random bric-a-brac – onto blankets around their cart. At least a hundred people stood in a line that snaked up Golden Gate Avenue and around the corner onto Leavenworth, waiting for a warm lunch at St. Anthony's kitchen. Small school children, no older than four or five years old, marched to school hand-in-hand in matching, brightly colored oversized tee shirts. Men and women in wheelchairs and walkers smoked cigarettes or just people-watched in front of their hotels. In this extremely densely populated part of the Tenderloin, private spaces are expensive, rare, and out of reach for most. As a result, residents live out daily activities a public way. The streets are, as Erin called it, the "biggest front porch in America."

The drug dealers were a menacing aspect of this front porch. They taunted Erin. Between Turk Street and Leavenworth Street to Eddy Street and Polk Street, as we weaved through the crowded sidewalks, she showed me what she was up against. We walked past a half dozen drug dealers who made themselves obvious by targeting us with not-so-subtle advertising. "Sup mommy," they murmured. She averted her gaze to ignore them. Regardless of this explicit social boundary, their solicitation was overt. One dealer even greeted Erin by her nickname, which infuriated her. After all, she later told me, what if I were a CPS worker instead of a researcher?:

Jamie: How do you avoid the encounters with drug dealers? Do you just ignore them?

Erin: Yeah. When I'm not-- like when I'm taking time off [drugs] or whatever, don't mess with me. I'm not even interested. Don't talk to me about it. Please don't come up to me . . . I think it's how you premise yourself, you know what I mean? You set those ground rules down. Like when you see me on the streets, you can still speak to me without asking me if I'm going to buy something . . . you don't never know who I'm with. I might be with [Lily], I might be with my CPS worker, and you might fuck my whole shit up . . .

Jamie: But . . . when we were walking down the street, they were kind of hollering at you.

Erin: Yeah. And the fact that the police drive by here every single day. They see the same amount of dealers out here every day. These boys be out here drinking beer, they know they don't live here, and they allow it.

We walked past Mini Park, one of two outdoor public children's playgrounds in the Tenderloin[25]. Enclosed by a twelve-foot-tall metal wire fence on one of the worst drug-dealing corners in San Francisco, it was difficult to imagine children feeling carefree here. On this sunny afternoon, two small children jumped off the tire swings onto tarmac. A group of adults sat in the tree's shade with their backs against the concrete base of the park fence, smoking and talking.

We were diverted for a moment. Erin spotted a woman she knew, Gina, sitting with her toddler son inside the park. We stopped to say hello, and as mothers do, the two women updated one another on their children. With the wire fence between, they discussed Lily's impending adoption. The conversation soon gravitated toward their children's health care. Gina mentioned that her son, who was about Lily's age, needed a behavioral specialist for something having to do with school. Erin, unprompted, offered Gina contact info for Lily's pediatric psychiatrist at San Francisco General Hospital, whom she liked very much. Gina thanked Erin, and after asking a few questions about insurance and waiting list, punched the psychiatrist's office number into her cell phone. Later in our interview, Erin told me why this type of informal information sharing between mothers with common experiences was important to her:

Jamie: So you know, when we were walking down the street, you and that woman that we found in the park with her son? You know, you guys just exchanged information? Do you think that's pretty common, like, sharing resources among people?

Erin: Yup. Just like I told you, it's almost like if you go to ask for help, it's this like, big handout, you know? Like, "We gon' do you this favor." Nuh-uh. You need to come on that common ground . . . .they don't feel that genuine-ness, you know?

About fifteen minutes after embarking on the interview, Erin and I arrived at her apartment, the *Family Building* (pseudonym). From the outside, the building stood out among the many tall, hotel-style buildings in the neighborhood. Many of the supportive housing buildings in San Francisco are converted from old, failed budget hotels, but Erin's apartment was built just a few years ago from the ground up, and is more distinctly more modern in appearance and well maintained. It was purposefully designed for families with children, which Erin and her daughter qualified for when they moved in three years ago. We ring the building door buzzer. In Erin's building, like many of the supportive housing buildings, tenants have keys to their rooms, and desk clerks regulate the main access to the building as a security measure. A desk clerk peered at us through the glass door and buzzed us into the lobby. Like all other visitors, I showed my identification and signed into the building roster. The desk clerk granted me access to the main hotel, and Erin and I found a quiet place to start the sit-down interview.

[25] Boeddeker Park, named for the founder of St. Anthony's, was overtaken by drug dealers shortly after it opened in 1985, and has been closed to the public, under development, for an astonishing 14 years. It is supposedly scheduled to open next year, though this seems like a stretch based on its abandoned condition today.

An hour later . . .

Having started the docent tour at the Treatment Program, toured the apartment complex, and conducted the sit-down interview, Erin selected a large Vietnamese sandwich cafe on Larkin Street as her "comfort zone" or "safe space" in the community, the final component of the docent tour. The major draw for Erin was the cleanliness of the café, the cheap, healthy-ish food, and the counter seats by the large windows facing Larking Street that begged for people watching. As we sat together at the window counter with our sodas, Erin eagerly relayed her scoop on people she recognized walking past:

Erin, commenting on another woman's appearance and clothing: "Wow, she's just doing it big. This is not the beach, girl. Ain't no water around here . . . [her] jaw is busted up, and she has a black eye. Look how she dress. She's not being aware of her surroundings. She talks to anybody, she jumps in anybody's car."

As opposed to another female passer-by: "See, she's safe. Not because of dope or anything like that. But see? She's very direct about what she wants. She's got her eyes focused on where she's going. She ain't trying to chit-chat on the block."

A woman walking along the sidewalk recognized us and knocked on the glass window. It was Ruth, another Tenderloin resident I incidentally interviewed just two weeks before in July 2012, but whom I first met in 2009. Erin knew Ruth as well. Ruth gave a smirk through the window, and we motioned for her to come inside . . .

2. February 2009, three and a half years ago . . .
(From field notes and interview with Ruth, February 2009)

I cannot forget meeting Ruth for the first time. It was early 2009, three and a half years before the sandwich shop, and I was a second-year graduate student working on my pilot project on homeless women. Ruth, a white woman, then 43-years-old, was the very first person I interviewed for my study – the first person I had ever formally interviewed. She called me upon finding a study flyer I posted on the Glide Memorial Church bulletin board, and we booked an interview the same day. She took the N-Judah train across the city to meet me at the UCSF library. I waited for her in front of the library for nearly an hour. She had never been to UCSF before and I figured she must be lost[26].

I scanned Parnassus Avenue but didn't have to look hard to find her. Tall and thin with long strawberry-colored hair, in tiny denim shorts, strappy high-heeled sandals and a sheer pink blouse, Ruth was smoking a cigarette (cheap Parliament 100's) in the Medical Center cul-de-sac, looking a bit fish-out-of-water among the buttoned-up UCSF crowd. Her squinted face relaxed when she saw me. She was pretty, though she missing several of her teeth, her skin densely speckled with anxiety scabs and scars. Ruth was a

[26] These early experiences conducting interviews in spaces like the UCSF library, offices, etc. made me aware of how problematic such spaces can be for collecting data. Ruth and other participants did not seem comfortable on campus at all, an early lesson that motivated me to develop the docent tour method.

soft-spoken, unassuming person, but to my enormous relief as a green interviewer, she was also warm and talkative.

As Ruth and I talked in a private study room in the library, I learned that she had lived between the Tenderloin, the city of Richmond, and the city of El Cerrito for the last twenty years. She was a military kid, and moved frequently with her father who served in the U.S. Navy. She dropped out of high school during freshman year after she gave birth to a baby boy. After her son, Ruth had six other children. Five of them are now young adults and two are under the age of eight. Ruth mentioned that her first five children were taken from her custody when they were young, but she didn't say more about the experience. I didn't feel comfortable enough to ask.

At the time of the first interview in 2009, Ruth lived with her two youngest children (5 and 7), her current husband, and his 14-year-old from a previous relationship. Her husband was emotionally abusive and tormented her deeply. She told me about their breakups and makeups, and her housing situation seemed to fluctuate depending on their relationship status. She was in recovery from crack-cocaine, but still dependent on drugs, mostly prescribed and street-purchased opiate pain pills like Vicodin. She said she became addicted to Vicodin after gastrointestinal surgery seven years ago, but her history of addiction to pills ran deeper. Ten years ago, she lost her job as a certified nurse assistant when she was caught stealing pills from work, and hasn't been able to work since then. She, like Erin, lives on disability. Ruth was also on daily methadone maintenance, 180 mg every morning at 7AM, which made her drowsy. Twice during the interview, she nodded off for a few seconds.

Ruth became animated, however, as she relayed stories of her husband's neglect, verbal assaults, and many infidelities[27]. But his recklessness was only part her problems – the family of five was on the brink of eviction from their home. The 6-month term for their one-room transitional housing[28] apartment near the Panhandle was expiring in a week. Though riddled by depression, pain and addictions, Ruth was the head of her fragile family, and she had to find someplace for her three kids to live, with or without her husband.

3. July 2012, two weeks before the sandwich café . . .

Long after our first meeting, I often wondered how Ruth was doing. I caught glimpses of her in the Tenderloin over the years, but the circumstances were never right to approach her. It was July 2012, and I received a call from a woman with a familiar voice. She got my phone number from a social worker at the TASH, who helped me to advertise my study for participants. I was thrilled when the familiar voice said her name was Ruth. We arranged to meet first thing the following day at her hotel, the *Adult*

[27] Ruth told me that her husband was not physically abusive but this experience left a strong impression with me. Since this interview, I have carried contact information for domestic violence, mental health, substance use, and legal services, which I offer to the participant if any of these issues are raised.

[28] Transitional housing was a popular model for substance use treatment and housing during the 2000's. These were typically short-term (6-months to 2-years) and provided services to homeless individuals and families to prepare them for permanent housing.

Building, an adult supportive housing apartment building. Though she was facing eviction the last time I saw her, Ruth had forged her way into permanent, affordable supportive housing.

When Ruth walked into the hotel lobby, I recognized her red hair right away. She didn't recognize me, or at least didn't indicate she did. Ruth, now 47, wore a charcoal gray cotton sweater and track pants, and looked more comfortable and healthier than the last time I saw her. Her skin was much clearer, and her missing teeth had been replaced.

When we sat down in the basement to do the interview, however, I learned Ruth was not in as good a place as it seemed. Ruth, like Erin, was in the process of losing custody of her two remaining children, now 8 and 10. She had already lost guardianship of them. Her kids have lived in Richmond, California with her in-laws—the parents of her husband who abused her —for the last year.

I was troubled by the response she gave when I asked her what happened with her children:

Ruth: [Housing organization] put up Family Building. And so they had chose five families, and we were one of the five that was chosen to go to Family Housing. And so it was me and my two children at that time. Uh, I met this girl, and she offered me a hit of crack one day, and I don't know why I accepted, but I did, after like 22 years. And so-

Jamie: This happened at Family Building?

Ruth: Yeah. I found myself getting back into a cycle. It wasn't like I could just say I'm going to isolate myself, because [drugs] was so heavy in that building, you know? There's so many drugs in that building. I tried to go to TASH [drug and alcohol treatment] there, but it's like, close to impossible because [drugs are] everywhere, you know? You walk out the building and they're there. And it's just so easy, and it's to the point to where you don't even have to go look for it. It comes to you. They come and knock on your door, you know, when the first comes around or whatever. And so, it just got-- it got really bad.

Jamie: Wow.

Ruth: Eventually, I went to Child Protective Services. I mean, CPS was on me so hard that I couldn't even breathe, I felt like, so I finally went to them and said, "You know what? Can you help me?" You know? "Will you help me get to a program, then, you know, let me keep my kids?" And the worker at that time was like, "Oh, sure, here. Sign here." The next thing I know I'm in court, and the kids were with CPS. That's how they helped me. They snatched the kids up.

To recap, shortly after we last met in 2009, as Ruth was being evicted from transitional housing in the Panhandle, she and her two biological children were among the homeless families selected to live in the Family Building when it first opened. The building possessed enormous potential and promise – built from the ground up, it offered brand new, permanent, affordable, housing for homeless families with specialized supportive services and resources geared toward families and children.

It's difficult to reconcile this potential with what Ruth experienced. Stable, affordable housing in San Francisco for Ruth meant living in a drug-saturated building in the Tenderloin, where she re-discovered crack-cocaine through a neighbor, and used for the first time after 22 years in recovery. (This is supported by her 2009 interview, in

which she stated opiates were her preferred drug - she had not used crack-cocaine, marijuana, or even alcohol in decades.) Life on crack-cocaine spiraled out of control, and Ruth sought help from drug treatment programs and from Child Protective Services. I do not know the circumstances of her children being removed, but Ruth (like Erin) felt betrayed by "the system" in a time when she was vulnerable.

Since her children were no longer under her care, Ruth was recently moved from Family Building to another hotel geared for single adults, the *Adult Building*. Most would consider Ruth's move a downgrade. Though the housing organization renovated the 100-year-old hotel in 2008, the design, infrastructure, room size, and facilities of the Adult Building are far inferior to the modern Family Housing. But Ruth surprisingly welcomed the change in environment. As we sat together in her chosen safe-space, the Starbucks on Market at 8th, I asked:

Jamie: If you had to identify your substance use triggers, would you say that you have any? I know the Tenderloin itself is one that you refer to a lot.
Ruth: Company. Certain people.
Jamie: Certain people. Would you like to say, not names or anything, but like, who? Family members or friends?
Ruth: No, like, I thought they were friends at the time, but they probably were more like associates . . . And I-- my purse actually got stolen a few months back in church, believe it or not. But that kind of helped me out, because my ID was in there, and I just haven't got another one, and I can't go in there without an ID.
Jamie: Go into--
Ruth: Family Building. So it kind of helped me get past that [recovery] hump, you know, because I moved into the Adult Building in March. It did help me, like, ban me from the Family Building. Which made it easier, because then I couldn't go to certain people's houses. So even if I had the desire, it wasn't going to happen, you know?

When Ruth lived Richmond, she used any reason to come into the City so she could stop by the Tenderloin. Now that she lives in the TL permanently and is actively trying to reduce her drug use for the sake of her children, she goes to great lengths to protect herself from the environment, many days even locking herself in her room . . .

4. August 2012, back at Vietnamese sandwich café

Ruth smiled as she came in from the sidewalk and approached Erin and I at the sunny window counter. Erin whispered to me under her breath, "She was my neighbor over at Family Building." We grinned as we greeted one another, like three people who had never expected to be a room together. Today, Ruth was all business. With a warm but drained look, she pointed to her bare ankles and calves, which were covered in tiny red bumps. She explained:

Ruth: We got a real bad, bad bed bug infestation. They're actually going to relocate me and about five other people to X [another building for adults]. You go and stand in my room, and you'll be like, fighting. That's how bad it is.
Jamie: Oh, at Adult Building?

Ruth: Yeah. I've been having an allergic reaction to the bites.
Erin: Wow . . . Oh yeah, you can see the little bites. So what are you going to do? If you need anything, just come to my house.
Ruth: I didn't sleep for three days because I was scared of going to sleep. When the lights go off, it's so bad.
Erin: You can stay at my house tonight. Call my unit.
Ruth: They don't let you go in there without an ID.
Erin: Okay. You want me to leave you a message at your place then?
Ruth: . . . My phone is busted.
Erin: Okay. No, I'll leave them a message at the desk or whatever.
Ruth: Like I said, you don't want to go upstairs. You have to send somebody up. You can ask somebody in the lobby. They'll have somebody in the lobby.
Erin: Okay . . .
Ruth: Bye.

Ruth left as quickly as she came. The conversation seemed to remind Erin of how tenuous her housing is. I could see the stress on Erin's face as she gazed off and contemplated her future aloud: "They ain't gonna move me there, no buddy." Since Lily will be adopted, Erin, like Ruth, will soon be moved from Family Building to one of the adult buildings. The condition of the SRO adult buildings will limit chances to visitation rights. She's upset, and it's not hard to imagine why. Her healing plan is to "let herself" use crack-cocaine for three more months until November (the date of Lily's final hearing), to allow herself to mourn Lily's separation, after which point she will get out of the Tenderloin and check herself into an inpatient residential treatment to get "cleaned up".

[End Exemplar]

C. Calculated Associations

The three-minute interaction between Erin and Ruth, in the context of their individual interviews, resonated with me for two reasons. First, the women's troubled circumstances were remarkably similar. They understood and mutually supported each other. Yet their dynamic was not straightforward. It was also apparent that Ruth overtly dodged Erin's repeated offers for a place to stay. Whether it was a problem with identification, a cell phone, or the condition of her apartment, Ruth had a reason she couldn't – or wouldn't – stay over. She was avoiding Erin.

As I recollected their histories, one possible reason was apparent. Ruth told me she was re-introduced to crack after 22 years by another mother at the Family Building. Erin, who also

lived in Family Building, was actively using crack – could Erin have been the mother who led to Ruth's relapse? Ruth, who was routinely being drug-tested by Child Protective Services, simply could not use crack-cocaine ever again. If her drug tests ever came back positive, she would lose her last two children for good. She was already too familiar with the experience from having lost her first four kids. Ruth told me in our one-on-one interview that she avoided certain people at the Family Building by not having an ID and phone, and those exact reasons were cited to avoid Erin during their exchange. Ruth would rather sleep in her bed bug infested apartment than accept an offer to stay at the Family Building, underscoring the tangibility of the risk she perceived.

When I asked Ruth and Erin separately in their interviews "Do you have friends in the neighborhood?" they responded (emphasis added):

> **Ruth**: *I have associates. I think everybody knows me, you know? But I don't really trust anybody out here, you know? I don't feel like you can.* I mean, they'll steal your shoes off your feet if they think that they'd benefit from it. …Everybody pretty much knows everybody. Even if you don't know them by name, you know who they are. You see their routine pretty much every day or whatever, you know? "Hi and bye" type thing. I mean, don't get me wrong, don't think anybody's your friend, because they're not, because the chance they get, they see you coming, they can take advantage of you, they're gonna do it. You know? So, it's a community, but it's a different type of community, you know? But actually, I feel safer in this neighborhood than I do in a lot of other neighborhoods.
>
> **Erin**: I would consider probably four people my friends. *Now I hang out with a lot of people, but they ain't my friends.* You know why? Because they ain't going to be sober when I'm sober. None of my close friends live in that building.
> Jamie: So [your friends] are not in the neighborhood necessarily.
> Erin: Nah. You know why? It's going to sound kind of wrong, but my close friends are people who are sober and doing the right thing. My close friends are people who know that I've relapsed, but still love me and still are supportive. You know? . . . So my really good friends are all sober people. No, I can't say that. Because one of my best friends in the building-- she's my best friend in the building, and I love her to death, [but] the majority of my friends are all clean people.

Using this exemplar and others, I argue that the Tenderloin is a social environment where relationships necessarily involve a balance between the potential for support and the potential for risk. Most docents did describe having a small handful of people they called "friends". But more often, their interactions and relationships were characterized by a distinct relationship dynamic I refer to as calculated associations. Two components I examine next created calculated associations: 1) interdependence on the basis of common need, and 2) instabilities that also presented a range of risks. As a result of these factors, the women created boundaries, both physical and social, to manage the needs versus risks in the Tenderloin. These boundaries could be thought of as the women's personal "yellow brick roads" – their mental maps of the sparse, narrow safeties they used to navigate the neighborhood.

1. Tenderloin Opportunities: Interdependence, Social Support, and Belonging

First, hotel tenants, like Erin and Ruth, were *highly interdependent, on the basis of common ground and need*. When they could, they looked out for one another. The residents of the hotels had a high degree of need – in many cases, the women were forging a life for themselves and their families with almost no money. Many women managed mental and physical issues, which elevated their need and simultaneously excluded them from many legitimate ways of earning money. Research has shown that one of the greatest risk factors of homelessness, especially among women, is lack of social support (Bassuk et al 1997). This was true for the women I interviewed. Some did have a partner or friends and family, but many did not. Often times, these relationships were fragile. Since they did not have a strong, supportive social network of their own, and there were few conventional places for residents to find consistent support. As a result, the hotel residents relied upon one another for financial, social, and emotional support, information about resources, and simply help with activities of daily living,

things most people take for granted. Even women who were seriously isolated and seemingly alone usually turned to their neighbors for help or support when it was needed.

Common ground in the Tenderloin facilitated interdependence and social support. In the example above, the women had their differences. Erin is black, Ruth is white. They were addicted to different substances, Erin to crack, meth and alcohol, and Ruth using methadone and other opiates. Ruth was involved in a relationship with her (unsupportive) husband, while Erin was single. Yet it was also apparent that the women had much in common. They were both about the same age, they came from unstable homes, and their own parents were addicted to substances. They moved to San Francisco in their twenties from other parts of California. They lived together in the same building (Family Building) for about three years. They were mothers who had children removed from them. They were on disability, they were dually diagnosed (mental health and substance use issues), and they had long histories with substance use including multiple experiences in treatment. They've both been incarcerated for reasons related to substance use.

These mutual circumstances and histories enabled the Erin and Ruth to understand one another, and as a result, they provided support to one another. Erin stated explicitly that support based on common ground was important to her (Page 8). And support she did. Erin adored Ruth's children, who were same-age playmates with her daughter Lily. Erin regularly tutored and watched the three kids together after school in her apartment while Ruth was in Richmond dealing with her husband. And as observed in their café interaction, Erin readily offered her home to Ruth at a time she urgently needed support.

In many other docent interviews, I saw and heard repeated occurrences of interdependence and social support that were fostered by common need and common ground.

Most hotel residents received welfare or disability payments. It was virtually impossible to save money on (average) $900.00/month disability checks. If money ran out early, as it often does in this expensive city, neighbors and friends relied on one another every month for personal loans or resources. Residents who were on disability routinely hired their family and friends for in-home care, another way residents were financially and socially linked to one other. Those who did not have in-home care relied on neighbors and building staff to support them through illness, helping them run errands or other activities of daily living. They relied on one another for information about an array of needs and resources, as Gina and Erin did in the exemplar (Page 8). Drugs are exchanged, bartered and sold between residents in the hotels, and were a meaningful form of currency that linked residents together.

This notion of common ground underscores one of the important things I learned about the Tenderloin. I once thought that the Tenderloin was a neighborhood that most wanted to avoid or leave. But for most women, there was an intense sense of belonging, connection, and protectiveness toward the neighborhood and its residents. Several docents described this sense support and security that characterized the neighborhood. Ruth, for example, feels safer in the TL than in Richmond where her children live, in part because people look out for one another in the Tenderloin:

> Ruth: A lot of people are scared in the Tenderloin, you know? To me, it's nothing to be afraid of. I'd rather be here than in certain parts of Richmond . . . in Richmond, you'd be walking down the street, and they do drive-by's and stuff so much. You know? And I mean, it's just all the time. And I don't know, it's different – [in Richmond] you want to be in before dark, that type of thing. Where, out here [in the Tenderloin], I think because you're known to people, I guess they might not know your name, but you know, they know who you are, that they kind of look out for each other.

Erika, the 36-year-old black woman I introduced in Chapter III, tells me she's far safer in the Tenderloin than the Potrero Hill projects where she grew up. She feels protected by, and protective toward, the neighborhood:

> Erika: Yeah like down here sometimes I feel safer at the Tenderloin area than I would in my own projects that I used to live in Potrero Hill. Everybody turning on each other up [in Potrero Hill] and we supposed to be like family. Down here [in the Tenderloin] there's always somebody walking, saying stuff [watching out for one another]. I've got into arguments for people that I don't even know. They could be using drugs or drunks, "Hey, he fucking with you? That person bothering you?" It's like I feel sometimes more protected down here, despite the fact that it's all dirty, grimy, stanky. People sleeping and shit and pissing out on the street whatever. You know what I'm saying? I still feel safer sometimes down here. They're [Tenderloin residents] more of my family than my mother and everybody else.

These quotes stressing social support, belonging, and interdependence were not empty words. There were several examples of women contributing and giving to the neighborhood on the basis of common understanding. Ruth, for example, volunteers at St. Anthony's or Glide kitchens a few times a week. Erika is a leader for the children's programs in her church and building. One particular example resonates in my memory. Pam, a 56-year-old black woman, and I were walking down Golden Gate Avenue when we crossed paths with a very thin elderly woman sitting on the sidewalk begging passers-by for spare change. Pam, who is actively addicted to crack-cocaine and struggling financially, produced a few dollar bills from her pocket, and handed the wad to the panhandling woman without saying a word. Your average San Franciscan ignores the homeless (it is so rare to see an individual actually hand the homeless money, especially in the Tenderloin), and I was genuinely surprised by her gesture:

> Jamie: It's really sweet that you just did that. I don't know why, but it surprises me for some reason.
> Pam: It's part of me, it's always been part of me. I don't know God has His ways. I have my ways of giving to Him.

This section demonstrates the protectiveness, ownership, and belonging women felt toward the Tenderloin neighborhood and its low-income residents. There is no place else in San Francisco, or perhaps anywhere, that the women could find the social resources, support, and sense of belonging the Tenderloin offered. Many of these opportunities stemmed from the interdependence among the residents, who understood one another's circumstances.

2. Yellow Brick Roads: Using boundaries to balance opportunities and risks

The Tenderloin is a place that fosters interdependence and support in relationships, but it is evident from the extended exemplar above that these same relationships simultaneously contain risk. These risks were rooted to the many instabilities of poverty and drug use. When Ruth and Erin met at the café, Ruth, despite being desperately covered in bug bites, explicitly avoided Erin. She dodged Erin's repeated offers for a place to stay, citing numerous barriers to the idea, like having no ID, not being allowed to enter the building, etc. What is key to the shift in relationship is that while the women had much in common, over the course of their relationship, they diverged on an important piece of common ground – drug use. While Ruth reorganized her environment to stay abstinent from the addictive pull of crack for the slim possibility of keeping her children, Erin was actively using drugs because she already lost her parental rights to Lily. Substance use links people together, and is a strong basis for mutual understandings, experiences, and support. Recovery also connects people together, but is a different form of common ground than people who are actively using. Because the substance use patterns of the women changed, an important basis for their relationships was no longer aligned. This shift is minor compared to many dramatic ways poverty and substance use can alter

relationships – incarceration or death, for example – but it was nonetheless a wedge in the women's relationship, pivoting them apart.

Physical and social boundaries were used to buffer relationships, to balance opportunities with risk, and to enforce the need for self-protection. In the exemplar, Ruth had to avoid Erin and other associates who could threaten her recovery. As a result of these necessary social boundaries, Ruth established her own boundaries and restrictions. For the women who managed or used drugs and alcohol, creating boundaries was not simply about evading drug dealers. It was also an effort to compartmentalize entire social groups – friends, family, intimate partners – who use substances. Maintaining these boundaries required a wholesale reorganization of her life. Ruth purposefully never carries identification, which presents a barrier from entering most residential spaces. She avoids entire buildings and sections of the Tenderloin that she knows from experience provide easy social access to drugs, or are likely to trigger of drug cravings. When she was moved from the Family Building to the Adult Building after losing her children, she worked to actively establish a new identity among her neighbors as a "non-user". Her room would be a drug-free zone, and she would only allow people into her room that respected her rules. This new social identity, which itself is a social boundary, would have been much harder to forge without the dramatic alteration of her physical living environment. She created her very own, personal "yellow brick road" – the safe zones in the Tenderloin that offered some protection from the environmental stressors.

Like Ruth, other women raised social and physical boundaries to balance the opportunities of the neighborhood with its risks. Roxie, a 60-year-old black woman, created boundaries between herself and her social network because of a change in her substance use. She described a commonly cited reason for creating boundaries – the perception of being taken

advantage of by neighbors who used substances, a notion that Ruth and Erin also described their quoted response to whether they have friends in the neighborhood (Page 12). Roxie, who used crack-cocaine for decades, has been in recovery for a year and has done very well in the TASH program according to the clinical staff. As a person in recovery, she refused to allow people into her home (boundary) if they were using drugs, not just because of a concern about potential relapse, but because of her experiences being taken advantage of. She says of her neighbors:

> Roxie: I don't deal with these people [in the building], most of them smoke [drugs] . . . I only open my door for these people when they're clean. They come for some sugar, I tell I don't have it, you know, I'm not going to start that. Okay, run into my house wanting this and that. If you need something, you should buy it before you start smoking. I buy a carton of cigarettes every month, okay? I take care of what I gotta do, okay? I don't use my money on crack anymore. No.
> Jamie: Is it hard to live in this situation because you see people all the time?
> Roxie: . . . I can see them but I don't deal with them. I stay to myself.
> Jamie: Mostly indoors?
> Roxie: Yeah, my room.

Like Erin and Ruth, Roxie's example shows how social boundaries lead to physical boundaries (not allowing people in her room), which emerge out of the high degree of interdependence and instabilities (in this case economic) that exist in the TL among hotel residents

Social and physical boundaries were raised between neighbors for a variety of reasons. Sometimes, the boundaries that resulted from substance use were direct and acute – for example, it wasn't uncommon for people to be suddenly incarcerated, or to die from overdoses or other circumstances related to drug and alcohol use or violence[29]. Death is so common, one hotel I visited has an altar in the lobby dedicated to loved ones who have passed away (Figure 4.2).

[29] During the five years at the drug and alcohol treatment program, seven people who were active clients of the program passed away.

Figure 4.2 - Memorial Altar in the Lobby of Hotel.

Beth, a 54-year-old white woman, described how the instability and emotional toll of death affected her personal boundaries. She distanced herself from people, emotionally and physically, because of the chronic stress and depression brought on by the recurrent possibility of death among her social network:

> Beth: It's very depressing down here, especially when people are bringing death to my door . . . I take death very personally because I've been to so many funerals. But see, I just don't like it when people trying to bring in depression and stuff, I try to avoid that now. So I'm like, "I don't want to hear it." People are who they're going to be, and everybody's going to live or die. I've accepted that and I try not to get personal with it . . . it could destroy me. I could get suicidal again and want to kill myself. That's why I try not to get too close to anybody anymore.

Death created obvious physical and emotional separations. Most other risks that motivated boundaries were less extreme but harmful nonetheless. Several participants described using boundaries because of verbal or physical hostilities that erupted between residents, even among people who were supposed to be in a supportive role. For example, one participant, Joanna, a 54-year-old African American woman, described having to manage past stressful

interactions that occurred in her hotel between she and man who lived in her building. Joanna and the man named "John" were both involved in the TASH program. A few months ago, John, who I knew as an upstanding client and peer mentor of TASH, had a physical altercation with Joanna in their building. I did not know this incident had occurred. When we ran into him during the walking interview in the building they shared, I was glad to see him. But as we greeted each other, Joanna was completely distant. After we walked on:

> Joanna: [Referring to John.] He's the one that assaulted me.
> Jamie: Oh, no.
> Joanna: I had a restraining order against him . . . He got all up in my face. He's different when he comes here. See how he acts with you? He's not like that in the building.
> Jamie: Hm, you have to see him in the building every day after that happens, too.
> Joanna: See, but Jamie, I'm a better woman than that. *See them, they're invisible to me*.
> Jamie: How do you mean?
> Joanna: So they're invisible to me. I can walk past them and it don't mean nothing. Nothing at all. I said people take your kindness as weakness. When you said "are you friends?", they're not a friend of mine. None of them. None of them. I have two friends - they're the only two I really deal with now. All the rest of them, I don't mess with. Ever since John did that to me, I'm cool. That taught me a lesson.
> Jamie: [Referring to another man we ran into earlier in the lobby of the hotel.] That guy with the missing eye? He told me that he was assaulted in this building too.
> Joanna: Yeah. And that guy is still here, the one who put his eye out. And that's a shame. I'm serious. That's a shame.

Because Joanna could not put a physical boundary between herself and John in the hotel's many shared spaces, she created different types of boundaries to buffer him - emotional and social boundaries. She mentioned above, for example, that John was invisible to her. When they crossed paths in the hotel hallways, lobbies, the street and the treatment program, she ignored him as best as she could. It was the one way she could reduce the interpersonal stress she experienced in the building.

The boundaries women used often went beyond the hotels. Boundaries pervaded their perceptions of the entire Tenderloin neighborhood. Time and time again, docents described that

they had personal yellow brick roads of which streets and spaces were safe, and which needed to be avoided. Their mental maps were almost always related to managing drugs, potential violence, or negative social situations. As the interview continued, Joanna, who is trying hard to stay sober from substances, said:

> Joanna: I have to avoid the street, Turk Street [the location of the TASH program] because it's [drugs] right there. You go down Market Street, it's [drugs] there. I avoid Turk, Sixth Street, Hyde Street. And I'm learning it now. Before I didn't know no better. I'd roll around everywhere looking around, Hyde from Turk on up to, what's that? Where Glide is.
> Jamie: Taylor and Ellis, I think.
> Joanna: I stay away from. Yeah. I stay away.

Roxie also deliberately avoided specific streets in the Tenderloin in order to maintain her recovery and stay safe:

> Roxie: I'm trying to change everything. My way of thinking, my sceneries of the things. That, you know, I'm getting new ways to walk so I won't go through the old neighborhood that I used to be in [when I was homeless].
> Jamie: You walk on different roads?
> Roxie: Oh yeah, I gotta have a whole new way up in the Tenderloin. I go all the way down Van Ness and down Market . . . I go to Van Ness because sometimes these people out there, they be tweaking you know all on the ground. You can't even cross the street you know. Buggies you know with all kind of filthy blankets and stuff.

For docent after docent, most of whom were seasoned women in the Tenderloin, avoiding drugs meant specific areas had to be circumvented. As Roxie and Joanna suggest, this can mean rerouting one's entire life into narrower but safer corridors.

For some docents, the social boundaries were so powerful, they resulted in near complete isolation. Sonny, the 54-year-old Asian American woman I introduced in Chapter III, was working to reduce her substance use, also avoided entire blocks wholesale to bypass painful or potentially harmful aspects of her past. She has lived in the same 8 x 10 room, in the same hotel, for fifteen years. Years ago, she was a regular on the Tenderloin street scene, the "front porch" of

the Tenderloin that Erin referred to in the extended exemplar. She used drugs to make friends, enable social interactions, and cope with her mental health issues and traumatic experiences. Yet she told me she learned over the years how risky even minor relationships in the TL can be. As she recounted some of her experiences, it is apparent that the negative experiences and social boundaries around her are so overwhelming that she confines herself into her room, locked away from the harms of the Tenderloin. Sonny describes how she puts up boundaries because of her social experiences:

> Sonny: I try to avoid going to the TL, the hotels and stuff, and Sixth Street . . . there's too much people.
> Jamie: Yeah. Do you feel like you know everybody?
> Sonny: I recognize a lot of people. Yeah. Especially after fourteen years . . . I don't know. I'm a very private person, so I don't know. I don't hang out. I stay indoors all the time . . .
> Jamie: So it was an isolating kind of a thing.
> Sonny: Yeah. You have to do that, almost, if you want to stay clean. Because any time you go-- especially the TL, any time you go there, people are approaching you, practically throwing the drugs on you. You know? I mean, you don't even need money, sometimes, to smoke. Especially when you're trying to quit, there seems to be more people that's offering to smoke with you than when you're trying to smoke-- you know . . .

In describing how her very social network can easily and readily entice her into relapsing, Sonny underscores how the same social networks that provide support (in this case through companionship) can also present risks. To manage the potential for support and harm, she creates enormous boundaries between herself and the Tenderloin. This not only applies to the neighborhood spaces, but also to her hotel. Sonny goes on to describe how hostile and violent interactions between she and other tenants of the hotel – people with whom she shares the public spaces of her home – stresses her to the extent that she spends nearly her entire life, almost twenty-four hours a day, alone in her room:

> Sonny: I used to come downstairs in this building, in the TV lounge and stuff. And then I got stabbed in there, in the lobby, and I stopped going downstairs.

Jamie: Was it a fight, or what happened?
Sonny: No, a girl, a woman was AWOL, and I asked her how she's doing. I said, "How you doing?" And that upset her and she came after me with a steak knife.
Jamie: Oh, my gosh. Were you hospitalized from that?
Sonny: No. She stabbed me in my hand.
Jamie: Okay. Is the woman still in the building?
Sonny: No. She stayed for about two years after that, but she moved out. But that's kind of hard. When you get in a situation like that with somebody, and they're still there. There's a lot of incidents happened to me in the building, where some of the other tenants would come after me. You know? And hit me. I've been pretty badly victimized in there. It's kind of-- that's why I stay in my room.
Jamie: Yeah. How many hours a day would you say that you're in your room?
Sonny: Most of the day. All day. Twenty-four hours, almost . . . Yeah, I've been stabbed in here; I've been raped in here. It's a very rough building. Used to be.

The concerns over both social and physical harm created powerful invisible boundaries. Sonny was anxious and nervous around her neighbors, even her associates, and this feeling resulted in the real life consequence of essentially living as a recluse. Like many other docents (ex. Roxie, Ruth), she spent nearly all her time indoors, inside her room. To compartmentalize her world and stay safe, Sonny is almost always alone.

Joanna and Sonny's examples underscore an important factor about calculated associations – that this dynamic was exacerbated by the very notion of a containment zone. In the containment zone, as I showed in Chapter III, the docents are symbolically, even physically, tethered to their buildings and neighborhoods. When conflicts occurred, which they tended to do because of the high degree of interdependence and instability among social networks, it was extraordinarily difficult to shield or protect oneself from the social, emotional, or economic aftermath. Even in circumstances where relationships were harmful and irreparably broken, disputing parties often had to continue sharing the same spaces. Joanna cannot avoid John, the person who physically hurt her, so she raised boundaries to protect herself, including a restraining order (legal boundary) and the practice of considering him invisible (social boundary), not even acknowledging his presence. Sonny, who is in the same circumstance with

other residents in her hotel, protected herself by living in isolation (social, emotional, and physical boundary). She has no yellow brick road to protect her from the outside word, and so she boxes herself indoors.

It is important to acknowledge, however, that not all women were limited by boundaries. All women recognized the Tenderloin boundaries and corridors, the spaces that were safe and those that weren't. But instead of avoiding them, some deliberately engaged them. They tested their mettle because they felt it was critical to maintain status and not appear vulnerable on streets so overrun with dealers that circumventing harm would be virtually impossible anyway. One of the participants, Nina, a 40-year-old black woman, is emblematic of this approach. Nina was born and raised in San Francisco, and has been a presence in the Tenderloin since she moved there as an eighteen year old. She spent almost two decades living with different boyfriends, girlfriends, and pimps, dealing crack-cocaine, and working as a prostitute. After some time in prison, she found permanent supportive housing. It was the first time she had a permanent home since she was a child. With the help of this stability, and after a spiritual reawakening at Glide Memorial Church, Nina has been sober for several months. Her approach to recovery was more reliant on willpower, versus adjusting her environment:

> Jamie: Are there places that you avoid because you're like-
> Nina: Nope.
> Jamie: So you're comfortable [in the Tenderloin].
> Nina: Yeah. I have to be. If I avoid it, in the back of my mind, I'm going to want to go back to it. I just still-- I walk around the block. I walk this way, I walk that way. Still see the same people. But I know where I don't want to be now. And a lot of other people can't do that. They have to avoid all people, places, and things. But I don't. And that's only by the grace of God, because He's the one who's keeping me strong.

D. Conclusion: Implications for Health

After Joanna and I bumped into John in the hallway of the hotel, we walked to the shared kitchen in her building. Just moments earlier, she conveyed the hardships of the neighborhood – the violent interactions, the inadequacy of the facilities, the drug dealers. Yet as she sat on the kitchen counter that overlooked Market Street, Joanna seemed at ease. She enjoyed the kitchen for people watching, or spying on the movies projected onto the wall of the art gallery across the street, like a drive-in without the sound. These moments remind us both of the simultaneous comfort and challenges of the neighborhood (emphasis added):

> Jamie: Wow. It's great view.
>
> Joanna: That's what I'm saying. It really is . . . it's nice. *So it [the Tenderloin] has advantages and it has disadvantages, right?* Over here, at nighttime, see that right there down the block where the booth is? They have a picture show.
>
> Jamie: Oh, is that the art gallery?
>
> Joanna: Yeah. The art gallery's up right here . . . and they got a picture show at night. I sit right here with my popcorn. I sit here for about two hours or so and watch the people go by. Watch everything . . . Everybody thinks this is a bad place. It's pleasant, you know? In San Francisco, anything goes. You gon' see some of everything right here. Jamie, I couldn't believe some of the stuff I would see, you know? But you know what, this taught me to learn to respect my own self . . . I did not know myself until I came here. And I raised three kids outside [homeless], you understand what I'm saying? This is what life is on life's terms. *It has up and downs.* Yeah. You know? Yeah, I do. I like being here.

In this chapter, I have shown how these "ups and downs," "advantages and disadvantages," as Joanna put it, shape interpersonal dynamics in the Tenderloin. The tenants of the hotels had much in common in terms of experiences and need, which fostered interdependence and social support. Yet these relationships were also laden with potential instabilities. As a result, the women established boundaries, the physical and social yellow brick roads, which helped to buffer stressors while enabling access to opportunities.

The calculated associations and ensuing boundaries I discuss here are important for health beyond the potential risks and opportunities that are exposed through social networks.

They also shape the interpersonal dynamics between clients, peers, and staff of group-based therapeutic settings, which are the foundation of substance use treatment programs ranging from harm reduction models to Narcotics/Alcoholics Anonymous (NA / AA). In group-based treatment, members of the group provide recovery support to one another by discussing experiences and challenges that stem from addictions, drugs and/or alcohol. Relationships between clients, as well as between the facilitator and group, are considered paramount to the success of these approaches. How can substance use treatment best facilitate group therapy programs in the context of calculated association relationship dynamics? What are the key strategies substance use treatment programs can use to acknowledge and address the personal boundaries that result from the relationship risks the containment zone presents?

This is related to a second implication for health – how should community-based health be delivered when the environment fosters severe personal isolation? As I've shown here and in Chapter III, isolation is a common reaction to the TL's environmental risks. And at the same time, isolation increases people's vulnerability to other health risks (Cornwell and Waite 2009; Locher et al 2005). How can community-based health programs target isolated individuals to promote access/quality of health and quality of life?

Relationships women had with people employed in a supportive role, like social workers, therapists, doctors, etc. are important relationships that were not discussed in this analysis because they are distinct from relationships among women in hotels. This was primarily because tenants shared less common ground with these individuals. People in the role of provider, case manager, counselor, etc. were critical supports that docents valued and relied upon. However, these relationships too entailed calculated associations. Most everyone working in housing and health in the Tenderloin, including myself, did so out of a deep desire to help and not harm. Yet

there were many examples of people employed in supportive positions creating increased stress or risk for participants. Women who had substance use problems and also raised children seemed particularly in a conflicted relationship with those working in health and housing. Yet there were several other vectors through community workers could create harm, for example through interpersonal stigma. In Chapter V, I discuss these and other implications of calculated associations to health and health delivery.

Chapter V: Conclusions for Place and Health

A. Overview

In this dissertation, I have examined the Tenderloin neighborhood of San Francisco in a nested fashion through a historic, sociological lens. The chapters build upon on another, with each addressing a different conceptual layer, and each subsequent chapter building on the prior. Chapters were concluded with a brief discussion about how places shape health, especially drug and alcohol use. In Chapter II, I presented a social history of the Tenderloin. Using primarily historical accounts, documents, and maps, I discussed the origins and development of Uptown Tenderloin, from the days when it was called Saint Ann's Valley up to its diverse social composition today. I focused on how the neighborhood was used, and the factors that made up its function and identity. Significant to this discussion were the "deviance" industries that fueled San Francisco's early cultural and economic development, the built spaces of the neighborhood (especially the many hotel-style buildings), and the national polices and trends that shaped the face of American cities over the decades. Throughout the overview, I emphasized that the social construction of the Tenderloin was driven by structural elements. Race, gender, and class dynamics created the notion of the Tenderloin as a stigmatized, marginalized, policed space, and these notions continue to persist today.

In Chapter III, I described how through this history, the neighborhood developed into the "containment zone" that dominates the narrative about the Tenderloin neighborhood today. I argued the Tenderloin containment zone has four central features: first, the Tenderloin is a central meeting place for a larger drug market. Both drug dealers and consumers "commute" from other parts of San Francisco and the Bay Area into the Tenderloin to transact drugs. Second, the Tenderloin is a neighborhood where poverty and the risks of the larger drug

marketplace are transferred and concentrated. This outcome is the result of an ongoing historical process involving multiple groups (possessing varying degrees of power) contesting over the Tenderloin identity. Third, the parallel practices of extensive policing and surveillance (formal and informal) are intensified in the Tenderloin. Forth, for Tenderloin residents, particularly if they are involved in drug economies or addicted to drugs, the containment zone is a space they are physically or symbolically tethered to. The containment zone analysis provided an example of how communities, which are situated in local, national, and even global contexts, undergo ongoing contestation by groups and people.

In Chapter IV, I examined social relationships in the Tenderloin, focusing on how the containment zone explored in Chapter III affected interactions and networks among women living in Tenderloin hotels. I found that women do indeed have only a few people they called "friends" – friends were the people they could unconditionally trust. However, in almost all cases, women had much more wide-ranging social support networks – a larger group of people they relied on for support ranging from emotional to informational to financial. Yet I also showed that there were risks to having social support systems that the women constantly recognized. The circumstances of relationships could change abruptly due to incarceration, death, conflict, and a slew of other common instabilities - sudden and dramatic losses linked to the intersection of drug use and poverty. As a result, relationships for women living in Tenderloin hotels were characterized by what I called *calculated associations* – the multiple ongoing interactions and social supports, which were buffered by varying degrees of self-protection. Physical and social boundaries were used to balance the opportunities and risks of relationships.

Above all, throughout the dissertation, I stressed that concepts that seem obvious – places, communities, health – are constructed, deeply contested concepts that mean different things for people based on power circumstances. This analysis leads to several implications for health. Multiple areas of health are addressed in this chapter since the focal health topic, substance use, is related to physical, mental, emotional, social, and economic health. The health findings are organized into two categories: contributions to sociological theory and methods, and substantive implications for community-based health service delivery.

B. Contributions to Sociological Theory and Methods

1. Clock Gear Model – A New Conceptual Model for Examining Places

Before I engage the substantive implications, this dissertation offers several key contributions for sociological theories of places and health. The first is a new model I call the *clock gear model*, which I developed to help conceptualize the historical, dialectical, contested relationship between places and health. One of the main concerns of contemporary place research is whether and how neighborhoods affect the health of its residents (Small and Newman 2001). In recent decades, *social ecological models* have been a popular approach in both public health and sociology as a way to conceptualize how people interact with multiple levels of physical, social, and ideological surroundings. The popularity and widespread use of these models was apparent to me last year at the ASA Annual Meeting in New York City as I presented the docent tour method in a session called "Social Ecology of Drug and Alcohol Use".

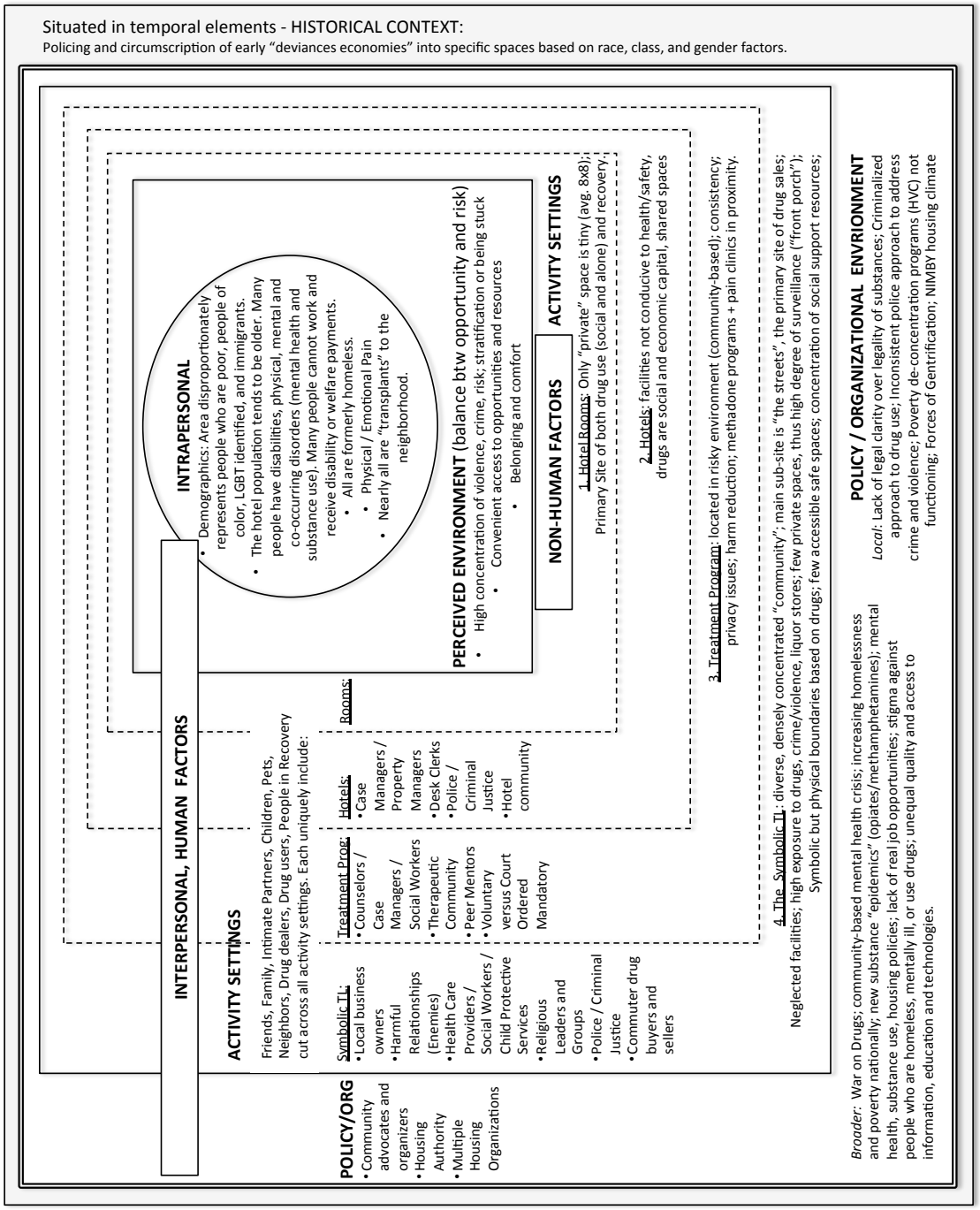
The purpose of ecological models is to shift the focus of health interventions from the individual-level into the *places* where health is enacted, and to explore how places affect health, with the goal of developing "place-based" interventions. There are several types of models, and

in summarizing their key concepts, Sallis, Owen and Fisher (2008, p. 466) suggest robust social ecological models contain the following four general principles:

1. There are multiple influences on specific health behaviors, including factors at the intrapersonal, interpersonal, organizational, community, and public policy levels.
2. Influences on behaviors interact across these different levels.
3. Ecological models should be behavior-specific, identifying the most relevant potential influences at each level.
4. Multi-level interventions should be most effective in changing behavior.

Based on example models (see Sallis, Owen, Fisher 2008) and guidelines like these, I built a social ecological model of health in the Tenderloin (Figure 5.1). I tried to adjust the content of typical social ecological models in order to underscore the contested and historically informed circumstances that I examine in-depth in this dissertation as influential to people's health in the TL. In the social ecological model, there are intrapersonal, interpersonal, and extrapersonal factors. The individual, who has unique intrapersonal characteristics, is influenced by key activity settings (hotel rooms, buildings, the streets/neighborhood), which have fluid boundaries. Within each activity setting, there are unique groups of people and physical objects/architecture that the individual encounters and interacts with. There are also policy and historical contexts that situate these interactions.

Figure 5.1 – Social Ecological Model of Substance Use in the Tenderloin.



In recognition that places structure health, social ecological models like the one I made have provided the public health community with a broader and more nuanced, less individual-focused lens. They give researchers, providers and policymakers a framework to imagine and study how many types of physical and social settings work together to influence a specific health domain. However, social ecology also has its limitations. First, the social construction of places is not included and not problematized in social ecological models. Rather, the contents of social ecology, indeed even its name, to me suggest an underlying natural or organic development to places, versus a *constructed* one. The historical social construction of the Tenderloin, which I discussed in Chapters II and III, has major implications for understanding health (Who defines, owns, accesses, and regulates health? What role do social factors like stigma and inequality play?). Yet it is entirely missing from social ecological models. This absence reduces the possibility and importance of thinking about health and places as outcomes of power struggles and social inequalities. Related is the second point that social ecological models rarely theorize places as *actively* contested, which is important for conceptualizing health realistically. Social ecological models offer a snapshot of place factors that may affect an individual, but rarely envision the factors themselves as entangled in a struggle for power and resources among themselves, as I have shown is the case through Chapters II-IV[30]. Related again is the third issue, that at the center of all social ecological models is the *individual*. The models are used to interpret how the various environmental contexts factor into individual behavior or decision-making. The individual is always at the center, the focal point of the health models. However, this somewhat contradicts the reality I observed while working in the Tenderloin. Although individuals had some choice when it came to their health decisions, the environmental factors,

[30] Clarke (2005) has argued that using approaches like situational analysis, which underscores the historical, anti-positivist, interactive, and variability of social ecologies, and the positions of (and differences among) its actors, is a way to address places in a postmodern framework.

the historical factors, and the social factors routinely played a deterministic role on the definitions of health, health needs, and the available health. I examine the deterministic, fundamental role of environmental factors in section B.3 below, which I argue not only shape but determine an individual's health decisions. Thus while social ecology models tend to conceptualize environments as background factors that influence health decisions and behaviors, I argue that they play major role in determining these activities. The social, historic, political, and environmental factors shaping health, therefore, are more than contextual concepts; rather, they should be viewed in parallel to the individual's actions affecting health.

To overcome the issues of place-based conceptual frameworks lacking the contested, historic, constructed realities of places, I developed a supplementary model that I call the clock gear model (Figure 5.2). The model was motivated by Chapters II-IV, which emphasized the social construction and contested meanings of places and health. The model is not a clock that gives us time, rather it helps us to think about how the built environments of places (social and physical) affect health over time through struggles between people/groups with varying degrees of power. In the model, the face of the clock and its gears reflect the time point of interest – in the model below, the time point is Tenderloin 2013, but we can imagine the clock set to any time point, even to the future. To examine health in the Tenderloin, the model stresses that we cannot simply look at the "health in place" symbolic hour hand. This is because the symbolic hour hand is a product of the minute hand, the second hand, and the very mechanisms of health that are inside the clock - the gears. The metaphoric clock gears are people and groups - those who are competing for power and resources in the Tenderloin. These stakeholders can be from within the place, or they can be outside factors that play a role in the environment. Each person or group may be a gear of its own, or even be represented by multiple, competing gears (ex. the landscape

of modern community-based organizations may be represented by several gears of different sizes, going in different directions.) As these gears compete with one another through actions, interactions, and counteractions, they create social activity in the place, which is manifested through the movement of the symbolic second hand of "social activity". As social activity occurs, the symbolic second hand pushes forward the development of the symbolic minute hand - the distinctive "objects, functions, and identities". These are the *built* social and physical constructs of places. The minute hand is slower and thicker than the second hand because these constructs have some degree of inertia once constructed. As the symbolic second hand of social activity continues to move around and around, within the context of the built and physical constructs, they are also shaped by these constructs. The outcome is hour hand, "health in places". Health in places is not a predictable outcome like the time of a clock, but like time, it represents the activity of the clock hands and gears over a historical period.

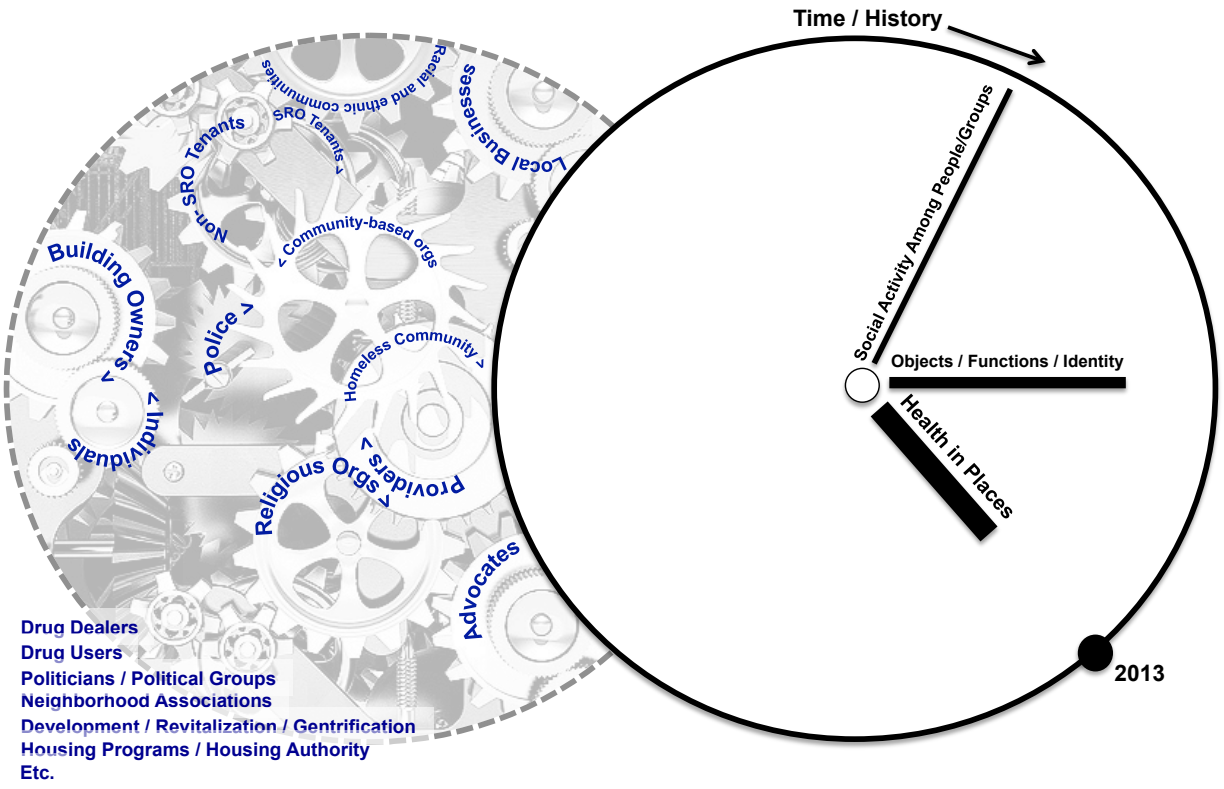


Figure 5.2 – Clock Gear Model

I stress that the clock does not provide the perfect metaphor, especially because the clocks we are familiar with are systematic and predictable. We think of clocks as mechanistic, gears working together in harmony, reliably keeping perfect time, and the model is therefore at risk of being interpreted as functionalist in implication. However, the intention of the model is not to suggest that the gears work in harmony to affect the hands in a predictable way. Rather, the gears symbolize that there are many people who act, interact, and counteract, producing processes and actions that affect health. From close up, the gears seem chaotic – even likeminded groups, like community organizations, neighbors, business owners, may crank in different directions with varying degrees of power. Yet from a distance, or cumulatively over time, they

are also somewhat systematic in that the power struggles are definable by inequalities along structural elements like race, class, gender and sexuality.

Despite its limitations, the clock gear model is useful for reminding us of what health in places, the hour hand, represents. It represents far more than an individualized, behavioral conceptualization of health. Health in places, regardless of what type of health one is examining (mental, physical, drugs, emotional, community, individual etc.), is the dynamic product of the ongoing struggle for power between the people and groups of a time point, set within the context of prior social histories. Thus when we check on "health" in a particular place at a particular point in time, we are seeing a complex manifestation of the contested activities (gears), and the dialectical relationship between activities (second hand) and social constructions (minute hand).

The clock gear model provides a conceptual basis for understanding historic social conditions and power struggles, especially those defined by race, class and gender, as a fundamental cause of health, risk, illness, and disease (Link and Phelan 1995; Williams and Collins 2001), which I explore further in B.3 below. The clock gear model also allows researchers, policy makers, and providers who are concerned with places and health to envision the subjectivity and political constructions of health – what type of health is available in a given place? What kind of access is there to health? Who is exposed to risk? Health has several definitions: the absence of disease and pain; mental, physical, emotional, health; and social wholeness or ability. There is moral authority in categories and definitions of health - poor health related to substance use, homelessness or mental health issues are stigmatized. And since health itself is obtained or sustained through good food, medicine and health care, safe environments, etc., it can also be thought of as a commodity that is bought and sold. Health then is owned by some and not by others. By examining how health is constructed and experienced in the

Tenderloin, the model stresses the political implications of these meanings, particularly within the race, gender, sexuality, and class structures that have driven this neighborhoods development.

2. Docent Tour Method – A New Participant-Guided, Place-Based Method

A second contribution of this dissertation to sociology is the *docent tour method*, which I described in detail in the introduction (See I.C, Page 9). In summary, the docent tour method is a place-based audiotaped and photographed walking interview that is designed so that expert docent participants (residents of the neighborhood) guide the researcher on systematic tours of key spaces of interest. In this study, the key spaces were the Tenderloin hotels, the "streets", the substance use treatment programs, and any "safe spaces" the participants identified. The docent tour is based on a hybrid of grounded theory, ethnography, walking interviews, and community-based participatory methods.

The method can be used for many purposes but I designed it out of specific necessity. Everyone who worked in the TASH program knew that the Tenderloin environment was a major factor affecting the health of TASH participants. And we knew that the environment was often a barrier to people's participation in the drug and alcohol treatment program. We needed to understand and characterize the environment because it was clear from our observations that the environment was a weighty factor that affected the outcomes and success of the program. This topic was discussed in several staff meetings. Data about places had to come directly from the participants since they were the only ones who understood these environmental effects, thus we needed to talk to them and other residents of the neighborhood. And since as a sociologist I conceptualized places and health as broad, contested concepts, it was important to me that the methods capture an array of place-based perspectives from the point of view of as many residents as possible.

Out of these needs, opportunities, and constraints, I developed the docent tour as a methodical and structured, but participant-guided and wide-ranging approach for studying places. The docent tour method is participant-guided – it enables us to examine the neighborhood dynamics historically, socially, and functionally from the perspective of its residents. But since it is designed with an interview guide, and specific spaces are visited with each participant, the same conceptual spaces and questions are visited over and over again. This allows a broad but also specific, systematic, targeted qualitative analysis of places.

I also suggest the docent tour method provides one way to conduct translational sociology – methods for researching environments based in sociological theories, which can produce outcomes translatable for use in community-based health organizations. There are several ways the docent tour method can be used by community-based health organizations. For example, in programs like TASH, the docent tour can be included as part of the participant's intake into treatment to learn more about the unique barriers and facilitators to health that individuals encounter in their community; the environment-based risks identified by participants can be used to set practical treatment goals or inform curriculum and discussion; and the practical harm reduction and risk management strategies identified by participants during docent tours can be developed into a strategy compendium that can be used in group treatment or one-on-one meetings. If the docent tour is regularly used, over time, community-based organizations can gradually build a participant-driven institutional memory of how specific places shape people's substance use and health.

3. Social Stratification and Fundamental Cause Theories

Social stratification is a significant theoretical framework that sociologists have used to examine inequalities. The basic concept of social stratification is that complex social institutions

exist that create multiple inequalities, including social, economic, educational, health, and more. The exact definitions and contours of these inequalities are actively debated, but social stratification entails the following concepts: 1) inequality is based on comparison. It is based on the distribution and concentration of access, resources, and wealth with some individuals/groups, and not others. 2) Systems of stratification are ridged. Pathways out of inequality are rare, and inequalities therefore persist over time. 3) Social inequalities and stratification systems are defined by structural categories, such as race, class and gender. At the same time, there is enduring ideology that status in social systems is merit-based. 4) Stratification is based on a set of resources and opportunities, ranging from economic to cultural to political. The more of this set an individual or group has, the stronger their social status (Grusky 1994).

The theory of social conditions as a fundamental cause of illness and disease (Link and Phelan 1995; Phelan, Link, and Tehranifar 2010) is a way theories of social stratification have been applied to understanding health disparities. The authors argue that there is a persistent relationship between low socio-economic status (SES) and high mortality rates. Access and deployment of resources (money, knowledge, power, prestige, and beneficial social connections), which are unequally distributed in society, is the key factor in understanding this association because these resources are used to avoid risks or to reduce the consequences of illness when it occurs. Over history, the association between SES and health has been explained through mechanisms like sanitation, diet, or behaviors like smoking or drug use, but the authors argue the underlying factor driving these explanatory mechanisms is SES itself. That is, socioeconomic status, not the health behaviors or choices, are the fundamental cause of illness and disease.

The analyses of the Tenderloin as a containment zone, especially the points raised in Chapter III, contribute to the theories of social stratification and fundamental causes of disease. The Tenderloin provides an example of how social stratification can occur *in and through places*, and how fundamental causes are operationalized in places. The elements of stratification - the persistence, rigidity, and the institutional reinforcement of inequality along structural lines - were evident throughout the interviews I conducted. Every Tenderloin resident I interviewed was born into low socio-economic status, and most were women of color. Low socio-economic status was generational in almost every circumstance, as most women were born into families with very limited resources. Each woman I asked had at least one parent who was involved with substances or drug-related economies. Each participant arrived in the Tenderloin because she was homeless, and the Tenderloin has become the de facto neighborhood for housing the city's homeless population, a process that has concentrated poverty. As I discussed in Chapter III, a complex of institutions (ex. federal housing policy, local housing policy, neighborhood associations, housing organizations, gentrification) have engaged in political battles over affordable housing, which for now assures the persistence of poverty concentrated in this neighborhood. The neighborhood provides its residents opportunities and resources, such as social and health services, but these are highly fragmented (imagine the Korean War bridge). Therefore despite massive efforts, there are few viable pathways out of poverty and the neighborhood. Indeed, the women repeatedly described feeling physically, socially, and economically "stuck" in the Tenderloin – a poignant symbol of stratification.

Meanwhile, the social conditions of the Tenderloin affect multiple aspects of the health of its residents, including physical, mental, economic, emotional, substance use, and social aspects of health. It is a destination, chosen or not, that contains a concentrated population of people with

health issues related to the most severe low SES circumstances – homelessness. It is also a neighborhood that potentially exposes residents to risks that can harm health. I argue that the neighborhood effects are related to a fundamental mechanism – lack of access to, and deployment of, resources like money, power, knowledge, status, and social networks. In conceptualizing how the resource mechanism works, Link and Phelan suggest that they shape both the ability to avoid risks *and* to reduce the consequences of illness when it occurs. This concept is similar to theories of "risk environments", an approach harm reduction drug and alcohol researchers have used to think about the advantages and disadvantages of environments (Rhodes 2002; Rhodes 2009). Risk environments are social and physical spaces "in which a variety of factors interact to increase the chances of drug-related harm" (Rhodes 2002:88). Places shape people's substance use and health by 1) increasing their susceptibility to health risks, like access to drugs, and 2) reducing their ability to protect themselves from the harmful effects of risks, creating vulnerability (Barnett et al 2000). Combining Link and Phelan's fundamental cause theory with the place-based concept of risk environments enables places to also be conceptualized as potential fundamental causes of illness through the mechanism of unequal resources.

Examples of Environmental Susceptibility and Vulnerability on Substance Use

Throughout the dissertation, I have presented multiple examples of how the Tenderloin both increased residents' susceptibilities and vulnerabilities to risk. Here (and in the substantive implications below) I summarize some of the tangible, specific ways the processes of susceptibility and vulnerability occurred for people with major substance use histories. I emphasize that it is not possible to describe the relationship between the Tenderloin and health

categorically, because the quality, resources, and location of women's salient environments varied widely (consider, for example, the differences in the Adult Building and Family building discussed in the extended exemplar in Chapter IV), as did their health needs. With these caveats in mind, I describe the everyday ways blended conceptual spaces affected health in different types of spaces and settings. The spaces I focus on are 1) the hotel rooms and buildings, 2) the Tenderloin neighborhood and streets, 3) the substance use treatment program, and 4) safe spaces, because these were the places salient to drug and alcohol use that were target locations of the docent tour interviews.

In considering susceptibility and vulnerability to risk, it is important to recognize that risk is not simply present or absent, rather it exists on relative scales that shift as people move through different places and periods of their lives. Hotel housing in the Tenderloin presented specific risks. Yet the hotel risks were of a different scale and type than the risks docents were exposed to on the sidewalks, shelters, and abandoned buildings they lived in when they were homeless. The perception of harm and risk for the women I interviewed in the hotels was always in relation to past experiences of homelessness. Given this, when I asked participants how obtaining permanent housing affected their substance use, I hoped they would all say they reduced drug or alcohol use. What I discovered, however, is that the way housing affected tenants substance use experiences seem to be temporally patterned: at first, affordable housing in the TL exacerbated substance use because of the many triggers, the availability of drugs, and the basic fact that housing provided a safe, stable space to use drugs privately. Over time, the pattern seemed to diverge. Some women like Roxie, Barbara, Abby, Erika, and May adjusted to the environment by taking advantage their newfound of stability to work toward regaining some control of drugs and alcohol in their lives. Yet several women like Sonny, Pam, Ruth, Erin,

Claire and Beth became more deeply mired in addictions, a process that involved painful back-and-forth struggle between managing the harms of drugs and alcohol with the obvious relief they provided. This struggle is played out, in some cases for decades, in a world where addictive substances are readily available.

Women's substance use histories almost always preceded life in the Tenderloin, but several docents made it clear that the neighborhood did impact women's substance use. One obvious way was through the enormous exposure to what the docents referred to as "triggers" – the sights, sounds, smells, people, memories and experiences that sparked or exacerbated substance use cravings. The meaning of triggers seems intuitive, and both researchers and people who use substances frequently evoke the concept as part of the experience of addiction, but the way triggers are theorized is complex and debate[31]. Oversimplifying, triggers are conceptualized as the link between the outside external world and the physiologic responses experienced by people with addictions in their bodies. When triggers are described in the literature, their basis varies – they can be positive associations with substances, but they can involve the use of substances to cope with acute or historic stressful experiences (Waldrop et al 2007).

There are many issues with these neuroscientific or brain theories of addiction, namely their individualized, mechanistic approach, but the concept of triggers is useful for explaining how the women described environmental affects on their substance use. In the Tenderloin, women were enveloped by substance use triggers. That is, *they were enveloped by substance use susceptibilities.* Sometimes triggers were physical, like the sound of a lighter, the smell of smoke in a hotel hallway, the sight of people using and selling drugs in their rooms, or the pain of substance withdrawal. Sometimes women related triggers to circumstances of access, such as

[31] It has been explained as a psychological or neurological concept, as the connection between external factors associated with drug use, for example an "explicit memory of past pleasure", and a positive dopamine response in the brain resulting in physical cravings (Robinson and Berridge 1993).

getting paid, having a partner who uses drugs, or knowing dealers who provide drugs on credit. Most often, however, the triggers of substance use described were emotional and social – drugs and alcohol were ways to cope with boredom, loneliness, difficult memories, hurtful relationships, depression, illness and death, and feelings of stress, anxiety and guilt. While some of these triggers were historic factors of the women's lives, yet others can be traced directly to their stressful, crowded, stuck lives in the substance-dense containment zone of the Tenderloin. I argue for many women, the density of triggers, combined with the widespread availability of many types of substances, considerably decreased her chances of overcoming addiction in the Tenderloin. Even for those who were highly motivated to quit or reduce their use, like Erin and Ruth in the previous chapter, the constant onslaught of triggers made achieving lasting goals a perpetual struggle. For people who are in recovery, any progress at reducing or abstaining from drugs or alcohol is relentlessly, continuously threatened. The environmental susceptibilities to substance use were profound.

Another way the rooms and buildings affected health was through vulnerability - by decreasing women's ability to protect themselves from the health risks related substance use. As I described in Chapter III through Molly's example, participants have faced major challenges to simply maintaining health in the hotels, and multiple docents I interviewed have filed complaints with the San Francisco Housing Authority for not providing basic, reasonable accommodations. Many very basic resources required to be healthy that are taken for granted outside the Tenderloin are limited or unavailable to women in the hotels. Running water in rooms, control over cooling and heating, and personal bathroom or kitchen facilities were almost non-existent in Tenderloin hotels, which posed harm especially for residents with complex disabilities and health needs. Several of the hotels have major problems with pests, such as bed bugs, fleas, flies,

roaches, and mice. Another docent told me that the shared laundry machines in her building didn't get hot enough to kill pests like bedbugs, so tenants resorted to spraying chemicals or bleach. The ventilation in the buildings was poor, which is especially problematic since some people smoke cigarettes and drugs in their units. Finally, as I devoted Chapter IV to, environment-based social dynamics also increased vulnerability. Due to the intersection of poverty and the hazards/criminalization of substance use, the women had few close friends and tenuous social networks. They therefore had less access to social stability, support, and protection. At times, this resulted in isolation, which is an influential health risk (Cornwell and Waite 2009, Locher et al 2005). These are just some of the ways the environment presented barriers to health, and increased vulnerability.

This brief examination of the Tenderloin susceptibilities and vulnerabilities demonstrates that the neighborhood does indeed shape its residents health. Affordable housing in the Tenderloin offers women greater access to health than circumstances of homelessness (risk and health are temporal), but the neighborhood nonetheless continues to expose residents to health risks vastly disproportionate other San Francisco settings. I argue that this finding brings attention to the health, social and ethical need to develop affordable housing in settings that *minimize* rather than increase exposure to risk. Developing affordable housing in other neighborhoods, in addition to the Tenderloin, is one possible way to mitigate the fundamental, SES-based affects on health. This would not only create pathways out of the Tenderloin for the people who want or need it, but it would also reduce the pressure and concentration of inequality and risk in the Tenderloin neighborhood, allowing it to be a stronger, healthier low-income community.

C. Substantive Implications for Community-Based Health Services Delivery

In this subsection, I refer to TASH as an example often because I worked as an on-site consultant evaluator for the program for five years. Because of my familiarity with the program, it provides a good example of research that led up to the community-based implications I discuss. However, I stress that the implications below are not necessarily derived from, nor do they specifically apply to, the TASH program or its sponsor organization, Community Housing Partnership. The TASH program was just one of roughly a dozen community-based programs where I gathered data. Also, although many of the women I interviewed lived in buildings owned or operated by Community Housing Partnership, about 25% of the participants in the study lived in permanent supportive housing provided by other housing organizations. Therefore the implications I discuss here are more broadly directed toward providers, researchers, community-based organizations, and people interested in health in places.

1. How Places Shape Community-Based Health

The most apparent substantive implication is the need for increased recognition that places impact health. Place-based health delivery is a public health ideal worth striving toward but as I have shown through numerous examples throughout the dissertation, places can involve both advantages and disadvantages. Place-based programs can improve access for large numbers of people in a targeted fashion. Programs can become stakeholders and advocates within the community, and can promote resources and healthier lifestyles. If there is local buy-in, there is even potential for community empowerment. But in the Tenderloin, providing substance use treatment services in-place means doing so in the thick of numerous substance use "triggers" or temptations – amidst the city's epicenter of drug dealers, social networks of substance users. The clients of the TASH program who are seeking help for substance use issues, for example, are

tasked to undergo recovery in this environment that presents an overwhelming challenge to even the most resilient residents. This issue seemed to be more acute when the TASH program moved from Market Street to Turk Street at Leavenworth in 2012. The new site of the TASH program was specifically high on the list of places avoided by the docents I interviewed. It was decidedly outside their safe "yellow brick roads". That is, the site where hotel tenants were expected to address their drug and alcohol problems was precisely the site that they knew to be dangerous. Although place-based health delivery increases access to health care services, the possibility of exposure to harm must also be recognized, which can actually deter clients from participation, or even worse, increase stress and risk.

Merzel and D'Afflitti (2003) reinforce the problematic double-edge of place-based health delivery in their review of thirty-two community-based public health prevention programs. They demonstrate that with the exception of HIV/AIDS programs, most community-based intervention programs "have not demonstrated substantial program effects in a number of other health areas, including substance use" (p. 563). They argue that although community-based programs are essential for health delivery, the modest programmatic outcomes are attributable to a number of factors, primary among them methodological and measurement issues consistent with the themes raised by this dissertation: how should community-based organizations define places or communities? Since health is contested, what program effects are we expecting, and how can we measure them? A second concern is the small scope of most community-based organizations and interventions compared to the enormous, complex demands placed upon them, particularly in the mental health and substance use service fields. They also raise the concern that there are often differences between the goals of researchers, organizations, and the residents of communities, which presents intervention and evaluation issues.

I do not argue against community-based health services delivery, because it is indeed incredibly pivotal for providing services to people in need. The residents of the Tenderloin would have far less resources without the work of these organizations. Rather, I stress that places are broad factors that directly affect the success of all community-based programs. Therefore to optimize how health is delivered in places, community organizations must examine and understand *how places are used* by the clients they hope to serve, and incorporate these environmental functions into their program goals/services/decision-making. In the micro-neighborhoods of the Tenderloin, there are specific locations that present a high level of risk, and yet other locations can provide access while reducing risk. Even a few blocks can make a major difference in risk. The unique neighborhood dynamics can be explored by community-based organizations through methods like the docent tour, or any number of the place-based methods I discuss in Chapter I, toward the goal of folding places into health delivery.

This leads to the third important implication for community-based health. Places also underscore the challenging position the people who provide services – the social workers, treatment coordinators, case managers, counselors, nurses, doctors, tenant services etc. – are in. Through this dissertation, I have shown that people working in communities like the Tenderloin are expected to support extremely poor clients with complex personal histories and health concerns (ex. physical disabilities, substance use, mental health issues, brain injuries, trauma) far, far downstream within the riptide of drugs, alcohol, stress, violence, and poverty. The job is undervalued and under-prioritized politically[32], which exacerbates its stress and difficulty. Many community-based health and social service organizations rely on private donations and

[32] One glaring example is when in 2011 Congress cut the emergency food and shelter program by 40%. San Francisco no longer qualified for funding because the city's poverty rate wasn't high enough (another effect of wealth disparity), leaving food banks and other free/low-cost food service organizations scampering for alternate ways to provide food for the poor.

fundraising to keep their health programs going because grant-based funding streams are often fragmented and short-term. This means community-based organizations must spend much of their staff time and effort working to find funding to stay afloat – time that could be spent directly serving the community. The TASH program, for example, which provided an invaluable service of one-on-one and group harm reduction therapy for formerly homeless women and men in the Tenderloin, has ended its 5-year SAMHSA funding term, and closed doors in October 2013. Despite many meetings and grant chasing, there were no financial avenues to keep the program running. Some of the treatment staff have been hired to provide on-site clinical services to tenants of Community Housing Partnership, but the formerly homeless community at-large has lost one of the few places they can receive free, daily harm reduction substance use services. Nowadays, 5-year SAMHSA grant opportunities are rare. Finally, it is also important to point out that people working to provide services are exposed to many of the same environmental stressors as their clients, and are not allocated the funding and resources to combat or manage these stressors for themselves. It is no wonder that burnout rates for mental health providers in communities are exceptionally high (Rossi, Cetrano, Pertile, et al 2012), even higher than for staff in hospital settings (Prosser, Johnson, Kuipers, et al 1996).

2. Calculated Associations: Therapeutic Relationships and Health Delivery

The final substantive implication I discuss is the way the Tenderloin shapes clinical/therapeutic/health relationships. The analysis of relationships (calculated associations) is also a theoretical contribution, but I discuss it here because it directly shapes community-based health service delivery. Relationships women had with people employed in a supportive role, like social workers, therapists, doctors, advocates, etc. were not discussed in Chapter IV, but

these relationships were vital to the women I interviewed. Like the relationships among women in hotels, these relationships were also *calculated associations*. Community workers were critical supports that women valued and relied upon frequently. Most everyone working in housing and health in the Tenderloin, including myself, did so out of a deep desire to help and not harm. Yet there were many examples of providers or staff employed in supportive positions creating *increased* stress or risk for participants. These examples were often linked to the criminalization of substance use. For example, personal drug use is a topic that was cautiously discussed in the TASH program and other treatment programs. The involvement with drug sales, large or small scale, on the other hand, seemed to be more rare of a discussion. I argue this is because of the hazards the conversations presented – people who sold drugs were at risk of being stigmatized or criminalized; clinical staff managing discussions were in a conflicted position in the context of drug treatment. Women who had substance use problems with children seemed to be in a particularly conflicted relationship with those working in health and housing. They were at risk of losing their children if they acknowledged their substance use, and perceived this risk even in private circumstances with counselors they trusted.

A subtler vector through which people working in a supportive role could present risks is though stigma. The importance of stigma was clear to me earlier this year when a Vice magazine interview, "Social Work in the Tenderloin Will Kill Something Inside You," (2013) went viral, sparking controversy among community advocates of the Tenderloin. A social worker who spent a few years working in the Tenderloin provided a number of decontextualized, scathing comments about the neighborhood:

> "Paranoid clients like to fixate on witches, Satan, etc. Anyway, we get ready to open and hand out checks to the clients who are either on daily budgets, or who make random check requests. The budgeted clients are the most low-functioning, as they can be restricted to as little as $7 per day in order to curb their harm reduction. They'll go and

> spend that $7 on whatever piece of crack they can find, and then two hours later they're back, begging for more money. Clients will find some really brilliant ways to beg . . . It's a fucked place: human shit smeared on the sidewalks, tweakers sitting on the corner dismantling doorknobs for hours, heroin users nodding out in the middle of the streets, drug dealers paying corner store owners $20 to sell in their stores, dudes pissing on your doorstep as you leave for work, etc."

Most community reactions to the article were blended between the two following: to some, the article represented the bitter truth about working in the Tenderloin. To others, the viral article was detrimentally stigmatizing and stereotyping of the residents of the neighborhood and recipients of social programs[33]. It raised the negative imagery and fears people had about those who are mentally ill or poor, and undermined their deservedness for health services. The harm was amplified because the stigma came directly from a person in a social work position, a person trained to help and protect people from harm. Regardless of one's position, the controversy was a tangible example of how the perpetuation of stigma by some providers was real.

Most programs and providers work very hard not to stigmatize clients. The curriculum and training at programs like TASH, for example, were entirely designed around supporting clients' substance use issues in a de-stigmatized way. Even for programs like TASH, however, a more subtle form of stigma is feasible if the social environmental context is not actively addressed as a part of treatment. In examining the Tenderloin environment, it is apparent what people with major addictions are up against if they want to reduce or manage substance use harms, which they often do desire. There are tremendous social environmental barriers to health, a high degree of exposure to harms, and a dearth of pathways out. Despite this context, most community-based substance use treatment programs ranging from harm reduction to AA or NA stress the individualized, "you can do it", willpower, inner-strength-based strategies for

[33] The article also involved violations of privacy. The original article contained photographs of clients and photographs of handwritten notes given social worker by clients. These photos were redacted.

treatment. These strategies are no doubt important to managing or reducing substance use. However, in the context of the Tenderloin, they are at risk of discounting the formidable importance and function of drugs in people's lives. In an ethnographic study of injection-drug users in San Francisco, Bourgois and colleagues (1997; 1998) showed how the biological imperatives of heroin addiction (avoiding painful withdrawal), the social and environmental factors of 'shooting galleries' frequently called for risky behavior. They argue that these lived realities of substance use are not often addressed by the "self-help" message of treatment. That is, since the discourse around recovery is often individually focused, despite the massive, obvious triggers in the Tenderloin, the people with addictions themselves are responsible for developing the willpower to control their use. In turn they are blamed when inner strength and willpower are not achieved. I have found that blame is often internalized – in multiple interview I conducted, the women held themselves responsible for not being strong enough to control their drug and alcohol problems. When the social realities of substance use within difficult environmental contexts are not fully recognized and addressed in treatment settings, people who use substances can feel blamed and alienated, which can harm the therapeutic relationship and undermine health and treatment efforts.

The risks involved in interpersonal dynamics in the Tenderloin affect all types of health and therapeutic settings, particularly substance use treatment programs. A final implication is for group- and peer-based therapy, which is the foundation of substance use treatment programs ranging from harm reduction models to Narcotics/Alcoholics Anonymous (NA / AA). In group-based therapeutic settings, members of the group provide recovery support to one another by discussing experiences and challenges that stem from addictions, drugs and/or alcohol. Relationships between clients, as well as between the facilitator and group, are paramount to the

success of these approaches. Interpersonal dynamics are a challenge in all types of treatment settings, but in the Tenderloin, calculated associations elevated the potential for common ground but also for heightened personal/emotional/social boundaries. These boundaries are important consider for all health care settings and interactions where open, honest communication is key to positive outcomes.

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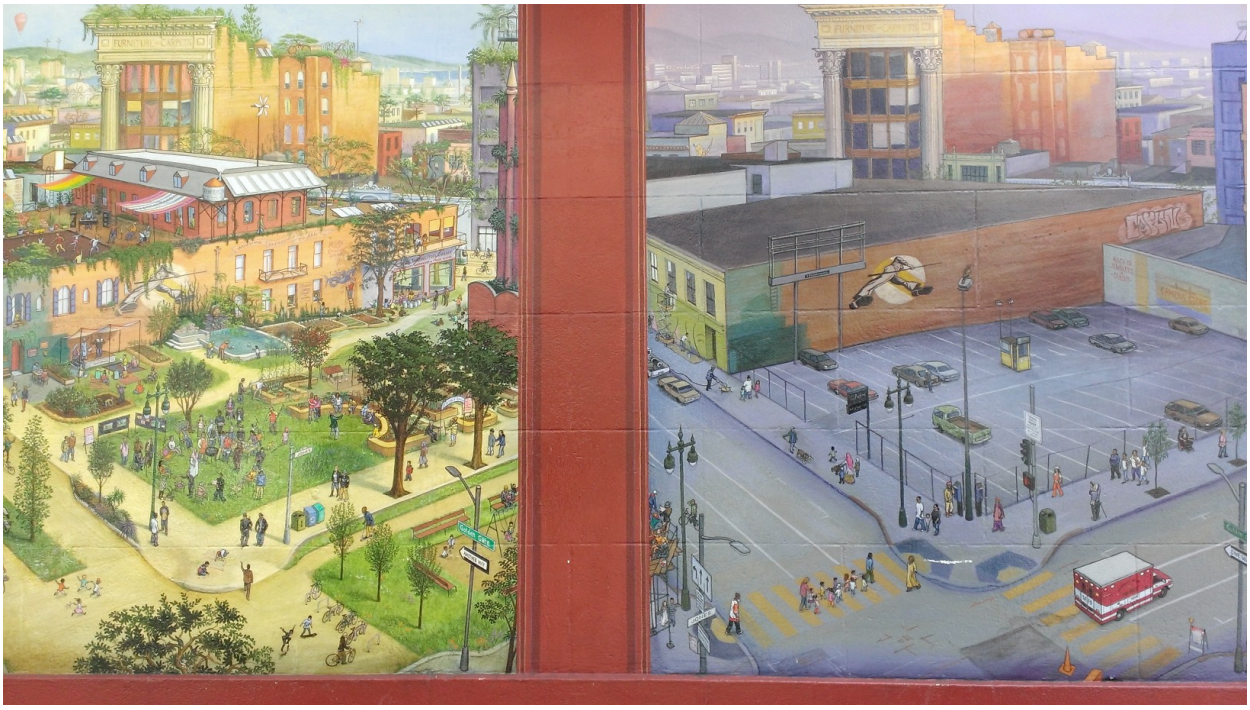

Figure 5.3 – Tenderloin Possibilities
"Windows Into the Tenderloin," mural by Mona Caron on Jones at Golden Gate. On the left, one possibility for the future Tenderloin. On the right, a depiction of the current Tenderloin.

In conclusion, I have presented a portrait of the Tenderloin neighborhood of San Francisco as a socially constructed place that is alive with history. This research, which was deeply informed by interviews and interactions with Tenderloin residents, is a step toward untangling the dynamic relationship between health and places. The identities, resources, activities, power, and inequalities in the TL continue to be contested – a struggle between groups

that seems to have reached fever pitch in recent years. It is unclear today what the Tenderloin will be in the decades to come, but change itself is a certainty.

The risks and harms in the TL are often the focus of health research, but I stress that poor neighborhoods also possess strengths and opportunities that are under recognized. For example, as I discussed, Tenderloin residents are more organized today than ever. People know one another, they are protective of others in their community, and informal social support is common even among strangers. These unique assets can potentially be studied and utilized to develop true community-based solutions to issues of health resources, information, opportunities, and supports.

This dissertation also demonstrates the importance and relevance of sociology to examining health. The contested and constructedness of health/place, the interpersonal dynamics, personal and physical boundaries, containment, stigma, stratification, and the many other sociological concepts discussed are factors that directly shape the health of Tenderloin residents every single day. A sociological lens enriches and informs providers, community-based organizations, policy makers, and researchers as we work together to improve health delivery and address health inequality in the historic Uptown Tenderloin.

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Appendix: People, Places and Things

People

Short Biographies

Abby is a 31-year-old white woman. She was removed from her mother as a child and lived in different foster homes throughout her childhood. She ran away from her last foster home around Stockton, California at age 14, and shortly after arrived in San Francisco. For over ten years, Abby was homeless, living on the streets, surviving primarily by panhandlings on Market Street. She was addicted to heroin until she became pregnant with her daughter six years ago. She, her daughter, and her daughter's father live together in Family Building with their small dog. She and her daughter's father do not get along well – they argued frequently over the course of the docent tour interview. Abby was not raised by a mother of her own, and she says it has been good but challenging to learn how to be a mother for her daughter.

Barbara, a 70-year-old white woman, moved to the Bay Area in 1962 following a divorce. She worked in a bakery in Berkeley, California that operated based on Buddhist principles. She experimented with drugs, but her major issue has long been with mixing prescription drugs with alcohol. She knows she has a mental health diagnosis, but doesn't know exactly what the diagnosis is. She lives in a newly constructed permanent supportive housing building in Western Addition area (operated by CHP), and is the only person I interviewed who lives outside the Tenderloin.

Beth is a 54-year-old white woman who was born in San Francisco and raised in the Outer Sunset neighborhood. She lost her home around 1996 following a divorce, a period that was too painful for her to discuss. She was homeless for about three years, living in shelters and on the streets, and addicted to crack-cocaine, which she still actively uses. She struggles with severe depression. She has lived in permanent supportive housing for fourteen years, but has never felt comfortable in the Tenderloin. She describes many negative experiences with friends, intimate partners, and other people in the community. She says she starts off every day attempting to gain control of her crack-cocaine use, but has never been successful.

Claire is a 50-year-old white woman. She was born into a military family and traveled a lot and a child. She began using substances at age 12, in junior high school. She is dually diagnosed with schizophrenia and major substance use issues. She is an injection drug user and lived in encampments with other homeless injection drug users for decades. She has been incarcerated several times for drug-related offenses, and has lost all four of her children to CPS. After being released from prison in 2003, she moved to the Tenderloin. She lives in permanent supportive housing with her partner.

Danielle is a 53-year-old black woman who lives in the same building as Beth. She is from Oakland, but moved to San Francisco in the mid-1980's when her mother made her leave home. She moved to the Tenderloin, initially living in the shelter system, and began using drugs (crack-cocaine). As she moved between San Francisco, Oakland, and

Sacramento over the decades, she struggled with addictions to crack-cocaine and methamphetamines and was also involved in sales. She loves her apartment (it's among the few with a private bathroom) but when she was moved into permanent housing two years ago, she began to use more substances. This was magnified when she went into a period of grieving – her only son recently died in a car accident. She sought substance use treatment through the TASH program for the first time in her life when I met her, and she has being doing very well in the program.

Erika is a 37-year-old black woman who grew up in the Potrero Hill projects. Her family was physically abusive, and she ran away from home at age 14, and moved to Modesto with a boyfriend (now deceased from gun violence). She, like Ruth, Abby, and several other docents, never made it to their freshman year in high school. She used to use powder cocaine, but she quit in 1996 when she developed health issues. She had a kidney transplant is currently on dialysis. In 1999, she moved to the Tenderloin and has lived in supportive housing she was 23. She is one of the few examples of younger women living in the hotels, though this number seems to be increasing. She uses cannabis and prescription opiates to deal with pain, and was once arrested and briefly jailed for drug possession. She is active volunteering in the children's program in her building.

Erin is a 42-year-old black woman who was born in central California. Her major substance use issues are alcohol, methamphetamine, and crack-cocaine use, and she is also diagnosed with bipolar disorder. She began drinking in junior high, and her parents were alcoholics. She has had several experiences with substance use treatment, and was referred to permanent supportive housing through a residential treatment program. She has one daughter (pseudonym is Lily) who she recently lost custody of. Erin is single and living in Family Building (same building as Abby).

Joanna is a 54-year-old black woman born and raised in San Francisco's Hunter's Point. She moved to Kentucky when she got married at age 16. After a brutal ten years of domestic violence, she escaped back to San Francisco with her small children and lived in a tent under the 101 freeway near Duboce Triangle for a year. For decades, she struggled with severe depression and addictions to crack-cocaine, prescription pills, and alcohol. Joanna and her children eventually moved back in with her mother, but when her mother passed away in 2000, Joanna became homeless again. She has lived in permanent supportive housing for over a year.

May is a 47-year-old Afro-Cuban woman who was born in New Orleans and moved to California in 1992. She used to be addicted to crack-cocaine, but quit about ten years ago. Nowadays, she smokes cannabis and drinks alcohol. She is diagnosed with bipolar disorder. She has had several brief periods of incarceration, in most cases for drug possession. For decades she struggled with major alcoholism also. She has six children, four of whom she lost custody of. When she divorced her last husband in 2008, she was homeless, living in shelters and on the streets with her two teenage children. Her life has stabilized tremendously since becoming permanently housed through CHP three years ago.

Molly is a 60-year-old black woman who was born and raised in San Francisco. She is single and has two adult children. She was paralyzed when she jumped from a third-story building window decades ago and relies on a wheelchair for mobility. Molly once worked in a support/advocacy role in community-based organizations, and she understands the social support and health landscape in San Francisco well. She has lived in permanent supportive housing since 2009 (same building as Pam). She is actively using crack-cocaine and prescription opiates. She wants undergo detox substance use treatment, but has not been able to access any programs.

Nina is a 40-year-old black woman who was born and raised in San Francisco. She has been a presence in the Tenderloin since she moved there as an eighteen year old. She doesn't know her mental health diagnosis, but told me she has been hearing voices since she was a teenager. Nina spent almost two decades living with partners, some of whom were pimps, dealing crack-cocaine, and working as a prostitute. After spending some time in prison, she found permanent supportive housing. It was the first time she had a permanent home since she was a child. With the help of this stability, and after a spiritual reawakening (Glide Memorial Church), Nina has been sober for a few months.

Pam is a 56-year-old black woman who lives in the same building as Molly. She currently uses crack-cocaine, cannabis, and she drinks a lot of alcohol. Pam grew up in what she described as a "Barbie doll world". She was raised by her grandmother in the Ingleside neighborhood of San Francisco, and went to private school. Her first partner was a drug dealer living on Haight Street during its heyday in the late 60's. She went to San Francisco State University for a few years (one of the few women to have attended college), and had dreams of becoming a journalist, but dropped out when she had her first child to earn money as a model and stripper. (Her mother and grandmother also worked as entertainers / strippers / sex workers.) Over the years, she lived in different parts of San Francisco and Daly City with boyfriends and husbands. She lost custody of both of her children due to issues with substance use, especially crack-cocaine. When I met her, it was her fourth or fifth experience with drug and alcohol treatment. She was suffering from major depression. She also had bone cancer (she showed me the massive lesion on her knee), and was refusing all types of treatment.

Roxie is a 60-year-old black woman who lives in the same building as Ruth. She was diagnosed with schizophrenia as a young woman. Her mother, who was her primary social support, passed away in 1985, and Roxie became marginally housed. She lived on and off with cousins in Richmond, California, who introduced her to crack-cocaine. To remove herself from her cousins, Roxie moved to the Tenderloin in 1987 where she was homeless and living in the shelter system and the streets. She obtained permanent supportive housing at Community Housing Partnership in 2008 and has been very successful in substance use treatment at TASH.

Ruth is a 48-year-old white woman who lives in the same building as Roxie. She is originally from Los Angeles, and moved to Northern California in her twenties. She used to work as a CNA, but lost her license when she was caught stealing pain pills from her job. She has been hospitalized with acute psychiatric issues several times. She has been

involved in an unstable, abusive relationship with her husband for about 15 years. The family has lived in and out of homelessness in San Francisco and in Richmond. She used to live in the Family building (same as Erin) until lost custody of her two children. (Her older four children were also removed from her custody.) Ruth actively used crack-cocaine and prescription opiates for decades, but is currently managing her substance use through methadone maintenance because she is being drug-tested by Child Protective Services. She does not believe harm reduction treatment programs work for women in her circumstances.

Sonny is a 54-year-old Asian woman. She was born in Japan and raised by her mother in San Francisco's Haight Ashbury neighborhood during its heyday in the 1960's and 70's. She was diagnosed with schizophrenia as a child, and, similar to both Joanna and Roxie, when her mother (her only social support) passed away, became homeless. She used crystal meth and crack-cocaine for over twenty years, which escalated after she moved into an SRO just off 7th Street in the Tenderloin "panhandle" in 1998. She's lived in the same 8 x 10 room, in the same building, and in the same neighborhood for fifteen years. She routinely isolates in her room to protect herself from the TL environment.

Places and Things

The Tenderloin is an unofficial neighborhood in the heart of San Francisco, approximately bordered by Cathedral Hill to the West, Market Street to the South, Downtown to the West, and Nob Hill to the North. It is one of the poorest and most densely populated sections of the city. It is a stigmatized neighborhood that had been characterized as a containment zone for activities unwanted elsewhere, especially drug sales and related crime/violence. It also contains a high concentration of social support services, including the housing and substance use treatment programs I studied. I conducted 95% of the docent tour interviews in the Tenderloin.

The TASH program, which stands for Treatment And Supportive Housing, is a voluntary substance use treatment program that is based in harm reduction principles (see harm reduction). This was the primary site for recruiting participants into the study. The TASH program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA, TI-020680), operated through Community Housing Partnership's clinical team, and is free-of-cost to anyone who lives in permanent supportive housing. Since it opened in 2008, it has had two locations – between 2008 to 2011, it was located on Market Street at 7th Street. After the lease ended on that location, the program was moved to Turk Street at Leavenworth Street from 2011 to its closing date in October 2013. The Clinical Services Director of Community Housing Partnership, a licensed clinical social worker, managed the TASH program with a team of three treatment coordinators. I have been a consultant on-site evaluator for the TASH program since its inception through DYJA.

Community Housing Partnership is one of many affordable housing organizations I studied that is centralized in the Tenderloin and operate on *housing first* principles (see

Housing First). The Housing Program is "supportive housing", meaning it provides both housing and supportive services. Most buildings operated by housing organizations like Community Housing Partnership are SRO hotels, but new buildings are also constructed from the ground-up.

Other Housing Organizations: Tenderloin Neighborhood Development Corporation, Tenderloin Housing Clinic, Mercy Housing, GLIDE Housing, and Episcopal Community Services, as well as the SF Department of Public Health Direct Access to Housing.

Housing first is a structural harm reduction intervention geared for addressing homelessness and the issues related to homelessness, especially mental health and substance use. It is one form of permanent supportive housing that is based on the principle that individuals with major substance use issues or co-occurring disorders require stable housing to focus on recovery goals. Thus, in housing-first programs, housing is not denied based on substance use issues, and abstinence from alcohol and drugs is not required for housing. Instead, residents are paying tenants with rights (1/3 of income is typical in SF) and are usually permanently housed. Often, supportive services like the TASH program are offered through housing first models.

Harm reduction is broad philosophy and social movement focused on addressing the harms of substance use (and other criminalized behaviors), without criminalizing or stigmatizing the person and the activity. It operates based on the following principles (Harm Reduction Coalition 2013):

- Drug use is part of our world - work to minimize its harmful effects rather than simply ignore or condemn them.
- Drug use is a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence. Some ways of using drugs are safer than others.
- Quality of life and well-being – not necessarily cessation of all drug use – is the criteria for successful interventions and policies.
- Non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live.
- Drug users should have a real voice in the creation of programs and policies designed to serve them.
- Drug users themselves are the primary agents of reducing the harms of their drug use. Users can be empowered to share information and support each other in strategies which meet their actual conditions of use.
- Poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect substance use and harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

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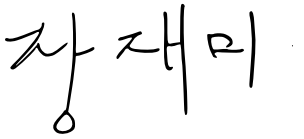

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