RESEARCH HIGHLIGHTS

Socio-Economic Series Issue 54

WOMEN ON THE ROUGH EDGE: A DECADE OF CHANGE FOR LONG-TERM HOMELESS WOMEN

Introduction

There have been major changes since 1988 in the profile of women's homelessness and the services available for them. For example, from 1988 to 1996, the number of homeless women using Toronto's emergency shelter system rose to 37 per cent from 24 per cent. Fewer homeless women have access to subsidized housing today than in 1988. More women have become homeless while at the same time, social housing and social service and health systems have become less able to help them. The result is that the most vulnerable stay homeless for longer periods.

Long-term shelter users (those who spend more than one year in shelters) make up 17 per cent of those in Toronto's shelter population but take up 46 per cent of shelter 'bed nights'. More than 40 per cent of long-term shelter users leave one shelter only to enter another. The longer they stay in shelters, the more they adapt to homelessness and street life and the more difficult it becomes for them to re-establish or join a stable household.

Women who have been homeless for more than one year were the subject of a recent study in Toronto. The study relied primarily on the observations of experienced shelter service providers. The study asked them to describe changes since 1989 in the population of homeless women who use shelter services and in the services available.

Methodology

The study relied on:

a) a review of Canadian and U.S. research on long-term homelessness among women, including unpublished Toronto agency data;
b) interviews of more than 30 front line staff and managers who provide shelter and services to homeless women; and
c) interviews of 10 women who have used shelters and shelter services for more than one year.

An innovative model: Savard's

The planners of Savard's in Toronto adopted a new shelter service model—a low demand, respite residence. The shelter helps chronically homeless women who either avoid using conventional shelters or have been barred from shelters.

Savard's interior space and programs are 'open and flexible' to the needs and preferences of the residents. Savard's opened in January 1997. It is designed to be an emergency shelter, residence, drop-in centre—or any combination of shelter, residence and drop-in centre.

Savard's filled fairly quickly to its capacity of 10 women, who settled in and started using Savard's mainly as a residence. A large, open room was fitted with three-walled nooks, each with a bed and storage space. There is a shared kitchen and a bathroom. The staff ratio is high—two staff members are at Savard's at all times.

Within the first 18 months, there were gradual improvements in residents' behaviour, appearance, social involvement, health and well-being. A few of the first residents moved on to establish their own households; two returned to the street; and a few made modest gains towards independent living.

The project has passed the experimental stage. It is clearly meeting a previously unmet need. The staff continues to develop ways to better serve its users. There are as few rules as possible and a high tolerance for aberrant behaviour. The staff encourage residents to use visiting health care and other services.

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Major Findings

- As their numbers rise, there is greater diversity among homeless women. The greatest concern is the increase in the frequency of severe mental illness and substance abuse over the past ten years.

- Shelter and related services have expanded and changed to provide for more users and for longer stays. At the same time, inadequate funding has reduced service levels and the number of staff. Service providers are highly stressed. Users reported that they receive less individual or direct support. Higher staff-user ratios and the addition of inexperienced staff mean that shelters are less capable of monitoring or intervening in potential and actual conflict or violence.

- Least-cost standards in a crisis management context are driving changes in service design and delivery. Facilities that started as temporary shelters are now an entrenched part of the system. The recent trend toward hastily erected, minimal shelter (such as floor mats or cots in large, mixed-gender facilities) compromises women's safety and well-being.

There is recognition that there are chronically homeless women now. Ten years ago only the front-line workers knew this, bureaucrats weren't so sure. Ten years ago, most hostels had a two-week limit, and women kept hopping around. The City has come a long way — now they have acknowledged the issue.

(A service provider)

- Ten years ago, long-term homeless women were generally either socially isolated or older, alcoholics. Drug addiction is now a much more serious problem. Use of crack cocaine, especially among younger women, is more common. Physical and mental deterioration from crack and new cocaine derivatives is much more rapid than from the drugs common 10 years ago. All types of addiction treatment programs now have waiting lists.

- Sexual violence is pervasive. Almost all the 10 homeless women interviewed reported some form of physical or sexual abuse in childhood that prompted them to leave home at an early age. Personal safety issues have escalated over the past 10 years as street violence and the use of weapons has increased. Each woman reported at least one serious, violent incident during the time they were homeless. More than half reported recent assaults.

- Long-term homeless women reported severe physical and mental health problems. They reported significant barriers to health care and mixed experiences with hospitals and health facilities. Outreach health services have improved access to health workers by changing delivery locations—an important change.

- The design of new emergency shelter models generally ignores the needs of long-term homeless women. The shelters are designed for large numbers of 'generic' homeless people. Long-term homeless women tend to avoid shelters or drop-in centres that do not set aside space for women with high service needs. However, different services are being designed to better deal with subgroups—such as long-term homeless women—of the general homeless population. A few agencies have developed shelters to suit their needs. Outreach services have appeared to link chronically homeless women to appropriate shelters and other services.

Conclusions

What has changed over the past ten years? The scale and intensity of homelessness has increased. The emergency shelter system and related services have expanded and adapted to accommodate more homeless people. The expansion and adaptation are designed for a population that is generally the same. But the homeless population is varied and diverse. Emergency shelters are not suitable for the few users who need them for long periods or intermittently.

A service provider distinguishes between transitional and long-term users. Most women and families are ***transitional***. They stay in the system for less than a year and do not return. They face a short-term crisis and need limited assistance. For them, affordable and safe housing is the main way to prevent and end homelessness.

Long-term homeless women are likely to have mental health problems. They can be divided into two sub-groups.

Episodically homeless women are likely to have serious addiction problems and be involved with the criminal justice system. They tend to be trans-insitutional users (moving among shelters, jails and hospitals). They are generally younger and fairly easy to engage, and they are likely to require residential treatment programs or transitional housing before considering permanent housing options.

Chronically homeless women are often middle-aged. Their behaviour is more stable but they may be hard to engage and less trusting. They are likely to require long-term, supportive housing.

I'd go and do a crime just to go to jail for the winter 'cause it was warm there. Or, I'd book into a detox, because it was warm and safe, and I didn't want to be on the streets anymore, and the shelters were full.

(A homeless woman)

There is sufficient research on the high-risk factors for homelessness to put in place a triage system. Such a system would prevent the discharge of the vulnerable from institutions (such as hospitals and jails) to shelters, as well as divert them from shelters as they enter. High-risk persons should have a choice of supportive housing options. Those with serious addictions should be offered assistance in harm reduction or residential treatment facilities and receive follow-up care, including supportive housing options.

Virtually all long-term homeless women have a history of abuse and family breakdown. They are highly susceptible to being victimized again. Shelter and housing design and management should make personal safety and privacy primary concerns.

Far too few shelter and housing services deal with gender issues. More gender-segregated and culturally-appropriate services (especially for Aboriginal women) and housing options are needed.

New service models, such as low-demand, respite shelters should be put in place. There should be an assessment of their effectiveness in providing shelter and improving health and well-being for chronically homeless women. Ultimate success depends on supportive housing options that match women's varied needs and preferences.

There is a shortage of supportive housing units in the Toronto area. This shortage limits the potential effectiveness of any shelter services for multi-need individuals and families.

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Research Report: Women on the Rough Edge: A Decade of Change for Long-term Homeless Women

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A full report on this project is available from the Canadian Housing Information Centre at the address below.

This project was carried out with the assistance of a grant from Canada Mortgage and Housing Corporation under the terms of External Research Program (CMHC file 6585-N027). The views expressed are those of the author and do not represent the official views of the corporation.

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