

**MODELS AND PRACTICES IN
SERVICE INTEGRATION AND
COORDINATION FOR WOMEN
WHO ARE HOMELESS OR
AT-RISK OF HOMELESSNESS:

AN INVENTORY OF INITIATIVES**

PREPARED FOR

THE ONTARIO WOMEN'S HEALTH COUNCIL

BY

INNER CITY HEALTH RESEARCH UNIT

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URBAN AND SOCIAL POLICY, PROJECT MANAGEMENT AND CONSULTING



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Every effort has been made to ensure accurate and up-to-date information about each of the organizations and programs mentioned in this report. We apologize for any errors or omissions that may have inadvertently occurred.

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EXECUTIVE SUMMARY

The purpose of this study commissioned by the Ontario Women's Health Council is to:

- Develop an inventory of promising models and practices in service integration and coordination for women who are homeless or at-risk of homelessness in order to improve their access to health care, and
- Research and identify common or general elements of best practice models of service integration and coordination that address the needs of homeless women or those who are at-risk of homelessness.

A review of current literature on homelessness, women, and health was undertaken, with particular emphasis on Canadian sources. Attention was paid to the impact of homelessness on women's health and barriers facing homeless women when trying to access health services. Drawing on the literature, three definitions of service integration were presented: (1) inter-agency coordination; (2) co-location; and (3) case management approach.

Using snowball survey techniques, and interviews with key informants across the province, information was gathered about a diverse range of services and initiatives designed to meet the needs of homeless or at-risk women. From this data, 35 initiatives were profiled in an inventory of services, grouped to illustrate different methods of service delivery to homeless populations and different models of service integration. The inventory of services include initiatives from community health centres, mobile health outreach services, case management services, shelter-based programs, programs located within community agencies, services attached to housing, and inter-agency networks. Examples of initiatives from urban, suburban, small town, and rural parts of the province are included, as are initiatives specifically designed for homeless women and others more focussed on women at-risk of homelessness.

Four focus groups were held with women who had experienced homelessness or who were at-risk of homelessness, one in each of the following locations: Haliburton, Kingston, Oshawa, and Toronto. Feedback from the focus groups echoed the literature review: women experience physical, mental, emotional, and spiritual health impacts when they lack affordable and secure housing. The focus groups illustrated how women's homelessness and the associated health problems are largely invisible outside of the central areas of large cities and highlighted problems that women in Ontario experience in accessing health services.

The literature review, interviews with agency staff, and focus groups with women who had experienced homelessness led to the development of seven principles for best practices in delivering integrated services for homeless and at-risk women. In brief, they are:

- Comprehensive needs assessments and evaluations that take into account homeless women's perspectives and quality of life
- Diversity of services and approaches to integration
- Accessible and comprehensive services
- Non-judgmental and non-discriminatory services
- Belief that recovery is possible
- Viable and sustainable services
- Coordination with other services.

Results of the study indicate the need for further investigation into three key areas:

- Effective methods for delivering integrated homelessness and health services in communities across Ontario, including small city,

suburban, small town and remote locations and ways in which service delivery models such as community health centres, mobile outreach services, case management services, and inter-agency networks can be adapted to meet service needs in these areas.

- Strategies and opportunities to address gaps in service for homeless and at-risk populations including the need for increased access to primary health care, mental health services, case management services, dental care, prescription drugs, homelessness prevention services, and substance abuse treatment services.
- New or re-designed funding programs to ensure that homeless services and innovative initiatives have a stable financial base to permit full development and evaluation of initiatives, long term planning, and sustainability over the long term.
- Development of a range of new affordable rental housing opportunities in communities across Ontario, including transitional and permanent housing with supports for women who need assistance in order to remain housed.

LIST OF ABBREVIATIONS

CAMH	Centre for Addiction and Mental Health
CAS	Children's Aid Society
CCAC	Community Care Access Centre
CHC	Community Health Centre
CMHA	Canadian Mental Health Association
FTE	full-time equivalent
HRDC	Human Resources Development Canada
MCFCSS	Ministry of Community, Family and Children's Services
MOHLTC	Ministry of Health and Long-Term Care
ODSP	Ontario Disability Support Plan
OW	Ontario Works
OWHC	Ontario Women's Health Council
PHIF	Provincial Homelessness Initiatives Fund
SCPI	Supporting Communities Partnership Initiative
STD	sexually transmitted disease
VON	Victorian Order of Nurses

1.0 INTRODUCTION

1.1 BACKGROUND

The Ontario Women's Health Council (OWHC) has undertaken a number of initiatives in accordance with its 2001/2002 Plan of Action which identifies poverty as an important health issue for women. A particular focus on under-housed, homeless and women at-risk of poverty led to two initiatives. The first was a commissioned study (*Health Status of Homeless Women: An Inventory of Issues*, September 2002) which identified specific problems faced by women who are homeless or at-risk of homelessness. The second initiative was the *Think Tank on the Health of Homeless and Socially Isolated Women* held in November 2001. Think tank participants recommended that the OWHC focus on ways to address the lack of health service integration and coordination for women who are homeless or at-risk of homelessness. The Council responded by commissioning St. Michael's Hospital and Oriole Research and Design Inc. to undertake this study on promising models and practices in integrating the delivery of health services with other services accessed by homeless women or women at-risk of homelessness. This study was conducted between September 16, 2002 and January 31, 2003.

1.2 PURPOSE

The purpose of this study is to:

- Develop an inventory of promising models and practices in service integration and coordination for women who are homeless or at-risk of homelessness in order to improve their access to health care, and
- Research and identify common or general elements of best practice models of service integration and coordination that address the needs of homeless women or those who are at-risk of homelessness.

1.3 METHODOLOGY AND SCOPE

The following summarizes the approach taken to data collection and analysis and defines the scope of the work.

1.3.1 Literature Review

A review of recent literature on integrating health care and other services for socially isolated women who are poor and persons who are homeless or at-risk of homelessness was undertaken, with particular attention paid to Canadian sources. This phase of the research established a framework for analyzing and interpreting the research findings. The literature review sets out working definitions of the terms "homelessness," "at-risk of homelessness," and highlights differences in how these terms are understood in urban and suburban versus rural, small town and remote settings. It articulates examples of specific and unique health care needs of women, and the implications of these health needs for women who are homeless or at-risk of homelessness. Discussion also focusses on barriers to accessing services, definitions of integrated health services, principles of best practice, and questions of evaluating services for homeless populations.

1.3.2 Snowball Survey

The researchers used *snowball* survey techniques to identify models of integrated services aimed at meeting the needs of homeless persons, or those at-risk of homelessness. Outreach to experts and practitioners in the health, social services and social housing sectors in Ontario who are familiar with the issues facing homeless persons uncovered examples of agencies who are delivering integrated services for homeless persons. From this base, the researchers interviewed senior staff from these agencies about the initiatives they sponsor. Particular attention was paid to initiatives which integrate health services with other services for

homeless persons, as well as those which identify and specifically address the needs of women who are homeless or at-risk of homelessness. Outreach efforts focussed on urban, suburban, small town, rural and remote parts of the province.

1.3.3 Focus on Services for Women

While the primary focus of the study is services for homeless women or women at-risk of homelessness, the researchers also explored relevant examples of integrated service delivery which are non-gender specific, or are for families, children, youth or men. This ensured that a broad range of current practices was identified and that initiatives outside of large urban areas were considered. The researchers recognize that rural and small town services for persons who are homeless or at-risk of homelessness are more likely to be non-gender specific or also inclusive of children and youth because the population base in these areas often cannot support many women-only services.

1.3.4 Developing an Inventory of Models

The snowball survey led to 145 contacts within over 120 agencies who are working with homeless or at-risk populations in Ontario (See Appendix A for the list of contacts). From this initial group of agencies and programs, 35 were selected to be profiled in this report. In selecting profiles for this inventory, consideration was given to:

- highlighting examples of good principles in integrating and coordinating health and other services for homeless people
- profiling agencies and programs that count homeless or at-risk women (including young women) among their client group
- presenting a range of programs aimed at meeting different segments of the population of homeless and at-risk women
- including programs operating in various parts of

the province, including urban, suburban, rural, and northern communities.

Given the timeframes for this research, the inventory of models presented in Section 3.0 is not intended to be an exhaustive compilation of all services or all types of services for homeless women, but instead focuses attention on key components of delivering integrated and coordinated services for this population, and illustrates how a variety of physical, mental, emotional and spiritual health related services are being delivered hand in hand with other supports.

1.3.5 Identifying Principles of Best Practice

From the research and the inventory of service delivery models, this report identifies key elements of integrated health services for women who are homeless or at-risk of homelessness. The researchers acknowledge that the concept of *best practices* is often problematic due to differences in interpretation, evaluation, and context. In the realm of service delivery for homeless persons, no accepted standards exist for measuring or evaluating best practices.

To accurately identify *best practices* among various service delivery models, extensive research and program evaluation for each initiative would need to take place. Data collection would include a longitudinal analysis of outcomes both at a health system level and in the satisfaction level of the clients using the service. Unfortunately, detailed program evaluations which capture this information are typically not found among the community or health services established to meet the needs of homeless persons. This type of research was beyond the scope of this commissioned report.

To avoid the confusion created by the term *best practices*, this research team began to identify a set of principles that characterize sound practice in integrating health and other services for homeless women or those at-risk of homelessness. Throughout the data collection and analysis phases

of the study, the list of principles was developed and refined. Consideration was given to whether specific principles should be identified for suburban, rural or remote versus urban initiatives. Four focus groups were held to gather input from women who have experienced homelessness or are at-risk of homelessness on the principles or desired elements of integrated health services for this population. The results of these focus groups, as well as input from individuals involved in service delivery for homeless people were instrumental in refining the principles identified as elements of good practice in this field. Sections 4.0 and 5.0 discuss the principles of best practice in more detail.

1.4 STRUCTURE OF THE REPORT

To establish the framework for this study and to outline key definitions, Section 2.0 contains a review of recent literature on women, homelessness and health, as well as issues related to integrated services for homeless populations. Section 3.0 is an inventory of 35 initiatives from across Ontario that demonstrate how various services for homeless or at-risk women are currently being coordinated or integrated within and between agencies. Section 4.0 presents the results of focus groups held in four Ontario communities and identifies key principles of best practice when providing services to homeless and at-risk women. Section 5.0 brings together the analysis and findings resulting from this study and provides a discussion of best principles in delivering integrated services for homeless and at-risk women. The conclusion, Section 6.0, highlights key findings emerging from this study as well as issues and questions for future consideration.

2.0 LITERATURE REVIEW

This literature review forms the basis for a discussion of best practice in integrated health services for homeless women. Excellent materials have been published recently within Ontario on the subject of women's health and homelessness.¹ This literature review will focus on two issues that remain under-researched: 1) issues of women's homelessness and health outside the centres of large cities; and 2) questions of integration, coordination, and best practice in the context of health services for women who are homeless and/or at-risk of homelessness.

This research is based on the understanding that women who are homeless or at-risk of homelessness face increased risks of ill-health, while also facing institutional barriers that restrict access to consistent, prevention-oriented health care. Homeless women live in suburban, small town, rural, and remote parts of the province, as well as the central areas of large cities. Therefore the researchers are focussing on models that occur in, and are adaptable to, a range of human settlements.

2.1 THE PROBLEM: WOMEN, HOMELESSNESS, AND HEALTH

2.1.1 Homelessness: Definitions, Incidence, and Policy Influences

In Canada, homelessness is now widely understood to encompass not only the *visibly homeless*, people who “stay in emergency hostels and shelters and those who sleep rough in places considered unfit for human habitation.” It also includes hidden homelessness, people “who are temporarily staying with friends or family... and those living in households where they are subject to family conflict or violence.” Hidden homelessness also encompasses people *at-risk of homelessness* because they are

¹ Novac 2001, OWHC 2002.

“paying so much of their income for housing that they cannot afford the other necessities of life such as food; those who are at-risk of eviction; and those living in illegal or physically unsafe buildings, or overcrowded households.”² The term *absolute homelessness*, lack of physical shelter, has been used by the United Nations to denote one end of a continuum whose other end is decent, secure, safe and affordable housing.³ Canadian, Australian, and mainland European literature are more likely to include broader definitions of homelessness, while US and UK literature generally concentrates on the visibly homeless.⁴

Homelessness is a growing crisis across Canada, although the absence of systemic and comparable data makes quantification difficult.⁵ Demand for emergency shelter beds in Ontario’s larger cities is growing, even as the number of shelter beds increases. The City of London now serves 4,000 individuals a year in its shelters; a 2001 service audit found demand sufficient for a 56 percent increase in shelter beds.⁶ Emergency shelter use in Hamilton increased 35 percent between November of 1998 and March of 2000.⁷ In Toronto, 15,000 people, representing half of the people using shelters in 1999, were first time users.⁸

Who are these newly visible homeless people? In Toronto, an analysis of shelter data between 1988 and 1996 reveals:

- An increasing minority of emergency shelter users, 29 percent in 1996, are female;
- The fastest-growing group of shelter users are youth under 18 and families with children; 19 percent of the homeless population are now children;
- In 1988, 24 percent of households in the shelter

system were headed by women; in 1996, 37 percent were headed by women;

- At least 47 percent of shelter users come from outside Toronto.⁹

Shelter use is the tip of the iceberg when it comes to homelessness. Shelters are clustered in the centre of a few big and mid-sized cities in Ontario, although they attract people from throughout the province. Recent Ontario-based literature suggests that affordability stress, the proportion of people paying over half of their gross income on rent, is actually greater outside the centre of big cities. Thus there is a considerable mismatch between the location of emergency and preventive services such as shelters, and the populations these services seek to assist.¹⁰

Various studies of homelessness in Canada have stressed two major policy factors in the growth of homelessness over the past 30 years: increasing poverty and cutbacks in social housing programs. A 1998 study of homelessness in the Ottawa–Carleton region focussed on the local impact of these senior government policy factors:

- poverty rose in the region by 26 percent between 1990 and 1996; including the 21.6 percent decrease in social assistance in 1995; leading to
- a large and growing shortfall between social assistance shelter allowance and rental costs; leading to
- evictions increasing 16 percent in the region between 1996 and 1998, which were expected to further increase with the removal of rent control in that year; with 20 percent of families in shelters reporting eviction as the reason for need;

² Sistering 2002:3–4; see also OWHC 2002: 4; Golden et al 1999.

³ Sistering 2002: 3; see also Craft–Rosenberg, Powell, and Culp 2000, Hulchanski 2002.

⁴ Novac 2002: 101fn.

⁵ As discussed in Golden et al 1999: 26; Novac et al 2002: 9; OWHC 2002: 5.

⁶ City of London 2001: 1.

⁷ City of Hamilton–Wentworth 2001: 1.

⁸ City of Toronto 2001: 3.

⁹ Springer, Mars, Denison 1998.

¹⁰ Bunting, Filion, Walks 2002.

- lack of affordable housing, with private market vacancy rates of less than one percent throughout the 1990s; and 15,000 on the regional social housing waiting list as of March 2000; exacerbated by the federal government withdrawal from social housing construction in 1993, and the provincial government withdrawal in 1995.¹¹

Three other policy factors are seen to have contributed the increase in homelessness: barriers to preventive health services; general cuts to social programs; and inadequate response to family violence. Issues such as the de-institutionalization of psychiatric patients in the absence of adequate supportive housing options, the de-listing of certain medications and medical services for health insurance coverage, the lack of affordable childcare for single parents seeking employment, and narrowing eligibility for Employment Insurance have all had direct and indirect impacts on homelessness.¹² Economic restructuring, the long-term shift of full-time jobs with benefits in the manufacturing sectors to part-time jobs with fewer benefits in the service sector, has also had an impact on homelessness. The relationship between sexual and racial violence and homelessness has also been stressed in recent Canadian literature on women and homelessness.¹³

These housing and income trends are found across Ontario, but few municipalities have the resources to research homelessness within their communities, let alone address the problem. In Ontario, research on homelessness has focussed on the central portion of Toronto, and to a lesser extent, Ottawa, two large cities of over one million people each. There has been a limited amount of research in two mid-sized cities of between 200,000 and one million people, Hamilton and London, yet less research has been undertaken in the separately incorporated suburbs of large cities, small cities and towns of less than 200,000 people, and rural and isolated areas. A recent study of the health status and resources of rural and small

town homeless women in the United States suggests that the issue of hidden homelessness is especially acute in these settings, with women and their dependent children moving in with relatives and friends, living in substandard housing or short-term accommodations such as motels, and staying within abusive relationships, rather than accessing shelters or other emergency housing services.¹⁴

2.1.2 Women and Homelessness: Gender Differences and Diversity

Women form the majority of the poor in Canada, with one in five women (2.8 million Canadians) living in poverty in 1997.¹⁵ Since living in poverty is defined by Statistics Canada as spending such a large proportion of an individual or family income on basic necessities such as food and rent so as to be living “in straightened circumstances” (the ‘low-income cut-off’ varying by family size and community), an extremely large number of women are at *some* risk of becoming homeless.

Homeless women are women of all ages and socio-economic backgrounds, with or without children. The diversity of homeless women includes:

- **Black, Aboriginal and Refugee women**, who are over-represented in the Toronto shelter system. Across Canada, Aboriginal women are more likely than other women to be sleeping rough in the centres of big cities.¹⁶ Almost three quarters of Aboriginal single mothers live below the poverty line.¹⁷
- The poverty rate for all **single women, including mothers with young children**, almost triples after divorce or relationship break-up, and many women who leave their spouses (including victims of wife assault) move in with relatives or friends immediately after separation, which may be the beginning of a spiral into homelessness.¹⁸

¹¹ City of Ottawa-Carleton 2000: 1.

¹² Novac 2001: 105-106; see also Bunting, Filion, Walks 2002; Mental Health Policy Research Group 1997; Golden et al 1999: v.

¹³ Novac 1995, Miller and du Mont 2000, Lenon 2000.

¹⁴ Craft-Rosenberg, Powell, Culp 2000; see also Cloke, Milbourne, Widdowfield 1999.

¹⁵ Morris 2002.

¹⁶ Novac 2001: 104.

¹⁷ OWHC 2002: 4.

¹⁸ Novac 2001: 108.

- **Women with disabilities and chronic poor health conditions** are much more likely to be living in poverty and inadequate housing conditions, with the national unemployment rate for disabled women standing at 70 percent in 1997, and over two thirds of disabled women living below the poverty line.¹⁹
- **Young women** form an increasing cohort of the visibly homeless, with many fleeing abusive family relationships.²⁰
- **Lesbians** are over-represented among homeless young women in Toronto, but there is no comparable data on adult lesbians across Ontario or Canada.²¹
- A growing number of **two-parent families** are applying for social housing waiting lists, due to inadequate income and housing supports; many of the women in these families are also caring for adult dependent children or elderly relatives.²²
- **Chronic or long-term homeless women**, those who have used shelter for a year or more, are perhaps the most visible face of homelessness. "The most common female profile is that of an older single woman with serious mental health and physical problems," including schizophrenia and addictions, and in need of long-term supportive housing.²³

These categories, of course, are not discrete. Yet the particular needs of diverse populations affect health service quality and access, and thus need to be taken into account in any consideration of best practice. For instance, a focus group study of young (12 to 18 years old) homeless women's opinions of health services in Seattle found confusion over consent, inadequate understanding of the impacts of survival

sex, lack of respect and 'judgementalism' to be significant barriers to access.²⁴

2.1.3 The Impact of Homelessness on Women's Health

Homeless women have a higher prevalence of emergency and chronic health impacts due to living circumstances, poverty, and lack of access to preventive services.²⁵ These include:

- **General Health Impacts:** Homeless women are subject to nutritional deficiencies, exposure to pollutants and extreme temperatures, lack of access to services (which may include lack of access to a telephone), lack of money for basic hygiene products (toothbrushes, soap, and menstrual supplies), insufficient sleep, and other by-products of extreme poverty and lack of housing. Because of these poor living conditions, homeless women are subject to higher rates of almost every disease and poor health condition (cancer, tuberculosis, arthritis/rheumatism, respiratory tract infections, hypertension, diabetes, anaemia, head injury, epilepsy, heart disease and strokes, dental disease, malnutrition, exposure, skin and foot diseases and disorders), as compared to the general female population.²⁶ A 1999 Ottawa survey of 230 people in shelters and on the street found women's rates for asthma, arthritis, rheumatism, back problems, chronic bronchitis or emphysema, and chronic pain to be between two and six times higher than the general population.²⁷ Prevention and health management measures, even if they are understood, may be impossible for homeless people to follow. For example, diabetics living in shelters may not be able to get enough fresh fruit, vegetables and

¹⁹ Chouinard 1999.

²⁰ Novac et al 2002.

²¹ Novac et al 2002; Novac 2001.

²² Golden et al 1999; 28.

²³ Novac 2001: 107.

²⁴ Ensign and Panke 2002.

²⁵ Novac 2001: 109; see also Ambrosio et al 1992.

²⁶ Novac 2001: 109; see also Ambrosio et al 1992.

²⁷ Novac 2001: 109; Ambrosio et al 1992, Craft-Rosenberg, Powell and Culp 2000, Farrell et al 2000, Hwang 2001.

²⁸ Farrell et al 2000.

other healthy food necessary to keep insulin levels down.²⁸ Homeless women are thus caught in a double bind: they are more at-risk for many diseases, such as cancer, yet are unable to follow simple preventive measures (eg. regular screening, better diet).²⁹

- **Physical and Emotional Impacts of Violence:** As a recent report summarizes, “sexual violence is commonplace in the histories of homeless women.” One Toronto study found three-quarters of a sample of 84 single homeless women in Toronto had been physically or sexually abused, usually by a male family member, prior to becoming homeless. Almost half of the women in the Toronto Street Health survey had been physically assaulted in a one-year period, with 21 percent reporting sexual assault.³⁰ A recent study of 2,000 US people living in shelters in 15 cities found similar results: half of the women reported a physical assault over the previous year, and 15 percent rape (with a narrower definition of sexual assault than the Canadian study).³¹ A survey of 967 women in Los Angeles found that 13 percent had been raped over the past year, with half of these women raped more than once; impacts included poorer physical and mental health and increased substance abuse.³²
- **Mental and Emotional Health:** Mental illness, ranging from severe depression to affective disorders, can be triggered by the experience of homelessness.³³ Mental illness is also a risk factor for becoming homeless and can be an important barrier that prevents homeless people from obtaining housing, health and other services. This reciprocal relationship has been

well discussed in the literature.³⁴ Research studies in US cities have shown that approximately 30 to 50 percent of homeless single adults suffer from a mental illness.³⁵ Contrary to popular misconceptions, however, only about 6 to 10 percent of homeless single adults have schizophrenia; the most common psychiatric diagnosis is major depression.³⁶ Homeless single women are more likely than homeless single men to experience suicidal depression and have multiple psychiatric symptoms, a fact that may be related to greater victimization levels.³⁷ In contrast, homeless mothers have a lower prevalence of mental illness than homeless single women or men, albeit a higher prevalence of emotional distress than mothers in the general populations.³⁸

- **Sexual and Reproductive Health:** Homeless women are at greater risk of abnormal pap smears, STDs, HIV/AIDS, and unwanted pregnancy, than the general female population. They are less likely to engage in preventive health, ranging from condom use to regular pap smears.³⁹
- **Pregnancy and Mothering:** Women who are assaulted by their spouses often report the abuse beginning during pregnancy, which means that the onset of pregnancy may be an instigator of homelessness among women.⁴⁰ Homeless women are less likely to receive regular medical care during pregnancy, and are more likely to have birth-related complications, experience inadequate nutrition for themselves and their children, and undergo severe stress in meeting their children’s basic needs.⁴¹ The blood and stool samples of children at one US suburban shelter were found to contain undiagnosed

²⁸ Hwang and Bugeja 2000.

²⁹ Chau et al 2002.

³⁰ Novac 2001: 114.

³¹ Lam and Rosenheck 1998.

³² Wenzel et al 2000; see also Goodman et al 1995, Lam et al 1998.

³³ Davis and Kutter 1998, Novac 2001.

³⁴ Buchner 1990, Goodman 1991, Daws and Kutter 1998, Rohde et al 2001.

³⁵ Lehman and Cordray 1993

³⁶ Hwang 2001: 231

³⁷ Ambrosio et al 1992, Mental Health Research Group 1998, Stuart and Arboleda-Florez 2000.

³⁸ Hwang 2001: 231

³⁹ Novac 2001, Wenzel et al 2001b, Rohde et al 2001, Weinreb, Goldberg and Lessard 2002, Ensign and Panke 2002.

⁴⁰ Weinreb L; Browne A; Berson J. 1995; Miller and du Mont 2000.

⁴¹ Ambrosio et al 1992, Hamm and Holden 1999, Kissman 1999, Wenzel et al 2001b, Novac 2001.

infectious diseases such as hepatitis B and giardia that would be of particular danger to pregnant women and newborns sharing the residence.⁴²

- **Substance Abuse:** Illegal drug and alcohol abuse is a common coping mechanism for homeless people, and like mental illness, can be a factor in the spiral of homelessness.⁴³ Cigarettes and prescription drugs such as tranquilizers are also used at much higher rates by homeless women than the general population.⁴⁴

2.2 THE APPROACH: INTEGRATED HEALTH SERVICES

2.2.1 Definition and Context of Health Services

Recent policy approaches taken by Health Canada, the Canadian Public Health Association, and international groups use the World Health Organization's holistic and values-based definition of health, going beyond the absence of illness to describe a state of physical, mental, spiritual and social well being.⁴⁵

In this approach, health promotion services can be defined in their broadest sense as services that seek to improve people's well-being, by focusing on the determinants of health. Health Canada articulates seven key determinants of health, all of which are relevant to the health status of homeless women:

- **income and social status:** All homeless women experience extreme poverty and low social status.
- **social support networks:** These are hard to sustain under the stress of homelessness.

- **education:** Many homeless women have low educational attainment and face almost insurmountable barriers to obtaining further education, and use of existing skills.

- **employment and working conditions:** It is extremely difficult to find a job without work-appropriate clothing, a fixed address, or a telephone.

- **social environments:** Discrimination and violence are endemic amongst homeless women.

- **physical environments:** Substandard housing, exposure to extreme temperatures, and limited access to basic hygiene needs are common.

- **personal health practices** are compromised and **coping skills** are tested to the limit.⁴⁶

Health services can be seen as one strand of a comprehensive web of services that can seek to reverse the vicious circle of homelessness. For instance, women may become homeless because of low income, exacerbated by a marital breakdown, which in turn may be related to violence in their past or present lives. Yet lack of decent, stable, safe, and affordable housing may lead to poor physical and emotional health, which in turn may prove to be a barrier to actions that might improve income prospects, such as employment or education. Obtaining housing may be the first step to better health prospects: research consistently shows that the further along a woman is in the good housing continuum (eg. sheltered as opposed to unsheltered), the more likely she is to get adequate and appropriate health care.⁴⁷ Alternatively, adequate and appropriate health and other social supports provided on the streets or in shelters can help women find more long-term housing options. A survey of 301 visibly homeless adults in Buffalo

⁴² Bass et al 1990.

⁴³ Mental Health Policy Research Group 1997, Craft-Rosenberg, Powell and Culp 2000, Wenzel et al 2001b.

⁴⁴ Farrell et al 2000.

⁴⁵ Canadian Public Health Association 1997, Burke 2000, Thurston and O'Connor 2002.

⁴⁶ Sistering 2002: Appendix 2.

⁴⁷ Nyamathi et al 2000, Lim et al 2002.

found that better health services was a more immediate priority than long-term housing;⁴⁸ while a survey of 24 young mothers in New York who had lived in shelters found that health and other social supports were a critical factor in their ability to find permanent housing.⁴⁹

2.2.2 Barriers to Accessing Health Services

There have been several recent studies that ask homeless women about barriers and enablers in relation to health care access. One theme that emerges is that there are significant differences between homeless women and men. Homeless women, whether single or with children, strongly prefer to avoid shelters, including shelters for abused women. This is because of legitimate concerns for their safety, and also because they wish to avoid the stigma and disruption caused by leaving their immediate environs, especially if they have children in school.⁵⁰ The subsequent dilemma results in women staying in an abusive relationship or doubling up with family and friends, over seeking refuge in a shelter. The recognition that women's homelessness is largely hidden has important implications for access to health care services, and may provide one of the reasons why low-income women with dependent children and fewer social supports are so much less likely to utilize health care options than low-income men or higher-income people.⁵¹ For instance, a recent survey of homeless people in Ottawa found that 47 percent of adult homeless women, and 36 percent of young homeless women, reported needing medical care, yet being unable to obtain it, in the previous year. This compares to 23 percent and 29 percent of adult and young homeless men respectively, and 4 percent of the general population.⁵²

The health needs of women who are homeless and at-risk of homelessness are also significantly different from other women. A survey of low-income women's priorities for primary care found that issues of access, including transportation costs, location, hours of operation, and possibly cultural or physical accessibility barriers, are a much higher priority than is usually reported by the general population of women. A respectful physician-patient relationship is seen as more difficult. The importance of multiple services at one site increases.⁵³

Specific barriers to homeless women accessing health services include:

- **Physical lack of access to appropriate services:** This problem is especially acute among small town, rural and isolated women, many of whom lack access to transportation, do not have family or social networks to rely on, and lack access to a telephone.⁵⁴ Even in cities and suburbs, crowding of emergency rooms (a primary source of health services for many homeless women) and lack of money for public transit fares are common concerns for women seeking access to health services.⁵⁵ Health services are often scattered in agencies throughout an area (with attendant transportation problems), and often there are lengthy waiting lines for many services (eg., free dental care, alcohol and drug treatment). There is a shortage of doctors in many rural and isolated areas. Simply not knowing about a service is a common barrier in all settings.⁵⁶
- **No health care coverage:** In the 1992 Toronto Street Health Report, 40 percent of the sample of homeless people did not have an Ontario Health Card at the time of the survey.⁵⁷

⁴⁸ Acosta and Toro 2000.

⁴⁹ Styron, Janoff-Bulman, Davidson 2000.

⁵⁰ Hatton 2001.

⁵¹ Acosta and Toro 2000.

⁵² Farrell et al 2000.

⁵³ O'Malley; Forrest; O'Malley 2000.

⁵⁴ Craft-Rosenberg, Powell, Culp 2000.

⁵⁵ Acosta and Toro 2000; Luck et al 2002; Sisting 2002.

⁵⁶ OWHC 2002: 14.

⁵⁷ Ambrosio et al 1992: 11.

Women without legal status in Canada are ineligible for health care cards.⁵⁸ Although health care professionals are supposed to provide service regardless of health coverage, the current fee-for-service system penalizes those who do so.⁵⁹ Medicines and medical services have been delisted from Ontario health insurance coverage, including preventive dental services.⁶⁰

- **Safety and respect issues:** Some homeless women refuse to be examined by a physician because of a past negative experience⁶¹; others report that medical staff are judgmental and refuse to treat symptoms and health issues adequately.⁶² Many homeless women accessing health services report linguistic barriers and cultural biases.⁶³ Some homeless people with histories of disruptive behaviour are barred from services.⁶⁴
- **Follow-up and continuity of care:** Follow-up is difficult for homeless women, who may not be able to afford or access tests, pay for prescriptions, follow special diets, or store medication at the correct temperatures. Medical follow-up is very difficult for women who live in temporary accommodations and do not have access to a telephone or mailbox, and frequent moves exacerbate the scattering of medical records, and the constant necessity to repeat symptoms and keep track of previous treatment suggestions.⁶⁵ Homeless women's need for non-acute medical care is often balanced against more immediate needs, such as food and shelter, leading to chronic problems being neglected until they become emergencies.⁶⁶

2.2.3 Definitions of Integrated Health Services

One summary of barriers to homeless women accessing services describes three common themes: "not knowing," "runarounds," and "constantly starting over again."⁶⁷ Given the frequent recurrence of these themes in the literature, almost every report on health services for homeless people stresses the importance of integrating health services in order to reduce barriers to access and provide continuous and coordinated prevention-oriented health services. However, there is no agreement about the meaning of the term *integrated*. Integration has been defined in at least three ways:

- **Interagency coordination:** Here the importance of integrating service delivery amongst agencies serving homeless people is stressed. Methods range from *coalitions* that exchange information and undertake advocacy and/or needs assessments on issues of common concern, to *service delivery teams* that coordinate services and may undertake cross-training or develop interagency protocols and shared funding mechanisms, to *management information systems* that may track clients through shared record keeping (from intake assessment to patient records).⁶⁸ This notion is applicable to all settings, from big cities to rural areas.
- **Co-location:** Also known as the *service hub concept*, this approach concentrates on the geographic co-location of services for homeless persons. For instance, the location of a disability benefits office within an agency serving homeless men with severe mental illness was found to increase income supports and enable these men to find more permanent housing.⁶⁹

⁵⁸ Sistering 2002: 79.

⁵⁹ Hwang et al 2000.

⁶⁰ Kushner 1998.

⁶¹ Ontario Medical Association 1996.

⁶² Ambrosio et al 1992, Zabos and Trinh 2001, Ensign and Panke 2002, Sistering 2002.

⁶³ Attala and Warmington 1996; Sistering 2002.

⁶⁴ Ambrosio et al 1992, Hatton 2001, Novac 2001, OWHC 2002.

⁶⁵ Gallagher et al 1997, Hwang 2000, Hatton 2001, Wenzel et al 2001b, Novac 2001, Diament et al 2002, OWHC 2002.

⁶⁶ Luck et al 2002.

⁶⁷ Hatton 2001; see also Jezewski 1995.

⁶⁸ Randolph et al 1997.

⁶⁹ Rosenheck, Frisman, Kaspro 1999.

Community economic development workshops and other employment generating activities can be located next to or as part of a battered women's shelter or agency serving homeless people. Hospitals can have social services nearby. Shelters can have visits from mobile health units. There is sometimes the concern about 'ghettoization' of service hubs, but the concept can also be the impetus for decentralized health planning. Service hubs can be provided in suburban and small town locations as well as the centres of larger cities. In rural areas, the aim might be virtual co-location through a telephone network of organizations.⁷⁰

- **Case management approach:** Here, the emphasis is on the individual homeless person, where integrated services are facilitated by an individual case worker, such as a social worker, a **primary care provider** (a doctor or nurse who provides regular health care to the person), or a team. Shelters for battered women routinely use a case management approach, as do mental health services and drug and alcohol addiction recovery centres.⁷¹ For instance, a pregnant woman who has been battered by a spouse might require assessment and treatment of physical and emotional injuries, continuous pre-natal care (including screening for injuries which might have occurred to the fetus), referral to housing and legal services, and income support information.⁷² Case managers may help by providing referrals to specific services or people, transit fares and detailed directions, advice on behavioural risk reduction, and informal counselling.⁷³ There may be confidentiality and privacy issues related to the case management approach.

These three approaches might operate independently. A good case worker might refer effectively without a formal interagency linkage, and co-location does not necessarily mean that information

is shared. Thus, a clear and explicit definition of service integration is essential to facilitating discussions of barriers, client-centred focus, and outcome evaluations, as well as best practice formulations.

2.2.4 Barriers to Integrated Services

US literature suggests that rural and isolated homeless women are far less likely to have access to sensitive and integrated health care services; there are simply no easily accessible options.⁷⁴ There is little Canadian literature on health care issues and services for suburban, small town, and rural homeless women. It can be assumed that barriers to services are much greater in these areas because of lower population densities, fewer resources, and possibly, community opposition.

In cities, and possibly in suburbs and towns, most visibly homeless women use emergency rooms for routine medical care, and have much higher rates of hospitalization than the general population. The Ottawa survey reports that 42 percent of adult homeless women and 33 percent of young homeless women were inpatients in a hospital, nursing home or convalescent home over the previous year, as compared to 8 percent of the general population.⁷⁵ The Street Health Report found that almost 75 percent of homeless people were discharged from hospital with no assistance in finding a place to go.⁷⁶ To state the obvious, emergency rooms are not the best setting for the delivery of preventative care or integrated services, or for effectively dealing with chronic health problems.

The centres of big cities offer the largest variety of integrated health services. Some hostels and shelters, including shelters for battered women, offer both referrals to off-site health care practitioners and clinics, or on-site health practitioner visits (eg., public health nurse).⁷⁷ There are drop-in medical

⁷⁰ Dear, Wolch, Wilton 1994.

⁷¹ Attala and Warmington 1996, Rosenheck et al 1998, Chinman, Rosenheck and Lam 2000.

⁷² Weinreb, Brown, Berson 1995.

⁷³ Hatton 2001.

⁷⁴ Craft-Rosenberg, Powell, Culp 2000.

⁷⁵ Farrell et al 2000.

⁷⁶ Ambrosio et al 1992.

⁷⁷ Novac 2001: 97.

clinics and community health centres (CHCs) in large and mid-sized Ontario cities, and the recent Sistering survey suggests that CHCs and innovative drop-in and shelter-based programs have a good record of providing sensitive, appropriate, and timely health care services to homeless women. Community-based counsellors and settlement workers also receive generally positive comments in terms of understanding and a non-judgmental approach, especially in regards to emotional and mental health issues.⁷⁸ It should be noted that many Toronto-area CHCs report being at capacity and unable to take on new patients, and community support workers affiliated with agencies are under constant threat of cutbacks.⁷⁹ Some of the more innovative programs operate under project funding, which may constrain who is accepted into the program, and may not be economically viable in the longer term. Many hidden homeless women continue to use their regular primary care givers, who may or may not be adequately trained or capable of addressing health problems specific to low-income women under stress.⁸⁰

Whether utilizing a family doctor or a CHC, an emergency room or a mobile health service, one point emphasized by homeless women again and again is the need for a holistic and patient-centred approach. Homeless women's health issues cannot be packaged in neat little boxes, encompassing as they do emergency and preventive medical care, violence prevention and healing from violence, risk and harm reduction, all under the shadow of inadequate income, shelter, and social supports.⁸¹

2.3 THE QUESTION OF EVALUATION

Many methods have been used for evaluating projects aimed at improving health services for homeless people. *Program* evaluations might look at how many people participated in a program,

whether there were significant differences between targeted groups, and whether the participants felt the service met their needs. *Outcome* evaluations, whether focussing on clinical outcomes or quality of life outcomes, are much more difficult to carry out, since so many individual and environmental determinants of health are beyond the scope of a specific project, and because of the long time-frame required to adequately study these outcomes.⁸²

The ACCESS project was the most ambitious attempt to study the effectiveness of improving the integration of services for homeless people. From 1994 to 1998, 18 sites in US cities were funded to establish Assertive Community Treatment (ACT) programs for homeless people with severe mental illnesses. Nine sites (the intervention sites) were randomly selected to receive an additional US\$250,000 per annum that was earmarked for improving the integration of services. These agencies were expected to strengthen their linkages with other organizations to provide not only psychiatric care, but also medical, substance abuse, housing and income support, and employment assistance to their clients. The nine control sites operated ACT programs but did not receive any intervention to improve the integration of the service system. Each site enrolled and tracked 400 people during the course of the project. Health and housing outcomes were compared among the clients of the nine intervention sites and the nine control sites.⁸³ Both the intervention and control sites were quite successful in terms of improving health status and housing outcomes (living in stable housing) among clients one year after enrollment. The intervention was successful in improving project integration (i.e., the integration of services between the agency running the ACT program and each of its partner agencies), but the intervention did not improve system integration (i.e., the integration of services among all agencies and service providers in the area). Although clients living in cities with greater integration of services

⁷⁸ Sistering 2002: 49-50.

⁷⁹ Sistering 2002: 78.

⁸⁰ See comments in Sistering 2002: 49.

⁸¹ Nyamathi et al 2000, Acosta and Toro 2000, Wenzel et al 2001a, Sistering 2002.

⁸² Randolph et al 2002.

⁸³ Randolph et al 2002.

had better housing outcomes, the experimental intervention to increase service integration did not have a significant effect on housing outcomes. One plausible interpretation of these findings is that even an aggressive and well-funded intervention to improve integration of the service system may not increase integration enough to have an appreciable effect on client outcomes.⁸⁴

One interesting finding of the ACCESS study was that cities with more community social capital, as measured by citizen involvement in organizations, projects, volunteer work, and interaction with neighbours, also had stronger network strength (ie., more effective coordination between agencies), and better housing outcomes for homeless individuals. The city's housing affordability, as measured by the proportion of households paying less than 30 percent of their income on housing, was also significantly correlated with positive housing outcomes.⁸⁵

The authors of the many articles on the ACCESS program provide important cautions about interpreting the results. The management of individual agencies was a significant factor in the success of integration, as was the overall viability of specific organizations, including other sources of funding.⁸⁶ The project dealt with a very specific subset of the total homeless population, visibly homeless people with severe mental illness, and may not be applicable to other people facing homelessness. Two thirds of the homeless people surveyed were men, and women were more likely to get lost in follow-up studies over time.⁸⁷ There are other caveats that could be added. The project dealt with one particular definition of integration: interagency coordination. The quality, stability and affordability of the more permanent accommodation was not discussed, reflecting the US tendency to see homelessness as dichotomous (visibly sleeping rough or in a shelter versus any other type of accommodation),

rather than as a continuum. Even with these important qualifiers, the literature on the ACCESS program remains the most comprehensive long-term evaluation of integrating services, and contributes to a more nuanced understanding of best practices.

2.4 PRINCIPLES OF BEST PRACTICE

The United Nations has developed criteria for best practices that address homelessness, which are similar to criteria raised in agency discussions that have taken place at the national and provincial levels.⁸⁸ These criteria, as well as the preceding discussion, inform the following best practice principles:

- ***Comprehensive needs assessments and evaluations that take into account homeless women's perspectives and quality of life:*** While the literature that includes the voices of homeless women is scarce,⁸⁹ there is a consensus among these voices that their priorities are not reflected in services offered. Inviting homeless women to participate in identifying and assessing services, establishing mechanisms for client feedback on the services, and regular evaluations with adjustments reflecting these evaluations are all examples of how this principle could be applied. Following from the earlier discussion of health determinants, outcomes that measure quality of life as well as clinical improvements are important.
- ***Diversity of services and approaches to integration:*** If the ACCESS evaluation proves anything, it is that one approach for dealing with service integration will not work. There are significant differences between women and men, and also differences amongst women based

⁸⁴ Goldman et al 2002.

⁸⁵ Rosenheck et al 2001; with social capital measurements based on Putnam 2000.

⁸⁶ Rosenheck et al 2002.

⁸⁷ Rosenheck et al 1998.

⁸⁸ Serge 1999.

⁸⁹ Exceptions include Ambrosio et al 1992, Acosta and Toro 2000, Farrell et al 2000, Ensign and Panke 2002, Styron, Janoff-Bulman, Davidson 2000, Sistering 2002.

on age, abilities, presence of dependent children, language, culture, sexuality, and health issues. Cultural and linguistically accessible services are a necessity for homeless women, which doesn't mean that every clinic can offer every service in every language, but does point to a need for better coordination with ethno-specific, multicultural, and multilingual agencies.⁹⁰ It is also necessary for health services to be accessible to women with disabilities, who form such a large proportion of homeless women. Access needs to be understood as going beyond design modifications for women with limited mobility, to encompass interpretation for the hearing impaired, public education materials for people with limited sight, and a generally increased understanding of disabled women's health issues, including increased risk of sexual violence. Programs or approaches suitable for large city centres may not be those that best serve homeless women in rural areas.

- **Accessible and comprehensive services:** These include services at shelters, CHCs, community and refugee settlement centres, and mobile health vans, that can reach visibly homeless as well as hidden homeless women, and offer a range of services (preferably in a range of languages) on site. For instance, if blood and urine tests can be given on site, this means immediate diagnosis and at least two fewer trips, an important consideration for homeless women without transportation money or a telephone number for a health care professional to call.⁹¹
- **Non-judgmental and non-discriminatory services:** This is also an issue that arises again and again in discussions with homeless women, and serves as a serious barrier to health care. The harm reduction approach, which has been effective in the fields of substance abuse and HIV/AIDS prevention, may need to be applied. For instance, women can be barred from health services because of their personal hygiene,

yelling or intoxication.⁹² Homeless young women who sell survival sex (the selling of sex to meet subsistence needs, including the exchange of sex for shelter, food, drugs, or money) may not return to a clinic that tells them to 'just say no.'⁹³

- **Viable and sustainable services:** Programs need to be cost-effective and sustainable over the long term. This is difficult in a funding environment that sometimes rewards innovation with project grants, but increasingly has large holes within basic services. Homeless women are experiencing the rough edge of the funding crisis in health care, with uncertainty regarding the continued existence and continuity of services appropriate to their needs. Emergency rooms are overcrowded, and community health centres are at capacity, as are many doctors in private practice. Public health nurses are also stretched beyond reasonable limits. At the same time, the need for services is rapidly growing, with an aging population and a growing number of poor people. The question of how to provide existing services in a viable and sustainable manner is difficult to answer at this point. There is a general movement towards preventive health services in government policy. However, the increasing emphasis on the determinants of health requires a commitment that goes beyond rewarding innovation, to recognizing the long-term nature of the problems facing homeless women in Ontario.

2.5 CONCLUSION

The findings of this literature review, including the principles of best practice, are examined in Section 5 in light of the results of the service inventory and focus groups undertaken as part of this study. The definitions of service integration which have been proposed provide a useful context for examining the examples of services for homeless people operating in communities across Ontario profiled in Section 3 of this report.

⁹⁰ Sistering 2002: 84.

⁹¹ Ontario Medical Association 1996.

⁹² Sistering 2002: 82.

⁹³ Ensign and Panke 2002.

3.0 INVENTORY OF INITIATIVES

The following is an inventory of programs and initiatives which demonstrate ways in which services for women who are homeless or at-risk of homelessness are being delivered in communities across Ontario. In selecting initiatives to profile in this report, emphasis was placed on projects and programs which illustrate one or more of the following three definitions of integration:

- A variety of services that ‘wrap around’ the client, including integrated physical and mental health services, and services that follow a client from emergency shelter to permanent housing
- Co-location of services: multiple services offered at a single site or in locations where women live or congregate
- Inter-agency coordination and partnerships that ensure women obtain appropriate referrals to services they need.

The initiatives were also selected to highlight a variety of locations (centres of big cities, suburbs, smaller cities, and rural and isolated areas) across the province. Initiatives that serve particular at-risk populations – Aboriginal, Black and refugee women, single mothers, women with disabilities or chronic poor health, young women, and lesbians – were also sought out.

A particular focus for the research team was how the delivery of health-related services for homeless populations is integrated with other services such as housing and income supports. Health services were understood to include physical, mental, emotional and spiritual components and include: primary care, dental care, treating the physical and emotional impacts of violence, mental and emotional health, sexual and reproductive health, pregnancy, peri-natal and pediatric services, and substance abuse prevention.

3.1 OVERVIEW

Outreach to 145 contacts in community agencies, service organizations, and municipal governments directed the research team to dozens of homeless initiatives across Ontario. (*See Appendix A for a list of contacts*). The 35 initiatives profiled in this report are from 15 communities in Ontario. (*See Table 1*). A selection of initiatives from urban, suburban, small town, and rural communities are included in this grouping, as are projects operating in Northern, South/ Southwestern, Central and Eastern parts of the province and the Greater Toronto Area (including Toronto).

Many of the initiatives were explicitly designed to meet needs of homeless people. Some can be described as initiatives which seek to prevent homelessness, through working with those at-risk of homelessness. In selecting initiatives to assist women who are at-risk of homelessness, the research team recognized risk factors such as abuse, marital breakdown, poverty, physical or mental illness, and have included initiatives which address these variables. All of the initiatives profiled count homeless or at-risk women among the client group they serve. Eleven are services specifically designed and delivered for women (including two aboriginal women’s services), four are services by and for aboriginal communities and two are services for youth/young adults. Twenty initiatives serve a mixed client group, both men and women, and many serve homeless people as well as those at-risk of homelessness.

This inventory includes a diverse range of initiatives, based in different types of settings, from health clinics to drop-ins to shelters to supportive housing. All the initiatives demonstrate some form of integrated or coordinated services, appropriate to, for example, their location, needs of their client group, and funding stream. The inventory is divided into eight sections:

- Health Centre Services

Table 1: Summary of Initiatives by Geographic Location

Region	Location	Number of Initiatives Profiled
Northern Ontario	North Bay	1
	Cochrane District	1
South/South West	Cambridge	1
	Hamilton	2
	London	1
	St. Catharines	1
	Southwold	1
	Windsor	1
Greater Toronto Area(GTA) - including Toronto	Oshawa	2
	Peel	2
	Toronto	13
Central Ontario	Haliburton	1
	Minden	1
	Peterborough	1
Eastern Ontario	Kingston area	1
	Ottawa	5
Total Initiatives Profiled		35

- Outreach Teams
- Case Management Services
- Programs in Women's Organizations, Drop-ins, and Community Organizations
- Shelter Based Programs
- Services Attached to Transitional and Permanent Housing
- Inter-Agency Networks

Some of the initiatives clearly span across these categories. The purpose in categorizing them is to draw attention to specific aspects of the way services are delivered.

Full contact information and a summary of each initiative profiled in this report can be found in Appendix B. References to agencies and programs that are bolded in the following texts indicate that there is a profile elsewhere in this section on that initiative.

3.2 HEALTH CENTRE SERVICES

Four years ago, the Province of Ontario funded a number of CHCs to do health outreach to homeless people and provide primary health care, assistance to individuals applying for health cards, mental health counselling, and psychiatry. The Health Outreach program of the London InterCommunity Health Centre Health (profiled in this report) was one of the programs originally funded, along with initiatives in community health centres in Toronto, Ottawa, Hamilton, and Windsor. Since then, the Ministry of Health and Long-Term Care (MOHLTC) has funded other community health centres to work with homeless populations. The particular services offered, however, vary by community health centre and location. The community health centres in North Kingston, Guelph, Oshawa, Barrie, and Thunder Bay as well as Centre médico-social communautaire in Toronto have received funding in recent years under the Ministry's program for outreach to homeless populations.

Aboriginal health centres, funded through the Ministry of Community, Family and Children's Services (MCFCS) (Aboriginal Healing and Wellness Strategy), are also dedicating staff and resources to street outreach activities. For example, Anishnawbe Health Toronto has operated a Street Patrol service for the past ten years, with outreach delivering basic provisions and assistance in accessing emergency shelters. An initiative of Ottawa's Wabano Centre for Aboriginal Health is profiled in this report as an example of off-site delivery of primary health care services and addictions counselling. Toronto's Street Health Community Nursing Foundation is profiled as another model of mobile nursing services that reach inner city homeless populations.

While not a CHC, the health clinic attached to Gate 3:16, a drop-in centre in Oshawa is also profiled in this report to illustrate another model for delivering primary health care services to homeless and at-risk populations. Finally, Lawrence Heights Community Health Centre is included in this report as an example of a health centre offering a variety of health and support programs to meet the needs of individuals at-risk of homelessness in an older suburb of Toronto.

3.2.1 London InterCommunity Health Centre: Health Outreach to People Who are Homeless

DESCRIPTION

Health Outreach to People Who are Homeless is a project of the London InterCommunity Health Centre. The project's mandate is to provide increased access to primary care to people who are homeless. When Health Outreach was first launched in 1998, it operated out of the London Intercommunity Health Centre. Since then, the outreach program moved to a storefront location, in a building attached to the health centre. This is a more relaxed and informal setting than the health centre, and serves as a drop-in with a range of complementary health, emergency, and support services for homeless and at-risk clients. Funded by

MOHLTC, Health Outreach is carried out by a multi-disciplinary team including a doctor, nurses, nurse practitioners, social workers, administrative staff, psychologist, and a consulting psychiatrist.

In 2002 Health Outreach had 1700 active clients (defined by having a client file and having seen the client at least once in the past three years). On a daily basis, staff see 5 to 20 people, depending on the weather and other factors. Approximately one third of the client group is female. About half of the program's clients are living on the street or in shelters, and the rest are in unstable or temporary accommodation or at-risk of losing their housing. Of the women who are clients, two thirds have severe mental illness, and five to ten percent are young single parents.

Recognizing the difficulty in measuring the health status of homeless people, the program looks at quantitative measures in their evaluation processes, including those related to the provision of basic needs. These measures include: number of loads of laundry, number of doctor's appointments, number of applications made for disability pensions, number of clients assisted in applying for identification, and number of prescriptions. Consideration is also given to health outcomes on an individual basis, a more qualitative measure. A research study is underway to look at the incidence of Hepatitis B in the homeless population. The second part of the study looks at the ability to implement an immunization program in this population and measures the effectiveness of such a program.

SERVICE INTEGRATION AND COORDINATION

The store front location results in a wide variety of primary health care and drop-in services being coordinated and delivered at a single site accessible to homeless or at-risk individuals. In addition to diagnosis and treatment of health concerns, Health Outreach offers laundry and shower facilities, clothing, emergency food cupboard, blankets and an ID replacement clinic. In addition to these services at a single site, nurse practitioners go to two women's shelters (Women's Community House and Mission Services London) to provide primary care diagnostic and treatment services. Nurses also run periodic flu shot clinics at the Sisters of St. Joseph's soup kitchen.

Health Outreach has agreements with various local agencies serving homeless and at-risk populations to accept their referrals to the clinic and to see their clients without health cards. These agencies include: The Salvation Army, London Coffee House (a social support agency for people with mental illness), Streetscape (outreach services to homeless individuals with severe mental illness), and Youth Action Centre.

Health Outreach receives students on placement from the nursing programs at Fanshawe College and the University of Western Ontario (UWO), as well as students from UWO's social work and family medicine departments. A new initiative will result in a four month student placement from Conestoga College's program in traditional healing.

In 2002, Health Outreach secured funding through Ontario Works to offer a dental program. Eighty clients from the general homeless population, including shelters, were seen through the program. Dental services were delivered through two dentists with practices near the health centre, and a third large dental clinic at the Middlesex London Health Unit. The services ranged from full mouth exams and root canals to dentures.

Health Outreach is an example of how primary health care, mental health and dental services have been integrated with drop-in and emergency services for homeless and at-risk individuals, all delivered at one site. Health Outreach has linkages with other community agencies to facilitate referrals for clients without health cards, and is proactive in partnering with colleges and universities to involve students in service delivery.

3.2.2 Wabano Centre for Aboriginal Health: Mobile Health and Addictions Outreach Team

DESCRIPTION

Established in 1998, the mandate of Wabano Centre for Aboriginal Health in Ottawa is to prevent ill health, treat illness, and provide support and aftercare programming. Services are offered in a

culturally sensitive way that welcomes, accepts and represents all Aboriginal peoples. A satellite health centre is provided for the Algonquins of Pikwàkanagàn First Nation community at Golden Lake.

At Wabano, a range of services is offered under one roof, including: primary health care, general and addictions counselling, peri-natal and youth programs, employment counselling, support for recovery from trauma, community kitchen, referrals to housing, and connections to legal assistance. The centre also has a *Mobile Health and Addictions Outreach Team* with the goal to improve access to all services offered through Wabano for Aboriginal populations who are homeless or at-risk of homelessness. This initiative began in April 2001 and is presently funded through to March 2003. This initiative looks for outcomes in its primary care services such as: number of referrals made by the nurse practitioner to Wabano or other health or community services, number of people treated on a daily basis, and reduction in the number of visits to hospital emergency departments by the clients served through the initiative.

The outreach team serves First Nations people in Ottawa as well non-Aboriginal spouses. Some non-Aboriginal persons are also served at the satellite sites. Over the period April 1 to September 30, 2002: 238 people were served, with 79 (33 percent) being women. Ninety percent of clients are living on the streets or in shelters, with another ten percent living in unstable housing or are at-risk of losing their housing.

SERVICE INTEGRATION AND COORDINATION

Within the health outreach program, a nurse practitioner provides primary health care services at two satellite sites operated at Centre 454, a drop-in, and Sandy Hill Community Health Centre. Health services include diagnosis and treatment of a range of medical conditions, breast exams, family planning and access to birth control, needle exchange and on-site blood and urine tests. Referrals to a physician at Wabano or for psychiatric care are made as needed and clients requiring gynaecological assessments are brought to Wabano. The nurse

practitioner and two full-time addictions counsellors provide mental health and addictions counselling. The outreach team also includes a foot care nurse one day per month. Transportation, advocacy and assistance with forms and ID are provided on an as-needed basis. The team has access to Aboriginal Elders to refer clients for spiritual counselling and provides opportunities for clients to learn Aboriginal crafts and participate in a lunch program.

Services are offered in English, French and Aboriginal languages in places where homeless or at-risk people live or congregate. One focus is to ensure clients know what services and resources they are entitled to obtain. The outreach team finds culturally sensitive ways to engage with First Nations people, and opens doors for clients to access a range of health services.

At the outset of the program, the outreach team, including the nurse practitioner, tried to be "everywhere all the time." Subsequent program evaluations concluded that this approach did not adequately promote access to services. The decision was made to limit the nurse practitioner's activities to two satellite sites. The result is less time spent traveling and walking and more time spent talking to clients and providing health services. The nurse practitioner frequently consults with the clients' regular primary care providers in attempts to improve continuity of care and reduce duplication of services.

Wabano has formal partnerships with Sandy Hill Community Health Centre and Centre 454 Drop for the space required to offer the health outreach services, a lunch program and craft programming at these sites on a weekly basis. At times the partner agencies also make supplies available. Other partnerships include the needle exchange program, anonymous HIV program and infectious disease services offered through the City of Ottawa public health department.

Wabano's Mobile Health and Addictions Outreach Team is an example of health clinic services being offered off-site in partner agencies, thus

bringing services to places frequented by homeless individuals, and allowing clients to access health related and other services at a single location.

3.2.3 Gate 3:16: Street Health Centre

DESCRIPTION

Serving Oshawa, Street Health sees about 400 people per month. Staff recognize that the homeless people seen in Durham Region come from many different places, including other provinces. Approximately 50 percent of Street Health clients are women. Clients have multiple issues including addictions, mental health issues, HIV/STDs, diabetes, and are homeless or at-risk of homelessness. Major problems include obtaining proper food (underweight and overweight health issues are significant), and accessing clothing, including shoes. Of the women using Street Health, 10 to 20 percent are single parents, with another 5 to 10 percent parenting with a spouse. Five to ten percent of female clients are over 65. Close to 50 percent of the women have disabilities or chronic physical illness, and about 50 percent of female clients have severe mental health issues.

When measuring client success, staff look for individual change in factors such as: improvement of health (if illness was pre-existing); improvement in overall hygiene, physical and mental health; achievement of housing; and acceptance and follow through of referrals to needed services.

Initially funding for Street Health came through the Supporting Communities Partnership Initiative (SCPI). Current funding, which ends in January 2003, is through the Region of Durham.

SERVICE INTEGRATION AND COORDINATION

Street Health is staffed by a nurse practitioner and an office coordinator who does some minimal counselling, both working four days per week. A physician comes in once per month to see patients whose needs are beyond the scope of practice of the nurse practitioner. The centre has also had a student on placement from Durham College in the Human Services Counsellor program. Services at Street

Health include: physical assessments, referrals to psychiatry, foot care, prescriptions, referrals to mammograms, x-rays and lab work services which are available across the street, sexual health counselling, treatment and counselling for diabetes, prescriptions, immunization, nutritional counselling, blood pressure, dressings, life skills counselling, management of aggressive behaviour, housing assistance, job counselling, clothes, showers, pregnancy counselling, and pre-natal care.

Street Health is located next door to Gate 3:16, a drop-in centre for homeless or at-risk individuals. Gate 3:16 has a literacy program, housing counselling, and crisis counselling, a food program, a barber, access to computers, and also refers clients to Street Health. The Refuge, a drop-in for teens is also located next door. Street Health staff facilitate information sessions on health issues at The Refuge.

A variety of other agencies refer clients to Street Health including: Cornerstone (men's hostel), Denise House (centre for abused women), YWCA women's hostel, Our Place (drop-in), Canadian Mental Health Association and the Salvation Army's Durham Region Mobile Outreach Project (street outreach). The clinic works with the Oshawa Community Health Clinic to jointly identify needs and find ways to respond. An example of an area of collaboration is an initiative to offer dentistry services.

3.2.4 Street Health Community Nursing Foundation

DESCRIPTION

Since 1986, Street Health has been providing services to homeless and under-housed persons. They provide outreach nursing clinics at a number of shelters and drop-ins in downtown Toronto and at outdoor locations where there are people sleeping rough. An AIDS prevention/harm reduction team is out each evening on the streets of the neighbourhood that is often described as the epicentre of homelessness in Toronto. Another program offers assistance with the replacement of lost or stolen identification. Through their

combined programs, they reach several hundred clients per week. Approximately one third of their clients are women, the majority of whom live on the street or in shelters and range in age from youth to seniors. Many of the female clientele are Aboriginal, immigrants or refugees.

SERVICE INTEGRATION AND COORDINATION

Street Health provides a range of health services during regular business hours, and an increasing number of services in partnership with night-time mobile outreach programs to people sleeping rough including Street Survivors of Central Neighbourhood House and Regent Park Community Health Centre. HIV and Hepatitis C testing is done in conjunction with Toronto Public Health's The Works (a needle exchange site with outreach van serving downtown core). A Cancer Screening Project for women is being carried out with St. Michael's Hospital, and a mental health case management program is being offered in partnership with Central Neighbourhood House and Fred Victor Centre. For dental care, chiropody and physician follow-up, clients are referred to the three central Toronto Community Health Centres. Street Health has a nursing volunteer component and encourages students (e.g. nursing and social work) to complete their placements at the agency.

3.2.5 Lawrence Heights Community Health Centre

DESCRIPTION

Lawrence Heights CHC is a multi-service centre in Toronto providing free primary health care along with a variety of health promotion programs. The centre sees a total of 2000 clients a month, with the centre's health promotion services helping approximately 300 people a month. Ninety percent of the health promotion clients are female, and 75 percent immigrant or refugee.

SERVICE INTEGRATION AND COORDINATION

The primary health care team consists of nurses, nurse practitioners, physicians, dieticians, and chiropodists. Additional services and programs run from the centre include: crisis counselling;

interpreters; pre- and post-natal programs with participants receiving transit fare, grocery vouchers, and food supplies; social and support groups for youth, women and men; and case coordination and support for individuals requiring help obtaining social assistance, housing, or other services.

Like several community health centres located in Toronto's inner suburbs, Lawrence Heights CHC is beginning to respond to the issues of women who are homeless or at-risk of homelessness in their community. A Friday drop-in program, begun in November 2002, offers a hot meal, access to showers, and programming to be set by the drop-in clients (likely to include a foot clinic and other health services).

In February 2003, the centre began offering dental programs for seniors and children. There are two new affordable housing projects opening on Lawrence Avenue West (Out of the Cold's Trellis Gardens and another project across the street) and the CHC is discussing what services will be provided for these potential clients. Lawrence Heights also works extensively with specific new Canadian communities (Somali, Spanish-speaking, and Caribbean), where families are severely under-housed but reluctant to self-identify because of immigration and building code issues. A pilot program on mental health services for the Eritrean community is underway, and Lawrence Heights is also working with Family Service Association, Community Resources Consultants of Toronto (CRCT) (see Hostel Outreach Program), and the Centre for Addiction and Mental Health (CAMH) (see Shared Care) to provide awareness training with and outreach to specific refugee communities (e.g. Tamil, Iranian, and Eritrean).

3.3 OUTREACH SERVICES

Outreach services exist in a number of larger urban communities and vary in terms of their services and mode of delivery. Some initiatives spring from community agencies or local government initiatives, while others originate from within faith communities.

The goals of these services are to reach out to people who are homeless, including people sleeping rough, develop trusting relationships with them and foster their connections with specific services designed to meet their needs. The process of building a trust relationship and then connecting the individual to services can take weeks or months and occurs over many different contact opportunities. Initial outreach typically begins with a range of services, from hot food to basic supplies, and basic health services.

Following are descriptions of three mobile outreach programs:

- Street Outreach (City of Hamilton)
- Durham Region Mobile Outreach Project
- Homeless Outreach Program: Region of Peel.

3.3.1 City of Hamilton: Street Outreach

DESCRIPTION

Street Outreach is a component of the City of Hamilton's Mental Health/Outreach Program, administered through the Community Programs Branch of the Social and Public Health Services Department and funded through MOHLTC and MCFCS. The City's Mental Health Outreach Program includes a case management service, harm reduction program, and a van needle exchange program that consists of a mobile service and a Street Health Centre. The Mental Health/Outreach Program also provides an outreach worker to assist on the community health bus providing general health and dental services.

Street Outreach goals include: outreaching to and developing relationships with individuals on the streets and in shelters who are not accessing social and health services; assisting them in accessing services; and promoting harm reduction behaviours. The program focusses on individuals who are homeless or at-risk of homelessness and targets individuals living with mental illness, those at-risk

of HIV/AIDS, as well as youth and families and others without significant mental health issues.

In 2001/2002, a total of 1,006 clients were seen – 568 clients on a one-time basis, engagement with 271 new individuals and an additional 167 clients continued to be seen from the previous year. Forty percent of the clients were female. In four years, the Street Outreach Team has seen an increase in the number of clients they visit more than once (from 35 clients to 438). The program has six street outreach staff funded by MOHLTC and two nurses funded by St. Joseph's Healthcare Hamilton who focus on individuals living with a mental illness; along with two staff funded by MCFCS who work with youth and families who are homeless. The 2.5 full-time equivalent (FTE) needle exchange program staff and the one harm reduction worker are funded by the MOHLTC.

SERVICE INTEGRATION AND COORDINATION

Street Outreach staff assist individuals living on the street and those who are at-risk of homelessness to access health care, transportation, supplies, food, educational and employment opportunities, housing, financial assistance, and home repair services. They provide substance abuse counselling, connect clients with spiritual communities and social service agencies, educate around harm reduction techniques, and advocate on their behalf.

The City contracts with local agencies to staff the street outreach team which is comprised of staff from agencies providing services in the following areas: addictions, housing assistance, family housing, health care, pastoral services, harm reduction, and sexual assault counselling. A Minister on the team also provides clients and staff with support related to issues around grieving, dying, death and spiritual counselling. These staff come to the outreach team knowing the client group, culture, and network of community agencies and they return to their agencies for half to one day per week, allowing for increased sharing of information, networking and capacity building.

The program has formal partnerships with the following organizations to obtain staff or services:

Hamilton AIDS Network; Wesley Urban Ministries; Housing Help Centre; Centenary United Church; Alcohol, Drugs and Gambling Services; St. Matthew's House; Salvation Army; Good Shepherd Non-Profit Homes Inc.; St. Joseph's Healthcare Hamilton; Hamilton Urban Core Community Health Centre; and the Sexual Assault Centre (Hamilton and Area).

3.3.2 The Salvation Army: Durham Region Mobile Outreach Project

DESCRIPTION

Begun in May 2001, the Mobile Outreach Project is an initiative of the Salvation Army Emergency Disaster Services. The project is funded through Durham Region's Homelessness Initiatives Fund with in-kind support from the Salvation Army's Family Services division and numerous agencies. A van travels twice a week to pre-determined stops to provide support and referrals to those who are homeless or at-risk of becoming homeless in Durham Region. Hot meals are prepared and served from the van, with over 50 people receiving breakfast on Wednesday mornings and 70 to 110 people receiving dinner on Monday evenings. An estimated ten percent of clients are living on the street or in shelters, with another 50 percent in unstable housing or temporary accommodation or at-risk of losing their housing. Approximately 40 percent of clients are in stable accommodation, but financial hardship brings them out to the van for the meals and other services. From July 1 to October 31, 2002, this program served 1,909 persons. An estimated 30 percent of clients are women, and of these an estimated 20 percent have severe mental health issues.

SERVICE INTEGRATION AND COORDINATION

In addition to the driver, the van travels with a cook, a nurse practitioner and a community health worker from a local hostel or women's shelter. A partnership with Durham College has resulted in student nurses also traveling with the van. The van stops at two designated areas, including a location adjacent to a creek area where some individuals

sleep in the rough. Clients know when and where to expect the van. The services available through the team on the van include hot meals, information and referrals, transportation to housing, sleeping bags, shoes, mittens, hats, needle exchange, housing counselling, and health services. Typical health services include health assessments, treatment for immediate concerns, blood pressure, temperature, dressings, referrals to clinics, and transportation to hospital.

Collaboration between a number of agencies makes this mobile outreach service possible. Outreach workers on the van come from Denise House (women's shelter), YWCA Women's Shelter, Bethesda Housing (Muslim Women's Shelter), Cornerstone (men's shelter), The Ark, Colbourne Crisis Centre (agency focusing on mental health issues), Gate 316 (drop-in centre), John Howard Society (services for individuals in conflict with the law), Our Place (youth drop-in), and South Oshawa Community Centre. Registered nurses come from Canadian Mental Health Association and Gate 3:16 Street Health Centre.

3.3.3 Region of Peel: Homeless Outreach Program

DESCRIPTION

The Region of Peel, like many other municipalities, has a homeless outreach program. In 2001, over 200 people were served through this program. This is a mobile case management service that operates with two vans and a help line which homeless individuals can use to reach the outreach staff. Referrals come from a wide variety of sources including the police, housing providers, shelter workers, Ontario Works staff, community drop-ins, and doughnut shops. Services are also available to individuals and families at-risk of eviction.

SERVICE INTEGRATION AND COORDINATION

The program results from collaboration between Canadian Mental Health Association, Peel Addiction Assessment and Referral Service, Catholic Cross Cultural Services, and the Region's Departments of Housing and Property, Social Services and Health.

Mobile case management services are operated with a team consisting of Ontario Works staff, mental health workers, public health nurses, addictions counsellors, and family transitional workers. The family transitional workers work with families in shelters or at-risk of homelessness in the community to help ensure rent is paid, children are in school, and family members are attending counselling and receiving any needed supports. The team is committed to following clients, responding to calls and referrals coming in and not just making scheduled stops in the van. Basic health care, food, coupons, clothes, and sleeping bags are available through the van, with the primary goal being to engage the client. If an issue is identified (e.g. addictions), then the team member returns the next day with a counsellor to address the particular need.

The outreach team does a follow up with families and individuals who have moved out of the Region's shelters, with the aim to help prevent eviction or further homelessness. Weekly team meetings ensure communications among the outreach staff, and other community agencies are engaged on an as needed basis.

3.4 CASE MANAGEMENT SERVICES

Case management can result in clients experiencing seamless access to a wide variety of supports and services which are brought together to meet the clients' individual needs. Many agencies offering case management services also have health or housing initiatives integrated into their programming. For example, CMHA in Windsor provides case management services for individuals with severe and persistent mental illness, and has an on-site health clinic staffed with a multi-disciplinary team to meet the needs of CMHA clients and their families. CMHA in Ottawa has extensive case management services, programs for outreach to homeless people in shelters and on the street, court support program as well as a housing program that has expanded over the years.

Following are two examples of case management services, both operating in Toronto. The first is the Shared Care Program, coordinated by the Centre for Addiction and Mental Health, which has a strong emphasis on mental and physical health issues and partnerships between multiple agencies to better coordinate services for clients. The second example of case management services is the Hostel Outreach Program, operated by Community Resources Consultants of Toronto.

While not strictly a case management service, a third initiative is also profiled: Pathways for Children and Youth: Wraparound Initiative. Similar to case management services, this initiative works with clients to identify their goals and needs, and works to link clients to the supports, services and opportunities they are seeking, by helping to reduce any barriers to access they may be experiencing.

3.4.1 Centre for Addiction and Mental Health: Shared Care Clinical Outreach Service of the Schizophrenia Program

DESCRIPTION

The Shared Care Clinical Outreach Service operates from nine downtown east Toronto sites, three of which (Fred Victor Centre, Adelaide Women's Centre, Metropolitan United Out of the Cold Program) serve women. The goal of the initiative is to provide holistic care to mentally ill homeless people in an accessible and respectful manner. This entails an approach integrating physical and mental health care as well as psychosocial considerations with a focus on initiating long-term preventive health relationships by bridging care between clients and the community resources meeting their biopsychosocial needs. The program serves about 250-300 people per four week period, of which approximately 25 percent of those served are female, mostly older homeless women with mental health problems. There are five nurses and five caseworkers, along with a housing worker (provided through the City of Toronto's Homeless Initiative Fund) working full-time on the project, and .3 FTE manager

(provided through CAMH), four psychiatrists and six family physicians working various sessions throughout the week.

SERVICE INTEGRATION AND COORDINATION

The partnership, which includes nine shelters and drop-ins, CAMH, St. Michael's Hospital, the University Health Network, the City of Toronto, and the Ministry of Health, has been in operation since 1998. Clients referrals are received from a variety of sources, including self-referral, counsellors at hostels and drop-ins and public health nurses. Every partner site has set clinic times, where family physicians provide primary care and psychiatric care to clients and a psychiatrist is available for consultation with the doctor and team. Shared Care also works in partnership with Houselink Community Homes at various sites in a project supporting clients' transition from hostels to supported independent living. Although clients may be accepted into a doctor's private practice, the program does not explicitly facilitate this process.

The service provides links between emergency and long-term housing, physical and mental health care workers, agencies and medical services. It is thus an example of integrated case management which also aims for continuous care and coordination between housing and health services. A common theme in this initiative, and the projects which follow, is bringing the health services to homeless people in order to surmount barriers to access.

3.4.2 Community Resources Consultants of Toronto: Hostel Outreach Program

DESCRIPTION

Since 1988, the Hostel Outreach Program, a program of Community Resources Consultants Toronto, has provided outreach and support to women who are homeless or at-risk of homelessness and who also have significant mental health problems. The program serves approximately 160 female clients at any given time. There is a parallel Hostel Outreach Program run by Community Occupational Therapists and Associates (COTA)

Comprehensive Rehabilitation and Mental Health Services for men. Of the 160 clients, about one quarter are living on the streets, another one in eight are staying in hostels, and the remainder are either in a mental health hospital, correctional facility or in a variety of transitional or permanent housing situations. Like The 416 and Sistering, two organizations that staff work closely with, the program's clients generally are adult women (average age 42), generally without custody of dependent children, almost all of whom have frail physical health conditions as well as mental health issues.

SERVICE INTEGRATION AND COORDINATION

The Hostel Outreach Program provides continuous and 'mobile' case management, since it can and does follow women to jails, hospitals and shelters. About 80 percent of their work involves outreach to women's temporary and permanent housing situations, with another 20 percent of clients accessing the program's two offices at Parkdale Activity and Recreation Centre (PARC) and the Adelaide Women's Resource Centre. Although the emphasis is on mental health services, the program works with the three central Toronto CHCs and a number of doctors who regularly provide care to homeless people. An internal evaluation of the program took place four years ago, and clients are involved in the steering committee of the program (including interviewing other clients as part of the evaluation). The street outreach component of the service has increased in recent years with help from MOHLTC funding.

3.4.3 Pathways for Children and Youth: Wraparound Initiative

DESCRIPTION

Beginning in September 2000 and serving Lennox and Addington, Frontenac, and Kingston, the goal of the Wraparound Initiative is to support people who are facing multiple challenges in various parts of their lives and who have not had success with other services. Specifically the initiative works with families who have several members facing challenges in more than four areas of their life including issues related to housing, medical,

emotional, behavioural, legal, cultural, and spiritual needs, among others. The program aims to help families reduce their dependence on formal support services and increase their reliance on community and informal supports. Desired outcomes include more stability, better quality of life, and a stronger network of informal supports.

Since the program was launched, 25 families (30 adults and 53 children and youth) have been supported and assisted. Of these families, 40 percent came into the program when they were in unstable or unsafe housing or at-risk of losing their housing. Two thirds of the families are single mothers with dependent children and about 25 percent are aboriginal. The majority of the women assisted through the program have disabilities or chronic physical illness and mental health issues. About 40 percent of families are facing addictions issues.

Funding for this initiative comes from the Frontenac Management Board, City of Kingston, Prince Edward and Lennox and Addington Social Services, foundations and the United Way. Similar initiatives exist across the province.

SERVICE INTEGRATION AND COORDINATION

This initiative results from a partnership between Pathways for Children and Youth, Kairos (an addictions agency), Youth Diversion (youth in conflict with the law), Frontenac CAS, Lennox and Addington Family and Children's Services, Limestone District School Board, Land O'Lakes Community Services, Lennox and Addington Addictions, St. Lawrence Youth Association, Lennox and Addington Interval House, Frontenac Community Mental Health, Algonquin and Lakeshore Catholic District School Board, District Health Unit, and Homebase Housing. All partners donate time for senior staff to sit on the steering committee for this program, and four agencies donate facilitators to work with the families. Pathways donates administrative assistance as well as facilitators, and Youth Diversion is helping by cost sharing.

The service is individualized to meet the needs of the family. Each family in the program is assigned a facilitator who works with the family to identify

their goals and strengths. The facilitator also helps the family identify who their informal and formal supports are, including friends and professionals. The facilitator then arranges child and family team meetings, to bring the family members together with support people in their life. These meetings typically bring together six to ten people with the purpose of finding ways to assist the family in practical ways as they work towards their own goals. During the meetings, the facilitator works to keep the focus on the addressing the families needs and to ensure that the family is fully participating. The team meetings usually take place in the client's home.

The Wraparound Initiative does not itself provide families with direct counselling, but instead looks for ways to meet the families' needs. The facilitators offer practical support to the family and ask the team members to take on tasks that will assist the family. The process goes on as long as it needs to, with more intensive work with the family taking place in the initial months and becoming less frequent over the course of several months. The initiative provides families with information about resources that are available to them, assistance with advocacy, links to community supports, and assistance with logistical problem solving. It also facilitates families' access to the services and supports they need by focussing on barriers to access and helping in practical ways (for example, by arranging child care or transportation in rural areas).

This initiative has one FTE and five part-time facilitators coming from partner agencies.

3.5 SHELTER BASED PROGRAMS

Across the province there is significant variation in the nature and types of shelter and shelter services which are available. These variations are in part due to the geographic and demographic characteristics of the area, client group served by the shelter or hostel, the size of the facility and the funding sources available to the agency. In some communities, shelters are closely linked with or are part of multi-service agencies. Elsewhere, shelters are operated

independently of other service organizations.

A number of initiatives are underway in Ontario communities to attach a full range of services, including health services, to shelters. Included in this section is a description of a multi-service facility, shelter and transitional housing development underway through the Cambridge Shelter Housing Corporation. Similarly, the Salvation Army in London is working on the development of a facility with over 200 emergency and short term stay beds combined with on-site primary health care services, dental services, psychiatric and addictions services and other supports to help stabilize the lives of homeless people staying at the shelter. The YWCA in Toronto has a new 30 bed emergency shelter for assaulted women scheduled to open in 2003, which will have links with community health centres and the Hostel Outreach Program, and provide both general and mental health counselling. An estimated 40 percent of clients at this shelter will be without formal citizenship status, and the majority of clients will be recent immigrants whose first language is not English.

Critical services that are now evident in some shelters and community organizations are follow-up and support programs for ex-residents of shelters. These are programs which continue to provide support even after clients move into permanent housing, and can help keep women from becoming homeless again. The Follow-Up Program operating through the Emily Stowe Shelter in Toronto, for example, provides women leaving the shelter with ongoing support such as advocacy with the legal system and income support programs, accompaniment to medical and other appointments, links to services to assist with mental health issues, and access to cultural interpreters.

The following are examples of programs based in shelters which demonstrate the integration and coordination of a variety of services for homeless people:

- Region of Peel: 24 Hour Shelter

- Cambridge Shelter Housing Corporation
- Robertson House: Young Pregnant Mother's Program
- At Iohsa Native Family Health Centre: Shelter and Transitional Housing
- North Bay Indian Friendship Centre: Shelter Project
- Ottawa Inner City Health Project.

3.5.1 Region of Peel: 24 Hour Shelter

DESCRIPTION

Responding to community needs for more shelter beds and support services for individuals and families in shelters, Peel Region opened a new 24 hour family shelter in December 2002. The region has two other shelters that are open 24 hours a day, seven days a week. The Mississauga location opened in 2000 and houses 40 men and 20 women and a Brampton shelter opened in 2001, with 84 beds. Peel Region covers a wide geographic area, includes one million people, and is lacking in public transit infrastructure. Up to 40 percent of shelter users at the Brampton site are employed, and are in the shelter due to a lack of affordable housing.

SERVICE INTEGRATION AND COORDINATION

A variety of programs and services are available in the new 24 hour shelter. Housing workers help clients broker relationships with landlords and provide advice about tenants' rights. They also assist clients in a housing after-care program when and if problems with employers or landlords emerge after the client has left the shelter. The shelter also has employment resource rooms and an employment counsellor, an initiative originally funded through Human Resources Development Canada (HRDC), and now funded by the Region. Front line staff provide clients with assistance with income supports such as Ontario Works, employment issues, referrals to outside agencies and help accessing health services. Health services are provided by a public health nurse and a physician (acting

in a volunteer capacity) who are in the shelter one day per week and can be contacted in emergencies.

3.5.2 Cambridge Shelter Housing Corporation

DESCRIPTION

The Cambridge Shelter Housing Corporation grew out of two initiatives: the local Out of the Cold program and a drop-in centre for homeless men and women. The corporation is developing a 40 bed emergency shelter, 20 bachelor units of transitional housing, a mini-apartment unit to use as emergency shelter for a family, and a drop-in, all to be contained within the complex. The start up and building costs are anticipated to be \$2 million, with an annual operating budget of \$350,000. Funding sources include SCPI, City of Cambridge, Trillium Foundation, Kiwanas Club, the Region of Waterloo, and fundraising. Construction is scheduled to begin spring 2003, with completion expected by Fall of 2003.

The goal of the Corporation is to work with persons who are homeless or at-risk of homelessness to help them realize their dreams and aspirations, and to assist them to move out of their homeless situation. Outcomes are measured by the number of people who are moved off the street into housing and into employment or income support programs and number of people moved into treatment and successfully moved into secure housing upon their return to the community. Consideration will also be given to what impact the new facility has on where homeless or at-risk individuals congregate in the city.

The currently location of the drop-in is the Lion's Community Hall where service is provided weekdays. When re-located to the new complex, the drop-in will operate seven days a week. At present 100 to 150 clients are seen in the drop-in each day, with women representing 20 percent of the client group. The Out of the Cold program feeds 60 to 80 people each day, and sleeps 20 to 30. Thirty percent of the clients fed through Out of the Cold are women and children, indicating that the

program is reaching families who are at-risk of losing their housing due to economic circumstances. Sixty percent of the clients are living on the streets or in emergency accommodations, with the remainder in temporary or unstable housing. Of the women served by the programs, over 50 percent are single parents with children, 20 percent are youth, 20 percent have disabilities or chronic physical illness, and 60 percent have severe mental health issues.

The drop-in and Out of the Cold employ three FTEs, with the drop-in having 60 volunteers and Out of the Cold having 600 volunteers. The corporation has an advisory council of clients to identify the service needs that the drop-in and the new facility should strive to meet and to participate in the evaluations of current services. Former clients of the drop-in are among the current volunteers, and the expectation is that some former clients may be hired to help staff the new facility.

SERVICE INTEGRATION AND COORDINATION

A visiting practical nurse and physician from Langs Farm Neighbourhood Association provide on site diagnostic and treatment services, manage chronic pain, and provide sexually transmitted diseases (STD) and gynaecological care. The local Victorian Order of Nurses (VON) provides foot care. Planned Parenthood provides access to birth control and family planning and the CMHA provides case workers for clients with mental health issues. The local public health unit provides supplies for a needle exchange service. The drop-in has linkages with five regional addictions counselling agencies and provides transportation to a detox centre in Kitchener. For people returning from a drug and alcohol treatment centre, the drop-in offers an after-care program. Staff from a local literacy organization spend a half day per week at the drop-in, a local employment agencies places trainees at the drop-in, and a divinity student from St. Paul's College in Toronto has a regular presence.

Agency staff advocate on behalf of clients with local agencies, and assist clients in obtaining ID and understanding what they are entitled to receive. Workshops are held at the drop-in on topics such as

AIDS/HIV, anger management, and alcoholism. A partnership exists with the YMCA to permit clients of the drop-in to use the Y's showers and pool.

Clients at the drop-in typically sign a release form that allows for sharing of information between health service providers. The drop-in's outreach workers refer clients to the literacy and other programs, and a file is kept on each client to track notes about referrals, and doctor's appointments. Services are offered in French and Portuguese as well as English.

While the drop-in has been offering a wide range of health, advocacy, education, and other services through partnerships with multiple agencies, the new facility will further assist clients in overcoming barriers to accessing services by co-locating the drop-in, transitional and emergency housing, health, and other supports under one roof, while maintaining community partnerships. This model of service is a strong example of inter-agency coordination as well as a service hub for integrating services for homeless women and men.

3.5.3 Robertson House: Young Pregnant Mother's Program

DESCRIPTION

Robertson House is a shelter for homeless women and their children, operated by the City of Toronto. Since 1998, Robertson House has provided between six and 12 single rooms for pregnant or young mothers living on the street or in shelters. A total of 86 pregnant women have used the program since its inception, staying an average of six months, usually from the sixth month of pregnancy onwards.

SERVICE INTEGRATION AND COORDINATION

The goal of this intensive program is to provide 'seamless' pre- and post-natal supports for young mothers and their children, and to try to move them out of homelessness. 'Seamless' implies both continuity of care, and a holistic health approach. The initiative uses a 'wraparound model,' whereby an intervention team, chosen by the woman herself, helps in the identification of individual strengths

and the development of a plan for moving to permanent housing. The initiative also provides integrated health care, through on-site counselling and medical care. There is a full-time counsellor and part-time nurse on site at Robertson House. Toronto Public Health, City of Toronto's Children's Services, all three Children's Aid Societies, Oolagen Children and Youth Mental Health Agency, and St. Michael's Hospital, all do site visits to Robertson House. The 'wraparound' team continues to provide services, after the family has moved to permanent housing.

There is a reference group of agency staff seeking to expand this model to other shelters and hostels. Oolagen Community Services provides staff training on the 'wraparound' model. In short, although this is an intensive and expensive model, it is replicable and considered to be a success, although actual outcomes have not yet been formally evaluated.

3.5.4 At Iohsa Native Family Health Centre: Shelter and Transitional Housing

DESCRIPTION

At Iohsa offers shelter services for aboriginal women in the London area combined with supports and a new transitional housing program. Serving over 280 women and 14 men in various programs over the past year, the centre has the equivalent of 32 FTE. Women who use the centre's emergency beds are in crisis situations or leaving abusive relationships. Sixty percent of the client group are aboriginal women and another ten percent are new immigrant, refugee, or visible minority women, including women who do not speak English. Roughly 65 percent of the women served are single with children, ten percent are youth, ten percent are seniors and 20 percent self identify as lesbian, bi-sexual or transgendered.

The centre operates a 20 bed emergency shelter in one downtown London location, and in April 2002 opened a second facility. By entering into a partnership and lease agreement with the owner of

the building where the centre's offices are located, they were able to have the second floor of the building renovated into two 1,000 square foot loft spaces. One space is operating as a crisis intervention centre, with five emergency beds, crisis counsellors, transitional workers, and a crisis line. The adjacent space has been organized into three bedrooms, housing up to six women in a transitional housing program. Women in this program are entitled to live in this rent-g geared-to-income loft apartment provided that they are working through and abiding by a plan of care (or contract) they signed with the centre. In addition to the shelter and transitional housing program, the centre has a three bedroom unit available in private rental housing where a family can live for up to two years as transitional housing. This housing is geared to income through the Province's rent supplement program. Other sources of funding for the Centre include SCPI and Urban Aboriginal Strategy funding, MCFCS, a private foundation, and fundraising.

The centre has both men's and women's counsellors available, and takes a traditional approach to healing the body, mind, and spirit. Transition workers are available to help women move out of the shelter or transitional housing. These workers accompany the women to look at housing, and will provide transportation to doctors appointments and lawyers if necessary. The centre has a small emergency fund available, as part of its homeless prevention work, and is accessed by households experiencing a financial crisis that could jeopardize their housing or the wellbeing of their children (e.g. unpaid utility bills). A partnership with the retailer Costco, a local native friendship centre, two native housing coops has resulted in food (dry goods) being dispersed throughout the community twice a month to households in need.

SERVICE INTEGRATION AND COORDINATION

At Iohsa brings together shelter and transitional housing and support services with traditional healing programs, in addition to entering into partnerships with other agencies for the delivery of particular programs. A public health nurse provides information and assistance with communicable

conditions (such as lice or scabies) as well as nutrition and hygiene counselling. Children's Aid Society (CAS) workers are on site for issues relating to supervision orders, or custody and access orders. A representative from the City of London's social housing registry is on-site weekly to take applications for rent-gated-to-income housing. A representative of the Ministry of the Attorney General victim witness program is on site to do safety planning with at-risk women in the shelter. The centre has arrangements with seven other native agencies to help clients access emergency beds elsewhere if they can not be accommodated at At Iohsa. Transportation is provided if necessary. Referrals are made to Nokee Kwe (which means 'working woman') on issues related to employment, job retraining or literacy.

3.5.5 North Bay Indian Friendship Centre: Weegwahs Weegwahn

DESCRIPTION

While Weegwahs Weegwahn (Birch Bark Home), a shelter, is new as of June 2002, the North Bay Indian Friendship Centre has been operating for 27 years. The combination of a new shelter with the services offered through the friendship centre exemplifies the integration of emergency housing, health, social, employment and other supports to meet a range of needs that Aboriginal clients in an urban setting are presenting. The shelter is located adjacent to the friendship centre.

A local study identified the need for about 40 beds to serve the needs of homeless Aboriginal people in North Bay. The friendship centre's 24 hour shelter provides six beds, and operates with one fulltime and one part-time staff person, with funding from HRDC's Urban Aboriginal Strategy fund. The goal of the shelter is to provide the homeless or at-risk person with a place to stay for a short term (no longer than four to six weeks); to link her or him to financial supports through Ontario Works or other income support programs as well as to needed health services; and then to link to landlords and assist with moving into a place of their own, that

can be sustained. Once a client has moved out of the shelter, the expectation is that she or he will stay connected with the friendship centre.

SERVICE INTEGRATION AND COORDINATION

Through the friendship centre, which offers services in English, Ojibway, and Cree, clients access health services through a nurse practitioner who is on site once per week. These services include: family planning and birth control, pre-natal care, gynaecological and STD care, substance abuse and addictions counselling, foot care, diabetes monitoring, and flu shots. Traditional Aboriginal healing programs are also offered, as is access to elders for supportive counselling. Staff assist with forms, advocacy and obtaining ID, and transportation is provided to clients as needed. HRDC employment resource centre services are housed within the centre. A variety of other programs, including Healthy Babies, family and criminal court services, and life long care (outreach to elderly persons living in the community), are also offered through the centre. In 2001, aboriginal clients made over 1,450 visits to the centre, with about 70 percent of the client group being female. Among a handful of women who have made use of the shelter since June 2002, all were women with children, all were under 25 with no identified disabilities or chronic physical illness. The issues facing these women using the shelter included substance abuse, poor self esteem, and abusive relationships. Coming into the shelter is an entry point for these clients into the friendship centre.

The strength of the integration of shelter services with a friendship centre is the non-institutional character of the facility. It is "user-friendly" with a variety of craft and social activities taking place. This more quickly fosters a trust relationship between the centre staff and volunteers, and the clients. The physical proximity of the shelter and the friendship centre makes a wide range of services and social supports more readily accessible to shelter users and provides linkages that can lead to ongoing and longer term support for the individual once her or his stay at the shelter has ended.

3.5.6 University of Ottawa, Faculty of Medicine: Ottawa Inner City Health Project

DESCRIPTION

Sponsored by the University of Ottawa's Faculty of Medicine, the Ottawa Inner City Health Project began in May 2001 and is currently funded to April 2003 through SCPI and the City of Ottawa's Homelessness Initiatives Team. The goal is to provide health care services to men and women who are chronically homeless and unable to use regular services due to lifestyle or complex health needs. Two thirds of the total clients served by the project have both severe and persistent mental illness and substance abuse problems. The project is targeted to serve 150 clients per year, half of whom are living on the street and the rest using shelter services. In the first six months of the current operating year, 111 clients were served, and expectations are that the project will exceed its targets this year.

Women account for about ten percent of the current client group. Of the women served by the project, all have severe mental health issues and addictions, and 80 percent are women with disabilities or chronic physical illness. Fifteen to 20 percent of the women served self identify as lesbian, bi-sexual or transgendered.

Serving Ottawa's downtown core, the Inner City Health Project has four main services:

- (1) Case Coordination and Ambulatory Care which includes intake and assessment, case management, on-site and community based primary care and assessments, coordination of care with other services such as hospitals, shelters, mental health agencies etc.)
- (2) Palliative Care which is a hospice with facilities for 24 hour care for up to 15 men, women or couples who are living with a life-threatening illness
- (3) Management of Alcohol Program for up to 20

people, where maintenance doses of alcohol are provided and clients have access to primary health care staff for assistance with health concerns; support is available 16 hours a day, seven days per week including harm reduction services and counselling.

- (4) Special Care Unit which is an infirmary with space for up to 20 men to receive care and recover from physical illness or injury for a period of up to three months; personal care is also available up to 16 hours a day, with visiting nursing and medical staff.

A multi-disciplinary team of health and service providers provides the care to clients around the clock. The team is aggressive in treating any health issues they can. Health services available to clients include: diagnosis and treatment of medical conditions (including HIV/AIDS), psychiatric care, mental health counselling, management of chronic pain, care following physical assault, substance abuse counselling, withdrawal management, needle exchange, foot care, on-site blood and urine tests, palliative care (through the "hospice" service), respite care (through the "Special Care Unit"), assistance with forms/advocacy, transportation, nutrition and hygiene basics.

Outcomes of the project to date include: improved health care for people who are chronically homeless, reduced health care costs, reduced costs of police and emergency response services, and improved quality of life for individual clients and the community. Successes of this project also include achieving a level of cooperation between all agencies involved (credited to a two year planning process) and the clients wanting to feel happy and healthy. Project evaluation includes clinical care indicators, direct feedback from clients, client satisfaction survey and resident meetings. Staff also measure clients' compliance with prescription medication and have found that 80 percent of clients take medication as prescribed (a higher compliance rate than in the general population).

SERVICE INTEGRATION AND COORDINATION

This project is a result of a partnership which

includes the University of Ottawa (Faculty of Medicine), City of Ottawa, the Ottawa Hospital, shelters for the homeless, Canadian Mental Health Association, Bruce House (serves people living with HIV/AIDS), Cornerstone (Women's Shelter and Supportive Housing), Sandy Hill and Centretown Community Health Centres, and Community Care Access Centre. Three shelters for the homeless (Union Mission, Shepherds of Good Hope, and Salvation Army Booth Centre) provide the beds and facilities required to house and care for clients in the program (in-kind contributions). Since the program began, additional partners have joined, including Wabano Centre for Aboriginal Health, the Royal Ottawa Hospital, the VON, and the Champlain District Health Council.

Physicians on the project come through the University of Ottawa/Ottawa Hospital. The City of Ottawa and the VON contribute the equivalent of two full-time nursing positions. Shelter workers at the three sites assist with referrals and some aspects of client care, and the project budget covers salaries for 20 client care workers who assist clients with personal care needs. The project is also funded for a medical director, a project director, an administrative officer, and a medical records assistant. The project also includes the equivalent of ten full-time employees from partner agencies and the equivalent of two FTEs in volunteer hours each week.

The Inner City Health Project links services for the chronically homeless to mainstream health and social services through case management and harm reduction strategies to encourage clients to reduce their substance use or to choose less harmful approaches. Substance use is not seen as a reason to exclude clients from the program if they are benefiting medically from the services. Better coordination of services for the client is the result when she/he experiences a seamless system, hence all health and service arrangements are made for the client. When a client needs care in a hospital, information about the client goes to the hospital in advance and clients do not go to a hospital emergency department without contacting the

program first. Care providers are introduced to program staff to ensure that everyone feels supported. Staff are on-call for their clients at all times, regardless of where the client is obtaining service.

The project is piloting a web-based health record, and has partnered with Dinmar Consulting to share the costs of developing the information technology system used for electronic record keeping. Multiple agencies working with the same client can share the records and use them to log the daily care provided. Clients sign a consent which identifies the team who will care for them and permits this sharing of information.

A steering committee, operating like a board of directors, oversees the whole project, and includes representatives from all partner agencies. Opportunities for student placements for social services, chiropody, physiotherapy, occupational therapy, nursing and medicine are an integral part of the project, and a multi-disciplinary curriculum on inner city health has been developed.⁹⁴

3.6 PROGRAMS IN WOMEN'S ORGANIZATIONS, DROP-INS, AND OTHER COMMUNITY SERVICES

A wide range of initiatives to assist women who are homeless or at-risk of homelessness are located within women's organizations, drop-ins and other community services. Initiatives profiled in this section come from a range of organizations, some of which specifically focus on the needs of women leaving abusive relationships or victims of crime (women who are at imminent risk of homelessness) while others are explicitly focussed on meeting the needs of women living on the street or in shelters.

The following profiles demonstrate how a variety of services are being integrated within one organization or coordinated between multiple partners:

⁹⁴ See: www.med.ottawa.ca/homeless

- Women’s Safety Network
- Nijkiwendidaa Anishnaabe Kwewag Services Circle
- Well-Come Centre
- Sistering Drop-In and Outreach Programs
- The Healing Centre
- 416 Drop-in
- St. Michael’s Hospital: Cancer Prevention Program
- Victims Crisis Assistance and Referral Service
- Concurrent Disorders Project.

3.6.1 YWCA of Peterborough, Victoria and Haliburton: Women’s Safety Network

DESCRIPTION

The Women’s Safety Network (WSN) is a satellite program of the YWCA of Peterborough, Victoria and Haliburton with the goal of assisting women and their families to be free from the effects of abuse. Begun in the early 1990s and funded by MCFCS, it is a rural outreach program for abused women and a resource centre offering crisis intervention services, court support, counselling, financial assistance to cover emergency transportation, advocacy with Ontario Works, assistance finding housing, information, and referrals. With three part-time staff serving an average of 230 women each year, WSN looks for the following outcomes: (1) that women and children are safe; (2) that women and children are housed, preferably in their home community; and (3) that abusers are charged.

About 90 percent of WSN clients are in unstable housing or temporary accommodation or are at-risk of losing their housing. Another ten percent are living in shelters or on the street. Half of the

clients have dependent children and about 40 percent have disabilities, chronic physical illness or mental health issues. WSN is able to offer 24 hour on-call support through the YWCA shelter in Peterborough.

SERVICE INTEGRATION AND COORDINATION

Staff meet with women at the resource centre, in their homes, in offices of other agencies, or other mutually agreed upon locations. WSN also uses space in church halls and elementary schools to run support groups. With many clients, support is provided over the telephone. Clients are welcome to spend the day in the resource centre. A local agency uses the WSN resource space to run programs for pregnant teens and new mothers, and the Centre for Community Living also uses the space to run its programs.

WSN maintains strong linkages with local agencies, such as Family Services of Haliburton County, CMHA Haliburton, Ontario Works, Ontario Provincial Police, CAS, and a family resource centre. WSN has a formal agreement with the latter to obtain daycare services as they are located next door to each other. They receive referrals from public health nurses, and work with Fourcast, a local addictions agency.

As there is no longer a shelter in Haliburton County, individuals and families facing a housing crisis can find themselves in difficult situations sharing with relatives or friends. These situations can be particularly difficult for women and children fleeing abuse. Currently WSN places clients in need in the YWCA’s two shelters in Peterborough, and if necessary other shelters in the area, and either transports or arranges transportation for them. Once clients move into housing, WSN has a program to provide on-going and follow-up counselling as the women continue to work towards stabilizing their lives.

3.6.2 Nijkiwendidaa Anishnaabe Kwewag Services Circle

DESCRIPTION

Established in 1994 and located in Peterborough, the Circle provides culturally relevant counselling services for First Nations women who have been, are being, or are at-risk of being abused and are residing in the Counties of Victoria, Haliburton, Peterborough, Northumberland and the Region of Durham. Services and programs are also offered for partners and families of women who have been abused. Therapeutic counselling services at the Circle include: confidential individual and group counselling, traditional Anishnaabe helping and healing methods, examination of issues resulting from early childhood trauma, crisis intervention, referrals as appropriate, and providing education and/or information on the issues of abuse.

SERVICE INTEGRATION AND COORDINATION

The circle runs three major programs at present which together result in a diverse range of services offered to clients at a single site.

Restoring the Balance assists clients in dealing with abuse that occurred in residential school environments, including how it affected a client's upbringing and the effects on all generations of her family. The program has three counsellors: one female, one male, and one for family counselling. Individual counselling, referrals to elders, sweat lodges, talking and sharing circles (separate ones for men and women), and workshops for women and their partners or women and their families are all offered as part of this initiative.

A second program offered through the circle and funded by the Ontario Women's Directorate focusses on helping women re-enter the workforce. Clients obtain assistance with job training, upgrading job skills, resume-writing workshops, and referrals.

Thirdly, MCFCSS funds transitional support workers to assist women who are in crisis or are leaving shelters. Two full-time staff provide

individual counselling, organize sharing and talking circles, assist women to leave crisis situations if appropriate, and assist women moving from shelter to transitional or permanent housing. The support workers also provide women with access to traditional medicine men and women, and advocate for the client on medical or housing issues. A long-term care coordinator oversees one day a week programming for disabled senior women. The centre also offers culturally based training and teaching involving elders and intergenerational groups ranging from crafts and sewing circles to groups on self esteem issues.

The centre has an informal partnership with Lovesick Lake Native Women's Association. The two organizations, for example, will share costs to bring a traditional healer into the community. Depending on where a client lives, the two organizations do reciprocal referrals to assist women to obtain the services they are seeking.

The Circle also runs women's talking and sharing circles outside of Peterborough (at the Native Cultural Heritage Centre of Durham and in Lindsay through the YWCA) and maintains a resource library material on oppression, cultural genocide, abuse, health, wellness, traditions and self-help sources.

3.6.3 Well-Come Centre: Shelter and Day Programs

DESCRIPTION

The Well-Come Centre in Windsor is a community based organization composed of staff, volunteers and board members dedicated to low income women and children. The philosophy is to focus on opportunities for women and children to empower themselves within a safe, supportive environment. The centre has both a shelter for homeless women and day programs. Together both programs served 1,111 women and 600 children in 2001. The client group is characterized by women on a fixed income or working poor. The education level of the client group initially is grade 12 or less. Some women pursue their education with support from the centre.

SERVICE INTEGRATION AND COORDINATION

The shelter is open 8:00 pm to 8:00 am, down from 24 hours a day, due to budget constraints. Shelter staff advocate on clients' behalf for social services, housing, legal aid, and provide court support. SCPI funding is allowing the shelter program to expand from eight to ten beds.

The Well-Come Centre day programs run between 9:00 am and 1:00 to 4:00 pm. A counsellor, funded through the Provincial Homelessness Initiatives Fund (PHIF), is on-site at the centre three days a week. Hired by the centre, she works with homeless women and women at-risk of homelessness and provides referrals to other agencies, including treatment centres as needed. The needs of the women using the shelter are usually so basic that they are not in a position to fully make use of the day programs. As a result, day programs have been adapted to include opportunities for life skills development, and budget counselling.

Housing Information Services, a local agency that matches individuals who need housing with home-share opportunities is on-site once per week as well. The Centre refers clients to legal assistance for landlord/tenant and income support issues; House of Sophorsyne (substance abuse treatment), CMHA, Sexual Assault Crisis Centre, and Community Mental Health Clinics, to mention a few. A nurse practitioner from the Street Health Program of Windsor's Teen Health Centre comes into the drop-in one half day per week and provides health services, medical assessments and treatment on site.

Other programs and services at Well-Come Centre include individual counselling, support groups (e.g. crisis and coping, boundaries, parenting, and anger management), food assistance, an informal daycare/pre-school program (while mothers attend programs), and an after school program for children in collaboration with schools.

3.6.4 Sistering: A Woman's Place: Drop-In and Outreach Programs

DESCRIPTION

Sistering: A Woman's Place operates two centres for women who are homeless, inadequately housed, or at-risk of becoming homeless: a Drop-In Centre in downtown Toronto, and an Outreach Program (which is also a drop-in) in west central Toronto (Parkdale). The Drop-In Centre is open seven days a week, from 9.30 am to 3:00 pm, while the Outreach Program is open five days a week from 9:00 am to 2:30 pm. Sistering serves mostly adult women (aged 35 and older), very few of whom have care of dependent minor children. Over half of Sistering's clients have some mental health issues, almost half are recent immigrants, 12 percent have physical disabilities or chronic illness, seven percent self-identify as lesbian, bisexual or transgendered, and about three percent are Aboriginal. The services are busiest at the end of the month, as social assistance cheques run out.

SERVICE INTEGRATION AND COORDINATION

Sistering offers clients shower and laundry facilities, use of telephones and newspapers, access to television, hot meals, and planned activities such as information sessions and workshops. Over the past year, Sistering has provided primary health care in their downtown drop-in centre, in partnership with St. Michael's Hospital. A nurse comes in two days a week and treats approximately 12 women. Although the primary purpose is cancer testing, a full range of diagnosis/treatment is offered, including diabetes, eating disorders, and care following physical and sexual assault. A mental health counsellor accompanies the nurse and provides brief counselling (see Cancer Prevention Program). They use the 'wrap-around service' model also used by the Young Pregnant Mother's Program.

A nurse from Access Alliance Multicultural CHC provides foot care every two weeks at the Drop-In Centre and every three weeks at the Outreach Centre, and a seniors nurse from Parkdale CHC provides services at both centres every two weeks. A dentist from Central Toronto CHC formerly

provided on-site services at the Drop-In Centre, but his services are now only available at public health offices. Referrals are also made to nearby health services including Central Toronto CHC, Parkdale CHC, and the Immigrant Woman's Health Centre.

Sistering has undergone external evaluations of its programs, including interviews and focus groups with its clients. Program evaluations have found that women prefer health care on site (hence integrated with other services) to referrals to other agencies. It helps to have health services available in a familiar space and medical staff who are knowledgeable and caring when working with women who are socially isolated and/or have mental health issues. Sistering has recently released a detailed report on women, homelessness and health in Toronto, *Common Occurrence* (2002).

3.6.5 Parkdale Activity and Recreation Centre: The Healing Centre

DESCRIPTION

The Healing Centre is a joint primary health care initiative of the Parkdale Community Health Centre (PCHC) and the Parkdale Activity and Recreation Centre (PARC) intended to improve access for particularly marginalized people. Parkdale CHC provides a wide range of health services within PARC, a drop-in centre for homeless and socially isolated individuals in Parkdale. Parkdale is an area of Toronto with a high proportion of low-income singles in substandard housing, many of whom have a history of mental health problems.

There are approximately 400 on-going clients of the Healing Centre, with approximately 200-300 people a year accessing services on a one-time or temporary basis. While in late 1998, when the centre opened, approximately 20 percent of the clients were sleeping rough at the time they accessed health services, now over 30 percent of the clients are living on the street at any given time. Eighty percent of PARC's clients have been homeless at some point in their life, and virtually all live in low-cost and often substandard

accommodations, including rooming houses and 'bachelorette' apartments.

Since the Healing Centre first opened, there has been an increase in female clients, to approximately 25 to 30 percent of the total clients served. Many of the women served by the Healing Centre have been institutionalized at a mental health hospital at some point in their life. Few of the women are mothers with dependent children living with them, although several have minors in care of the CAS, or older children who are no longer dependent. An increasing number of senior women are among the clients at the healing centre. A minority of clients have Aboriginal heritage (approximately five percent) or are new immigrants, refugees, or visible minorities (approximately 20 percent). Due to the nature of PARC and the availability of other services in the area, this agency is not a primary point of first contact for newcomers to Canada or for Aboriginal people. There is a small proportion of self-identified lesbians and transgendered people among the client group. PARC, like most drop-ins and hostels, does not serve youth under the age of 16. PARC is busiest in very cold and very hot weather, and when social assistance cheques run out every month.

SERVICE INTEGRATION AND COORDINATION

PARC offers a full range of drop-in services, from meals to housing referrals, a case management program and general counselling. The Healing Centre, housed in two rooms off the main lounge, offers a very large range of acute care, chronic care, and wellness services, on and off site. These include treatment of skin rashes, parasitic insect infections, upper respiratory ailments, muscular and arthritic conditions, diabetes, high blood pressure, acid reflux and other digestive ailments, and wounds. PCHC provides a chiropodist three hours a week, a nurse from Community Care Access Centre (CCAC) of Toronto is on site three to six hours a week, and a physician has regular drop-in hours at PCHC. Gynaecological exams are not feasible due to the open nature of the area. Psychiatric services are provided off-site, and there are links to local dentists, cross-addictions services, alternative mental health and other services. The nurse practitioner

spends approximately 10 to 15 hours a week visiting outdoor sites where homeless people are living (e.g. High Park), and makes site visits to rooming houses. PARC links with nearby hospitals and Homecare to facilitate discharge planning and ensure effective community based care.

Like several other drop-in based services provided by the Regent Park, Central Toronto, and Parkdale CHCs with funding from the MOHLTC, this is an effective way to provide continuous and accessible care to people who are homeless and socially isolated.

3.6.6 416 Drop-In and Crisis Centre

DESCRIPTION

The 416 Drop-In and Crisis Centre (Friends of Shopping Bag Ladies) has been serving homeless women in east downtown Toronto since 1984. Their aim is accessible and continuous care for women who would not otherwise access health services, and who are particularly vulnerable to acute and chronic health problems.

At present it serves approximately 250 women a day, the majority of whom are living on the street or in shelters, and a small number of fragile men who receive their services for mental health reasons. With eight full-time staff, the 416 is open seven days a week, 365 days a year, and has an unusually early opening time (5:00 am). There is also an outreach service with the purpose of visiting and supporting women in rooming houses. Trusteeships (handling the finances of individuals who are unable to do this on their own) are a very important part of their operations.

SERVICE INTEGRATION AND COORDINATION

The 416 has a full-time nurse on staff, and two doctors who each make weekly visits. A chiropractor is on-site every two weeks. The 416 has the only shelter or drop-in electrocardiogram machine in Toronto. Staff from the 416 accompany women to St. Michael's Hospital for mammograms. The 416 advocates for clients within the health care, social services, court and mental health systems. Staff help clients obtain identification (including social

insurance and landed immigrant cards) and health card replacements. The ID worker is called out by social workers and physicians to assist clients who are living on the street, are ill or infirm, or are unwilling or unable to leave their homes.

Clients can also access meals, clothing, food bank, hygiene supplies, showers, and washing machine facilities through the 416. Other services include daily dispensing of medications, addiction counselling, anger management groups, assistance with budgeting, access to a welfare worker (on-site weekly), as well as rent and bill payments.

3.6.7 St. Michael's Hospital: Cervical and Breast Cancer Screening Program

DESCRIPTION

For the past year, St. Michael's Hospital, in partnership with eight community-based agencies in central Toronto, has been offering enhanced nursing services at drop-in centres and shelters, with the general aim of encouraging preventive health care, and the specific aim of increasing breast and cervical cancer screening and early treatment for homeless women. Although homeless women are at increased risk for cancer, they are less likely to access preventive health services. The community agencies involved in the project are: Sistering Drop-In Centre, Adelaide Resource Centre for Women, Street Haven, 416 Drop-in Centre, Friendship Centre, Street Health, Shout Outreach, and Regent Park CHC. Each site assists approximately 10 to 15 women each week. The project is funded by the Ontario Women's Health Council.

SERVICE INTEGRATION AND COORDINATION

This project is integrating cancer prevention and acute care at sites frequented by homeless women. It also recognizes the importance of accompanying homeless women to medical appointments, and assisting them in obtaining health cards. An outcome evaluation is planned for this pilot program, the first such program in Canada. Discussions with the 416 Drop-in Centre, Street Health, Regent Park CHC, and Sistering indicate

that while cancer screening is not a primary priority for the women served, the program is having a positive effect in that it provides more time for nurses to establish relationships with particular patients, and it is also encouraging 'wrap-around' and continuous care links between women and services agencies. See *Sistering* for a specific example of how the program works on site.

3.6.8 Victims Crisis Assistance and Referral Service (VCARS)

DESCRIPTION

VCARS is a community response program providing immediate on-site service to victims of crime or disaster, 24 hours a day, seven days a week. It is currently available in 35 sites across the province and has served Timmons and Cochrane District over the past five years. Funding is through the Ministry of the Attorney General.

With three full-time employees and over 80 volunteers (which includes some former clients of the program), VCARS provides crisis intervention services to assist victims of crime. Referrals to the program come from local police services and women's groups. The client group is about 70 percent women, 30 percent men. Almost all of the clients are in unstable or unsuitable housing. Support for victims of crime can include assistance with installing new locks, alarm systems, and new windows for example. Through VCARS, clients can access temporary housing, such as motel rooms, or obtain assistance with home repairs to make their home more stable or livable. Clients can also be provided with a cellphone that dials directly to 911.

SERVICE INTEGRATION AND COORDINATION

While VCARS does not offer any health support, it is a 'clearinghouse,' identifying health or emotional needs of clients and knowing where to refer the client for the help needed and arranging transportation if required. It provides on-site short term assistance to clients, referring them on to other community agencies for longer term assistance. The program provides services in English and Cree

and provides multiple services at a single site as well as takes services to women's homes or wherever they are.

VCARS has partnerships with the local police forces, including the native force, the local CMHA women's shelter, Timmins and Area Women in Crisis, local hospital, Child and Family Services, Native Child and Family Services, Crown's office, Canadian Red Cross, and Ontario Works. A key to delivering services is identifying exactly what needs the clients have and linking them with the appropriate services.

3.6.9 Canadian Mental Health Association: Concurrent Disorders Pilot Project

DESCRIPTION

The Concurrent Disorder Pilot Project is an initiative of the CMHA, Ottawa branch with the goals to:

- (1) Develop five to ten treatment groups for homeless individuals with both addictions and mental health issues to be facilitated by mental health workers and addiction specialists
- (2) Develop a culture of integrated treatment for homeless people with concurrent disorders,
- (3) Develop the capacity to provide integrated treatment training for frontline workers from the mental health, addictions and homeless communities.

Beginning in April 2000, with SCPI funding until March 31, 2003, this initiative has served 70 clients by offering ongoing group treatment utilizing a harm reduction stages of change approach. Two surveys were done prior to start-up: one involved interviewing frontline CMHA workers to gather their perspectives on clients' needs and the other involved a survey of addictions agencies to identify barriers to accessing services. A literature review was also conducted.

One quarter of the clients served are homeless or in shelters, half are at-risk of homelessness, and one quarter are in stable housing. Twenty women have participated in the program. Most women are single and many have children who do not live with them, which is an important issue in their lives. All the women have severe mental illness and substance abuse disorders.

SERVICE INTEGRATION AND COORDINATION

In addition to the seven facilitated groups run through the initiative, staff also provide individual follow-up, mental health counselling, substance abuse and addictions counselling, information and referral to other services, advocacy, assistance with forms and ID, hygiene counselling, and assistance with obtaining and maintaining housing. Staff provide clients with referrals for needle exchange, detox, and psychiatric care (they refer to a doctor at the Royal Ottawa Hospital). All clients in the program are CMHA clients and have access to extended hours service and individual support through their case managers.

A contractual relationship exists between CMHA and five addictions agencies to pay for the time addictions workers spend on the project. The partner agencies are: Rideauwood, Lifestyle Enrichment for Seniors (LESA), Amethyst Women's Addictions Services, Sandy Hill Assessment for Addictions and Maison Fraternelle. The agencies donate the space used for the treatment groups.

This program helps clients overcome accessibility to barriers to services by not requiring ID, using a harm reduction approach, offering services in English and French, providing meals and transportation and ensuring clients know what services they are entitled to. Participation in the program is not dependent on the client being in stable housing or in a shelter. Key successes of the project include the client being able to work on both mental health issues and substance abuse together, rather than separately; bringing these issues to the fore in the community; and the development of a training program for front-line staff. A significant challenge during this pilot project has been working within the whole system of addiction

services, coping with the under-funding among these services, and their lack of experience with homeless people. The Concurrent Disorders Pilot Project is being formally evaluated through the University of Ottawa as part of a city-wide initiative to evaluate the SCPI funded projects.

3.7 SERVICES ATTACHED TO TRANSITIONAL AND PERMANENT HOUSING

Many different forms of transitional and permanent supportive housing exist across the province. For instance, there are supportive housing projects aimed at women re-building their lives after leaving an abusive relationship; projects for individuals with developmental and/or physical disabilities; initiatives for individuals living with severe mental illness, HIV/AIDS, or substance abuse disorders, in addition to other factors that increase the risk of homelessness for these individuals. Each form of supportive housing or delivery model reflects the specific or diverse needs of clients served by the housing. If the housing is "transitional," the philosophy is to provide a supportive environment for individuals and families to stabilize their lives after leaving a shelter or other homelessness situation, and before moving into independent permanent accommodation.

By necessity, housing for people with special needs, or housing which has a support services component built in, is developed and operated to be appropriate to the community where it is located.

Consideration is given to:

- Who lives in the community and their supportive housing needs
- What other agencies, housing providers, and support service providers are in the community
- Amount of rental housing stock in the community including the mix of private sector rental housing, municipal or public housing projects, non profit or co-op housing

- The length of waiting lists for social housing and how rent-geared-to-income housing in the community is accessed,
- What funding programs are available for developing housing in that community.

The supports offered vary between agencies and housing providers, depending on, for example, the needs of the client group, the linkages with other community agencies, and the source of the program funding.

No one model of supportive housing fits all communities and likely there is no model that is possible in every community. Further, no one package of services would fit the heterogeneous group of individuals who have experienced homelessness or are at-risk of homelessness and who require supportive housing to rebuild their lives and remain housed.

To suggest and reflect some of the diversity of models of supportive housing which exist in Ontario, that are specific to the communities they are located and the current funding environment, this report profiles five approaches to supportive housing and services in four different settings:

- A small housing provider (Bethlehem Projects of Niagara) serving both a rural and urbanized area and offering transitional housing to at-risk women and children.
- A multi-service agency in Toronto serving youth has transitional housing (Eva's Phoenix) integrated with a variety of employment and support programs
- A large suburban non-profit housing provider (Nepean Housing Corporation) that has used an outreach worker to better meet the needs of women who have left abusive relationships
- A rural-based agency (Haliburton Mental Health Services) providing a small number of clients with serious mental health issues with supportive housing through partnerships with

private sector landlords.

- A support program in Toronto for women moving from shelters to permanent housing (Hostels to Homes) committed to long term continuous care and eviction prevention work regardless of where the client lives.

3.7.1 Bethlehem Projects of Niagara: Transitional Housing and Supports

DESCRIPTION

Bethlehem Projects of Niagara provide transitional housing and supports for singles and families in Niagara Region who are working towards developing the skills and stability necessary for independent living. Bethlehem Place is a 27 unit apartment building, with capacity for approximately 65 residents. The maximum stay is one year in this rent geared to income accommodation. The Bethlehem Projects of Niagara also include a Community Support Home (five residents) and a Community Transition Support Home (four residents), and two family resource centres.

The client group includes victims of abuse, individuals recovering from addictions, individuals with physical disabilities and mental health issues, and individuals who need support around parenting or other life skills. Funding for the housing support programs comes largely from the community: the organization was originally started by local church groups who continue to support the initiative, as do individuals, businesses, the United Way, and other community groups. Funding for the housing program comes from the Regional Municipality of Niagara.

Three counsellors provide supportive counselling, offering both individual support and support groups dealing with themes such as positive relationships, co-dependency, and creative parenting without anger. Areas of focus for individual counselling include: relationships, addictions, budgeting, education, employment, household management

and parenting. Programming also includes cooking circles to help with meal planning and raise awareness about nutrition.

SERVICE INTEGRATION AND COORDINATION

Bethlehem Projects is able to offer their clients a range of on-site services and supports as a result of a number of partnerships with local agencies. For examples, Billes, the newest housing project opened in 2002, is the result of collaboration with local agencies including Gateway, a mental health support group, Housing Help Centre of Niagara, and Start Me Up, an employment resource centre.

A significant initiative in recent years, developed with Port Cares (another multi-service organization) is the *Skills for Success* program. It is funded through the Trillium Foundation. This program, consisting of 10 three-hour workshops, including videos, a participant's handbook and facilitator's guide, focusses on issues facing unemployed or underemployed women. Topics include assertiveness, decision making, goal setting, legal matters, money management, and communication skills. This program has been extremely successful in Niagara and there are plans to make it available across the province.

Bethlehem Projects have helped over 1,000 families become more stable, by providing safe and decent housing, alongside a variety of supports, life skills, and goal setting. The focus is on personal wellness and health, and imparting a sense of belonging.

3.7.2 Eva's Phoenix: Transitional Housing

DESCRIPTION

Eva's Phoenix is a project of Eva's Initiatives, a multi-service agency for homeless youth which operates two shelters in Toronto. Starting in June 2000, Eva's Phoenix has offered transitional housing (up to one year) as well as employment training and job placements to homeless youth aged 16 to 24. Approximately 35 to 40 percent of the clientele are female (Shout Clinic estimates that 40 percent of street youth in Toronto are female). Although a

young woman in the early stages of pregnancy may be admitted to the 50 unit building in downtown Toronto, the program is not suitable to adolescent parents with children. There are a number of clients who self-identify as lesbian, gay, bi-sexual or transgendered, and a small number of Aboriginal and new immigrant youth. The goal is to move youth into long-term employment and long-term housing, through emphasizing job training along with overcoming barriers, including health barriers.

SERVICE INTEGRATION AND COORDINATION

As is the case with the shelters operated by Eva's, there is a case management approach to the clientele, which includes on-site mental health counselling, and a 'life skills' approach to health promotion. The staff team includes two front-line housing staff on site 24 hours a day, as well as three employment support workers, a part-time mental health counsellor (new this year) and two job developers whose mandate includes management of workplace issues. In addition, there are staff responsible for delivering mentorship programs and housing support in the community. While Eva's Phoenix has links with the Shout Clinic and to Queen West Community Health Centre, there is no accompaniment to medical appointments or on-site medical services. Public Health nurses give workshops on family planning and prevention of STDs, and there are anti-homophobia workshops as well, in response to an increased emphasis on physical and mental health issues over the two years of the project's existence.

Funding has recently been made available from the Hamilton Community Foundation for an outcomes evaluation of the innovative project, as interest from other cities across Canada in this model is high. The evaluation will include health outcomes. The project shows integration of housing, employment and to some extent, health issues.

3.7.3 Nepean Housing Corporation: Women's Support Worker

DESCRIPTION

From 1999 to December 2002, the Nepean

Community Resource Centre had funding for a part-time Women's Support Worker to work with tenants in buildings owned by Nepean Housing Corporation. The goal of the initiative was to provide community supports for women coming out of shelters and other unstable housing situations, and who were victims of abuse. The need for ongoing supports for women leaving abusive situations was identified in an Ottawa community consultation that led to the city's community action plan on homelessness.

The support worker helped tenants by advocating for them on income and financial issues, and landlord and tenant problems. She provided counselling and programming on stress reduction, budgeting, employment and retraining. Mental health counselling included care after assault, pre-natal issues, addictions and referrals to other community agencies and health services. Through the support worker, clients could also access transportation. There were 30 women in housing, yet about 50 women were counselled, and over 300 helped over the term of the initiative. The support worker position was staffed by one part-time employee, who met with clients in their homes or in community centres. Services were offered in both French and English.

The benefits of this approach to supporting a vulnerable group of tenants appear to be fewer police reports, fewer evictions due to unpaid rent, fewer neighbour complaints, greater resident involvement in the community, enhanced social skills and higher self esteem among the women themselves.

SERVICE INTEGRATION AND COORDINATION

The main thrust of this initiative was to bring counselling and mental health supports to women who are at increased risk of becoming homeless after fleeing an abusive relationship. The relationship with the housing support worker (a trained social worker) can be understood as a type of case management, linking women with supports and resources to help them with various facets of their life on an as-needed basis. Deliberate outreach to women who were coming into Nepean Housing

Corporation through the victims of violence priority list, and meeting with them regularly in their homes were key ingredients for breaking the isolation that these women can experience and mitigating against the factors which can destabilize their housing in the short to medium term.

The initiative came about as a result of a partnership between a housing provider and a community resource centre, who provided the staffing for the program and had secured the funding. An ongoing challenge for the partners in this initiative was the lack of stable funding for such a service. At the time of writing this report, no new funding source had been secured.

3.7.4 Haliburton Highlands Mental Health Services: Housing Program

DESCRIPTION

Haliburton Highlands Mental Health Services (HHMHS), a program of Haliburton Highlands Health Services, serves individuals with mental health concerns. Their clients may be homeless or at-risk of homelessness, but their first contact with the organization is initially because of mental health issues. HHMHS deals with about 200 new clients per year, most from shelters, or in unstable or unsuitable housing, and offers a range of mental health services, including:

- crisis response to consumers engaged in the program
- general individual, couple and family counselling
- psychotherapy and intensive case management
- family support
- multi-agency coordination of services.

Services to clients are varied and are tailored to meet individual needs. The agency has visiting specialists for regular psychiatric consultations

with clients. Agency staff also offer substance abuse counselling, assistance with forms and advocacy, financial management, and referrals to other health services and agencies. In providing service to their client group, key considerations are: client driven services; being responsive to the client and ready to act as soon as called; and home visits, as clients are often reluctant to visit an office.

In March 2001, HHMHS was approved for funding under MOHLTC to implement an initiative to provide housing and case management support to clients suffering from serious mental illness and considered to be at-risk of homelessness. This initiative currently includes 12 housing units, with women representing about half of this client group with serious mental illness. All of the housing is rent-g geared-to income, through the Province's rent supplement program.

SERVICE INTEGRATION AND COORDINATION

The housing program of this agency is based on formal partnerships between HHMHS and private sector landlords. The program brings both housing and supports together to help keep individuals with serious mental health issues successfully housed. Multiple services are offered in the places where clients live. In a case management approach, agency staff provide ongoing counselling, crisis response and facilitate clients' access to other community and health services as needed. The agency has informal partnerships with substance abuse agencies, the local hospital, and other counselling services for referring their clients. They also receive requests for assistance from these other agencies when mental health needs are identified.

3.7.5 Sistering and Fred Victor Centre: Hostels to Homes

DESCRIPTION

Hostels to Homes is a joint program of Sistering: A Woman's Place and the Fred Victor Centre. Since 1996, the initiative has been providing ongoing support to women moving from emergency

housing (shelters) to transitional and/or permanent housing. Approximately 500 women are served annually, mostly single women with a similar demographic profile to Sistering's client group. Referrals come not only from these two agencies, but also from hostels and from the women themselves.

SERVICE INTEGRATION AND COORDINATION

The two full-time staff provide supportive counselling and also refer to the Shared Care team on site at the Adelaide Women's Centre. Health-related referrals occur with the three central Toronto community health centres, and also with St. Michael's Hospital. The program is funded by the City of Toronto.

Like several other initiatives (e.g., Hostel Outreach Program, Young Pregnant Women's Program), Hostels to Homes aims to provide long-term continuous care and support to women, even after they move into permanent housing. Homeless prevention work is also part of the services provided. Staff work with clients to maximize the income they are entitled to receive and connect women with income support program to ensure they have enough money to pay rent. Staff also negotiate with landlords around arrears owing and mediate conflicts with other tenants. The program supports approximately 15 units provided directly by Fred Victor Centre and approximately ten by St. Clair Multifaith Services. The program works with single women or women with children.

3.8 INTER-AGENCY NETWORKS

While networks, reference groups or committees of agencies operating in a particular sector or in a particular geographic area do not in themselves provide direct services to homeless or at-risk women, it is nonetheless useful to look at the ways in which they result in better coordination and integration of services for homeless populations.

Following are four examples of inter-agency networks which are working to identify and respond to gaps in service in their community and

who through collaboration are strengthening local partnerships between agencies:

- Regional Psychiatric Program
- Young Parents No Fixed Address Committee
- Homelessness and Health Reference Group
- CMHA: Mental Health Community Support Services.

In addition to these inter-agency initiatives, there are many other excellent examples of inter-agency coordination and networks. Municipal staff, housing providers and agency staff in Ottawa have worked closely together through the Alliance to End Homelessness; City of Toronto staff and council members have a long history of supporting community-based committees to address homelessness and identify service needs and are pro-active in disseminating information about best practices.

3.8.1 Regional Psychiatric Program, Hamilton

DESCRIPTION

For the past ten years, the Regional Psychiatric Program (RPP) has coordinated psychiatric services in Hamilton. Its goal is to facilitate the planning, integration, coordination, and ongoing evaluation of a recovery based continuum of child and adult mental health services in the City of Hamilton. With a part-time Director through funding from McMaster University and the two hospitals, RPP has a formal agreement with the Hamilton District Health Council to collaboratively plan for mental health care in the City of Hamilton. The District Health Council in turn provides planning and logistical support to the program. This is a systems networking body rather than a decision making body.

SERVICE INTEGRATION AND COORDINATION

The steering committee is made up of senior staff from McMaster University, Department of Psychiatry; St. Joseph's Health Care; Hamilton Health Sciences; CMHA; Wellington Psychiatric

Outreach Program; Hamilton Program for Schizophrenia; Family Education Network; Community Mental Health Promotion; MOHLTC; Hamilton District Health Council; CCAC; Homes (Supportive Housing Program); Hamilton Addictions Services Coalition; and Mental Health Rights Coalition. Standing and ad hoc working groups bring together representatives from these and other organizations to work on specific issues.

Members work from a model of respect and a desire to collaborate to promote an integrated, accessible and coordinated system of care that is client centered. The work and interests of RPP go beyond treatment issues and include the broad determinants of health from policy and planning and systems level perspectives, taking into account provincial and national issues and identifying local needs and gaps in service delivery. Examples of the policy and planning activities of RPP include: advocating for housing for people with mental health problems and co-leading a working group with Hamilton Addictions Services Coalition to develop a system-wide plan for meeting the needs of individuals with concurrent disorders (severe mental illness and addictions).

Systems level activities include a working group to build a recovery oriented system: a system that goes beyond treatment and maintenance and assists individuals with serious mental illness to move on with their lives. RPP is also developing programs and services to assist people with severe mental health issues to take steps in their lives towards engaging in meaningful recreational activities and volunteer and paid work opportunities. Other systems level support work includes problem solving and service planning to meet the needs of the hardest to serve populations, and recruiting and retaining staff.

RPP has a number of other projects, including a working group looking at education and service development needs related to sexuality and people with severe mental illness. This working group is looking at attitudes and awareness as well as information needs.

RPP is an example of service coordination through inter-agency networking and strategic planning on a sector-wide basis.

3.8.2 Young Parents No Fixed Address Committee, Toronto (downtown)

DESCRIPTION

The Young Parents No Fixed Address Committee originated in 1997 when the City of Toronto Department of Public Health was approached by front-line workers at several youth agencies about the unmet needs of pregnant adolescent females aged 14-20 living on the street. A 1998 report by the Department of Public Health estimated a need of 300 families per year, mostly single mothers, but some dual parents. The parents either live on the street or in unstable housing conditions (e.g. couch-surfing) in downtown Toronto. There are institutional barriers to accessing long-term housing, including age and inability to obtain welfare. Many children have been taken into care, due to lack of stable housing.

SERVICE INTEGRATION AND COORDINATION

The coalition presently includes about 20 partners, including youth agencies (such as Jessie's Centre for Teenagers, Evergreen Health Centre/ Yonge Street Mission, Native Child and Family Services), CASs, Toronto Public Health, other health care providers (e.g. Oolagen Community Services, St. Michael's Hospital, Sherbourne Health Centre, and Shout Clinic). Funding comes from a variety of sources, including the United Way, CASs Child Abuse Prevention Fund, and private sources such as the Rotary Club. Toronto Public Health recently assigned two public health nurses to do casework with these high-risk parents, although there is no full-time staff assigned to the project.

This inter-agency committee aims to improve physical health outcomes and coping skills of adolescent parents and their children, through coordination of services and joint projects. Health issues include pre-natal care, addictions, sexual health, stress, and loss and grief issues for those parents who have had children taken into care.

Coordination includes improved referral, for instance, from St. Michael's Inner City Health Unit to agencies and vice versa, and improved 'wraparound' training, although case management is still provided by individual agencies. The group has also produced a Parent Resource Guide. Another project is the Parent Relief Program (also known as respite care), in which Jessie's provides short-term overnight childcare services for emergencies. There is also an afternoon Parent Relief Program at Evergreen. The working group is attempting to build a 50 unit housing project, Jordan's Village, which will combine a shelter with transition and long-term housing for this client group. The housing would either have links to a CHC or on-site health support. There is also no evaluation of the working group itself, although there are project and individual agency evaluations.

This is a good example of an inter-agency committee working to meet the integrated service needs of a mostly female homeless population.

3.8.3 Homelessness and Health Reference Group, Toronto (downtown)

DESCRIPTION

The Toronto-based Homelessness and Health Reference Group was set up as the result of recommendations from the Golden Report on Homelessness. The reference group includes CMHA, Centre for Addictions and Mental Health, Regent's Park CHC, University Health Network, St. Michael's Hospital, Street Health, and representatives from all three levels of government.

SERVICE INTEGRATION AND COORDINATION

Through working groups, the Homelessness and Health Reference Group had dealt with a number of issues including:

1. The need for an infirmary for sick people living on the street: Sherbourne Health Centre will be filling that gap. In the meantime, Street Health and St. Michael's Hospital have

opened up a ten bed infirmary at Seaton House, but it is for men only.

2. The need for harm reduction approaches in shelters and drop-ins: This approach has been approved in principle by Toronto City Council, and integrated into SCPI proposals being fielded by the City.
3. Discharge Planning: A toolkit has been produced and distributed at hospitals to respond to issues stemming from weak linkages between hospitals and shelters and to avoid situations where people are discharged from hospitals onto the street.

There is also a Youth with Concurrent Disorders (Addiction and Mental Health) Group dealing with gaps in service to this vulnerable group, involving CAMH and youth serving agencies. There will be several pilot projects attempting different approaches in the near future.

3.8.4 Canadian Mental Health Association: Mental Health Community Support Services

DESCRIPTION

Originally called Regional Case Management Services and begun in 1988, Mental Health Community Support Services (MHCSS) is an initiative coordinated by CMHA, Ottawa Branch funded by MOHLTC, the United Way and SCPI. The mission is to "provide and coordinate individualized client-directed mental health services in a manner that promotes a continuity of services and enrichment of the quality of life for people with a severe and persistent mental illness." MHCSS offers a streamlined access point for information, referral, intake and assessment, with the ability to link the client to case managers (42 FTE) in ten partner agencies, offering services in eight languages. Clients can also access the services through mobile access points, as a result of CMHA outreach services.

In 2001-2002, MHCSS had 278 men and

300 women in long term case management, with many clients living in shelters when they first came into the service. Another 200 clients were on the waiting list for case management, and through CMHA intake assessment and outreach services, 324 clients received some short term or crisis help. Of the women receiving case management services through MHCSS, most are not married and are generally without dependent children. Almost all are under 65 years old. All have severe mental illnesses and many have physical disabilities or suffer from chronic physical illness. Eighty of 578 clients, half of them women, received services in languages other than English and French (including Vietnamese, Cambodian, Somalian, Arabic, and American Sign Language).

Most clients coming into the service obtain independent housing quickly, and do better when they receive supports that allow them to live independently. Clients do not prefer, and are typically not well suited to, congregate living.

SERVICE INTEGRATION AND COORDINATION

MHCSS results from a partnership between ten organizations, including Canadian Hearing Society, CMHA, Ottawa Community Care Access Centre, Ottawa Carleton Immigration Services, Ottawa Chinese Community Services, Ottawa Salus Corporation, Pinecrest Queensway Health and Community Services, Project Upstream, Royal Ottawa Hospital and Somerset West Community Health Services. Benefits of this partnership include: increased capacity to serve special populations such as new immigrants or individuals with hearing impairments; increased capacity to do comprehensive assessment at the time of the referral as a result of the coordinated access point; and increased capacity among a broader range of agencies to identify and meet the needs of people with severe mental illness due to increased training opportunities for case managers and settlement workers.

With a case load of 15 to 20 clients, case managers work from a Strengths Model, (using the clients' strengths as the starting point). They provide intensive, individualized, portable, client directed

supports and are committed to a long term working relationship with the client. The case managers help clients define goals and develop and work through a plan. They also teach skills, link clients to needed community services, intervene to prevent or diffuse crisis, offer supportive counselling and early motivational counselling for substance abuse, assist with forms and advocacy and arrange transportation as needed. Health monitoring and appropriate referrals are an integral part of this work. Case management services are provided in shelters, in clients' homes, on the streets, and in hospitals.

To ensure the flow of communication between the partner agencies, a common data sharing system is used in the outreach and intake portion of the initiative, with the permission of the clients.

3.9 CONCLUSION

The 35 initiatives profiled in this inventory illustrate different ways of delivering services to homeless and at-risk women. The initiatives are varied in what combinations of services are offered to clients, where they are offered, and how long a client is expected to stay connected to the service. Section 5 of this report looks at the findings coming out of this inventory along side the key findings of the literature review (Section 2) and the results of the focus groups, presented in Section 4.

4.0 RESULTS OF THE FOCUS GROUPS

The literature review and interviews with service providers gave insight into integrated health services for women who are homeless and underhoused. A third essential element of this project was speaking to the real experts: holding focus groups with women who have experienced or are at-risk of homelessness in Ontario. This section summarizes what we heard during the focus groups.

4.1 OVERVIEW

In order to speak with a range of women across Ontario, four locations were chosen in which to hold focus groups:

- Haliburton, a small town 250 kilometres north of Toronto and just south of Algonquin Park, with a population of 5,000; the area is heavily dependent on tourism, especially during the summer;
- Kingston, a medium sized city 250 kilometres east of Toronto, with a population of 100,000; a university town whose economy is also largely tourism-dependent;
- Oshawa, 50 kilometres east of Toronto, with a population of 140,000; once an city with a large industrial sector, it is still largely associated with automobile manufacturing;
- Parkdale, a neighbourhood in west downtown Toronto, with a large concentration of services for homeless people; it has a large stock of small apartments (including rooming houses and self-contained rooms known as bachelorettes), but affordable housing stock is being lost to gentrification.

Each two hour focus group was arranged in partnership with a local community agency serving women who are underhoused. In Haliburton we

spoke to women at Family Services of Haliburton County; in Kingston, we spoke to women enrolled in the methadone program at the Street Health Centre; in Oshawa we spoke clients of the Oshawa CHC; and in Toronto, we spoke to women at the Parkdale Activity and Recreation Centre, a drop-in which has an on-site health care clinic associated with Parkdale CHC. Arrangements were made for honorariums for ten women at each location, as well as to provide food and cover childcare costs. The focus groups, held in late November and early December 2002, ranged in size from five women in Haliburton (several women could not make it due to inclement weather), to 11 women in Parkdale.

The participants in the focus groups ranged in age from teens to late 60s. The women were also varied in their marital and family status, ethnic/racial backgrounds, and physical and mental health histories. Many of the women in the Haliburton, Kingston, and Oshawa groups had custody of dependent children, although several had lost custody at some point due to housing crises. Several of the women in the Kingston and Parkdale groups spoke of presently not having custody of dependent children. All of the women had direct experience of homelessness or being at-risk of homelessness. Their experiences ranged from living on the street, to extended periods without secure private accommodation, to one woman who still owned the marital home, but was at imminent risk of losing it.

The women were asked the same questions. Similarities and differences in responses are summarized and illustrated with quotes from the participants.

4.2 WHAT WOMEN TOLD US

HOW MUCH OF A PROBLEM DO YOU THINK HOMELESSNESS IS IN THIS COMMUNITY?

All groups agreed that homelessness was a large problem in their community. Every participant in the four focus groups knew several other people who were homeless or without stable housing.

Whereas in Haliburton, participants felt that housing problems were largely hidden, women in the other focus groups saw people living on the street in their communities, and knew that this was merely the tip of the iceberg.

There is a stigma attached to homelessness; everyone can quickly know your business, so you keep your experiences to yourself (Haliburton).

It's a lot more common than people think – a lot more common than visible 'street people.' There is a lot of 'couch surfing' (Kingston).

We see women in drop-in centres, crashing, showering, using the washing machine (Oshawa).

All four groups agreed that homelessness was the result of low incomes combined with high housing costs.

The problem is a lack of affordable housing (all four groups).

During summer, it is hard to find a job or housing [due to the influx of student workers and tourists] (Haliburton).

You face discrimination in renting a place: landlords give priority to housing students from Queen's [University] or St. Lawrence College (Kingston).

You have no financial cushion, so if something happens you can lose your place without having a second chance and then it is hard to find another place to live (Kingston).

My job isn't paying enough to support me as a single woman. Even as a single woman, there are no places I can find (Oshawa).

I can't keep up with my mortgage payments, but I have to fight to keep what I have. Rent would cost more (Oshawa).

Money is tight all over Canada. I came from Vancouver and it is the same story there (Parkdale).

In the Haliburton, Kingston, and Oshawa focus groups, women talked about the need to keep their

situations invisible:

You want to protect your kids from being stigmatized or teased at school (Haliburton).

Relatives who are helping you out will keep quiet about it (Haliburton).

If you have kids, there is the danger of CAS involvement as soon as you get services from an agency. You can lose your kids. When the crisis is over you are dropped from the CAS caseload, but the record stays with you and can be used against you later in custody issues, etc. (Kingston).

I have to work in a [downtown Toronto corporate] office, and my clothes come from Value Village (Oshawa).

HOW HAS THE LACK OF SECURE HOUSING AFFECTED YOUR HEALTH?

In all four focus groups, the difficulties of meeting basic needs for shelter, food, clothing, and transportation led to a great deal of stress, depression, and anger.

You can't eat or sleep properly (all four groups).

Getting any decent sleep is a big problem. You are always tired and cold. You can't think and have no energy (Kingston).

You're so hungry and tired and your health is shot to hell. Even people who have apartments (or closets), after you pay your rent, there's no money for food (Parkdale).

I've lost my money 'cushion.' I'm getting calls from bill collectors every day. They've started calling me at 6 am (Oshawa).

Landlords will use anything to get you out – criminal record, kids, pets, etc. and you are left with little recourse even though what the landlord is doing is illegal. Harassment and fear become an issue (Kingston).

Housing workers don't understand my desperation. Who wants to live in a crack house, with needles on the floor? (Oshawa)

The injustice of it all makes you angry – results in ulcers, indigestion, makes you crazy. You get panic attacks, headaches. You turn into an emotional basket case (Haliburton).

It leads to mental darkness, reclusiveness (Parkdale).

The worst is seeing things fall apart, getting to homelessness, and thinking about being on the street. Before I became homeless, and I could see it coming. It is like a roller-coaster of stress (Oshawa).

Depression affects everything, including your judgement. You don't care, you can't be bothered. Everything seems too hard then and you get stuck. Then it is hard to ask for help (Kingston).

You get tired of always asking friends. When they don't help, you lose your self-esteem. It is hard to say, "I don't have the money" and beg for a lift (Oshawa).

You're so tired of being kicked down, shut out. You lose hope and give up and die on the street (Parkdale).

Women with dependent children were especially affected with stress, compounded by their insecure living situations and lack of privacy.

People you are staying with may want to take over how you are raising your kids (Haliburton).

It is stressful to be a mom with kids in a shelter. No privacy and a lot of unrealistic and unwanted inference on how to handle kids. Stressed out moms and stressed out kids cause problems (Kingston).

When you need help to get a decent place to live, CAS gets involved and will take your kids because you don't have a proper place for them. This is a big threat and a Catch 22. Getting kids to school when using shelters is really tough (Kingston).

I'm always making priorities. I don't have enough money for bus fare to get to work, food for me and the kids, toilet paper. I can't afford it all [at that point every participant agreed that they had had the experience of not being able to afford toilet paper] (Oshawa).

The stress was exacerbated by feelings of self-blaming, especially among women who had known better lives.

I feel ashamed at how my house has been furnished. Pride is expensive, and I can't afford pride (Haliburton).

I didn't think I would lose what I had, what I had built up, and have to start again with almost nothing (Oshawa).

I feel it is my fault. I have to blame someone, who else is there to blame? (Oshawa).

Personal hygiene can be difficult, whether living on the street or sharing a bathroom between two families.

There's a lack of adequate facilities to shower or clean up. You can find the basics if you really want, like a washroom in a gas station, but you can also get turned away or told to leave. If you take too long they bang on the door and threaten to call the cops (Kingston).

Violence is fact of life, especially among women who have slept rough.

Outside [sleeping rough] you get raped, inside [in a hostel] you get robbed (Parkdale).

Women report lower resistance to almost every physical health problem.

Colds, flu, pneumonia, arthritis and other joint problems, back aches, kidney problems (Kingston).

The stress affects my immune system. I never feel really well [general agreement from group] (Oshawa).

Many women who were not on benefits said they could not afford basic medications.

I can't afford money for cold medicine, so I miss work and then lose more money (Oshawa).

I don't have money to pay for prescriptions and food, rent and electricity, so I've stopped my [prescribed anti-depressant] medication (two women in Oshawa).

A number of women turned to alcohol or illegal drugs as a coping mechanism, which in turn, can increase health stresses.

You fear repercussions if you complain or cause trouble, especially with landlords. The landlord threatens to tell the police we are using (Kingston).

If I go to a shelter, I'm worried that exposure to others will start me using again (Kingston).

I've been accused of using drugs at a shelter, when I was really sick with withdrawal symptoms. I don't want the challenge and the judgement. When you are already down and out it is just too hard to do sometimes (Kingston).

If you don't have crack you aren't welcome at a crack house. I got turned away from where I was living, and had a miscarriage in a donut shop (Parkdale).

I don't have a health card. If you don't have a health card you have to pay to see the doctor. If I get sick, I just smoke crack. When you're using crack, you don't care about a health card (Parkdale).

WHAT KINDS OF SERVICES HAVE YOU USED WHEN YOUR HOUSING WAS NOT SECURE? HOW DID YOU FIND OUT ABOUT THEM? HOW WERE THEY HELPFUL? HOW COULD THEY BE MORE HELPFUL?

In Haliburton, women complained of not being able to find services.

There aren't any services or support, except a clothing and food depot (Haliburton).

I went to my own church for help, but it is humiliating to ask (Haliburton).

In the other focus groups, women reported finding out about services through word of mouth, from others in similar circumstances, advertising at public events, and agency referrals.

I found out about [other services] through the health centre. They are good at referring to other services. Even when I don't know what to ask for, the health centre tells me about stuff (Oshawa).

Some services were described as being particularly helpful.

Housing Help Centre is good. They will help with money and help you find a place (Kingston).

The Y took me in for a while and got me to the next step. I was living with some other people in Bowmanville [a town near Oshawa], but they got interested in heroin. I couldn't get into a battered women's shelter, because I wasn't battered. My child had been taken in by her grandmother, and I needed to find a place so I could get her back. So I moved here (Oshawa).

I was living on the street, and I was sick but I was afraid of doctors and hospitals. I got sick and went to a shelter. They brought me to the hospital where I was diagnosed with thyroid and diabetes. I ended up staying in the Friendship House for more than a year. Now I'm living in a shared house with a Christian family. They are very kind (Oshawa).

Queen West Health Centre, Meeting Place, St. Christopher House, The Works, Yonge Street Mission, the 416 [all downtown Toronto drop-in services] are good. They didn't just send me running in circles. They knew where to send me (Parkdale).

Women in Oshawa, Toronto and Kingston praised the services of the Oshawa Community Health Centre, the Parkdale Activity and Recreation Centre and Kingston's Street Health Centre respectively, for their responsiveness and sensitivity to women's concerns.

You can always call the health centre. When I was in 'spin-cycle stage,' I knew someone would call me back (Oshawa).

You get to know everyone here. You get help and hope here (Oshawa).

Women's Wellness [a weekly program offered by the Oshawa CHC] made a huge difference to me. I felt it was okay to take care of myself. I got another message from Welfare!

You need a place that is safe, where you are not ostracized (Parkdale).

I was homeless one year when I was expecting a baby. I was moving from friend to friend. A worker helped me with [Family Benefits Allowance (FBA)]. It was sent directly to PARC. I was praying to find someone I could trust. PARC helped (Parkdale).

If it wasn't for this place [Street Health Centre], I'd be on the street. There is no where else I can go for health care (Kingston).

Women told stories of how their lives had been transformed through help they received at these centres:

I've been here since the health centre started seven years ago. My family doctor moved here, and I followed her. My husband had just left, my baby had severe chicken pox, and I was alone with my three kids. The doctor came to my house. I was really depressed, but I didn't know about depression. I got help and a prescription from the therapist here. The therapist and the doctor consult together, with my permission (Oshawa).

My child was taken in care by the CAS, and I had to attend a parenting course here to get her back. Now we are attending couples counselling (Oshawa).

I got into a deep depression, suicidal or euphoria with drugs and alcohol, and what women do to get drugs [ie. prostitution]... The services that allowed me to withdraw from that lifestyle were the vans and PARC (Parkdale).

[PARC] helped me get my own room. It's by the Anglican church and it's nice there. I can take a bath, listen to the radio, don't have to lug my clothes and sit in a restaurant all day (Parkdale).

Several other health services and individual health providers came in for praise from women in the focus groups.

The CMHA is going to help find housing for my son with schizophrenia, and then I can find housing for myself. I had to leave a lot of messages over a couple of weeks, though, before they called back (Oshawa).

COPE has some good community services on depression and bereavement (Oshawa).

Simcoe Hall Settlement House does good anger and stress management seminars (Oshawa).

My doctor runs a methadone program. He gives me the medicine I need. He isn't shocked when you say "I'm a hooker". He doesn't pull out the gloves (Parkdale).

Some services were praised for their flexibility.

The school my kids go to has known me since my husband left. They know my kids are going through a rough time. They gave my son an in-school suspension this week, because they knew I couldn't afford to stay home with him (Oshawa).

When my mother died in March, I was really depressed. I stayed at McKay House in Whitby, which is a residence for the mentally challenged, but they let me stay for a while. They had 24 hour counselling there, and it really helped (Oshawa).

Other services came in for condemnation. Women in all four focus groups reported very negative experiences with Ontario Works (OW), and other services that were felt to be judgemental and inflexible.

They humiliate you at the OW office. Staff are not compassionate (Haliburton).

Welfare categorizes and stereotypes people. They stick to the rules. I was sleeping on couches, and my EI had run out. I asked for a bus pass to keep my new job. They said: "Congratulations, you have a job. You don't qualify" (Oshawa).

It you don't meet the specific criteria you don't get any start-up money, no matter what the situation is or how much you need some help to get back on your feet (Kingston).

Some agencies stigmatize moms with mental health issues. They assume the kids are not being looked after (Haliburton).

You get turned away from the overflow shelter because some of the other shelters are not yet full. So you go to those shelters and by the time you get there, they are already full. It is easier to sleep in my tent (Kingston).

Having a dog is a barrier to me using a shelter (Kingston).

Housing Help wasn't helpful. They don't cross off rented places, so I wasted quarters and transportation money I don't have. I'm better at finding leads than they are (Oshawa).

When I applied for Legal Aid, I was told I could sell my home. But then where would I go? (Oshawa)

Most women in the Haliburton focus group are not happy with the local walk-in clinic, and travel long distances to visit family doctors.

The local clinic is staffed by residents, so it is never the same doctor. No consistency. You have to repeat your health history each time you visit. I'd have to be pretty ill before I go (Haliburton).

I was concerned about my underweight baby, and visited the local clinic. They didn't show concern, but when I went to a Bobcaygeon doctor [50 km south], he immediately referred me to a pediatrician in Peterborough [another 50 km south] (Haliburton).

Services here are overstressed and overbooked (Haliburton).

[One Haliburton woman talked about problems accessing TeleHealth, a new 24 hour telephone service staffed by nurses. She felt that the nurse was trying to limit the length of the call].

A woman in Oshawa also referred to the shortage of good doctors in small-town Ontario, and the reliance on overworked walk-in clinics.

Not enough good family doctors. Where I used to live, my doctor was three or four towns away. I used the walk-in clinics, where their whole attitude is 'NEXT!'. They don't have time to ask you any questions.

In Haliburton, Kingston, and Oshawa, women report having to go to the 'big city' for specialist services. They are having difficulty meeting the transportation costs.

My son has diabetes, and I need to go to Oshawa [150 km south] for a doctor who knows what he is doing. I went to the local clinic when my son was having an episode, and they weren't listening. Having money for gas has been a problem. I have to stay with relatives there (Haliburton).

I see a doctor in Toronto. Sometimes gas money comes out of food money, housing budget, kids' costs, or you beg from people you are staying with (a woman in Haliburton with complex physical and mental health issues).

When my baby was born, she had to be in Sick Kids [Hospital in Toronto] for about five months. We couldn't afford the parking there. We got a pass for a couple of weeks from a nurse and that was it. We brought food, but it wasn't enough, and the food around there is too expensive (Oshawa).

Even transportation to local health services is inaccessible to many women, especially those with children in tow.

When you have a therapy session or doctor's appointment, it is a major struggle to get kids around to these appointments and to have them with you in the appointment, especially if the appointment is in another town, or it is winter. I can't afford daycare (Haliburton).

With physical pain it is hard to get around, especially in the winter. It is hard to access doctors, general medical care and medication (Kingston).

At the emergency room of the local hospital, you have to pay for parking and then wait for a long time. I've been there with my child, and I had to park the car illegally. What would happen if I got towed? I can't pay for parking, so I can't pay for a ticket (Oshawa).

All the shelters are in one part of the city and all the services you need in the day are on the other side of the city. 'Walking distance' in this city can mean a long distance (Parkdale).

I got a lift to physio, but it took me two hours to walk home (Oshawa).

Negative and impersonal attitudes were described as a barrier to getting the holistic health care women need.

When the public health nurse does her Healthy Baby visits, you are just a number. They don't want to get to know you, there is no compassion, no real help (Haliburton).

Some family doctors don't have a waiting list for a good reason! (Oshawa)

The emergency room humiliated me when I brought in my son without a health card (Oshawa).

Doctors overlook their patients' emotional and mental health (Parkdale).

Women in the Kingston and Parkdale groups spoke of being discriminated against by medical services because of addictions issues.

If you even mention Street Health, agencies assume you are on drugs. Hospitals think you are a junkie, and dismiss you (Kingston).

They black-flag people who are addicts or in methadone or on the street. When I delivered my baby, they didn't even give me any Demerol. They called Children's Aid right away. It is assumed you aren't capable of raising your child (Parkdale).

I was seven months pregnant and I had pneumonia, coughing all the time. I collapsed and [the Emergency Room at Toronto General Hospital] said: "Get out, you aren't going to get drugs from us" (Parkdale).

I would go to a doctor, and when I say I'm a prostitute and a drug addict, the plastic gloves come out and I don't get proper care. But I can't get the care I need if I don't tell them about my addictions (Parkdale).

WHAT KINDS OF SERVICES (INCLUDING HEALTH SERVICES) WOULD BE HELPFUL WHEN YOUR HOUSING IS NOT SECURE? WHAT IS MISSING?

The need for affordable housing came up as a first priority in every focus group.

We need more non-profit, rent geared to income housing for single moms and kids (Haliburton).

A big house with small rooms/ bachelor apartments for short term stays to allow time to get on your feet [ie., transitional housing] (Kingston).

Emergency and affordable housing which is clean and offers privacy (Kingston).

We need affordable housing. Some people become homeless because they are mentally ill, but homelessness can make you mentally ill (Parkdale).

The need for adequate income supports came up in every focus group.

Make it easier to get off assistance and get ahead, without financial penalties [in relation to Ontario Works (OW), Rent-Geared-to Income housing and Ontario Disability Support Plan (ODSP)] (Haliburton).

Enough money to rent decent housing and still buy necessities. The living allowance provided through social assistance isn't enough to live on. The shelter portion is not enough to rent something with (Kingston).

The need for short-term and emergency help, before things get worse (Oshawa).

We need more money for housing. Welfare rates are too low (Parkdale).

The need for more one-stop holistic services came up in all four focus groups.

Provide one-stop shopping: a combination of health and social services all in one building. OW, food, clothing, health care all together. This would avoid the stigma of having to access the services individually. You could walk in the door and no one seeing you would know what

service you were there for. It would cut down on gas costs, and would be easier with kids. This type of facility would need to be available in different towns (Haliburton).

A mobile health and outreach service for street youth and others who are homeless, with primary health care, needle exchange, hygiene basics, advice, info and referrals (Kingston).

Having a client advocate in each agency, to help sort out needs and the supports that are available. If there is a problem, the advocate could help solve it, or be a go-between (Kingston).

I wish there was counselling for kids at the same time as counseling for parents (Oshawa).

We need little pockets of services and shelters all around the city (Parkdale).

Emergency storage came up as an issue in Kingston, Oshawa, and Parkdale.

Having a secure place to keep stuff. This is a major issue as theft at shelters is a problem (Kingston).

I needed a locker room to store my furniture until I found a place. My friend got in trouble [with her social housing provider] when she stored my stuff, because they thought she was making money (Oshawa).

It's hard to hold onto things like Health Cards (Parkdale).

The need for free dental care was raised in Oshawa and Parkdale.

No dental care and my teeth are rotting (several women in Oshawa and Parkdale).

The immediate need for better mental health services for children, youth, and single mothers was a key issue in Oshawa and Kingston.

I need counselling right now for my teen daughter and son. They are in serious trouble (Oshawa).

There needs to be more suicide prevention for teens. My daughter needed to spend three months in a psychiatric

hospital before she was assigned a therapist (Oshawa).

Yes, there is never any help beyond the immediate crisis at Lake Ridge [a local hospital] (Oshawa).

At home help for single moms; help them out with their kids, help them to keep their kids. Help keep them from getting evicted. Provide a caregiving service, to allow moms some time to take care of themselves (Kingston).

Better mental health services for adults was stressed in Parkdale.

We need more psychologists. Psychiatrists just want you to take meds.

The need for more and better drug and alcohol rehabilitation services was important in both Kingston and Parkdale.

We need more rehabs. The waiting time is 6 to 12 months. Detox waits are long too (Parkdale).

Other specific services were brought up in the focus groups.

Budgeting assistance –help in handling money, paying bills, developing a workable budget (Kingston).

I get no help with nutrition as a diabetic (Oshawa).

I need a chiropractor, but it isn't covered (Oshawa).

Some people do smoke [crack] 24/7. Those people need the most help. 'Bring Mohammed to the mountain' [ie., outreach workers to them] (Parkdale).

WHAT ARE THE MOST IMPORTANT THINGS WE SHOULD CONSIDER WHEN DEVELOPING AND DELIVERING SERVICES TO HOMELESS PEOPLE? WHAT DO YOU WANT IN A SERVICE PROVIDER?

The attitude shown by service providers was central to all four focus groups. The need for responsiveness to women's needs was a common concern, as were flexibility, empathy, and the need for a 'harm reduction' approach.

Show consideration, show empathy, give us choices, make it so we can get ahead and out of this situation (Haliburton).

We need coffee, people, and workers to talk to. Good workers who are understanding, non-judgemental and accepting, and who will listen and let you talk to them. Workers who are willing to help you and advocate for you (Kingston).

Talk to the clients. Find out what they want and need. Don't assume to know better or judge them if they don't want what you think is best. Have respect for the clients (Kingston).

Protect confidentiality. Recognize a client's right to get help anonymously. I don't always want to give my name. Sometimes I just use my street name (Kingston)

Staff need to understand the judgements they are making, and to not assume that a homeless person will be grateful for the chance to live in substandard housing. Understand that we have the right to dignity and to say no to what is offered (Kingston).

Individual attention, instead of strict rules. Usually the rules are really rigid in health services. [Oshawa CHC] is an exception.

Please listen (Oshawa).

Continuity in local health care was a big issue in all four focus groups, especially in relation to supports as women obtain permanent housing.

It would be helpful to have a permanent doctor in the local clinic, one who would take on new patients, or could look back at patient files and provide continuity (Haliburton).

Need an after care program [for people dealing with addictions] that has substance. This would help support people as they stabilize their lives and housing (Kingston).

Addicts and alcoholics get housing, then they lose it. You get kicked out. Just because you have housing doesn't mean you change your lifestyle all of a sudden (Parkdale).

I don't like having to explain again and again to different workers (Oshawa).

Consulting with and hiring women with direct experience with homelessness came up in several focus groups.

Come live at my house for a week. People in social services need to know what it is like to walk in my shoes (Haliburton).

Hire staff who have experience living on the street. If they've been there, they understand the issues and that can make a big difference (Oshawa).

Ask people who have been homeless. Welfare workers especially need to hear from people's experiences (Oshawa).

The best workers are ones who have been on the streets the way we are (Kingston).

Transportation assistance and on-site childcare were raised in the Haliburton and Oshawa groups.

Help with gas costs, [childcare] support (Haliburton).

Transit money. I can't afford to go anywhere other than work and home (Oshawa).

The need for help in getting prescription medicines was a big issue in Oshawa and Parkdale.

Working poor women can't get medicines. I can't afford medicine for my asthma or rosacea. I can't get the money back from taxes, either (Oshawa).

Finally, the women we spoke to want better supports for the services and individuals who are doing good work in their communities. They want agencies judged on their performance and the feedback of the clients, not on their proficiency in funding applications.

The problem is that [Oshawa CHC] outreach creates needs for more resources, that they don't have.

Outreach and front-line workers do the most work, but they don't have the tools or resources that they need. They need more back-up. They burn out. With more time, they can do more (Parkdale).

Agencies shouldn't have to fight each other for funding (Parkdale).

While the principles may be agreed upon by the agencies, in actuality that is not how they are delivered (Haliburton).

Certain projects are government favorites, and get more than their fair share of the money (Parkdale).

4.3 LESSONS LEARNED

In general, the four focus groups reiterated themes found in the literature review and agency interviews. Women across Ontario are facing homelessness, and suffering from physical, mental, emotional, and spiritual health impacts because of their lack of affordable and secure housing. But outside the central areas of big cities, the problems of homelessness and health are largely invisible. This invisibility only adds to the extreme stress of not being able to live decently, and maintain a family. There is the need for more and better income and housing supports across the province.

In suburban, small city, and rural areas, the problems of lack of adequate health care, especially specialized services, is endemic. But for women who can't afford transportation or childcare, the problems of accessing appropriate health care are virtually insurmountable. While some central city agencies provide public transit tickets, more imaginative responses (mini-busses, gas money, emergency childcare) need to be explored outside the central city.

Good health services, especially those that are integrated with other services such as housing help and income supports, can make a huge difference in preventing homelessness, and moving women into permanent housing. This service integration may mean co-location, or it may simply mean

interagency collaboration and good referral systems. Women need health services that integrate emotional and physical healing, including support on childrearing and addictions issues. They need health care providers who are flexible, non-judgemental, and responsive to women's concerns. Women with mental health and/or addictions issues especially need support as they try to maintain permanent housing and keep their children out of institutional care.

Women say they need health care providers who share information (with the women's permission) on emotional and physical health issues. They want a holistic approach, whether they are being treated by doctors, nurse-practitioners, or therapists. Women say they need to be provided with choices, including the choice not to follow the health care professionals' advice. They say they sometimes need time and long-term support to get better. The lessons from positive examples such as the Oshawa CHC and Parkdale Activity and Recreation Centre need to be integrated in funding programs.

Finally, the women we spoke to want to be treated as unique individuals whose opinions and experiences matter.

5.0 FINDINGS AND ANALYSIS

This section explores the findings and the areas for further exploration which emerge from the literature review, service inventory, and focus groups. Specific themes include:

- Women's experiences of homelessness
- The range of service delivery models
- Differing definitions of integration
- The significance of location (centre city, suburb, small city, rural and isolated areas)
- Gaps and trends in services
- Funding and policy issues
- Evaluation of homeless initiatives.

This section also presents a set of principles of best practice which have been informed by each phase of this research.

5.1 WOMEN'S EXPERIENCES OF HOMELESSNESS

Participants in the focus groups noted a wide range of mental and physical health problems which accompanied their homelessness, including: depression, stress, anger, panic attacks, tendency to self-blame, inability to eat or sleep well, ulcers, indigestion, headaches, and weakened immune system. Some women said it was hard to maintain a comfortable level of personal hygiene. Some experienced increased threats and incidents of violence. These experiences of health and homelessness are consistent with the research discussed in the literature review (Section 2) and reinforce the need to see these two issues as closely linked.

Women in each of the three focus groups outside Toronto spoke of trying to keep others from knowing about their homelessness in order to protect themselves and their children from being stigmatized. These women found it hard to seek help. A few women in the Haliburton and Kingston groups coped by relying on friends and family for assistance. In the case of Haliburton, women reported that "there aren't any services or support [here], except for a clothing and food depot." The only place one woman in a small town had to turn was her church, which she found humiliating. Women in rural areas are facing a barrier to accessing services that is different from their urban counterparts: there are few or no services to go to for help in some towns and counties. When there are services, women do not have much, if any, choice about where to seek help. For women in rural areas as well as small and large cities, transportation, lack of money, childcare issues, health status, addictions issues and many other factors, including stigma, can make it difficult or impossible to access the services they need.

A common theme heard in all the focus groups was the need for more affordable housing and for women to have choices about where to live. For example, women want to be able to say no to housing that appears unsafe, unclean, or connected with a crack house. Some women specifically mentioned the need for transitional housing, which could give them time for them to re-stabilize their lives. Women in all focus groups spoke about financial difficulties. Whether on social assistance or working full-time in a minimum wage job, women reported not having enough income to cover basics, including food, transportation, toilet paper and prescriptions (of most concern to the working poor).

5.2 INVENTORY OF SERVICE DELIVERY MODELS: OBSERVATIONS

The following discussion stems from analysis of the inventory of profiles within the contexts set out by the literature review and results of the focus groups.

5.2.1 Client Group

Of the profiles included in this report, 25 of the 35 profiles are initiatives or agencies that provide direct services to homeless women. Many of these also count women at-risk of homelessness among the clients they serve. Three initiatives provide services to a diverse group of women, some of whom are clearly at-risk of homelessness but not necessarily homeless as point of entry into the service (VCARS, Nijkiwendidaa Anishnaabe Kwewag Services Circle, and Pathway's Wraparound Initiative). Four housing organizations are profiled to draw attention to how services and programming can support tenants who are at high risk of losing their housing or who were formerly homeless. Finally, three inter-agency networks are profiled which do not provide direct services to homeless clients yet do focus on identifying and responding to system-wide or sector needs.

Among the agencies and services who provide direct services to homeless women, many informed us that as many as 50 to 70 percent of the women they serve have mental health problems. This figure is notably higher than the range of 30 to 50 percent typically cited in the research literature.⁹⁵ This difference may be due to a number of factors. A given agency may focus on a specific subgroup of homeless women and may in fact gear their services towards those who are most likely to have persistent mental illness. In contrast, research studies have usually examined the prevalence of mental illness across all homeless people in an entire city. An agency serving chronically homeless single

⁹⁵ Lehman and Cordray 1993

women would be expected to report an extremely high rate of mental health issues in its clientele, whereas this might not be the case for an agency serving single mothers who are newly homeless. An additional consideration is that research studies cited in the literature usually use rigorous diagnostic interviews with homeless people to identify mental illness; whereas the survey tool used in the present study asked agency staff to informally estimate, based on their experience, the percentage of women in their client group with mental or emotional health problems.

Given this context, the information obtained from agencies regarding mental health problems among their clients should not be construed as supporting the stereotype of homeless women as "bag ladies" with severe and persistent mental illness. Instead, the understanding is that homeless women form a large and diverse group of individuals, many of whom are among the invisible homeless who are couch-surfing, living in unstable housing situations, or relying on friends or family for temporary accommodation. As a result of this diversity, homeless and at-risk women do not all have the same service needs.

5.2.2 Models of Service Delivery

The 35 initiatives profiled in Section 3 of this report were grouped into seven categories or models of service delivery:

- Health centre services
- Mobile outreach services
- Case management services
- Shelter based programs
- Programs in women's organizations, drop-ins and community services
- Services attached to transitional and permanent housing
- Inter-agency networks

Clearly not all initiatives fit neatly into a single category and many could arguably have been categorized differently. The ambiguity about how to characterize some of the initiatives may in fact be a good indicator of examples of effective service integration and coordination across health, social services, emergency services and housing sectors. Nevertheless, the categories of initiatives and the profiles included in each category bring to light some of the advantages and challenges inherent in different service delivery models when working with homeless populations to improve their access to health services.

1. *Community health centres* provide a setting for "one-stop shopping" for a variety of health and support services for people who are homeless or at-risk of homelessness. Many also support outreach programs which take primary health care services to the places where homeless people live or congregate. The health centre approach is one that typically values client-centred services and takes a holistic approach to health, including physical, mental, spiritual, and emotional health. With strong links to other community services, health centres also seem well equipped to make appropriate referrals and assist clients with issues related to housing or income supports. Challenges for health centres working with this population include: (1) many health centres seem to be operating at peak capacity; (2) health centres in suburban areas may be hard for many homeless or at-risk clients to reach; (3) health centres are limited in their ability to ensure follow through to specialist medical services, which are less accessible to homeless populations and often less sensitive to the service needs of this population.

Aboriginal health centres seem to be effective in reaching a particular at-risk population with an approach well-suited to their needs. There may be lessons for health centres serving new immigrant and refugee populations, especially given that new immigrant and refugee populations are no longer concentrated in the centres of large cities, but are found throughout the suburbs of Toronto and Ottawa, and elsewhere. Lessons from street health

clinics can inform suburban and rural health centres, especially if homeless outreach funding is extended to these centres.

2. *Mobile outreach services* definitely help the homeless populations that are the hardest to reach. While working to develop trusting relationships with individuals who are living on the street or in shelters, outreach teams connect with clients at whatever place they are at in their lives. The teams provide basic and emergency supplies and food, while working to bring homeless individuals into shelters or connect them to other needed services. As a model of service delivery that includes a health service, the health interventions are limited to immediate crisis care and identification of physical and mental health issues which require follow-up, and some harm reduction strategies (eg. needle exchange). Mobile outreach teams have little scope to deliver health services that are holistic, prevention-oriented, or focussed on treatment of chronic conditions.

3. *Case management services* that follow women (especially women with severe mental illness and/or addictions) through a variety of stages of homelessness and into long-term housing can result in the client seamlessly accessing a wide range of services that can meet her own individualized needs. These services can include, but are not limited to, primary health care and specialist services to deal with physical and mental health concerns. However, many of the long-term case management services appear to be operating at capacity, with individuals in some Ontario cities unable to access them when they need them. There is definitely a need for increased capacity within case management services to support at-risk women once they are stably housed to prevent further homelessness. The need for 'wrap-around teams' to provide individuals with long-term care and support regardless of where they are living was heard in a number of different contexts, including from shelter and housing providers, as well as from focus group participants. Some concern was raised about

the heavy emphasis on psychiatry which can occur on some teams, resulting in a team that is not directed by, or sensitive to, the client's needs.

4. *Women's organizations, shelters and drop-in based services* bring a wide variety of services to places where women live or congregate. The services are typically wide ranging and can include everything from advocacy around income supports, to food programs, to employment and re-training assistance, to individual supportive counselling. When looking at health services, these multi-service environments are limited in the scope of primary and follow-up health care that can be provided. For example gynaecological care, dental care, long-term treatment or monitoring of chronic conditions are typically not available in these settings. The health care and other services provided in these settings may not typically continue once the client has moved into long term housing, and there is often little or no follow-up programming attached to these services to help keep her from becoming homeless again.

5. *Transitional and permanent housing* that comes with supports results in a variety of services being available in places where women live. The services do not typically include primary health care, but can range from supportive counselling, case management, assistance with income and employment issues to conflict resolution. There are wide variations in the supports attached to housing as they are tailored according to the client group receiving the assistance, the tenant group being housed, the agency providing the support, and the funding stream for the support services. The support women receive, combined with affordable rents, can be instrumental in keeping them housed longer and preventing eviction. There are, however, long waiting lists in many Ontario cities for social housing, even for the supportive housing geared to meet the needs of people coming from the streets and shelters. The social housing sector does not currently have the capacity to meet the demand for

transitional and supportive housing that exists, and in some areas private sector landlords have been reluctant to enter into agreements with agencies who are housing and supporting individuals with mental or physical health issues or those with physical and developmental disabilities. Within the wider social housing sector (non-profit, co-op and municipally owned housing that does not have a support component attached) concerns have been expressed that these organizations are not able to provide the ongoing supports required by individuals coming out of shelters. Despite access to affordable rents, formerly homeless tenants can find it difficult to stay in the housing without some assistance in a transition period and often over the long term.

6. *Inter-agency networks* can effectively unite all agencies in one part of the homelessness services sector (eg. all agencies providing mental health services) as well as provide a forum for organizations from across health, social services, housing, and emergency services sectors to work together. These networks are vehicles for identifying local service gaps, local challenges and solutions in coordinating services, and innovative ways to meet local needs that build on services that are already available. Challenges inherent in inter-agency networks and collaboration include: having a clear sense of purpose; identifying goals that can be embraced by all participating agencies; identifying a common philosophy for service delivery; allowing time to build the network contrasted with the need to realize successes and practical actions coming from the network beginning in the early stages. When inter-agency collaboration begins, agencies may also struggle with differences in their philosophy for service delivery. An example is a collaborative program involving both agencies that work from a harm reduction model for clients who use alcohol or drugs and agencies that require abstinence from alcohol and drugs while clients are accessing services.

5.2.3 Integrated and Coordinated Services

The literature review in Section 2 of this report provided three different ways to think about service integration and coordination, all of which have some applicability to urban, suburban, small town, and rural settings. They are:

1. *Interagency Coordination* which can result in coalitions, multi-agency staff teams delivering services, or information systems to manage information between agencies for better coordination of client care.
2. *Co-location or a Service Hub* where a variety of services are delivered at one site or in close proximity to one another. Numerous agencies may be involved in delivering services at any one site where homeless people live or congregate.
3. *Case Management Approach* which relies on a case worker, assigned to a particular individual, to facilitate access to the full range of services and supports required by the individual. The case manager may, for example, provide informal counselling, assist the client to identify goals and service needs, assist with transportation, provide information and referrals to other agencies, and assist in finding or maintaining housing.

The initiatives profiled in Section 3 provide examples of integration and coordination of services within and between agencies. Many initiatives rely on partnerships with a variety of agencies for the delivery of services.

5.2.4 Geographical Considerations: Inner city versus suburban, small town and rural areas

Across Ontario, a 'ring model' is emerging, whereby the central city has relatively good inter-agency coordination, co-location, and integration, yet inner suburbs, especially in Toronto,

are seeing increases in demand for services without appropriate funding and coordination. Similar pressures are likely being felt in smaller cities, suburban communities in the Greater Toronto Area, and more rural settings. Ottawa, Toronto and some municipalities in the Greater Toronto Area are demonstrating a commitment to integrating homelessness and health services informed in part by gender analysis. There is an understanding that health services need to be brought to shelters, drop-ins, and sites where people are sleeping rough. In Toronto, for example good coordination is evident across the sectors serving homeless populations and between key partners, including:

- The three central Toronto CHCs (Regent Park, Central Toronto/Queen West, Parkdale), and several specialized health clinics (Access Alliance Multicultural Health Centre, Shout Clinic for street youth, Sherbourne Centre which will be focussing on the needs of the lesbian, gay, bi-sexual and transgendered communities, Anishnawbe Health focussing on needs of aboriginal communities);
- Central city hospitals (especially St. Michael's Hospital and University Health Network);
- CAMH and CMHA;
- Central city agencies, shelters, and drop-ins serving homeless people;
- Transitional and long-term housing organizations (including Houselink, Fred Victor Centre, Ecuhome, Toronto Community Housing Corporation as examples).

In Ottawa, service coordination is evident within and across sectors as reflected by initiatives such as:

- Mental Health Community Support Services, intake, assessment and case management services which have evolved through more than fifteen years of collaboration among agencies providing mental health services;
- The Inner City Health Project which results

from collaboration between 16 partners from health care, shelter, municipal, and mental health sectors, as well as the University of Ottawa; and

- The Alliance to End Homelessness, an inter-agency network of service providers, housing providers, municipal staff, and advocates working together to identify and respond to homelessness issues in the city.

These partnerships are leading to innovative services, including 'wrap-around services' for those hardest to house (severely mentally ill, young people with children) that follow these individuals into transitional, supportive, and permanent housing. There is also a much greater emphasis on 'harm reduction' and 'client-centred' approaches, which reflect the impact of the health promotion model on all aspects of service delivery.

At the same time, the inner suburban community health centres, shelters, and agencies are struggling to respond to increasing service needs from homeless and under-housed people. Increasingly, Toronto's inner suburbs are dealing with low-income immigrants and refugees, with attendant lack of documentation, language, and cultural issues that make health services hard to access. Low-income immigrant and refugee women are reluctant to 'self-identify' as homeless, because of social stigma and fear of losing what inadequate (eg. overcrowded) housing they have. They are also less likely to be hooked into social support systems, because of linguistic and cultural barriers. There is particular reluctance to seek help for mental health issues, even though stress and severe depression are endemic. Inner suburb agencies are aware of the problem, and are scrambling to respond with links between shelters, transitional or supportive housing providers and community health centres. However, the development of these networks appears to be lagging about five to ten years behind those seen in central cities. This may be attributed in part to the government's focus on dealing with the more visible homelessness crisis in urban core areas, rather than adopting a broader system-wide integration approach.

Regional governments in the Greater Toronto Area face challenges in delivering accessible services to homeless and at-risk populations due to the size of their catchment areas, weak public transit infrastructure, limited supply of affordable rental housing and long waiting lists for social housing. Some responses to these challenges which became apparent during this study include: (1) delivering a variety of services, including homelessness prevention initiatives, at multiple satellite sites; (2) operating mobile case management and homeless outreach services; (3) integrating a wide range of services into shelters that are open 24 hours per day; and (4) implementing an after-care program to ensure follow-up with clients who leave the shelters and move to transitional or permanent housing.

Looking province-wide, the issue of women, homelessness, and integrated health, is the intersection of two invisibilities. In smaller cities, towns, and rural areas, there are not many people sleeping rough and few or no shelter services, thus homelessness is largely invisible. Homelessness is also contrary to the stereotypes of suburbs, small towns and rural areas as places where people take care of themselves and do not have "those kinds of problems." Arguably, this is a perception very much encouraged by senior levels of government and some municipal governments, yet it is also deeply internalized at the individual and institutional levels.

There is also the relative invisibility of women among the population sleeping rough and in homeless shelters outside the centres of big cities, although this is changing. If the perception of the 'typical' homeless person is an older single man with mental health and addictions problems, then the low-income mother with children staying in a violent relationship in order to avoid total destitution, the queer teenager couch-surfing, and the older refugee woman living with extended family in a one-bedroom apartment, while seen as a 'problem,' are not necessarily seen as a problem of homelessness. Again, this is internalized by the individual women ('I'm not homeless') as well as within institutions like governments, the non-profit sector, and private charities.

A further consideration that emerged during the focus group discussions is whether it is better to have a single "super-agency" or multi-service centre provide all needed services for homeless and at-risk individuals or whether multiple agencies should strive for more effective inter-agency coordination of services. There may be a desire among clients in rural or suburban areas for one stop access to a wide range of services, but in larger cities, agencies and programs are so numerous and dense that this may not be practical or desirable. This is an issue of trade-offs, with a single super-agency seeming preferable in terms of coordination and planning of services, avoidance of duplication of services, sharing of information, and follow-up as the client moves from place to place. On the other hand, multiple smaller agencies are better able to build special relationships with clients and tailor their services to very specific subgroups (for example street workers, immigrants, or lesbians). These organizational issues also raise funding and jurisdictional issues (see Section 5.2.4).

5.2.5 Trends and Gaps in Services

While this section highlights some specific trends and gaps in services for homeless and at-risk women which became apparent during this study, the starting point needs to be a general observation about women's services in rural areas. Overall, small town, rural, and remote areas of the province have been found to be severely lacking in services for women at-risk of homelessness or those who were actually without a home. When services for this population were identified, there was little evidence of any significant or innovative integration or coordination of services.

In urban areas where a variety of services exist, homeless and at-risk clients are better served when there are strong connections across the various models of programs. For example, mobile outreach teams linked to health centres and case management teams, and shelter-based programs linked to programs and agencies that will follow the women after they leave the shelter, can more effectively meet a range of physical, mental, emotional and spiritual health needs as well as other practical needs

of clients. This is an area in need of increased funding within the homeless services sector, especially among shelters for battered women and emergency shelters for homeless women.

Service- or site-specific programs can be effective in connecting with women at distinct points in their homelessness experience. They may, however, be weaker at providing continuity of service across time and space, as homeless and at-risk women lead relatively unstable lives. Looking at the experience of evolving programs at the Oshawa CHC, as an example, it appears that one way to increase the long term relationship a woman has with a health service, even after she is stably housed, is to keep the definition of health service broadly defined and to tailor programs to meet the continually changing and evolving needs of participants.

Particular gaps in services for homeless and at-risk individuals, or services where there needs to be additional capacity in the system, were noted during the course of this study, including:

- *Primary health care for homeless and at-risk women.* CHCs operating at capacity, rural women travelling far from their home communities for health services for themselves and their children, and a shortage of family doctors across the province points to the need for more accessible primary health care services for homeless and at-risk populations. Primary health care for much of the homeless population is currently provided at a number of community health centres due to the need for a particular kind of expertise and skill. With limited resources within CHCs, the existing capacity of the current infrastructure is not likely to meet this need over the long term.
- *Case management services without long waiting lists.* In urban areas additional capacity is needed among these services to meet the growing need. In rural areas, the issue is even more basic: women need to be able to access such services for short, medium or long term assistance.

- *Emotional and mental health counselling services.* Clients and service providers express a need for counselling services that are not "psychiatric" in nature (i.e. based on a medical model centred on the diagnosis and pharmacological treatment of psychiatric illness). Clients need timely access to the services they require without long waiting lists. This includes mental health counselling for children who, for example, are escaping an abusive father or adjusting to issues of impoverishment and emotional loss following their parents' relationship breakdown.
- *Dental care that is free and available to homeless and at-risk women.* This service is equally needed in urban, suburban, and rural parts of the province. Only a few services contacted as part of this study reported that they were able to offer it in a limited way or were planning to offer it.
- *Free or inexpensive prescription drugs.* This issue is especially important for the working poor, regardless of where a woman lives in the province.
- *Substance abuse treatment services.* Homeless and at-risk women from across the province need to be able to access treatment services which are sensitive to their needs and accessible when clients are ready for them. Increased services for women with both substance abuse and mental health problems are needed across the province.
- *'Wrap-around' services that follow women as they move from unstable housing or shelters into transitional or permanent housing.* While programs such as Hostels to Homes exist, the need is greater than the available services can meet. This is a need that is felt in urban and suburban areas as well as small towns and rural parts of the province.

Many of these gaps in service are also mentioned in the recently released Romanow report from the Commission on the Future of Health Care in Canada.

Shelters for abused women do not have the same access to integrated services as multi-purpose shelters, creating a severe service gap. This may be due in part to current funding streams and priorities for homelessness prevention work or the organizational culture within shelters for abused women. Many shelters for abused women in Toronto contacted as part of this study are serving mostly new immigrants, with about one third to one half of the women being refugees without status. The proportion of immigrant and refugee clients is much lower at mainstream shelters for the homeless. Consequently, a big focus of integrated health services in shelters serving immigrant and refugee women is arranging cultural interpretation with medical people, assisting women in accessing services that do not require health cards.

Another service gap which particularly affects clients coming from shelters for abused women is that there is not widespread understanding of the impacts of post-traumatic stress. As a result, many transitional and long-term social housing providers are ill-equipped to provide appropriate supports. This compounds the problem of women leaving shelters after fleeing abuse and ending up in housing with few or no ongoing supports. The Women's Support Worker initiative linked to the Nepean Housing Corporation attempted to address this problem on a small scale. While there are initiatives helping women leaving mainstream shelters (See Hostels to Homes, and Peel's 24 hour shelter as examples), there appear to be few such programs operating through abused women's shelters. The YWCA's Women's Safety Network and Nijkiwendidaa Anishnaabe Kwewag Services Circle, profiled in this report, are examples of follow-up care services for women being re-housed after leaving a shelter for abused women. In the case of Toronto's shelter for abused women, the absence of follow-up care programs for abused women results in differential access to "wrap-around" services for immigrant and refugee women.

A final issue that can lead to gaps in services and can undermine the coordination of existing services between agencies, relates to the sharing of

information about clients being served by different agencies. For example, an outreach team that includes a nurse practitioner has no way of knowing what other services a client is accessing, including other places the client may be obtaining prescriptions. While many agencies report informal sharing of information within and between agencies as needed and with the consent of the client, there is no consistency in what types of information are shared and how this is done. Furthermore, within agencies medical and non-medical members of a team typically chart information in different ways. Ottawa's Inner City Health Project is piloting an initiative to develop and test a web-based health records system that can be accessed by team members from a variety of agencies, all with the consent of the client. This program has made the sharing of information between members of a client's care team a priority.

5.2.6 Mainstream Versus Parallel Services

The issue of services specifically designed and delivered for homeless people versus making mainstream services accessible to this population points out differences in the philosophy of care which can exist between agencies and policy and program guidelines which result in these programs. Some advocates for homeless people point to tensions between the integration of homeless and socially isolated people into the regular health system through supportive programs, and the creation of a parallel (possibly a second tier) system that at best, takes specific needs and health conditions into account, and at worst, offers little follow-through beyond the specific clinic or drop-in.

In the current environment, both approaches (training mainstream health services and developing specific responses for particular groups of homeless people) are necessary. There is a shortage of 'mainstream' doctors and dentists (outside of community health centres) willing and financially able to take on patients without health cards, and there is also lack of training for these medical staff

on issues specific to homeless people. Systemic issues related to a lack of discharge planning from hospitals remain, and again, are generally more acute in inner suburban hospitals than in downtown Toronto for example.

Another reality is that the benefit of many services is how they are specific and tailored to the needs of homeless and at-risk populations and are targeted to them (eg. clients in shelters for abused women). Within services especially for homeless or at-risk populations, however, it is critical to ensure that these programs are delivered in a way that does not stigmatize the client or require the client to accept a label, as many women who are homeless or at-risk are reluctant to see themselves or label themselves that way.

5.2.7 Policy and Funding Issues

The Golden report on homelessness identified a number of system-wide barriers to integrated services including:⁹⁶

- Lack of funding coordination from governments, charitable and private sources, pointing to the need for system-wide service priorities and an end to unstable funding practices;
- Emergency versus Preventive focus: increased demands combined with more limited resources (especially in terms of cutbacks to social housing provision in the 1990s), placing service providers in a stop-gap, rather than pro-active, position.

As a result of provincial downloading of a number of key services, municipalities are now responsible for social housing, shelters, and programs to meet the needs of homeless populations, although Toronto, Ottawa and other Ontario cities had some pre-existing expertise with service planning and delivery in these realms. In Toronto, Ottawa, Peel, Hamilton, Waterloo, and elsewhere, an increasing emphasis is being placed on homelessness prevention programs (such as eviction prevention) and also on moving people out of homelessness.

But health, a determinant of homelessness just as housing is a determinant of health, is a provincial responsibility. If one objective of downloading was disentanglement, this has not been successful in the realm of housing, supports and services for homeless populations. It has merely added a new layer of 'entanglement,' wherein many programs are administered by the municipalities but are funded by senior government (for example, federal SCPI funds along with municipal-provincial Homelessness Initiative Funds). In addition, while social housing is largely a municipal level responsibility, the Province has retained control of some specialized and supportive housing.

One constant refrain is the insecurity of funding and lack of stability in programs serving homeless populations. The result is that agencies rely on project-based funding and do not always have the financial means to continue to run a successful program once start-up funding or project based funding has ended. Project-based funding can also be allocated for one or two years when the initiative really needs four or five years to be fully implemented, refined and evaluated.

A noted gap in service is primary health care for homeless women, services which are typically available through CHCs where resources are already stretched. Because primary health services fall within the mandate of the MOHLTC, no other agency or organization is willing to fund this activity.

While a number of larger cities (Ottawa, Toronto, and Hamilton for example) have experienced health, housing, and community service divisions working hard to coordinate services and programs, especially in terms of SCPI funds, they are doing it despite the governmental 'silo' system and because of strong histories of collaboration. Smaller Ontario municipalities are less experienced in blending disparate granting sources into effective policy at the local level. There is also evidence of municipal governments linking with local universities to carry out research and evaluation.⁹⁷ There is a potentially expanding role for colleges and universities to

⁹⁶ Golden et al. 1999

work with communities on issues of homelessness and health.

There has been the precedent of intergovernmental committees at the provincial and federal levels on crime prevention. Consideration needs to be given to what forms of intergovernmental committees, involving all levels of government, can effectively respond to housing and health needs in communities across the Province.

5.2.8 Service Evaluations

Feedback received during this study indicates that many feel that evaluation still tends to be seen as a ‘stick’ rather than a carrot. Evaluations are expected to show large numbers of clients served or else funding will be in jeopardy, an approach which can be perceived as threatening. A more useful approach to evaluation would be to focus on ‘learning from best practice.’ This approach would require adequate funding and expertise in conducting external and internal evaluations. Funders, however, appear to be reluctant to provide financial and training supports for comprehensive outcome-based evaluations.

When looking at evaluating services for homeless people, a useful starting point is to clarify the different reasons for undertaking the evaluation. From this understanding, appropriate evaluation strategies can be formulated. These may include: evaluations of the effectiveness of the program, client satisfaction, or system analyses.

Evaluations of the effectiveness of programs need to identify and examine objective outcomes. Outcomes of health-based initiatives should focus on improved housing and stable, adequate income as well as health. These longitudinal evaluations are rigorous and expensive, and are arguably best reserved for specific situations such as evaluating a new model of service delivery, a very expensive service or achievement of a very important outcome. Outcome evaluation is by no means an exact science, however, since there are so many

other ‘determinant of health’ factors involved. For instance, the Access to Community Care and Effective Services and Supports (ACCESS) program in the US found that a city’s social capital and housing affordability are as much factors in positive health outcomes for homeless mentally ill people as the actual integrated health initiatives they funded.

Evaluations of client satisfaction can involve a cross section of an agency’s client group, and be much less expensive to undertake. Most agencies have incorporated clients in their process evaluations: they measure client satisfaction with services and elicit ideas for improvement of service through a variety of formal and informal mechanisms. If agencies and funders want these evaluations done more rigorously than is current practice, a standardized framework could be developed that would allow for comparisons of client satisfaction across different programs or geographic locations.

System analyses are critical in order to achieve more integrated and coordinated services across the homelessness services sector. These evaluations go beyond assessing a single program and look instead at the totality of programs and services in the system to assess what services are not well integrated with other client needs and/or agencies. System analyses could be undertaken in the context of inter-agency networks.

There is general consensus in the literature and among our informants that coordination and integration of the delivery system for homelessness services is an objective to work towards. However, in view of the experiences of the ACCESS project (described in Section 2), it is important to recognize that such integration is likely to improve processes, but may not necessarily have a significant impact on client outcomes. Since the ultimate goal is to improve the health and well-being of homeless women, it would be prudent to avoid spending large amounts of money on service system integration per se. Instead, simple low-cost methods of improving service integration (eg. inter-agency

⁹⁷ The City of Ottawa for example has contracted with the Centre for Research on Community Services at the University of Ottawa to develop and implement a system-wide performance measurement process for programs provided by community agencies participating in the City’s homelessness initiative (which includes SCPI). The performance measurement system involves 51 programs in 39 different agencies.

networks) should be encouraged, and new and existing resources should be preferentially directed towards integrated or coordinated programs. In other words, the focus should not be on coordination or integration as an end in itself, nor should it be the outcome by which a program is measured.

5.3 PRINCIPLES OF BEST PRACTICE

This discussion of principles of best practice is informed by a number of sources, including experiences of the research team, current literature on services for homeless people, United Nations criteria for best practices that address homelessness, public policy reports, interviews with agency staff, and focus group discussions with women who have experienced homelessness. (See Appendix C for a more detailed summary of the principles considered at different stages of the research). The concepts included in this list were endorsed by participants in the focus groups held during this study.

The following are proposed as principles of best practice and were found to be reflected to some extent in all initiatives profiled in this report:

- ***Comprehensive needs assessments and evaluations that take into account homeless women's perspectives and quality of life:*** This includes involving homeless and at-risk women in service evaluations and in identifying needs to be addressed; participation of those who deliver and fund the services in evaluation processes; implementing a system for making on-going adjustments to services; and including outcomes that measure quality of life issues as well as clinical improvements in evaluation processes.
- ***Diversity of services and approaches to integration:*** The key is recognizing that there is no one approach to service delivery or service integration that will work for all clients or all communities. Programs or approaches suitable in large cities may not be the same approaches that best serve homeless women in rural areas. Services for homeless populations need to be

sensitive to the significant differences in health and service needs between women and men, and also differences among women based on age, abilities, presence of dependent children, language, culture, sexuality, citizenship status, home community and health issues. From a systems perspective, homelessness services need to be accessible to women from a wide range of cultural and linguistic groups, and while not every clinic will offer service in every language, there needs to be system-wide commitment to better coordination with ethno-specific, multi-cultural, and multilingual agencies. Health and homelessness services need to be accessible to women with disabilities, who form such a large proportion of homeless women. Access for these women goes beyond design modifications for women with limited mobility and includes interpretation for the hearing impaired, provisions for people with limited sight, and a generally increased understanding of disabled women's health issues. Services for homeless and at-risk women need to be available and accessible to women in rural and remote parts of the province.

- ***Accessible and comprehensive services:*** These include services at shelters, CHCs, community and refugee settlement centres, and mobile health vans, that can reach visibly homeless as well as hidden homeless women, and offer a range of services (preferably in a range of languages) on site. It also includes services that meet the needs of women in a number of domains of their life that are coordinated and made accessible to clients through case managers. Services ideally will focus on long-term solutions around homelessness, health and other issues and/or have a component that focuses on prevention.
- ***Non-judgmental and non-discriminatory services:*** This includes respect for the client and where she is in her life; programs and services with no hidden agenda (for example, the client needs to feel that the goal is to house them, not reduce their dependency on alcohol); and an atmosphere of trust. Clients need to feel they

have choices and that they are at the forefront in directing what services will best meet their needs.

- ***Belief that recovery is possible:*** This refers to fostering an environment where clients believe in themselves, are supported to have a strong sense of self, where there is respect for the client's capabilities, and the client has a right to define her own life, including her right to fail.
- ***Viable and sustainable services:*** From a funding and resource viewpoint, programs need to be cost-effective, stable and sustainable over the long term.
- ***Coordination with other services:*** While not every agency can offer services that meet a client's legal, housing, physical, mental, emotional, and spiritual health, personal care, and financial needs, among others, the client benefits when mechanisms are in place to ensure the coordination of services between agencies. This may be achieved in a number of ways, such as inter-agency networks, informal and formal service agreements, locating a variety of services at one site, building outreach teams using staff from a variety of agencies, and centralizing intake and assessment procedures.

The profiles of homelessness services and programs included in this report all exhibit at least some of these principles of best practice. While it was beyond the scope of this research to rate any of the initiatives against these best principles, we recognize that while the process of identifying "best practice principles" may be straightforward, it is much more difficult to use them to measure any specific program. An unbiased third party could survey clients of a program in a systematic way and obtain information on how well a program was meeting certain criteria such as respect for people who are homeless; active participation of clients in program assessments; and how well programs meet a diversity of needs. However, such an activity is time-consuming and is rarely done in a rigorous way. For other best practice principles (such as how accessible and comprehensive the services are, their

viability and sustainability over the long term or the extent of their inter-agency connections), without in-depth knowledge of an initiative, it is very difficult to know how well an initiative or agency measures up. Nevertheless, with enough familiarity, a qualitative assessment of these characteristics could likely be made.

5.4 CONCLUSION

The discussion and analysis coming out of this research points to several over-arching themes:

1. A wide range of programs to meet needs of homeless and at-risk women are currently operating across the province. Funders and policymakers need to recognize their effectiveness as well as the gaps in service which are emerging.
2. Attention needs to be paid to homelessness prevention within and outside central cities, including suburbs, small cities, and rural areas. There needs to be recognition of the value of planning and coordinating housing and health services to meet the unique needs of communities and build on the strengths of the services already in place.
3. There needs to be clear recognition of the range of organizations who are involved in planning and delivering services needed by homeless women, and the ways in which health services are woven into them. In working towards increased coordination and integration of health and homelessness services, partnerships can emerge between a wide range of players, including CHCs, hospitals, district health councils, drop-ins, shelters for abused women, and housing providers, as well as municipal and senior levels of government.

6.0 CONCLUSIONS

Within the context of Ontario, and an understanding that health includes physical, mental, emotional and spiritual dimensions, the purpose of this study was to:

- Develop an inventory of promising models and practices in service integration and coordination for women who are homeless or at risk of homelessness in order to improve their access to health care, and
- Research and identify common or general elements of best practice models of service integration and coordination that address the needs of homeless women or those who are at risk of homelessness.

To establish a framework for this study, a literature review examined current issues related to integrated health services for homeless and at-risk women across Ontario. Attention was paid to the health issues of this population, the diversity of needs, barriers to accessing services, and the impact of location on service delivery. Key concepts for understanding and defining integrated and coordinated services were set out and principles of best practice in delivering services to this population were identified.

Interviews with key informants, including agency staff across the province, led to the development of an inventory of initiatives to demonstrate how health services are being delivered along side other services that homeless and at-risk women need. The initiatives highlight a range of successful services that are operating across the province as well as a variety of mechanisms for delivering services.

Focus groups were held in small town, small city, suburban and central city locations with women who had experienced homelessness or were at-risk of becoming homeless. These women spoke about their homeless experience in the context of health issues and access to services. Participants provided information on how services could better meet

their needs and confirmed a set of best principles for delivering services to homeless and at-risk women. Feedback from the focus groups also informed the understanding of how homelessness and health experiences among women vary by where they live in the province and the quality of services available to them. The focus groups confirmed themes which are reflected in the literature about the health issues facing homeless women, barriers women face when accessing services, and key considerations in delivering services to this population.

6.1 INVENTORY OF MODELS

This report has brought together 35 initiatives, which exemplify a range of models and practices for delivering services. The inventory provides a snapshot of initiatives taking place in a variety of urban and rural communities across Ontario and led by a wide variety of organizations, including hospitals, universities, shelters, health centres, community agencies, and faith based organizations.

The inventory of models, together with the literature review, provides background material and a context for the Ontario Women's Health Council to further investigate a smaller number of promising approaches to delivering services, including issues such as the transferability of promising initiatives to other communities in Ontario and sustainability of homeless initiatives over the long term.

6.2 PRINCIPLES OF BEST PRACTICE

The literature review, focus groups, interviews with agency staff, and public policy documents informed the development of seven principles for best practices in delivering services for homeless and at-risk women. In brief, they are:

- Comprehensive needs assessments and evaluations that take into account homeless women's perspectives and quality of life

- Diversity of services and approaches to integration
- Accessible and comprehensive services
- Non-judgmental and non-discriminatory services
- Belief that recovery is possible
- Viable and sustainable services
- Coordination with other services.

By taking an in-depth and qualitative approach to program evaluation, it would likely be possible to assess to what extent particular homeless initiatives measure up against these principles.

6.3 TOPICS FOR FURTHER INVESTIGATION

The findings and analytical section of this study point to a number of policy, strategic, and service issues that need further consideration.

1. Integrated Services in Communities across the Province

Clearly the need exists for well-developed and integrated systems of services for women who are homeless or at-risk of homelessness in communities across province. By ensuring a range of services, women will more likely feel they have choices in the services they access and a greater variety of needs will be met. The model of CHCs located in urban areas, which take a holistic and women-centred approach to health, appears to be adaptable in meeting a range of health, emergency, information and service needs among homeless populations. This model of service delivery could be investigated further to determine potential benefits for suburban as well as rural communities.

A more in-depth look at mobile outreach services would identify the types of services which are best delivered this way in central city versus suburban

communities. Consideration should also be given to how these services can effectively reach and support women who are at-risk of homelessness, and whether some form of the service is viable in rural communities.

Continued support for case management services is needed in central city and suburban areas, with a view to assessing how much extra capacity is required to meet community needs. Particular attention should be paid to services that support women as they move from shelters or temporary accommodation to permanent housing, and help prevent the clients from becoming homeless again. Case management services need to also be available for women in rural communities and small towns. Consideration needs to be given to how best to integrate these services into existing or new delivery mechanisms outside of cities.

Communities of all sizes, whether rural or urban, can benefit from inter-agency networking to identify and respond to community needs in serving homeless and at-risk populations. In small cities, towns and rural communities, cross sector networking (eg. between the health sector, municipal sector, housing and social services sectors) will be vital. In larger urban areas, there is a need for collaboration across sectors and also within particular sectors (eg. mental health services sector or health services sector). Agencies, universities and colleges, and municipal governments can all play a role in building networks to find local solutions to local problems and undertake system-wide analyses of services and gaps in services for homeless and at-risk populations.

2. Gaps in Service

A number of significant gaps in health care for homeless and at-risk women were identified during the course of this study. Further investigation is needed to determine how best to fund and deliver the following services for this population in a variety of communities across the province. Gaps in service include:

- Primary health care within the context of limited resources among existing CHCs and a shortage of doctors across the province. Consideration needs to be given to how mainstream health service providers can be trained to deliver sensitive and appropriate services to homeless and at-risk populations.
- Mental health services including a focus on mental, emotional and spiritual health issues for all family members, which are available and accessible when assistance is required, including in transitional and permanent housing.
- Case management services that can be accessed without being on a waiting list and that can be accessed by women in their home communities.
- Homelessness prevention services that identify and work with at-risk women in whatever capacity is needed, from advocacy around income supports, to mediation services, to negotiation with landlords around arrears, to referrals to health or other support services.
- Substance abuse treatment services which are accessible to women who are homeless or at-risk of homelessness, including women with mental health issues.
- Dental care and prescription drugs that are accessible to homeless and at-risk populations with little or no ability to pay for services. Urban, small town and rural areas across the province all appear to be severely underserved in terms of dental care for this population. Lack of access to prescription drugs was identified as a barrier to health for many low-income women who are not on government benefits.

3. Stable funding programs

Many innovative projects are limited in scope or are not fully developed and tested because funding horizons are too short. Consideration needs to be given to extending the funding programs for homelessness initiatives, and working towards an environment where agencies can effectively

plan their service delivery over the medium and long term, knowing that funding is stable. Funding programs should proactively assist agencies in securing the resources to undertake evaluation processes that will foster learning about best practices, information that can be shared between agencies.

4. Transitional and permanent housing with supports

Even if homeless or at-risk populations had easy access to comprehensive health services, there remains an obvious need for an increased supply of affordable housing in communities across Ontario. Most urban and many rural areas are experiencing not only a shortage of rental accommodation, but also an affordability crisis. The need is for more affordable rental units, preferably rent-g geared-to-income units, to assist homeless and at-risk women to regain and maintain stable housing. For women with significant health or other issues that are exacerbated during a period of homelessness, opportunities to be housed in supportive transitional or permanent housing need to be available across the province. Alternatively, women need to be able to access supports from agencies who are partnering with private sector landlords and housing organizations to provide on-site service in the places where women live.

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APPENDIX A: OUTREACH LIST

Northern Ontario

Victims Crisis Assistance Referral Service	Timmins
Thunder Bay District Social Services Administration Board	Thunder Bay
Manitoulan-Sudbury District Social Services Administration Board	Manitoulan
Red Cross	Timmins
Cochrane Social Services Administration Board	Cochrane District
Algoma Social Services Administration Board	Algoma
City of Sudbury	Sudbury
North Bay Indian Friendship Centre	North Bay

South/Southwest

City of Brantford	Brantford
London Homelessness Coalition	London
YWCA	Kitchener
CMHA	Windsor
Bethlehem Projects of Niagara	St. Catharines
Regional Municipality of Niagara	Niagara
London InterCommunity Health Centre	London
Regional Psychiatric Program	Hamilton
Hospice Niagara	Niagara
Teen Health Centre	Windsor
MACDOOR	Hamilton
City of London	London

Regional Municipality of Waterloo	Kitchener
London Polonia Towers Inc.	London
City of Windsor	Windsor
De dwa de dehs nye	Hamilton
At lohsa Family Health Centre	Southwold
Urban Core CHC	Hamilton
Heart Space	London
Working Against Violence Erie	Niagara Region
Ontario Healthy Communities	Middlesex
Well-Come Centre	Windsor
Cambridge Shelter Housing Corporation	Cambridge
Regional Municipality of Waterloo	Kitchener
City of Hamilton	Hamilton

Central Ontario

Kawartha Participation Projects	Peterborough
Family Services of Haliburton County	Haliburton
City of Peterborough	Peterborough
Housing Resource Centre	Peterborough
YWCA of Peterborough, Victoria and Haliburton Counties	Haliburton
YWCA of Peterborough, Victoria and Haliburton Counties	Peterborough
CMHA	Peterborough
Haliburton Highlands Mental Health Services	Haliburton
Women's Resource Centre	Lindsay

Nijkiwendidan Ashnishaabe Kwewag Services Circle	Peterborough
Haliburton Highlands Mental Health Services	Minden
Staanworth Non-Profit Housing Corporation	Haliburton

Greater Toronto Area (including Toronto)

Lakeshore Area Multiservice Project	Toronto
Sherbourne Health Centre	Toronto
St Michael's Hospital	Toronto
Street Health	Toronto
Queen West CHC	Toronto
CMHA	Durham
Regent Park CHC	Toronto
City of Toronto	Toronto
Regional Municipality of York	Newmarket
City of Toronto Public Health	Toronto
Ecuhome	Toronto
College of Physicians and Surgeons of Ontario	Toronto
Covenant House	Toronto
City of Toronto Family Residence Shelter	Toronto
Oshawa CHC	Oshawa
The Salvation Army	Oshawa
Parkdale Activity and Recreation Centre	Toronto
Fred Victor Centre	Toronto
CRCT	Toronto
Gate 3:16: Street Health Centre	Oshawa

Emily Stowe Shelter for Women	Toronto
Women's Health in Women's Hands	Toronto
Halton Region	Halton
Durham Region	Durham
Eva's Phoenix	Toronto
Access Alliance Multicultural CHC	Toronto
Shout Clinic	Toronto
Canadian Public Health Association	Toronto
Lawrence Height CHC	Toronto
Advocacy Centre for Tenants in Ontario	Toronto
416 Drop-in and Crisis Centre	Toronto
Region of Peel	Mississauga
Sistering: A Woman's Place	Toronto
YWCA Spadina Shelter	Toronto
Sistering: A Woman's Place	
Anishnawbe Street Patrol	Toronto
Street Haven	Toronto
Robertson House	Toronto

Eastern Ontario

University of Ottawa, Centre for Research on Community Services	Ottawa
Options Bytown	Ottawa
Centretown Citizens Ottawa Corporation	Ottawa
Pathways for Children and Youth	Selby
Red Cedar Shelter	Tyendinaga MT

Nepean Housing Corporation	Ottawa
Homelessness Initiatives Team-Housing Branch	Ottawa
Central Frontenac Community Services	Frontenac
Cornerstone	Ottawa
CMHA	Ottawa
City of Kingston	Kingston
Homebase Housing	Kingston
Dawn House	Kingston
Ryendale Shelter	Kingston
Interval House	Kingston
Mental Health Services	Belleville
Carleton University	Ottawa
Street Health	Kingston
Wabano Aboriginal Health Centre	Ottawa
Ottawa Inner City Health Project	Ottawa
Bridge House	Kingston
County of Hastings	Hastings
Ottawa Community Housing Corporation	Ottawa
The Ottawa Hospital	Ottawa

Other

Association of Municipal Clerks and Treasurers of Ontario	Ontario
Ontario Prevention Clearinghouse/ Ontario Women's Health Network	Ontario
Ontario Association of Indian Friendship Centres	Ontario

MOHLTC	Ontario
University of Calgary	Alberta
Ontario Non-Profit Housing Association	Ontario
HRDC	National
St.Paul's Hospital	Vancouver
Raising the Roof	National
Direction de la sante publique de Montreal	Montreal
MCFCFS	Ontario
Ontario Municipal Social Services Association	Ontario
HRDC	Ontario Region

APPENDIX B: SUMMARY OF PROJECT PROFILES AND CONTACT INFORMATION

Northern Ontario

Lead Agency

North Bay Indian Friendship Centre

Project Name

Weegwahs Weegwahm

Contact Information

Art Parke

Executive Director or

Richard Assinewai

Home Coordinator

960 Cassells

North Bay, ON P1B 4A6

Phone: 705 472-2811 or 705 840-5094

Fax: 705 472-5251

director@NBIFC.org

Goal/ Description

Offers homeless or at-risk individuals a short term place to stay while linking them to other supports

Services Provided

Shelter services, in addition to Friendship Centre services, including: health care; traditional aboriginal healing programs; supportive counselling; assistance with ID; forms; advocacy; employment services.

Client Group

Homeless or at-risk aboriginal women and men

Timmins, ON P4N 1E3

Phone: 705 264-4242

Fax: 705 264-4340

benderc@ntl.sympatico.ca

Goal/ Description

Offers front-line crisis intervention service for victims of crime

Services Provided

Clearinghouse for identifying health and emotional needs of clients and facilitating their access to needed services

Client Group

Victims of crime

South/Southwestern Ontario

Lead Agency

At lohsa Family Health Centre

Project Name

Shelter and Transitional Housing

Contact Information

Darlene Ritchie

Executive Director

1638 Elijah Rd.

Southwold, ON N0L 2G0

phone: 519 438-0068

fax: 519 438-0070

atlohsa@on.aibn.com

Goal/ Description

Helps with healing and recovery from the effects of native family violence through protection, support, education and intervention

Services Provided

20 bed shelter; 5 bed crisis intervention centre; 6 bed transitional housing program; support services

Lead Agency

Victims Crisis Assistance and Referral Service (VCARS)

Contact Information

Christine Bender

Executive Director

250 3rd Avenue

Client Group

Aboriginal women primarily; some programs for men

Lead Agency

Bethlehem Projects of Niagara

Contact Information

Julie Dennis

Executive Director

Bethlehem Projects of Niagara

58 Welland Ave

St. Catharines, ON L2R 2M5

Phone: 905 641-1660

Fax: 905 641-3813

Goal/ Description

Provides transitional housing and supports for singles and families working to develop skills and stability necessary to live independently

Services Provided

27 unit apartment building; 2 community homes; supportive individual counselling; support groups; life skills programming; early learning centres

Client Group

Varied client group: all are singles and families needing support

Lead Agency

Cambridge Shelter Housing Corporation

Contact Information

Anne Tinker

Executive Director

6 Cambridge St.

Cambridge, ON N1R 3R6

Phone: 519 624-9305

Fax: 519 621-6061

OOTC@on.aibn.com

Goal/ Description

Works with persons who are homeless, assists them to realize their dreams and aspirations and moving them into housing.

Services Provided

Health services; case managers; needle exchange; advocacy; information and referrals; housing

Client Group

Homeless and at-risk women, men, families

Lead Agency

City of Hamilton, Community Programs Branch

Project Name

Mental Health/ Outreach Program

Contact Information

Valine Vaillancourt

Social and Public Health Services,

City of Hamilton

71 Main St. West

Hamilton, ON L8P 4Y5

Phone: 905-546-3597

Fax: 905-546-3547

vvaillan@hamilton.ca

Goal/ Description

Outreaches to and develops relationships with individuals living on the street or in the shelter and assists them in accessing health, social and housing services

Services Provided

Assistance with accessing health care, housing, transportation, community services, financial assistance, case management services, spiritual counselling, addiction counselling, sexual assault counselling and harm reduction strategies

Client Group

Women and men of all ages who are homeless or at-risk of homelessness

Lead Agency

London InterCommunity Health Centre

Project Name

Health Outreach to People who are Homeless

Contact Information

Kathy Gelinas
Coordinator
 London InterCommunity Health Centre
 659 Dundas St. E.
 London, ON N5W 2Z1
 Phone: 519 660-0874
 Fax: 519 642-1532

Goal/ Description

Increases access to primary health care for people who are homeless

Services Provided

Primary care at Health Outreach clinic and 2 satellite sites; includes access to showers, food, clothing, blankets, laundry, ID clinic

Client Group

Homeless or at-risk women, men, youth

Lead Agency

Regional Psychiatric Program

Contact Information

Dr. Lindsey George
 c/o Hamilton Assertive Community
 Treatment Team
 370 Main St. E. Suite 401
 Hamilton, ON L8N 1J6
 Phone: 905 525-4273
 Fax: 905 525-4926

Goal/ Description

Facilitates the planning, integration, coordination and evaluation of mental health services in Hamilton

Services Provided

Inter-agency strategic planning; program and service planning; educational programs; advocacy with senior levels of government

Client Group

Organizations serving adults and children with mental health issues

Lead Agency

Well-Come Centre

Project Name

Shelter and Day Programs

Contact Information

Pat Taman
Executive Director
 Well-Come Centre
 263 Bridge Ave.
 Windsor, ON N9B 2M1
 Phone: 519 256-2940
 Fax: 519 971-7596

Goal/ Description

Provides 11 bed shelter and day programs for women delivered in drop-in setting with goal to provide opportunities for women to empower themselves

Services Provided

Support groups (self help programs); individual/budget counselling; children's informal daycare; children's after-school program; food assistance program; food cooperative; shelter services advocacy; housing referrals; and on-site nurse practitioner

Eastern Ontario**Lead Agency**

Canadian Mental Health Association

Project Name

Concurrent Disorder Project

Contact Information

Mary King
 CMHA Ottawa-Carleton
 1355 Bank St. 3rd floor
 Ottawa, ON K1H 8K7
 Phone: 613 737-7791
 Fax: 613 737-7644
 maryk@cmhaottawa.ca

Goal/ Description

Provides treatment groups for homeless individuals with both addictions and mental health issues

Services Provided

Facilitated treatment groups; mental health counselling; substance abuse and addictions counselling; information and referral services

Client Group

Homeless or at-risk clients with addictions and mental health issues

Lead Agency

Canadian Mental Health Association

Project Name

Mental Health Community Support Services (MHCSS)

Contact Information

Marnie Smith
Coordinator, MHCSS
CMHA Ottawa-Carleton
1355 Bank St. 3rd floor
Ottawa, ON K1H 8K7
Phone: 613 737-7791 x 126
Fax: 613 737-7644
marnies@cmhaottawa.ca

Goal/ Description

Offers coordinated individualized mental health services

Services Provided

Streamlined access to case managers in 10 agencies; coordinated intake, referral, information and assessment; long term case management services in 8 languages

Lead Agency

Nepean Community Resource Centre/Nepean Housing Corporation

Project Name

Women's Support Worker

Contact Information

Lynn Carson
General Manager
Nepean Housing Corporation
101 CentrepoinTE Drive
Nepean, ON K2G 5K7
Phone: 613 828-8452 x 118
Fax: 613 823-8453
lynncarson@bellnet.ca

Goal/ Description

Offers community supports for women victims of violence being re-housed after leaving a shelter or other unstable situation

Services Provided

Mental health counselling; programs on budgeting, stress reduction, employment; advocacy on financial issues and landlord/tenant problems

Lead Agency

Pathways for Children and Youth

Project Name

Wraparound Initiative

Contact Information

Jen Brittain
Wraparound Coordinator
1201 Division St. Suite 215
Kingston, ON K7K 6X4
Phone/Fax: 613 388-2222
jbrittain@pathwayschildrenyouth.org

Goal/ Description

Supports families facing multiple challenges and who have not had success with other services

Services Provided

Facilitated team meetings to increase a family's informal and formal supports; information; advocacy; arranging practical assistance for families to improve their access to services and opportunities

Client Group

Families and youth facing multiples challenges in more than 4 areas of their lives.

Lead Agency

University of Ottawa Faculty of Medicine

Project Name

Ottawa Inner City Health Project

Contact Information

Wendy Muckle, *Director*
OICHP
500 Old St Patrick St. Unit G
Ottawa, ON K1N 9G4
Phone: 613 562-4500
Fax: 613 562-4505
ichpsuo@uottawa.ca

Goal/ Description

Provides health services to chronically homeless women and men who are unable to use regular services due to lifestyle or complex health needs

Services Provided

Case coordination and ambulatory care; palliative care; management of alcohol program; infirmary

Lead Agency

Wabano Centre for Aboriginal Health

Project Name

Mobile Health and Addictions Outreach Team

Contact Information

Lorrie Langevin
Nurse Practitioner
Wabano Centre for Aboriginal Health
299 Montreal Rd.
Ottawa, ON K1L 6B8
llangevin@wabano.com
phone: 613 748-5999
fax: 613 748-0550

Goal/ Description

Outreach team improves access to all services

offered through Wabano for Aboriginal populations in Ottawa who are homeless or at-risk of homelessness.

Services Provided

Primary health care; street outreach; addictions counselling; information and referrals; transportation; lunch; and traditional crafts programs.

Greater Toronto Area (including City of Toronto)

Lead Agency

Centre for Addiction and Mental Health

Project Name

Shared Care Clinical Outreach Service of the Schizophrenia Program

Contact Information

Carol Zoulalian
Manager, CAMH
1001 Queen St. W.
Toronto, ON M6J 1H4
Phone: 416 535-8501 x2828
Fax: 416 583-1302
carol_zoulalian@camh.net

Goal/ Description

Provides integrated physical and mental health services to mentally ill homeless people; initiate long-term preventative health relationships between clients and medical staff

Services Provided

Triage/immediate health care at 9 shelters and drop-ins; primary care; psychiatric care

Client Group

Homeless women and men with mental illness

Lead Agency

Community Resources Consultants Toronto

Project Name

Hostel Outreach Program

Contact Information

Sheryl Lindsay

Program Manager CRCT

c/o PARC

1499 Queen St. W.

Toronto, ON M6R 1A3

Phone: 416 482-4103 x 240

Fax: 416 482-5237

slindsay@crct.org

Goal/ Description

Provides outreach, support and case management services to women who are homeless or at risk and who have significant mental health problems.

Services Provided

Case management; Mental health services; links with primary care physicians

Client Group

Homeless and at-risk women with significant mental health problems

Lead Agency

416 Drop-In and Crises Centre

Contact Information

Joy Reid

Executive Director

416 Dundas St. E.

Toronto, ON M5A 2A8

Phone: 416-928-3334

Fax: 416-928-2044

Goal/ Description

Serves homeless women

Services Provided

Services include primary health care; foot care; assistance obtaining ID; hygiene supplies; showers; laundry facilities; advocacy; medication dispensing; trusteeships etc.

Client Group

Homeless women (and a small number of men)

Lead Agency

Eva's Phoenix

Project Name

Transitional Housing

Contact Information

Jennifer Morris

General Manager

11 Ordnance St.

Toronto, ON M6K 1A1

Phone: 416 364-4716

Fax: 416 364-7533

Goal/ Description

Moves youth into long term employment and housing

Services Provided

Transitional housing with case management approach; mental health counselling; life skills; employment supports; job placements

Client Group

Homeless youth 16 to 24 years for housing program; homeless and at-risk youth 16-24 for employment program

Lead Agency

Gate 3:16

Project Name

Street Health Centre

Contact Information

Catherine Loftski

Nurse Practitioner

Gate 3:16 Street Health Centre

10 Mary St. S.

Oshawa, ON L1H 8M3

Phone: 905 432-5316

Fax: 905 436-7946

Goal/ Description

Offers health services for homeless and at-risk individuals in Oshawa

Services Provided

Primary health care; counselling; clothing; information and referrals; housing and job counselling; nutrition; showers; pregnancy and pre-natal support; foot care

Client Group

Homeless and at-risk women, men, youth

Lead Agency

Homelessness and Health Reference Group

Contact Information

Liz Janzen

Manager

City of Toronto Health Promotion

277 Victoria St. 5th floor

Toronto, ON M5B 1W2

Phone: 416 392-7541

Fax: 416 392-0713

Goal/ Description

Identifies and addresses gaps in services for homeless populations across health and government sectors

Services Provided

Inter-agency networking; policy recommendations to government; program planning across agencies

Client Group

Toronto hospitals, mental health agencies and health clinics working with homeless people; local, provincial, federal government staff

Lead Agency

Lawrence Heights Community Health Centre

Contact Information

Sherry Phillips

Lawrence Heights CHC

12 Flemington Rd.

Toronto, ON M6A 2N4

Phone: 416 787-1676 x 252

Fax: 416 787-3761

sphillips@lawrenceheights.on.ca

Goal/ Description

Offers free, high quality health care for all ages in addition to other complementary services

Services Provided

Primary health care; counselling; drop-in; pre and post natal support; nutrition; help with housing; employment and immigration; youth, seniors' and women's programs; interpretation services

Lead Agency

Parkdale Activity and Recreation Centre (PARC)

Project Name

The Healing Centre

Contact Information

Pat Larson

Nurse Practitioner

PARC

1499 Queen St. W.

Toronto, ON M6R 1A3

Phone: 416 537-2591 x234

Fax: 416 537-4159

plarson@parc.on.ca

Goal/ Description

Operates within a drop-in setting. It is intended to enhance access for particularly marginalized women and men

Services Provided

Primary health services; foot care; combined with drop-in services (meals, housing referrals, counselling, case management)

Client Group

Homeless and socially isolated women and men

Lead Agency

Region of Peel

Project Name

Homeless Outreach Program

Contact Information

Sue Ritchie

Supervisor, Ontario Works

6715 Millcreek Drive, Unit 1

Mississauga, ON L5N 5V2

Phone: 905 793-9200 x 8605

Fax: 905 826-9801

Goal/ Description

Multi-disciplinary team staffs this mobile case management service

Services Provided

Food; clothing; sleeping bags; assistance dealing with addictions issues, financial issues, accessing services; follow-up with people who have moved out of a shelter

Client Group

Women, men, families who are homeless or at-risk of homelessness

Lead Agency

Region of Peel

Project Name

24 Hour Shelter

Contact Information

Sue Ritchie

Supervisor, Ontario Works

6715 Millcreek Dr., Unit 1

Mississauga, ON L5N 5V2

Phone: 905 793-9200 x8605

Fax: 905 826-9801

Goal/ Description

Operates 3 shelters, 24 hours a day with a variety of support services available

Services Provided

Housing workers; employment counsellors; health services; assistance with Ontario Works

Client Group

Homeless women, men, families

Lead Agency

Robertson House

Project Name

Young Pregnant Mother's Program

Contact Information

Gail Stanish

Program Supervisor

Roberston House

291 Sherbourne St

Toronto, ON M5A 2R9

Phone: 416 392-5655

Fax: 416 392-3897

gstanish@toronto.ca

Goal/ Description

Provides seamless pre- and post-natal supports for young mothers and their children to move them out of homelessness

Services Provided

Intervention team to support client; primary health care; mental health counselling.

Client Group

Pregnant or young mothers living on the street or in shelters

Lead Agency

Salvation Army

Project Name

Durham Mobile Van Service

Contact Information

Norm Kitney

Coordinator

Salvation Army Family Services

45 King St. E.
Oshawa, ON L1H 1B2
Cell: 905-261-7753
Fax: 905 723-8276

Goal/ Description

Provides support and referrals to individuals who are homeless or at-risk of homelessness

Services Provided

Van travels to 2 designated stops in Oshawa; hot meals; health services; info and referrals; supplies; needle exchange; housing counselling

Client Group

Women and men sleeping in the rough or in shelters; individuals experiencing financial hardship

Lead Agency

Street Health Community Nursing Foundation

Contact Information

Laura Cowan
Executive Director
Street Health
338 Dundas St. E.
Toronto, ON M5A 2A1
Phone: 416 921-8668
Fax: 416 921-5233
michelle@streethealth.ca

Goal/ Description

Offers health services for homeless and under-housed persons in downtown Toronto

Services Provided

Outreach nursing clinics at outdoor locations and at various shelters/drop-ins; ID replacement clinic; anonymous HIV/Hepatitis testing; cancer screening; sleeping bag exchange; needle exchange; case management services

Client Group

Homeless and underhoused women, men, youth in downtown Toronto

Lead Agency

Sistering: A Woman's Place

Project Name

Drop-In and Outreach Programs

Contact Information

Angela Robertson
Executive Director
Sistering
523 College St.
Toronto, ON M6G 1A8
Phone: 416 926-9762 x 226
Fax: 416 926-1932
arobertson@sistering.org

Goal/ Description

Provides drop-in and programs for women who are homeless, under-housed, or at-risk of homelessness

Services Provided

Drop-in services include: access to primary health services; cancer screening; foot care; mental health counselling; information and referrals; hot meals; telephone; shower and laundry facilities; and structured programs

Client Group

Adult women who are low-income, homeless or at-risk of homelessness

Lead Agency

Sistering: A Woman's Place/Fred Victor Centre

Project Name

Hostels to Homes

Contact Information

Kate Scaife
Housing Worker
Sistering
523 College St.
Toronto, ON M6G 1A8
Phone: 416 926-9762 x224
Fax: 416 926-1932
kscaife@hotmail.com

Goal/ Description

Offers ongoing support to women moving from shelters to transitional or permanent housing

Services Provided

Mental health counselling; referrals to health services; long term continuous care and support even after women are into permanent housing

Client Group

Homeless and at-risk women

Lead Agency

St. Michael's Hospital

Project Name

Cancer Prevention Program

Contact Information

Dr. Stephen Hwang
Inner City Health Research Unit
St. Michael's Hospital
30 Bond St.
Toronto, ON M5B 1W8
Phone: 416 864-5991
Fax: 416 864-5485
hwangs@smh.toronto.on.ca

Goal/ Description

Aims to increase breast and cervical cancer screening and early treatment for homeless women

Services Provided

Enhanced nursing services at 5 locations; cancer screening

Client Group

Homeless women

Lead Agency

Young Parents No Fixed Address Committee

Contact Information

Alice Gorman
Community Health Officer

Co-Chair of Committee,
City of Toronto, Toronto Public Health
277 Victoria St., 3rd Floor
Toronto, ON 5B 1W2
Phone: 416 338-7980
Fax: 416 338-7096

Goal/ Description

Improves physical health outcomes and coping skills of adolescent parents and their children

Services Provided

Coordination of services and projects across agencies, across sectors

Client Group

Services for adolescent parents and children

Central Ontario Region**Lead Agency**

Haliburton Highlands Mental Health Services

Project Name

Housing Program

Contact Information

Jose Urbano
Program Manager
HHMHS
Box 539, Minden ON
K0M 2K0
Phone: 705 286-4575
Fax: 705 286-6123

Goal/ Description

Housing program provides homeless or at-risk individuals with serious mental illness with RGI housing and supports to live independently.

Services Provided

Case management approach; counselling; crisis response; access to health services

Client Group

Women and men with serious mental illness

Lead Agency

Nijkiwendidaa Anishnaabe Kwewag
Services Circle

Contact Information

Suzanne Smoke
Assistant to the ED
295 Stewart St.
Peterborough ON
Phone: 705 741-0900
Fax: 705 741-4816
nijkiwe@pipcom.com

Goal/ Description

Provides counselling services for First Nations women who have been or are at-risk of being abused

Services Provided

Individual counselling; group programs; traditional healing practices; crisis intervention; information and referrals; advocacy; support leaving shelter

Client Group

First Nations women with some programming for men and families

Lead Agency

YWCA of Peterborough, Victoria and
Haliburton Counties

Project Name

Women's Safety Network

Contact Information

Linda Reade
Women's Safety Network Services Coordinator
Box 766
Haliburton, ON K0M 1S0
Phone: 705 743-3526
Fax: 705 457-3289

Goal/ Description

Offers a rural outreach program for abused women and a women's resource centre

Services Provided

Crisis intervention services; counselling; court support; transportation assistance; assistance with housing; information and referral services; ongoing support after leaving shelter

Client Group

Abused women

APPENDIX C: PRINCIPLES OF BEST PRACTICE

The discussion of principles of best practices included in this report is informed by a number of sources, including experiences of the research team, current literature on services for homeless people, public policy reports, interviews with agency staff, and focus group discussions with women who have experienced homelessness. The following summarizes the principles which emerged during the course of this study. Rather than to synthesize what was heard, the intent of this appendix is to capture the breadth and richness of what the literature and other informants revealed. Section 5 of this report outlines the principles that emerged from a synthesis of key considerations in this study.

In the proposal submitted to the Ontario Women's Health Council to undertake this study, the research team identified the following principles of best practice as a starting point for discussion. They were:

- Involving clients in identifying and assessing the service needs to be addressed
- Establishing mechanisms for client feedback on the services
- Evaluating the initiative at regular intervals and implementing a system for making adjustments to the service
- Ensuring the initiative is sustainable over the long term
- Timely and culturally sensitive access to services
- Elimination of service gaps and duplication
- Coordination with other service needs, including legal, personal, and housing related counselling.

From the literature review conducted for this study, these best practice principles emerged:

- Comprehensive needs assessments and evaluations that take into account homeless women's perspectives and quality of life
- Diversity of services and approaches to integration
- Accessible and comprehensive services
- Non-judgmental and non-discriminatory services
- Viable and sustainable services

A report to the City of Toronto Community Services Committee identified the following 'best practice' principles related to coordinating services for homeless people:⁹⁸

- *Respect* for the dignity and capabilities of people who are homeless
- *Participation* of people who are homeless, formerly homeless, or at-risk of homelessness as well as those who fund and deliver services.
- *Responsiveness* to the diverse needs of people who are homeless through a continuum of supports and services.
- *Focus on prevention* and long-term solutions
- *Build on existing service strengths*
- *Maintain and enhance the stability of services*

⁹⁸ Report to City of Toronto Community Services Committee from Commissioner of Community and Neighbourhood Services on "Enhancing the Coordination of Services to People Who are Homeless (Clause 9, Community Services Committee, May 18, 2000 pp 5-6)

INPUT FROM AGENCY STAFF

Interviews with agency staff during the initial phases of this research identified the following additional principles and concepts:

- Flexible and portable services that can go to where homeless and at-risk people are
- Client-directed services; listen to the client and find out what they say they need
- Recognition that the agency needs to rationalize the services that they provide: not everyone will obtain everything they need; rationalize what resources you have and who you serve.
- Services should have no hidden agenda: Homeless women need to feel that the only motive for the service is to provide affordable housing.
- Support for the client's sense of 'self': Homeless women have been marginalized in their day to day existence; they need to feel they are individuals with unique needs and be dealt with accordingly.
- An atmosphere of trust: clients need to feel there is high quality help available, and that the staff we send out are ready and willing to offer any help necessary.
- Belief that recovery is possible: clients need to believe in themselves. They also should have the right to define their own life, or their right to fail.
- Enhanced interactions and communications with other agencies; work with the communities and services that already exist.
- Strive for a complete understanding of the complexity of the issues facing the client.

- Partnerships with agencies who have specialized skills and expertise; look where services can come from to help clients feel the most at ease
- Close proximity of a range of services, for example within one city block
- Security of funding
- Services which have "curb appeal" (a friendly look)
- Belief that homeless people are entitled to receive service
- Adaptable services so that clients can access it from shelters and beyond
- Attention paid to what homeless people need in order to access services (eg. transportation, food, interpretation services)

FEEDBACK FROM FOCUS GROUPS

A set of principles were discussed and rated on a scale of 1 to 10 during the focus groups with women who had experienced homelessness. There was widespread agreement that the following principles⁹⁹ were important when delivering services to this population:

1. Staff tell us that it's important to invite the women who use their services to give the agencies feedback on the service(s) they received and to help evaluate it. Part of that feedback includes asking the women questions about how well their lives are going and whether they've noticed any changes in their health (physical, mental or emotional).
2. Agencies tell us that they think it's important that the individual needs of clients be recognized. For example, they say that differences in age, abilities, language, sexuality, and health should all be recognized and that

⁹⁹ This list shows how each principle was presented during the focus groups. Participants asked questions to clarify meaning in some cases, and verbal explanations were given. Then participants rated the importance each principle on a scale of 1 to 10 (with 10 being "very important". Results from this exercise showed very high endorsement of these principles, with the vast majority of respondents rating each principle at a 9 or 10 level.

- one size doesn't fit all. They also think it's important to meet the unique needs of women who have difficulty getting around or who have hearing or seeing problems. This also means that how services are delivered in a city might be really different than how they're delivered in a rural area.
3. We've also been told that women who are homeless need to be able to easily get service at places that meet all their needs (such as medical help at shelters or community and refugee centres).
 4. Staff say that it's really important that women who are homeless should not be judged or have their access to health services blocked because they are drunk, high or stoned. In fact, they think that it is through access to these services that women will be able to overcome their addictions.
 5. Agencies say that it's hard to provide good, cost effective service when their funding is often short term and that we all have to recognize the lengthy time it can take for those who are homeless to get back their health (physical, mental, emotional, spiritual). Therefore, programs need to have secure, long term funding.
 6. Agencies who provide affordable housing say that homeless women who use their services need to know that that's the only reason they exist – they are not there to get them off drugs if the woman doesn't want that.
 7. We've also been told that it's important that homeless women who use services feel that they are unique individuals with their own needs and desires and that they not all be treated the same, just because they are homeless.
 8. Staff say that it's really important that women know there is high quality help available and the staff they meet are ready and willing to offer and help that is necessary. They also think it's important that they earn the trust of the women they work with.
 9. Staff want their clients to believe in themselves and to assist them to achieve their own goals. However, the clients get to say what they want their life to look like, not the staff, and that includes the right to fail.
 10. And finally, agencies have said that it's important that they have good relationships with other agencies so that staff know what services are out there in case women need to go elsewhere.

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and English at www.womenshealthcouncil.on.ca