

***The Experience of
Homeless Women:
Considerations for an
Effective Harm Reduction
Response***

Prepared for Cornerstone Women's Shelter

By



L. Bonnie Dinning
Health and Social Services Consulting
Organizational Development

April 2005

A doctor who occasionally sees clients at a shelter for the homeless was just leaving when a woman covered in blood is tossed out of a car nearby. Multiple curses fly through the air. "Get outta here you useless trash!"

The doctor helps the woman to her feet and says, "I am a doctor who works here, can I help you?"

"Sure you can, doc" she said sarcastically, "my face has been smashed in, I'm a prostitute, I'm HIV positive, I'm hooked on smack and I'm pregnant."

Over the next few months the doctor learns Mary's story. She didn't wake up one morning and think, "I'd like to be a homeless prostitute." Rather, she became addicted to cocaine at a young age after moving from foster home to foster home. She then dropped out of high school. She went to multiple treatment programs but couldn't complete even one. She would curse the staff or lose her temper with another client and she'd be asked to leave.

In her twenties she switched to junk. Injections were a better high for her. One day she took it too far and ended up at the general hospital with an overdose.

After her recuperation she said to the doctor, "Doc, I really need to give quitting another try."

Every drug rehabilitation program in the surrounding area had rejected her. The doctor finally found a program 7 hours away that was willing to accept her after she was detoxified.

Mary was going to a small town 2 hours outside of Toronto. Arrangements were made to have shelter workers in Toronto meet her at the bus terminal to ensure she made her bus connection. The doctor did not want her to end up on the streets in Toronto.

Mary called the doctor two days later to say that she had arrived and that she hated the treatment program. She was going to quit. The doctor pleaded with her to at least stay for the weekend.

Sunday night Mary called again from a city near her treatment program. She said she had left the program but she was really enjoying her new city.

Christmas day, 3 months later, the doctor received a phone call from Mary, "Hey doc, I'm in town visiting." "Do you want to join us for a drink?" "No thank you," the doctor replied, "but Merry Christmas."

The doctor was reading the newspaper one morning and a particular story captured your attention. "Homeless Woman Possibly Beaten by Police." The description of the woman reminded him of Mary. When his secretary informed him that Mary was on the phone he was not surprised. She explained that she had been in a bar and a large man had solicited her for prostitution. She declined and he became aggressive. She pushed him away forcefully and in response he beat her to the ground.

Two weeks later the doctor received a call from the police department. They had found Mary's body floating in the river. She had named the doctor "next of kin."

The doctor wonders about the connection between Mary's death and the police. A funeral service was held for her at the Shepherds of Good Hope shelter in Ottawa.

Case study used by the University of Ottawa, School of Medicine

*A special thank you to the women struggling
with homelessness and substance abuse that
spoke openly about their experiences.*

Your voices live on in the pages that follow.....

TABLE OF CONTENTS

EXECUTIVE SUMMARY 5

1. INTRODUCTION & BACKGROUND	9
1.1 LEXICON	11
2. METHODOLOGY	12
3. KEY FINDINGS	13
3.1 PATHWAYS TO HOMELESSNESS FOR WOMEN	14
3.2 BARRIERS TO TREATMENT	15
3.3 WOMEN WITH SPECIAL NEEDS	16
3.3.1 <i>Pregnant and Parenting Women</i>	16
3.3.2 <i>Aboriginal</i>	17
3.3.3 <i>Members of Ethno-Cultural Minority Groups</i>	17
3.3.4 <i>Experiencing Concurrent Disorders</i>	18
3.3.5 <i>Involved With the Criminal Justice System</i>	19
3.3.6 <i>Sex Trade Workers</i>	19
3.3.7 <i>Gay, Bisexual, Lesbian, Transgendered (GLBT)</i>	20
3.4 SUBSTANCE RELATED HARMS	20
3.4.1 <i>Harm to the Individual</i>	20
3.4.2 <i>Harm to the Community</i>	23
3.4.3 <i>Harm Associated With Criminal Penalties for Drug Use</i>	23
3.5 THE HARM REDUCTION MOVEMENT	23
3.5.1 <i>What is Harm Reduction?</i>	24
3.5.2 <i>Harm Reduction Principles</i>	24
3.5.3 <i>Criticisms of Harm Reduction</i>	25
3.6 BEST PRACTICE HARM REDUCTION INTERVENTIONS	26
3.6.1 <i>Needle & Syringe Programs (NSPs)</i>	26
3.6.2 <i>Safer Injecting and Other Drug Consumption Rooms</i>	27
3.6.3 <i>Methadone and Other Replacement Therapies</i>	28
3.6.4 <i>Heroin Prescribing</i>	29
3.6.5 <i>Information, Education and Communication (IEC)</i>	29
3.6.6 <i>Pill Testing and Allied Warning Systems</i>	29
3.6.7 <i>Motivational Interviewing & the Stages of Change</i>	30
3.6.8 <i>Law Enforcement Policies</i>	33
3.7 GENDER ANALYSIS	33
3.7.1 <i>Sex Differences and Gender Influences</i>	34
3.7.2 RESEARCH AREAS REQUIRING GENDER ANALYSIS	35
3.8 IMPLEMENTATION CONSIDERATIONS FOR SERVICES/PROGRAMS/HOUSING FOR WOMEN ABUSING SUBSTANCES	37
3.8.1 <i>The Harm Reduction/Treatment Relationship</i>	37
3.8.2 <i>Program/Service Development & Implementation</i>	38
3.8.3 <i>Staff Requirements</i>	40
3.8.4 <i>Gender Issues</i>	41
3.8.5 <i>Continuum of Care/System Development</i>	42
3.8.6 <i>Housing</i>	44
3.8.7 <i>Governance</i>	49
3.9 THE VOICES OF WOMEN	51
3.9.1 <i>Focus Group and Questionnaire Results</i>	52
3.10. KEY INFORMANT FINDINGS	53
3.10.1 <i>Agency Responses</i>	53
3.10.2 <i>Expert Response</i>	54
4. A FRAMEWORK FOR ACTION IN OTTAWA	55
4.1. DEVELOP A MUNICIPAL DRUG STRATEGY	55

4.2. MAP OUT A HARM REDUCTION CONTINUUM OF SERVICES FOR OTTAWA..... 57

4.3. DETERMINE AGENCY CAPACITY TO IMPLEMENT A HARM REDUCTION APPROACH FOR WOMEN.. 60

 4.3.1 *A Role for Cornerstone*..... 60

6. REFERENCES..... 622

7. APPENDICES 666

***The Experience of Homeless Women:
Considerations for an Effective Harm Reduction Response***

EXECUTIVE SUMMARY

Homelessness is a “revolving door” crisis! Individuals and families exit homelessness on a daily basis, but at the same time others replace them by becoming homeless or returning to homelessness. Repeated experiences of being homeless can eventually lead to long term or chronic homelessness for some. These are mainly individuals with serious issues and disabilities - heavy users of emergency shelters and services.

Communities across Canada and the United States typically identify less than 20% (56) of their homeless population within the chronic homelessness category. Predominantly men, their needs - especially related to substance abuse and mental illness, drive the development of programs and services aimed at ending homelessness. Yet recent studies note some disturbing statistics regarding women, homelessness and substance abuse.

- The 'new' homeless are distinguished from the 'old' as being younger, more often female, disproportionately racial minority, and arguably, have more problems with mental illness and drug abuse. (17)
- The most common female profile (shelter user) 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. (32)
- Except for a minority of younger women who want to remain with a male partner, mixed-sex shelters are unsafe for women, and are not used by long-term homeless women for that reason. (50 & ¹)
- Women involved in the sex trade in the (Vancouver) Downtown Eastside are more likely to use crack. (33)
- Women who misuse substances are at high risk for suicide ideation and completion. (20)
- A comparison with the national average age at time of death (75 for men and 81 years for women)² to that of the average age of death (52 years for men and 39 years for women) (27) of homeless individuals in Ottawa is quite dramatic!
- There are now more long-term homeless women with drug addictions who are pregnant and giving birth to babies that are taken into public care. (50) Women who drink alcohol or take drugs during pregnancy risk harming their unborn child. Children affected by Fetal Alcohol Spectrum Disorder (FASD) are at high risk for homelessness as youth and adults. (23)
- The physiological differences between men and women make women more vulnerable to the health effects of certain drugs.
- Women with substance use problems experience concurrent mental health problems, especially depression, to a greater extent than do men. (11) Almost two thirds of women alcoholics have mental problems. The most common disorders are anxiety, depression, phobias, post traumatic stress and panic disorders. (20)
- Over the long term, women develop alcohol-related disease more quickly and after drinking less alcohol than men. (48)
- It is estimated that 56% of the female prison population in Canada (at high risk for homelessness) has been involved in drug-related crimes. (20)
- Approximately one-third of injection drug users are women. (30) Women injection drug users in Canada are particularly at high risk for HIV infection.

¹ Interview with W. Muckle, Ottawa Inner City Health Project.

² Statistics Canada, 2002

Advocates for women who are homeless recognize that their needs are incredibly diverse, and distinct from that of men. Women identify different reasons for using substances – mainly a coping mechanism for crises or problems in their lives. This perception determines their definition of “problem,” identification of needs and their approach to seeking help.

Studies of American programs targeted for women have consistently concluded that they result in more positive outcomes for women, especially in terms of program retention. Treatment approaches for women must take their unique issues into account, such as experiences with physical and sexual abuse and with motherhood. This is particularly important for dually-diagnosed homeless women. (70)

Gender appropriate services require attention to:

- Women’s perspectives and expectations regarding quality of life;
- Access to health care appropriate for women;
- Consistent staffing within programs/services developed specifically for women;
- Ensuring staff are mainly women, well trained and committed to a harm reduction approach;
- Reproductive/neonatal health;
- Child care/welfare;
- Women oriented addictions and mental health treatment (Women with substance use problems experience concurrent mental health problems, especially depression, to a greater extent than do men.);
- Communicable disease prevention/treatment, and;
- Counselling/therapeutic approaches suitable for women.

Intersecting issues – substance abuse, mental health, inattention to gender needs, and resulting health impacts – create complex needs. Emerging new initiatives using a harm reduction approach are sparking interest in how such services can assist the growing population of women in Canada who are homeless.

A review of documents and surveys of selected key informants and agencies in Canada and the United States produced the following understanding of principles that should be considered to guide the development of a continuum of harm reduction services for women who are homeless and abusing substances:

Integrated Services – Substance abusers have a wide spectrum of needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, housing and treatment/support services should be integrated and easily accessible.

Care Coordination – Research has demonstrated that coordination of care, particularly for consumers accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved outcomes.

Assessment – Frequent assessment of client status is essential for the appropriate delivery of services. Assessment allows for early intervention and client education aimed at preventing disease progression and/or transmission. Pregnancy and mother child relationships are important aspects of ongoing assessment.

Referral – Referring clients to appropriate services and housing is a cornerstone within a continuum of care approach. Strong referral networks for this population provide a seamless process for clients who require different approaches and assistance at various stages of their relationship with substances.

Staff Education and Support – Continuous staff training, supervision, and evaluation enhances the success of reaching women and improves their health and housing outcomes.

Consumer Education/Information – Consumer education/information assists in reducing harm to women, their children and the community by providing accurate information geared towards reducing risk, preventing infection, and initiating behavior change.

Quality Improvement – Harm Reduction is a relatively new and inexact science/approach. Protocols are continuously evolving. Provider facilities must have quality improvement activities in place to continually measure the effectiveness of their programs/services in improving health and housing outcomes for this population.

Confidentiality – Literature reveals that the stigma associated with women involved with substances remains pervasive and can become a barrier to reaching and assisting them. Written confidentiality policies, protocols, and practices can help alleviate client hesitation to reveal their status, particularly regarding pregnancy, parenting and sex trade involvement.

Gender Sensitivity and Competence – The reasons why women abuse substances, their experiences within the drug culture and the consequences of such abuse are different from those of men. Sensitivity in working with women who abuse substances helps to establish trust between provider and consumer, and is critical to engaging and supporting women.

Consumer Involvement - Consumer input and involvement is an important component of high quality care. Consumer preference must be a priority in making service planning decisions, as consumers are more likely to adhere to plans if their preferences and needs are considered. Consumer involvement helps persons with limited experience or ability in making independent choices, make decisions for themselves and/or assume increasing responsibility for making decisions.

Despite the fact that harm reduction is a relatively new concept, current studies of interventions associated with harm reduction reveal that they:

- Definitely work – such as methadone and other replacement therapies, or needle and syringe programs.
- Show promise and require cautious expansion with evaluation in ways that are adapted to local settings e.g. the use of drug consumption/safe injection rooms
- Are widely used yet under-researched - notably communication strategies and motivational interviewing approaches to conventional harm reduction targets such as the prevention of HIV, hepatitis C, hepatitis B and overdose.

A 3 tiered action plan to meet the needs of homeless women in Ottawa involved with substances is proposed:

1) Develop a municipal drug strategy:

To gain local acceptance, harm reduction must be identified as one component of a larger framework involving prevention, treatment and enforcement. Each is an essential component and integral to the success of the others. A gender analysis can assist with documenting the need for women only programs/services and housing.

2) Map out a harm reduction continuum of services for Ottawa:

Existing and missing services/programs and housing/shelter options for women need to be identified within a larger generic continuum. Unification of the continuum requires service integration, referral agreements, and service system management for effective function.

3) Determine agency capacity to implement a harm reduction approach:

Individual agencies require an introspective approach to assessing their capacity for such a role. An understanding of sex differences and gender influences is also required to guide program/service implementation. Governance, organizational structure, property management, facility design, and staff hiring & training can all be affected.

Cornerstone Women's Shelter, in commissioning this report, is particularly interested in what changes it must undertake to better support its clients. In addition to assuring what is recommended above, an interview with Wendy Muckle, Director of The Ottawa Inner City Health Project (ICHP), regarding the health needs of women reveals the following.

ICHP uses a harm reduction approach in the provision of its palliative care, short term medical care and Management of Alcohol Program. Services are available to men and women in mixed gender settings. The lack of a "women only" access point to ICHP services is an identified gap. Cornerstone Women's Shelter is the logical location, however, barriers exist to the provision of ICHP services at this site. Cornerstone's current physical layout is prohibitive to the provision of good quality care. A design is needed that allows health care staff to see clients. A client on a separate floor does not work. Staffing changes are also required. The current staffing mix and roles prevent similar care to what is provided by ICHP in other locations.

1. INTRODUCTION & BACKGROUND

Communities from Vancouver to Halifax consistently describe a significant incidence of mental illness, substance abuse and concurrent disorders (substance abuse combined with mental illness) for homeless men and women when compared to the general population. Alone or combined, it is difficult to determine which came first for these individuals - the loss of housing due to mental illness and/or substance abuse; or mental health issues precipitated by life on the streets, often compounded by self

medication and an inability to attain and maintain housing. While popular images of homelessness continue to focus on older men with mental illness and/or addictions issues, the proportion of women without secure, affordable shelter continues to rise. (51) Since the 1960s, the 'new' homeless are distinguished from the 'old' as being younger, more often female, disproportionately racial minority, and arguably, have more problems with mental illness and drug abuse. (17)

Traditional abstinence-oriented programs are being challenged about their effectiveness in addressing the issue of substance use in the homeless population. Recent literature documents a revolving door syndrome whereby individuals enter treatment programs, supported/supportive housing or shelters only to be ejected onto the street when they are unable to maintain the abstinence required. (61) Chronic homelessness for many and extensive costs for health, emergency and corrections services are noted as the results.

New programs are appearing in which mental illness, disease prevention, and substance abuse approaches are merged to provide a continuum of treatment and housing support options based on the principles of harm reduction. Examples such as Vancouver's Portland Hotel purport to demonstrate how adequate housing, combined with supportive services and without a requirement for total abstinence from substance abuse, forms the required framework to address mental health and chemical dependency problems. In addition, reduced harm to clients and the community in which they live is being translated into health, emergency and correctional savings. For example, interventions undertaken by the Ottawa Inner City Health Project have been estimated to save Ontario's health care system more than \$3 million annually.

Most programs known through the literature have been developed to address the needs of homeless men or a mixed clientele predominated by men. Little is published about the existence or success of programs provided by agencies whose clientele are only women, because few such services exist (4) and they have typically been under-funded by government. (21) Yet 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. (32)

Women's shelters emerged across Canada in the early 1970's, many of them inspired by feminist philosophy. A reaction to this movement may be the cause of a disturbing trend toward minimal shelter provision and decreased attention to women's issues including those of personal safety and privacy.

While some degree of shelter service differentiation has begun to accommodate the particular needs of long-term/chronically homeless women, the trend toward large-scale, sex mixed shelter facilities present great danger for this subgroup and homeless women in general. Except for a minority of younger women who want to remain with a male partner, mixed-sex shelters are unsafe for women, and are not used by long-term homeless women for that reason. (50)

More recently, feminist goals and strategies of empowerment for homeless women are being lauded for creating better models of emergency shelter – enabling clients to access housing and employment opportunities. Low-demand flexible programs like those offered at Savard's in Toronto provide a critical transitional service for long-

term women who have high support needs but have become alienated from conventional shelters. (50)

This report details the findings of a study, commissioned by Cornerstone Women's Shelter in Ottawa. The need for such a study came from Cornerstone's growing concern about the incidence of chronic addictions/substance use combined with mental illness in the clientele accessing its services.

1.1 Lexicon

Several terms noted in the reviewed literature and used by surveyed key informants and agencies appear to be used interchangeably.

Substance Use/Abuse/Misuse, Addicted and Dependence - The terms "substance use", "substance abuse", and "addictions/addicted" were all used to describe women's involvement with substances in the reviewed literature.

According to the American Institute on Alcohol Abuse and Alcoholism (47):

- Substance Use includes the consumption of alcohol, other non-prescribed drugs, or the misuse of prescribed medications.
- Substance Abuse includes any of the following consequences recurring within the last few months:
 - Failure to fulfill major obligations at home, work, or school;
 - Engaging in potentially hazardous behavior;
 - Legal problems; or
 - Social or interpersonal problems.
- Substance Dependence connotes more severe manifestations of abuse, including signs of physiologic dependence.

In the writing of this document, the terms "substance abuse" or "substance involved" were employed where possible as umbrella terms to connote the broader range of situations

Harm Reduction/Minimization and Risk Reduction - "Harm reduction", "harm minimization" and "risk reduction" are used by various disciplines to describe common targets, goals, approaches or policies. In writing this document, the term "harm reduction" was employed as it is the more frequently used term when describing approaches to working with homeless individuals.

High Tolerance/ Low Demand/Low Threshold - Several other terms associated with harm reduction, substance abuse and mental illness were discovered during the course of this study and appear to be similar in context. They describe housing/shelter/drop-in options with an approach or service philosophy that places little or no demands on those accessing them. One source describes low-threshold as, "based on users being supported in identifying their own needs and setting their own pace". Similarly, another notes: "Low threshold" means removing traditional barriers to treatment that insist on a commitment to abstinence as a requirement of admission and as the only acceptable goal. Examples of "low threshold" approaches to accessing services might include street-outreach, drop-in centres or information groups that allow people who are actively using drugs to take part in treatment

activities on site. Low threshold programs could also include “wet” shelters or housing that does not require abstinence.

Concurrent Disorders/Dual Diagnosis/Secondary Disabilities/Co-Occurring - Various documents use differing terms to describe the situation in which individuals are abusing substances and possibly mentally ill. “Concurrent Disorder” is the most commonly known term applied to those who are mentally ill and abusing substances. “Dual Diagnosis” is often seen but is also used to describe individuals who are developmentally delayed and mentally ill. The term “secondary disability” is used to describe individuals who are affected by Fetal Alcohol Syndrome (FASD), and who may be dealing with a variety of other disabilities such as mental illness and substance abuse. The term co-occurring also appears in the literature connoting that the individual is dealing with more than one issue or disorder at the same time

2. METHODOLOGY

The original study goal was to provide Cornerstone Women’s Shelter with information about how it might best support clients who abuse substances. The goal was subsequently changed to: provide Cornerstone with information useful to the broader service delivery system for women. Early reviews of collected information made it obvious that solutions to this issue are broader than what Cornerstone can undertake on its own.

Specifically the consultant was directed to:

- Identify services/programs for women across Canada that offer alternative residential/shelter or housing programs for homeless women dealing with substance abuse or Dual Disorder: particularly those programs which incorporate high-tolerance/low demand or harm reduction approaches into a supportive/supported living or shelter environment;
- Obtain information/advice from such services/programs about what works/doesn’t work when implementing such services/programs and approaches for women;
- Analyze the results of 3 focus groups and individual interviews with Cornerstone shelter users and other women who are homeless, or at risk of homelessness, in order to gain a consumer’s perspective on service/housing needs for those with substance abuse issues;
- Dialogue with management of the Ottawa Inner City Health Program (OICHP) in order to map out the potential for future liaisons between the 2 agencies regarding health/harm reduction services for women;
- Produce a point form document of useful information that can be used in the future development of proposals and planning exercises Cornerstone may wish to undertake.

Several avenues were taken to identify information, agencies and experts relevant to this study:

- An internet search through Google was undertaken using key search words such as: homeless women, substance abuse/use, addictions, housing for homeless women, sex trade workers, homeless pregnant women, homeless single mothers, supported/supportive/transitional housing, harm reduction, best practices, high tolerance, low threshold, gender analysis, etc.;
- A Literature search was undertaken using similar words through search services such as PubMed, Library of Congress, and Library and Archives Canada;
- E-mails to National Homelessness Initiatives (NHI) contacts for Victoria, Vancouver, Edmonton, Calgary, Winnipeg, Toronto, Montreal, Dartmouth and Halifax;
- Telephone and e-mail contact with National Secretariat personnel on Homelessness;
- Telephone and e-mail contact with national organizations such as the Canadian Centre of Addictions and Mental Health, the Canadian Centre on Substance Abuse, and the American National Centre on Homelessness and Mental Health;
- Telephone, face to face and e-mail contact with specific individuals previously known to the consultant or Cornerstone, or identified through the internet about specific topics such as gender analysis and the sex trade, service requirements of women who are homeless and abusing substances, continuum of harm reduction services/programs/housing for women, etc.;
- Development, distribution, collation and analysis of an e-mail administered survey to identified agencies serving women involved with substances and key informants working in the addictions/ substance abuse/homeless/women sectors;
- Focus Groups and individual interviews with Cornerstone Shelter users and other women who are homeless or at risk of homelessness.

3. KEY FINDINGS

Key findings from all sources are captured under the following headings:

1. Pathways To Homelessness For Women
2. Barriers To Treatment

3. Women With Special Needs
4. Substance Related Harms
5. The Harm Reduction Movement
6. Best Practice Harm Reduction Interventions
7. Gender Analysis
8. Implementation Considerations For Services/Programs/Housing For Women Abusing Substances
9. The Voices Of Women
10. Key Informant Findings

3.1 Pathways to Homelessness for Women

For some young women, the transition to adulthood is a prolonged and complex process with few employment opportunities. Those who lack family support during the transition are at risk of becoming homeless. Studies about homelessness show that young women in public care, aboriginal women, and lesbian women are all overrepresented.

Young women constitute one third to one half of homeless youth in major urban areas across Canada. The proportion of females to males increases as age decreases, so the problems faced by legal minors are of special concern. Many homeless young women are early school leavers and lack the education required for employment. Despite the availability of government-sponsored training programs, homeless young women find it very difficult to obtain employment - more so than young men.

Violence against girls and young women plays a significant role in the dynamics of their homelessness. While most homeless youth have histories of family instability, conflict and abuse, more young women than young men have experienced sexual and physical abuse within their families. Young women who have been abused, especially sexually abused, are more vulnerable to re-victimization. (49)

Women with substance use problems often have a history of physical or sexual abuse, or are currently in an abusive relationship. Women are prescribed mood-altering drugs more often than men and they use other drugs in combination with alcohol more often. Some women suffering with depression will use alcohol or other drugs in ways not prescribed in an attempt to feel better, but this can worsen the depression. Women with substance use problems experience concurrent mental health problems, especially depression, to a greater extent than do men. (11) Problems with relationships, with work or school, and with finances or the law, can arise as alcohol or drug use increases (2) – leading to an uncertain lifestyle, unstable housing and possibly homelessness. (27)

Findings of an Ottawa study on pathways into homelessness revealed high levels of mental health problems and addictions among studied single adults who became homeless. The lack of treatment of emotional or mental health problems and access to health and social services that address both mental health problems and addictions were cited as missing. In the case of single women, care for physical health problems in addition to mental health services was identified. (5)

Another local study (27) on homelessness and death noted the following points relevant to women who are homeless:

- A comparison with the national average age at time of death (75 for men and 81 years for women³) to that of the average age of death (52 years for men and 39 years for women) of homeless individuals in Ottawa is quite dramatic!
- Some lifestyle practices emerged as long-term contributors to homelessness and death, especially activities that increase the risk of acquiring communicable diseases (e.g., unsafe sexual practices, substance use, and involvement in prostitution). Uncertain lifestyles may contribute to the inability to maintain stable housing.
- Some individuals, in particular, women, had safety concerns about the nature of their housing, and abandoned some living arrangements as a consequence.
- Substance abuse emerged frequently as a subject. Some of the most important areas mentioned were unavailability of suitable programs to address addictions and substance abuse, the importance of individual readiness to address addictions, and recognition of a need to tackle deeper emotional and physical issues (e.g., pain management, difficult personal history).

3.2 Barriers to Treatment (2)

Women who want help for a substance abuse problem often face barriers that make it difficult for them to get to treatment⁴ services or to successfully complete treatment.

For example:

- Women often have many family responsibilities, such as looking after other children.
- Some are single parents. As a group, mother-led families have the lowest incomes of Canadian families and they are often isolated without much support.
- Women who have a substance abuse problem often feel ashamed or guilty. These feelings make it harder to face the problem or ask for help. For a woman who is pregnant and/or a mother, or a sex trade worker, the feelings of guilt and shame may be even greater.
- Women are afraid of losing their children.
- Services do not always address the unique needs and issues that women face.
- Finding ways to get professional help can be confusing and overwhelming.
- Service providers sometimes seem judgmental and inflexible.

³ Statistics Canada, 2002

⁴ Treatment is considered to include detoxification services, early identification and intervention, assessment and referral, basic counselling and case management. Treatment is offered on an out-patient or in-patient basis, including short-term and long-term residential care (Health Canada, 1998)

- People have negative stereotypes about women who have a problem with alcohol or drugs.

3.3 Women with Special Needs

Women who are homeless and: pregnant, parenting, Aboriginal, members of ethno-cultural minority groups, sex trade workers, experiencing concurrent disorders, involved with the justice system, bisexual, lesbian, or transgendered; all require services and programs geared to their unique needs. Such needs become more acute when they abuse substances. The following sub sections provide an overview of the issues faced by these women and descriptions of or links to resources that may prove useful to women in Ottawa.

3.3.1 Pregnant and Parenting Women

There are now more long-term homeless women with drug addictions who are pregnant and giving birth to babies that are taken into public care. (50)

Pregnant drug users suffer severe stigmatization and degradation in a policy context that holds them solely responsible for the "bad product" of a drug-involved pregnancy. They are not only pregnant drug users but mothers, daughters, victims, poor, homeless, and malnourished. Drug use helps them to cope and to survive but also causes serious problems. (45) The consequences of alcohol on a fetus can lead to homelessness for the child affected by FASD. (23)

The National Advocates for Pregnant Women (NAPW) (45) in the U.S. attempts to address this issue. NAPW is an organization dedicated to securing the human and civil rights, health and welfare of pregnant and parenting women, and furthering the interests of their families. NAPW seeks to ensure that women do not lose their constitutional and human rights as a result of pregnancy, that addiction and other health and welfare problems they face during pregnancy are addressed as health issues, not as crimes; that families are not needlessly separated, based on medical misinformation; and that pregnant and parenting women have access to a full range of reproductive health services, as well as non-punitive drug treatment services.

Two programs detailed below provide promising models to assist women who are pregnant and abusing substances. Although not specifically for women who are homeless, their strategies should be considered when identifying activities that assist women who are pregnant/parenting to stay housed.

Mothercraft in Toronto - Breaking the Cycle Program (42) - Breaking the Cycle is based on a "one-stop access" or "single access" model. Core components of "Breaking the Cycle" are delivered from a single site and case management is used to assist clients in accessing other agencies in the community. This hub or focal point is critical to the program design. The site is located in the City of Toronto and offers intensive outreach to transient or resident high-risk populations in the immediate and adjacent neighbourhoods. The site is safe, non-threatening, warm, inviting, and easily accessible by public transportation.

The Parent-Child Assistance Program (PCAP) (53) - PCAP paraprofessional advocates work with a caseload of approximately 15 families each, for 3 years beginning at enrollment, during pregnancy or in the postpartum period. PCAP does not provide

direct treatment services. Instead, advocates help substance-abusing mothers address a wide range of environmental problems, connect mothers and their families with existing community services, coordinate services among a multidisciplinary network, assist mothers in following through with provider recommendations (including obtaining substance abuse treatment and staying in recovery), and assure that the children are in safe home environments and receiving appropriate health care. A unique feature of the model is that women are never asked to leave the program because of relapse or setbacks.

The lives of mothers enrolled in PCAP are characterized by poverty, upbringing by substance-abusing parents, childhood abuse, abusive adult relationships, trouble with the law, and chaotic and unstable living conditions. As products of this background they are often distrustful of community service agencies. PCAP paraprofessional advocates have themselves overcome many difficult life circumstances prior to achieving successes in school, jobs, and parenting. Because of this, the advocates are able to inspire trust and hope, and act as realistic role models and guides toward meaningful change.

Paraprofessionals can be dynamic members of the community provider system when they build long-term relationships with families, firmly link clients with professionals in the community, and establish strong communication networks among service providers around individual clients. Components of the program important to job satisfaction and retention of paraprofessionals include comprehensive and ongoing training, individualized supervision and consistent feedback from evaluation and administrative staff, group support, encouragement of creativity, and community recognition.

Outcomes were examined across two time intervals: between program enrollment and 3-year exit, and between 3-year exit and post program follow-up an average of 2.5 years later. At post program follow-up a significant increase in abstinence from alcohol and drugs for 6 months or more and significant decreases in subsequent pregnancies and deliveries were noted. These outcomes are of special importance because PCAP intervention efforts target behaviors that put mothers at risk for future alcohol and drug exposed births. A significant post program increase in living in permanent housing and a significant decrease in incarceration were other notable findings. These outcomes are credited to facilitated linkages to appropriate community services, the necessary time for gradual change to occur, and supportive paraprofessional advocacy that can assist many high-risk mothers in moving toward sustained recovery and improved stability even years after intervention.

3.3.2 Aboriginal

Programs/services for women may provide cultural barriers for Aboriginal women. There is a need for attention to spiritual values and traditional ceremonies for them to feel comfortable. Gender specific programming is especially important to ensure safety, freedom from harassment and opportunities to explore past relationships more openly. (20)

3.3.3 Members of Ethno-Cultural Minority Groups

Attention is required to language barriers; and cultural structure, beliefs or values which discourage acknowledgment of substance abuse. Referral and outreach processes need to include connections with organizations that support minorities.

3.3.4 Experiencing Concurrent Disorders

Women with substance abuse problems experience concurrent mental health problems, especially depression, to a greater extent than do men. (11) Women with a substance abuse problem also may experience eating disorders, agoraphobia, and other panic disorders. (2)

Three out of every four clients receiving treatment for a substance abuse disorder will have a concurrent psychiatric disorder. Similarly, up to half of those receiving treatment for a psychiatric disorder will have a concurrent substance abuse disorder. The mental disorder usually occurs first, often beginning in adolescence predating the substance abuse disorder by as much as a decade.

People with serious mental illnesses are more sensitive to the effect of alcohol and other psycho-active substances. Alcohol and psycho-active substances are often used to self medicate the symptoms of a mental illness. There is also a higher usage rate among specific populations such as the homeless. People with severe mental illnesses report using psychoactive substances (usually alcohol) to combat loneliness, social anxiety, boredom, and insomnia, rather than the symptoms of their illness, or the side effects of their medications. (15)

The high prevalence of severe mental illness and addictions among long-term homeless women requires appropriate health services. A study on substance abuse treatment for homeless persons revealed that stigma, program inflexibility, and difficulties in following a treatment regimen without a stable home present serious barriers. For those who also have a mental illness, access to treatment programs is quite restricted. This is the group who is at highest risk of death and impaired health due to the interaction of prescribed and non-prescribed drugs. There is not yet a coordinated service delivery system in the addictions and mental health fields. This is compounded by a lack of accountability regarding who is responsible for service delivery to the homeless population. (50)

Clinicians who work with dually diagnosed clients have expressed support for the harm reduction approach. For example, one study that included four focus groups with clinicians who were nominated by their peers as experienced and/or experts in treating persons with substance use and psychiatric disorders found that while abstinence was the preferred goal, they expressed a pragmatic flexibility and other views consistent with the principles of harm reduction. (13)

Some clinicians who work with dually diagnosed individuals have also acknowledged that requiring abstinence as a condition of entering or continuing treatment may be too high a threshold for people who believe that they receive real benefits from drug and alcohol use. These individuals may be willing to enter treatment but not to be abstinent. Reasons for continuing to use drugs and alcohol are often more compelling than reasons to stop. Nevertheless, dually diagnosed clients may be interested in other benefits of treatment, such as attending to their psychological and emotional problems. They may also be interested, as a goal of treatment, in changing or reducing their use of substances. (40)

Current research indicates that integrating mental health and substance abuse treatments is more effective than offering services in parallel systems. Integrated treatments, generally delivered by multidisciplinary teams, emphasize outreach, comprehensiveness, and a stage-wise approach to treatment and recovery. Overcoming the barriers to the implementation of integrated treatments in routine health care settings is an immediate challenge. Specific psychosocial and pharmacological interventions also need further development and testing, particularly for patients who do not respond to basic integrated interventions. (24)

Coordination and integration between mental health and addictions services is required involving:

1. Staff trained to recognize and assess both problems;
2. System agreements on integrated treatment protocols;
3. Coordination between systems to ensure a client centred approach;
4. Provision of support services during and immediately following hospitalization or incarceration.

3.3.5 Involved With the Criminal Justice System

A Lack of discharge planning from correctional institutions or probation staff unfamiliar with community resources, leave substance abusing women at risk of causing more harm to themselves or the community in which they live. It is estimated that 56% of the female prison population in Canada has been involved in drug-related crimes. (20) Treatment programs may restrict the entry of women involved with the justice system. Women who have been involved in the criminal justice system have difficulty trusting staff in community programs/services/housing.

3.3.6 Sex Trade Workers

The reasons why women enter the sex trade are complex. A study undertaken in Victoria (14) cites the need for food and shelter. It also notes, however, that it may be due to the coercive manipulation of boyfriends or family members. Drugs and alcohol are noted as both a contributing factor to entry into the trade and a way of coping with the working conditions. Sex trade work then becomes a source of income to purchase their substance of choice.

The study notes the need for a continuum of harm reduction supports and services that include health services, needle exchanges, street nurses, street outreach programs, 24 hour crisis lines and intervention services, food banks/vans, information brochures, soup kitchens, mentorship, advocacy, training/education and drug/alcohol treatment. These services should be encouraged to work in coordinated ways and to be sensitive to the special needs and issues of sex trade workers of all ages. The need for transitional and second stage housing is also noted in which youth are not separated from adults (as is the case with most housing services). It is recognized that these youth have been adults in terms of responsibilities for some time.

Crack is often the drug of choice for women in the sex trade. (33) In a Vancouver study involving more than 1,400 injection drug users between May 1996 and December 2000, frequent crack use, defined as weekly or greater, increased from 18 per cent to 40 per cent between 1997 and 2000 among drug users in the city.

The study revealed crack use was more common among women than men (42 per cent versus 30 per cent) and those who had unstable housing.

3.3.7 Gay, Bisexual, Lesbian, Transgendered (GBLT)

GBLT teens encountering rejection may drop out of school, leave home, and end up on the streets where they may use alcohol or drugs. A 2002 American study reports that possibly 35% of homeless youth are lesbian, gay, bisexual or transgender. (18) Lesbian women are overrepresented in the homeless population. (49)

Several resources are available on the 519 Community Centre website (1) including the Trans Communities Shelter Access Project. The Project has produced information on transgender health, homelessness, and community building including recommendations for homeless shelters. A similar American resource (44), on line at <http://www.nationalhomeless.org/civilrights/transshelters.pdf>, contains policy and staff training recommendations.

With few job opportunities, some transgendered MtF⁵ women turn to the sex trade as favorable sexual responses from clients may boost MtF women's self-esteem and sense of value as women.

Information about engaging transgendered substance users in treatment is contained in Appendix 1.

3.4 Substance Related Harms

3.4.1 Harm to the Individual

Heavy Drinking

Alcohol is the most common substance used and misused by women, and women drink most frequently with a spouse or partner. When compared with men, women are less likely to report heavy drinking occasions and alcohol-related problems (36% of those reporting such problems are women). (20) A strong case can be made that heavy drinking is more risky for women than men. Heavy drinking increases a woman's risk of violence and sexual assault. Over the long term, women develop alcohol-related disease more quickly and after drinking less alcohol than men. (48) Excessive drinking can affect the menstrual cycle, fetal development, child birth, menopause and sexual responsiveness. Eating disorders, particularly bulimia, frequently occur concurrently with alcohol problems. (20)

Alcohol abuse is a prominent factor in death by exposure. Those who cannot afford liquor will drink cooking wine, disinfectants, and solvent, leading to many health-related problems such as blindness, kidney disease, impairment of motor skills and bodily functions, brain damage, and ultimately death. (50)

⁵ Male to Female

Almost two thirds of women alcoholics have mental problems. The most common disorders are anxiety, depression, phobias, post traumatic stress, and panic disorders. (20)

Injection Drug Use/IDU (12)

Approximately one-third of injection drug users are women. (30) Women injection drug users in Canada are particularly at high risk for HIV infection. For women, the proportion of AIDS cases attributed to injection drug use increased from 0.5 per cent during the period before 1989 to 16.1 per cent during 1989-93 and to 25.8 per cent during 1994-98. For men, the increase over this same time period has also been pronounced, but less dramatic: from 0.8 per cent to 3.1 per cent and finally to 7.6 per cent. Injection drug use is also a problem among prisoners. Estimates of HIV prevalence among prisoners vary from one to four per cent in men and from one to ten per cent in women, and in both groups infection is strongly associated with a history of injection drug use. Once in prison, many continue injecting. In a study among incarcerated men and women in provincial prisons in Montréal, 73.3 per cent of men and 15 per cent of women reported drug use while incarcerated; of these, 6.2 per cent of men and 1.5 per cent of women injected drugs.

Drug injection and sexual risk behaviours among injection drug users are prevalent. The sharing of needles is a very efficient mode of transmission of HIV (and other infections), and is relatively common among injection drug users. Studies across Canada have shown that about 40 per cent of injection drug users report borrowing used needles. The sharing of other injection drug equipment such as spoons/cookers, filters and water – known as “indirect sharing” – is also associated with HIV transmission.

Among needle exchange program attendees in Ottawa and in Québec, 9.4 percent of men and 47.3 per cent of women reported having sex-trade clients. Of these, 63 per cent of men and 35 per cent of women never or only sometimes used condoms with clients. Condom use is also low among injection drug users with regular and casual opposite-sex partners

HIV/AIDS - The spread of HIV among injection drug users in Canada merits serious and immediate attention.

There have been several studies on prevalence and incidence of HIV among injection drug users in the larger cities of Canada.

Some of the studies undertaken to date in different parts of Canada illustrate the urgency of the problem:

- HIV prevalence among injection drug users in Montréal increased from approximately five per cent prior in 1988 to 19.5 per cent in 1997
- In Vancouver, HIV prevalence among injection drug users increased from about four per cent in 1992-93 to 23 per cent in 1996-97
- HIV prevalence among injection drug users in Toronto increased from 4.8 percent in 1992-93 to 8.6 per cent in 1997-98
- In Ottawa, a 1992-93 study of injection drug users found an HIV prevalence of 10.3 per cent among persons who attended needle exchange programs; a 1996-97 study showed that prevalence had increased to 20 percent.

Viral Hepatitis - Many other blood-borne viruses besides HIV can be transmitted through sharing injecting equipment. Hepatitis B and C are currently regarded as the most important of these because of their widespread prevalence and impact on health. Globally, about 170 million people are estimated to have hepatitis C.⁶ In developed countries about 90% of people infected with C are former or current injecting drug users.⁷ Between 50-90% of people who become infected fail to clear the virus and develop a chronic infection, with a consequent risk of developing liver cirrhosis and liver cancer and the corresponding social and economic costs . By contrast, only about 5% of people infected with hepatitis B develop chronic liver disease, although the consequences are equally serious for those who do. Unlike hepatitis C, which is not commonly transmitted sexually, hepatitis B is readily spread through sexual contact. People with hepatitis B are also at risk of co-infection with hepatitis D, which cannot be acquired independently. In general, co-infection with different viruses and re-infection with different strains or sub-types of the same virus worsen the person's outlook.

Local and Systemic Bacterial Infections (34) - Besides blood-borne viruses such as HIV, Hepatitis B and Hepatitis C, bacterial infections are also common among injecting drug users due to poor injecting hygiene or the use of contaminated drugs. Local infections such as abscesses and cellulitis are common especially among populations with poor access to sanitation, such as the homeless. Endocarditis, septicaemia and outbreaks of botulism, tetanus and other clostridial infections are also known among IDUs.

Overdose (34) - Among young adults, overdose is among the leading causes of premature death in many countries. The use of cocaine, ecstasy, methamphetamine and other amphetamine-type-stimulants can all precipitate life threatening, and sometimes fatal, emergencies.

Suicide - Women who abuse substances are at high risk for suicide ideation and completion. (20) Women entering treatment for a substance use problem are more likely to have attempted suicide than men. (2)

Heroin Dependence (34) -Heroin dependence is increasing in many countries. Heroin dependence is a major public health problem with an elevated risk of illness and of death, and has high social and criminal costs. Heroin is the most frequently used drug among people seeking treatment for drug problems in Europe, Asia, and Australia, and is second to cocaine in North America.⁸ A shift from heroin use to increasing use of cocaine in Canada may be a significant factor in the escalation of HIV prevalence and incidence. Cocaine users typically have a high injection rate; they may inject as much as twenty times a day.

Other Physical and Mental Health Problems (34) - Drug dependence and infections associated with injecting contribute to general physical debilitation and lowered immunity, which in turn increases vulnerability to infections such as pneumonia and tuberculosis, with respiratory problems particularly affecting people who inhale their

⁶ World Health Organization (WHO)1999 statistics

⁷ WHO 2000 statistics

⁸ United Nations Office on Drugs & Crime 2000 statistic

drugs e.g. crack smokers and heroin users who 'chase the dragon'. Cocaine and amphetamine type stimulants are associated with drug-induced psychosis.

3.4.2 Harm to the Community

At the community level, drug use can cause a nuisance and pose a health hazard when people discard drug related litter such as used needles and syringes. Open drug scenes can affect the real and perceived safety of people who do not use drugs. High levels of drug use and drug dealing can contribute to crime and problems in neighbourhoods and communities. Intoxication can contribute to accidents, aggression and injuries which in turn impact on the cost and availability of emergency services within a community.

3.4.3 Harm Associated With Criminal Penalties for Drug Use

Two key issues affect the care, treatment, and support to injection drug users in Canada (particularly those who are street-involved or marginalized). (3)

Legal status of drugs as a direct cause of harm: The pharmacological effects of illegal drugs used by injection drug users are not, in themselves, necessarily harmful. Much of the harm is secondary, caused either by the legal status of the drugs themselves, or by things such as dangerous injecting practices, criminal behaviour, and uncertain drug strength or purity that results directly from the legal status of drugs.

Legal status of drugs as a barrier to treatment: The legal status of drugs is a barrier to client utilization of much of the addiction and medical services system. Treatment approaches, admission protocols, and staff and public attitudes are more reflective of the legal status of drugs than the treatment needs of the client population. Approaches to managing substance use that are being tried with considerable success in some other countries (e.g., prescribing of heroin or cocaine) are not available in Canada because of legal restrictions on medical practice.

3.5 The Harm Reduction Movement (34)

The HIV/AIDS epidemic provided the need and momentum for the consolidation, refocusing and reinvigoration of a number of existing interventions as well as the development of new ones. The harm reduction movement has provided an important vehicle for this response and has matured to encompass the breadth of drug related harms such as overdose, viral hepatitis, the impact of drug use on communities and the impact of criminalization on drug users. It has allowed a diverse group of disciplines to collaborate on the basis of broadly shared values and principles to find and disseminate effective responses to the numerous harms associated with legal and illicit drugs and the contexts within which they are used. Among these principles, and perhaps better reflected within the membership of the harm reduction movement and its organization than within the academic literature, is a commitment to genuine and valid drug user involvement and empowerment within the systems and responses that affect the lives of both people who use drugs and those who don't.

Despite the fact that the bulk of its development has occurred in just 20 years or so, there is an extensive and rapidly developing literature on interventions that can be

situated within a harm reduction perspective. This evidence base reveals that there are interventions that:

Definitely work – such as methadone and other replacement therapies, or needle and syringe programs. These should be considered for adoption in regions where they are currently unavailable;

Show promise and require cautious expansion with evaluation in ways that are adapted to local settings e.g. heroin prescribing, the use of drug consumption rooms and pill testing;

Are widely used yet under-researched - notably information, education and communication programs and motivational interviewing approaches to conventional harm reduction targets such as the prevention of HIV, hepatitis C, hepatitis B and overdose.

Just as the evidence-base in other fields such as the treatment of schizophrenia continues to develop, so does that of harm reduction. It is a project that is incomplete. Harm Reductionists would argue strongly that harm reduction is an empirically-based approach. The best response to this is to better develop the evidence in order to discard approaches that do not work and develop and disseminate those that do.

3.5.1 What is Harm Reduction?

Harm reduction refers to policies and programs that aim to reduce the harms associated with the use of drugs. A defining feature is their focus on the prevention of drug-related harm rather than the prevention of drug use per se. Harm reduction at different levels - individual, community and societal - and of different types - health, social and economic is often noted.

The definition of harm reduction that was developed by the HIV program at the Centre for Addictions and Mental Health and adopted by the Champlain District Implementation Committee and Ottawa Working Group on Substance Use in the Homeless Population (2001) is as follows:

“Harm reduction is a set of strategies and approaches aimed at reducing the risks and harmful effects associated with substance use, and addictive behaviours, for the person, the community and society as a whole. While helping users abstain from substances or addictive behaviours is one appropriate long-term goal for some, harm reduction strategies place the emphasis on the most immediate achievable and positive changes whether or not they are shown to reduce use”. (69)

3.5.2 Harm Reduction Principles

Harm reduction is partly defined by a range of principles in which policies and programs are grounded. The Canadian Centre on Substance Abuse (CCSA) offers the following on its website:

Pragmatism: Harm reduction accepts that some use of mind-altering substances is a common feature of human experience. It acknowledges that, while carrying risks,

drug use also provides the user with benefits that must be taken into account if drug using behaviour is to be understood. From a community perspective, containment and amelioration of drug-related harms may be a more pragmatic or feasible option than efforts to eliminate drug use entirely.

Humanistic Values: The drug user's decision to use drugs is accepted as fact. This doesn't mean that one approves of drug use. No moralistic judgment is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected.

Focus on Harms: The fact or extent of a person's drug use per se is of secondary importance to the risk of harms consequent to use. The harms addressed can be related to health, social, economic or a multitude of other factors, affecting the individual, the community and society as a whole. Therefore, the first priority is to decrease the negative consequences of drug use to the user and to others, as opposed to focusing on decreasing the drug use itself. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence. In some cases, reduction of level of use may be one of the most effective forms of harm reduction. In others, alteration to the mode of use may be more effective.

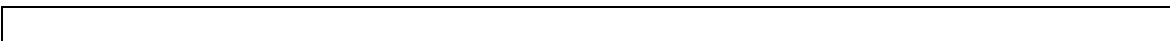
Balancing Costs and Benefits: Some pragmatic process of identifying, measuring, and assessing the relative importance of drug-related problems, their associated harms, and costs/benefits of intervention is carried out in order to focus resources on priority issues. The framework of analysis extends beyond the immediate interests of users to include broader community and societal interests. Because of this rational approach, harm reduction approaches theoretically lend themselves to evaluation of impacts in comparison to some other, or no, intervention. In practice, however, such evaluations are complicated because of the number of variables to be examined in both the short and long term.

Priority of Immediate Goals: Most harm-reduction programs have a hierarchy of goals, with the immediate focus on proactively engaging individuals, target groups, and communities to address their most pressing needs. Achieving the most immediate and realistic goals is usually viewed as first steps toward risk-free use, or, if appropriate, abstinence.

3.5.3 Criticisms of Harm Reduction

Harm reduction is not without its critics. Despite the fact that it is an approach grounded within public health, for which a considerable evidence base now exists, there remain people with reservations about:

- Its effectiveness;
- Its effects; and,
- Its intentions.



News brief: Canada to Look at Subsidized Housing for Junkies 10/24/03

Canada Press reported Sunday that Canada Mortgage and Housing Corporation, the federal government's housing agency, is looking into alternative residential programs for drug users who are homeless or at risk of becoming homeless. Such housing would be based on harm reduction principles and could include safe injection sites, according to a CMHC spokesman.

The proposal is in stark contrast to the United States, where convicted drug users are barred from public housing and other benefits under federal law. "We want to look at that population and how people are already helping them, or the kinds of cutting-edge ideas on how we can best create long-term housing for this group," said Jim Zamprelli, a senior policy researcher at CMHC. "Harm reduction, at least theoretically, would create an environment which doesn't bar [substance users] and recognizes that at this point maybe complete abstinence is not the answer," he added. Housing for drug users based on harm reduction principles could well include the controversial but effective safe injection sites. "One could suggest building a living environment around a safe injection facility," said Zamprelli.

The proposal got a predictably cool reaction from Member of Parliament Randy White, the conservative Canadian Alliance's shadow minister for drug issues. "This idea of harm reduction is not reducing harm. It's keeping people on drugs," he said.⁹

3.6 Best Practice Harm Reduction Interventions

3.6.1 Needle & Syringe Programs (NSPs) (34)

Intravenous Drug users (IDUs) mix and cook illicit drugs with water in a 'cooker' or spoon, then filter the preparation through a 'cotton' or cigarette filter before drawing it up for injection. Sharing such paraphernalia is a risk factor for disease transmission. The distribution of other equipment, such as sterile wipes, cookers, filters and sterile water discourages re-use.

Some programs increase their impact by:

- Communicating with IDUs to provide information and education – such as how best to disinfect used syringes/needles, the dangers of frontloading or backloading to divide drugs, prevention of sexually transmitted diseases, etc.;
- Providing easier access to addiction treatment, health and social services; and,
- Using outreach methods to make contact with hidden populations.

People who inject drugs and work in the sex industry are, potentially, doubly exposed to risk. For example, a study of women in five U.S. cities found that, compared to other women who inject, they reported higher rates of needle sharing and unprotected sex with their primary partners. Whilst condom distribution is a common feature of many NSPs, some localities with high levels of prostitution have developed services that target female and male commercial sex workers. In this way it is possible to provide a more accessible service that is likely to be more effective and better adapted to the specific needs of this doubly marginalized population.

⁹ PERMISSION to reprint or redistribute any or all of the contents of *Drug War Chronicle* (formerly The Week Online with DRCNet) is hereby granted. We ask that any use of these materials include proper credit

NSPs are a cost effective intervention for preventing HIV. Their eventual capacity to produce outcomes in other areas - notably reducing overdose deaths and preventing hepatitis C - is less certain but probably already adds to the current cost effectiveness of NSPs.

NSPs can take the form of:

- Pharmacy exchange schemes;
- Dedicated' (i.e. stand-alone) exchanges;
- Community outreach schemes and mobile services;
- An activity at Safe injection sites, etc.

3.6.2 Safer Injecting and Other Drug Consumption Rooms (34)

Consumption rooms aim to reduce harm both for the drug user and the wider community. A number of potential outcomes have been suggested.

Among these, the benefits to drug users include:

- Reducing overdose;
- Preventing infection;
- Reduced venous damage;
- Facilitating access to treatment; and,
- Providing social support and social reintegration.

Community level benefits include reductions in: discarded needles and syringes and other drug related litter; and, open drug scenes and public injecting.

Consumption rooms may be effective for:

- Contacting hard to reach or vulnerable drug users including people with HIV, HCV, the homeless, and foreign nationals;
- Promoting safer injecting;
- Reducing overdose risks;
- Preventing HIV infection;
- Decreasing discarded needles and syringes in public areas;
- Reducing crime; and,
- Reducing public drug use.

There is good evidence that, when developed in consultation with the wider community, a range of operational models for drug consumption rooms is possible, and these can serve differing populations and local needs. Data concerning the number of visits they receive provides evidence of the amount of injecting that is transferred to a safer environment, probably decreasing nuisance and in which skilled personnel with access to emergency equipment are in attendance. In line with their objectives, consumption rooms have demonstrated an ability to attract more marginalized and vulnerable drug users. There are indications that they are likely to have an impact on overdose deaths and may reduce risk behaviours for blood-borne viruses. However, these cannot yet be well-quantified. Beyond this, they can provide access to a range of drug treatment, health and social care services. As yet, the cost-effectiveness of consumption rooms is uncertain. Whilst they show some

promise, further research is required to clarify their overall impact and value for money.

Further information about Safe Injection Sites is available in the Canadian Centre on Substance Abuse Fact Sheet on Safe Injection Sites <http://www.ccsa.ca/pdf/ccsa-010657-2004.pdf>

3.6.3 Methadone and Other Replacement Therapies (34)

Methadone maintenance treatment is the most researched treatment currently available for people who are dependent on opioids. Its use is supported by an evidence-base developed over almost 40 years and from across many different countries. It retains patients in treatment for longer than any alternative, non-replacement therapy, and has a superior effect on the reduction of heroin use and crime associated with opioid dependence. It is effective at reducing HIV risk behaviours and there is evidence that it also reduces the risk of mortality from opioid use. Increasingly, buprenorphine is used and appears to have merit as a second line treatment. It may offer benefits under certain circumstances, but methadone treatment prescribed at an adequate dose and with suitable psychotherapeutic and social support is currently the first treatment that should be considered and the most effective.

Substitution treatment aims to:

- Assist the patient to remain healthy, until, with the appropriate care and support, they can achieve a life free of illegal drugs;
- Reduce the use of illicit or non-prescribed drugs by the individual;
- Deal with problems related to drug misuse;
- Reduce the dangers associated with drug misuse, particularly the risk of death by overdose and of HIV, hepatitis B & C, and other blood-borne infections from injecting and sharing injecting paraphernalia;
- Reduce the duration of episodes of drug misuse;
- Reduce the chances of future relapse to drug misuse;
- Reduce the need for criminal activity to finance drug misuse;
- Stabilize the patient where appropriate on a substitute medication to alleviate withdrawal symptoms;
- Improve participation in other medical care; and,
- Improve overall personal, social and family functioning.

Within replacement therapy, abstinence is not ordinarily excluded as a long-term possibility. Nevertheless, it will often be a subordinate and longer term objective due to the following factors:

- Clinics based on maintenance treatment have better outcomes than those with abstinence as their primary treatment goal;
- Longer stays in methadone maintenance treatment are associated with better outcomes;
- Patients whose treatment ends with staff approval do better than those who leave for other reasons;
- Early curtailment of methadone treatment produces poorer outcomes.

3.6.4 Heroin Prescribing (34)

The evidence base for heroin prescribing is weak – with few studies, and only four with control groups. Therefore no more than cautious conclusions can be drawn about the merits of prescribing heroin.

That said it appears that there are health and social gains when this treatment is offered to long term injectors and smokers for whom other treatments have failed.

- Prescribing heroin is feasible in specialist clinical settings.
- It is not known whether heroin attracts more people into treatment.
- Patients receiving heroin are well retained in treatment, and generally better retained than those receiving methadone.
- It is possible to maintain patients on a stable dose of heroin.
- Patients improve in most areas – physical and mental health, illicit drug use, crime, and employment.
- It costs more than methadone but has been shown to be cost effective.
- It is not known whether it is more cost effective than methadone.
- It is not known who would most benefit from this treatment.

3.6.5 Information, Education and Communication (IEC)

Information, education and communication interventions are widely used to try to reduce the risks and harm associated with drug use. Although a common public health strategy, impact is usually limited to those seeking ways to improve their health. There is a need to better understand outcomes and the factors that produce or impede their achievement when the intended audience is disenfranchised. (34)

The flyer to the right is an example of an attempt to communicate with injection drug users in the U.K.

3.6.6 Pill Testing and Allied Warning Systems (34)

A wide variety of *early warning systems* exist. They are primarily established to

Recently, Courtney, a four year old girl from one of the estates that ring our city, picked up a used works, complete with pin that she found dumped in a park near her house. Courtney was no stranger to syringes and needles. She had previously received treatment for a rare form of cancer. A treatment that had involved her being given lots and lots of injections. In fact, she had a real thing about injections. When she found this works, she gave herself some injections.

Her parents and other local residents were outraged, and not unreasonably. They even talked about getting a petition up, calling for DNA testing of discarded syringes, and a change in the law that would allow the police to trace and prosecute people who disposed of used works in public places. Courtney is okay now and has not caught anything nasty from her experiment.

But this kind of shit, dumping works in public places – streets, playgrounds, parks, empty houses and so on – is completely out of fucking order. And what's more everyone knows it. I wouldn't like my kid picking up a works, would you?

Beyond this effect, there's the knock on for needle exchange services. It's this kind of behaviour that makes local communities say stuff like, "Why should we have a needle exchange here? All the bastards do is get fresh tackle and throw the old ones where our kids can find 'em. Them exchanges create the problem in the first place". So:

Dispose of your works safely in a sharps bin or strong container and don't just chuck them away in a public PLACE

If you're a non-user, or ex-user who doesn't want any reminders, and you find discarded syringes, phone your local council's Environmental Health Department and report where you've found them. They'll come and remove them. If you can't do that or don't mind doing it yourself, take a strong container (ideally a sharps bin, if you happen to have one in your shopping bag), pick the syringe up by the barrel and dispose of it. Taking care not to stab yourself accidentally with it. If you do get a needlestick injury, get down to your GP or A&E fast.

Don't Dump drug debris-You make us all look bad.

operate as alarm systems. When necessary, these can be linked to targeted information campaigns through governmental and other health and social care agencies to alert drug users to hazards due to contaminated or adulterated drugs.

Pill testing interventions are important measures to enter into contact with hard to reach populations and to raise their interest in preventive and harm reduction messages. On-site pill testing interventions should be closely linked to preventive and "safer use" messages.

Harm associated with unregulated, illicit drug production occurs in several ways:

- Contamination – residues from the production process or contaminants that are unintentionally incorporated during the production or distribution process may cause poisoning;
- Adulteration – diluents (bulking/cutting agents) and other substances deliberately added during the manufacturing or distribution process can result in poisoning;
- Dosing/purity errors – uncertainty about the strength/purity of illicit drugs means that dose estimation is uncertain and – especially when drugs of unexpected purity become available - can result in unintentional overdose.

3.6.7 Motivational Interviewing & the Stages of Change

Appendix 9 contains information that may be useful to shelter and supportive housing workers assisting substance involved women. Suggestions about screening for substance abuse, using motivational interviewing and a stages of change approach are provided. Additional information is provided about working with individuals with cognitive limitations such as those affected by FASD.

Motivational Interviewing (MI)

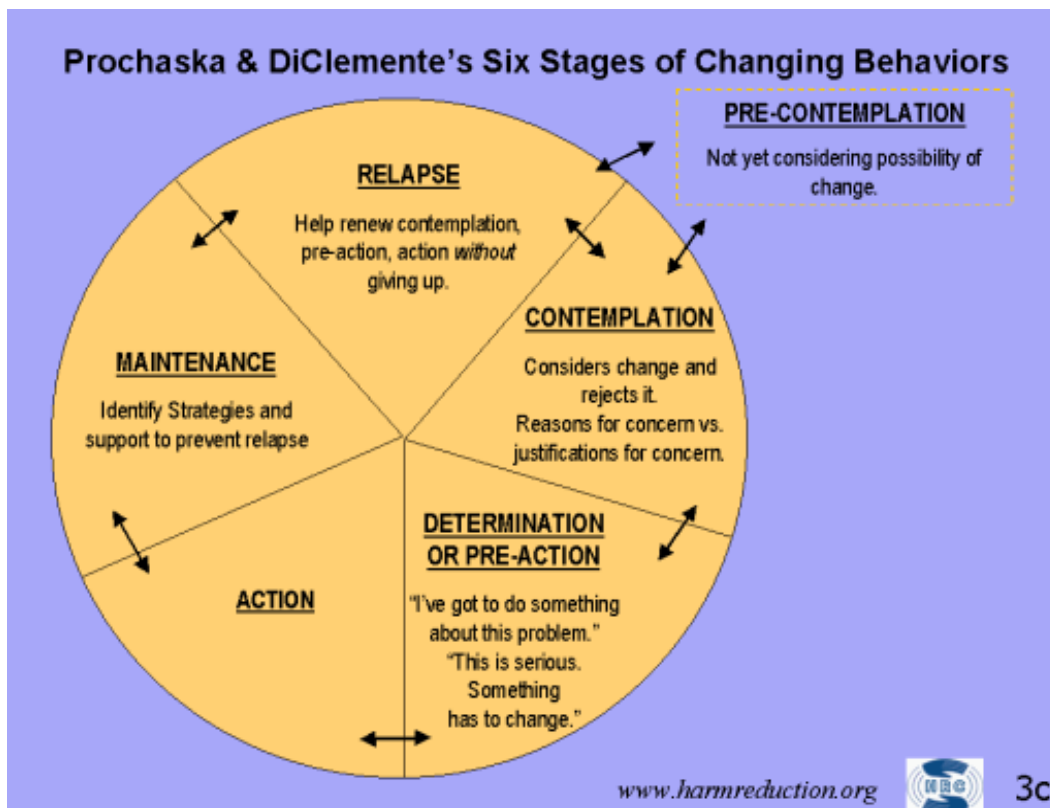
Motivational Interviewing (MI) provides a theoretical framework that is broadly consistent with the values underpinning the way many harm reductionists engage with drug users. It gives a widely researched set of principles and techniques that can be drawn upon by low-threshold services such as NSPs and community-based outreach, and within methadone and other replacement therapies as part of efforts to promote behaviour change and reduce drug related harm. From a clinical perspective, motivational interviewing is an important frame of reference for people working with drug users and provides a clear theoretical rationale to a humane and client-centred approach. (34)

In an article (67) linking Motivational Interviewing to The Stages of Change, Motivational Interviewing is cited as a popular method of intervention within the field of drugs and alcohol. It is considered by many to be an effective tool for working with people with "compulsive" or "addictive" behaviour. In a recent survey of alcohol workers the model was cited as the most influential in assisting theoretical understanding of change, and has been regarded by some as the most important and innovative therapeutic intervention of the 1980's.

Motivational Interviewing is a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour. It works with the client's own agenda to explore change, exploring the resistance people have to change, and by working creatively with an individual's attachment

and ambivalence to certain behaviours. Motivational interviewing works on the assumption that people have implicit attachments to the behaviours they engage in, in other words they are functional to the person. In order to assist people to change it is important to be able to work strategically with the client. Such an approach supports them in overriding their attachment to the behaviour and resolving their ambivalence before moving onto change. The intent is to work with the natural resistance that is characterized in people with addictive behaviours, using techniques and strategies to direct towards change based on the "Stages of Change Model", developed by Prochaska and DiClemente.

The Stages of Change



The "Stages of Change Model" describes a cycle of six stages through which people progress as they begin to consider and recognize that they have a problem, weigh up the pros and cons of change and decide to change, (or not!). A description of each step follows:

1. *Precontemplation*: A stage where people do not identify that they have a problem, and are not thinking about change. Others, or external agents may perceive that there is a problem but it is not internalized by the client.
2. *Contemplation*: A stage where someone begins to weigh up the pros and cons of their behaviour, thinking about whether there may be a problem or not and whether change is either necessary or desirable.
3. *Decision*: A stage where someone decides to do something to change their behaviour. A point at which there is a conscious decision to do something.
4. *Action*: The process of actively doing something. The person chooses a strategy for change and pursues it, taking steps to put their decision into action.
5. *Maintenance*: A stage of actively working on and maintaining change strategies. This is a stage of conscious effort and attention to sustaining change strategies.
6. *Lapse or Relapse*: A stage where the client either slips (lapses) back from a strategy to change, or return to previous levels and patterns of behaviour (relapse).

LISTEN

When I ask you to listen to me and you start giving me advice, you have not done what I asked.

When I ask you to listen to me and you begin to tell me why I should not feel that way, you are tramping on my feelings.

When I ask you to listen to me and you feel you have to do something to solve my problems you have failed me...strange as it may seem.

LISTEN!...ALL I asked is that you listen...not talk or do ...just hear me!

Advice is cheap...ten cents will get you both Dear Abby and Billy Graham in the same newspaper.

When you do something for me that I can and need to do for myself, you contribute to my fear and to my weaknesses...

BUT...when you accept, as a simple fact, that I do feel what I feel, no matter how irrational, then I can quit trying to convince you, and get about the business of understanding what's behind this irrational fear...

And when that is clear, the answers are obvious and I don't need advice...

So PLEASE LISTEN and just hear me...

And if you want to talk, wait a minute for your turn, and then I promise I will listen to you...

Anonymous

The Relationship between Motivational Interviewing and The Stages of Change

It is important to be able to assess in which stage a client is, in relation to each behaviour. Strategies for precontemplation are different from strategies for a client in action. Practitioners should initially work in areas of least resistance i.e. where the client is furthest in the cycle. The goal of MI is to elicit self motivational statements from the client about change, and direct these statements towards change. The intent is to actively seek out statements that reflect 6 key motivational areas:

1. *Self Esteem*: Statements from the client that they are OK. People have to believe they are OK to be able to change. Raising self esteem is a cornerstone of MI.
2. *Concern*: Statements from the clients that express concern about their behaviours.
3. *Competence*: Statements from the client reflecting an ability to do things.
4. *Knowledge of Problem*: Statements from clients recognizing problem behaviour.
5. *Knowledge of Strategies*: Statements reflecting strategies for change.
6. *Desire to Change*: Statements that reflect a desire for things to be different.

These self motivational statements are used to create a state of internalized conflict in the client, to allow them to experience the conflict between present and desired behaviour, and to assist them to make informed decisions about change. However it

is important that clients are the ones who articulate the need to change and are able to attribute change to themselves. Supporting self esteem and self efficacy become central strategies in this process. It is important to "roll with resistance", finding positives in no change, and encouraging the client to be the one who says they have a problem and want to change. Once a decision to change has been reached, appropriate strategies for change can be negotiated and supported.

3.6.8 Law Enforcement Policies

The general approach toward drug use in Canada has been criminalization, although this is now under public scrutiny and debate. Shifts toward community policing, recommendations for, and the availability of, treatment for people involved in the legal system, and review/revision of legislation may allow for the application of more harm reduction measures by enforcement authorities in the future. (63) *Illicit IV Drugs: A Public Health Approach* by Mark Haden (28) provides a good overview of the current Canadian situation.

3.7 Gender Analysis

Gender analysis offers an opportunity to explore why women and men are affected differently by the social, economic and political systems in which we live. It can provide new and often deeper insights into what needs to be done to ensure that men and women share equitably in the kind of world we want to build.

Compiling information on women's (and men's) needs does not automatically lead to more responsive services. It can, in fact, lead to increased citizen/consumer frustration. However, compiling information from a variety of sources could engage more organizations in the development of more responsive services and provide opportunities to profile successful programs. Governments and communities need to be prepared to make changes based on new evidence of community needs.

Gender analysis (26) requires those undertaking research or planning to:

- Avoid perpetuating stereotypes about women, girls, boys and men;
- Include women, girls, men and boys as sources of information;
- Encourage the equitable participation of women and girls, men and boys;
- Gather information about the needs and experiences of individual family members, not just the family unit;
- Gather information about those women, girls, men and boys who carry a greater burden of illness or whose health may be more vulnerable;
- Use existing knowledge about gender differences;
- Include gender-based analysis in the analysis of other data which are included in the project.

3.7.1 Sex Differences and Gender Influences (62)

It is essential that the variables of sex and gender¹⁰ be investigated across areas of alcohol and illicit drugs research. However, sex and gender are more than just control variables; they are issues that merit direct investigation themselves.

The following general topics require further scrutiny, but do not represent an exhaustive listing.

- Accounting for developmental life-stages;
- Acknowledgement and exploration of links among mental health, addiction, violence and trauma, including co-existing mental health and substance abuse problems;
- Biological differences affected by hormones/genes and substances, i.e., the impact of substance use on women's bodies;
- Consideration of sex and gender in all research themes;
- Differential responses to alcohol and drugs (e.g., biological and disease trajectories) between women and men;
- Differential effects of treatment, relapse, prevention, access to care, initiation, etc.;
- Effects/implications of social inequality;
- Gender specific research;
- Heterogeneity: acknowledging diversity among women and between men and women;
- Pregnancy: effect on fetus and children, stigma, parenting, etc.;
- Roles in the addiction subculture: who influences whom to use substances;
- Roles: motherhood, impact on children, etc.

Relevant sources of information include:

1. *Is Anyone Listening? A Gender Analysis of Sex Trade Work* -Through the support of Status of Women Canada, PEERS has done a gender analysis of the sex trade. It involved a series of focus groups to find out the differences and similarities for men and women in the trade. This document can be obtained from PEERS.¹¹
2. The Pan-Canadian Vibrant Communities Gender and Poverty Project was a unique partnership with and between six local communities. The final report reflects upon this partnership, articulates findings and makes recommendations for future direction. It includes a toolkit for gender analysis that can be downloaded from their website. (37)
3. *Best Start Barrie* worked with two groups to plan a Women's Drop-In and Resource Centre. Although not specifically for homeless women or substance abusers, information on their website (9) documents how organizers created a place where low income women could come for support and to make connections

¹⁰ "Sex" refers to "biological trait." "Gender" refers to "the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis."

¹¹ Prostitutes Education, Empowerment and Resource Society (Peers) #1-744 Fairview Rd., Victoria , BC. Telephone: (250) 388-5325, e-mail: info@peers.ca, website: www.peers.bc.ca

with other women. It is applicable to any initiative building a case for a "women only" program or service.

4. *The City For All Women Initiative (CAWI)*¹² report was submitted to the City of Ottawa's Health, Recreation and Social Services Committee on May 20/04. It noted that a former "Working Group on Women's Access to Municipal Services in Ottawa" discovered examples of City activities of interest to women but where no comprehensive gender lens was being applied to City practices. CAWI, a one-year research project funded by the Status of Women, Canada will build on the work of the Women's Access to Municipal Services Working Group.

The project goals for CAWI are:

1. Increase the capacity of collaboration between the City of Ottawa, community women's organizations, and individuals interested in enhancing gender inclusive practices;
2. Expand the knowledge base of the governmental practices that promote gender equality at the municipal level, drawing on examples from across the world;
3. Increase understanding of how existing data collection in the City of Ottawa has impacts on decision-making and gender equality;
4. Obtain a commitment to implement strategic plans that have the goal of increasing gender sensitivity and enhancing gender equality.

CAWI conducted a survey in April 2004 to listen to the experiences and concerns of the full-diversity of women across the City. A total of 29 women's organizations and community organizations serving women participated. Utilizing this baseline data, the project plans to work with community groups and the city staff to take the following steps:

1. Look at current practices and ways of operating in the city government
2. Learn from what has worked in other cities in Canada and globally.
3. Identify gender-inclusive strategies and ways of ensuring their implementation.

The Deputy City Manager's Office of Community and Protective Services will support the work of CAWI. The Community and Protective Services Department will be the lead department and will coordinate efforts with other city departments and the City Manager's Office.

3.7.2 Research Areas Requiring Gender Analysis

Participants at a recent *Forum on Alcohol and Illicit Drugs Research in Canada (62)* identified the following questions unanswered by existing research:

- How do we create treatment services that are accessible to women (e.g., pregnant and mal-diagnosed)?

¹² Contact information: Suzanne Doerge, Project Coordinator 1439 Tedder Avenue Ottawa, ON K1H 6A5
Phone: 613-526-5235 Fax: 613-526-4512 sdoerge@sympatico.ca

- How does stigma impact women and men differently (e.g., treatment, prevention, risk factors, recovery)?
- How is the “consumer” involved in the research process?
- What are appropriate gender-specific responses from police to judges in drug treatment court and the criminal justice process?
- What are the barriers to appropriate resources, information and related services such as housing?
- What are the differential biological impacts?
- What are the differential social/environmental impacts for women and men?
- What are the disease trajectories and patterns (morbidity among women and men) for substance use?
- What are the factors affecting sex-trade workers?
- What are the factors and dynamics influencing the medication of women and men? For example, why are more women than men being medicated with benzodiazepines?
- What are the prevention and treatment issues related to gay, lesbian, bisexual and trans-gendered individuals?
- What are the sex differences in developing dependency?
- What are the techniques of advertising and responses by women and men to marketing?
- What is effective FASD prevention (including drugs) for girls and women?
- What is the differential effect of HIV/AIDS transmission through intravenous drug use, e.g., on pregnant women?
- What is the relationship between alcohol, drug and tobacco use for women and girls?
- What is the relationship between trauma, mental health and addiction?
- What is the relationship between violence in the family and alcohol and drug use?
- Will the marijuana laws result in differential prescription of medical marijuana for women and men?

This list speaks to the limited research and evidence about best practices to guide the implementation of services/programs and housing specific to substance involved women. What was discovered in the literature follows.....

3.8 Implementation Considerations for Services/Programs/Housing for Women Abusing Substances

A guide on how to reach drug using homeless people, developed in the U.K., (57) identifies the following key factors in successful projects:

- Inclusion of harm reduction and accommodation stability
- An offer of detoxification and rehabilitation
- Agreed upon long term regional strategies and detailed planning
- Good pre-existing partnerships between agencies and written protocols
- Pre-existing access to the client group
- Staff skilled in working with the client group
- A good range of specialist resources on all health matters

These factors are compatible with the more detailed findings of this study captured under the following headings in this section:

1. The Harm Reduction/Treatment Relationship
2. Program/Service Development & implementation
3. Staff Requirements
4. Gender Issues
5. Continuum of Care/System Development
6. Housing

Additional information relevant to the implementation of services, programs and housing for women can be found in Appendix 4. It contains information about Canadian and American agencies that assist women who are homeless and abusing substances. Most of the information was obtained from the websites of the noted agencies. In compiling this appendix, attempts were made to identify best practice programs and services for women. The American National Resource Center on Homelessness and Mental Health and the National Corporation of Supportive Housing Resource Center (American) were most responsive to requests for information, as was the City of Toronto about its local programs and services. Contact with National Homelessness Representatives in large urban centres across Canada and its head office in Ottawa provided no information about Canadian best practices.

3.8.1 The Harm Reduction/Treatment Relationship

Documents recently written on the topic of treatment dispel the long held myth that abstinence is both a requirement and a goal of entering treatment programs in Canada. A review of several publications on Health Canada's Drug Strategy website (31) provide evidence that successful treatment¹³ programs for women are offering a variety of services and individual treatment within a continuum of care – a statement compatible with the following excerpt from a document produced about harm reduction training needs in Ottawa.

"A Harm Reduction Continuum of Services provides a range of support to reduce harm with homeless people who are using substances, ranging from housing and

¹³ Treatment is considered to include detoxification services, early identification and intervention, assessment and referral, basic counselling and case management. Treatment is offered on an out-patient or in-patient basis, including short-term and long-term residential care (Health Canada, 1998)

shelter to income support to addiction stabilization, to, for those who choose, support for abstinence." (69)

The Treatment on Demand Guidelines (25) in use in San Francisco and contained in appendix 2 also support the notion of treatment as one intervention within a comprehensive system of programs/services - all working towards a common goal to reduce harm.

3.8.2 Program/Service Development & Implementation

A collection of learnings from the literature pertaining to the development and implementation of programs and services follow. Many of the points are from Health Canada's Drug Strategy Website:

- Successful programs address cultural differences;
- Women are less likely to disclose in mixed-gender groups;
- Mixed gender groups are usually educationally based or are only appropriate for individuals who are further along on the recovery continuum;
- There are chemical links between smoking and drinking, and where needed the two should be addressed jointly;
- A harm reduction rather than abstinence approach is recommended, particularly at the treatment intake stage; (20)
- It is "OK" to come back. Relapse should be seen as a learning opportunity for both the client and the service provider;
- At the end of an intense treatment and rehabilitation program, women tend to feel empowered. However, it needs to be recognized that recovery plans are essential to maintain treatment and rehabilitation gains;
- There is a growing research base demonstrating that women who have experienced violence need to deal with that at the same time that they're addressing their substance use problems, rather than dealing with the issues sequentially. This enhances a holistic approach to women's lives and reduces the possibility of relapse to substance use as a coping mechanism for the sequelae of violence. There are more and more models that respond to that need (for example, Jean Tweed Centre in Toronto, and Amethyst Women's Addiction Centre in Ottawa;
- Ensure that mixed-gender groups never include more male clients than female, and ensure that mixed-gender groups are co-led by strong female and male counsellors who bar unproductive communication patterns;
- Ensure that facilities are welcoming and inclusive of women, considering furniture, art, brochures, resources (books, videos, audiotapes), on-site support group meetings or referrals to support groups in the community;

- Where numbers permit, consideration should be given to the establishment of women-specific services. Otherwise, within each system, access should be provided to women-only groups, and to women counsellors for any one-to-one work, with group leaders and counsellors who are versed in women-sensitive treatment;
- Consideration should be given to the provision of on-site child care. Residential treatment services that have had beds cut, but are in fixed physical locations, may be able to convert the extra space for this purpose. This may also provide an opportunity to address any problems the children may have resulting from one or more parent's substance use;
- "Wrap-around" services that follow women as they move from unstable housing or shelters into transitional or permanent housing are needed. (68) The Health, Housing and Integrated Services Network in California (HHISN) (39) has adopted a best-practice approach to multi-disciplinary, wrap around service delivery to its homeless clients. They use an Integrated Service Team delivery approach to coordinate client-centred services to homeless individuals. Each Integrated Service Team functions as a cohesive interdisciplinary team, even though the members come from different agencies and may be funded differently. The services coordinator at each site convenes weekly team meetings where team members share information, develop staffing and program calendars, coordinate services, problem solve and develop action plans for difficult issues facing individual clients. Topics of discussion also include issues of staff development, training and clinical supervision. The services coordinator has the primary responsibility for the day-to-day supervision of the team. Even though he or she does not have formal line authority over most of the team members because team members work for different agencies, he or she functions as the team leader for all of them. He or she assigns staff to individual clients and is responsible for the overall functioning and development of the program. Organizing and developing a services team is a challenging one, given that the team members come from different agencies with different cultures, missions, philosophies, policies and service delivery methods. Integrating or reconciling differences among the service models, priorities and philosophies of the HHISN organization has been an ongoing challenge for the HHISN. Because of the multiple agencies represented in the team, the lines of authority and responsibility are not easily drawn.

The HHISN adopted the following guiding principles in developing partnerships:

1. The involvement of the service partners in the planning of services from the beginning of the housing development phase is critical to the development of a cohesive, coordinated service delivery system;
2. The representatives of the planning partner agencies must have the backing of their executive directors and policy makers to make binding decisions, otherwise the decision-making process becomes slow and cumbersome;
3. Senior management from the participating service agencies must take the lead in the development of program policy and procedures. However, line staff members who participate in the Integrated Services Teams must also be involved in fashioning the policy and procedures; and
4. A group or individual must take responsibility for insuring adherence to the original mission and purpose of the building and the HHISN team must

develop a process of program development and evaluation that is consistent and continuous.

- A key element of harm reduction is to provide a “client-centred” approach to working with people “where they are” rather than “where they should be” as dictated by treatment providers. With this approach, clients are allowed to set their own goals while receiving support and assistance. A literature review of approaches to homeless persons with multiple problems found that the best approach was a client-centred one. Success depended on the ability to respond to different needs and provide individualized services adapted to the daily reality of clients. Flexibility, tolerance, and addressing the concrete problems expressed by the persons are also important; (22)
- A number of initiatives to assist individuals who are homeless and abusing substances have involved various forms of case management. Case management can include the following services: (43)
 - Client identification and outreach;
 - Assessment;
 - Planning – to develop a treatment and service plan;
 - Linkage to services, treatment and support systems;
 - Monitoring; and
 - Client advocacy – to help clients access services.
- A document called Practice Guidance for Delivering Outcomes in Service Coordination can be found at:
<http://www.thecouncil.org/freeresources/ServiceCoordination.pdf>.
Its contents may be helpful in determining guidelines/procedures for service coordination, wrap around services, case management, systems navigation, person centred planning, etc.
- Planning groups should include a significant number of members who are knowledgeable about and experienced in treatment that is women-sensitive. The planning group should consult with local groups and agencies that serve women and that may be the first point of contact for women with substance use problems

3.8.3 Staff Requirements

Many of the following points are from Health Canada’s Drug Strategy Website:

- Staff need to set very clear boundaries re: disclosure, both in the group and individually;
- Staff need to set a very appropriate pace for group learning, integration, and disclosure. Several excellent resources on working with groups can be found on the B.C. Self Help Resource Association web site at:
<http://www.vcn.bc.ca/shra/resources.php>;
- Women often view their counsellor as the main connection for all life issues, for example, “I’m thinking about moving.” Staff need to assist women in ‘naming’ what they want;

- Women need lots of reassurance. Staff need to emphasize assisting women to try new behaviours;
- Individualized, client-centred approaches to service delivery are slowly coming into focus and being effective. However, this individualized approach is often more challenging for programs to integrate since it requires staff to use discretion, judgment and to have the ability to be more flexible with rules and guidelines; (36)
- The development and use of structured professional training and support for service providers is required, as they provide the essential vehicle for change. (27) A broad understanding of substance abuse problems and its health impacts provides the foundation for a more holistic approach to working with clients;
- Staff need to examine their styles of counselling for any practices or procedures that penalize women for socially-constructed behaviors, and engage in training and support for staff to initiate and maintain any needed changes;
- The personal qualities of service providers are significant when working with the challenges faced by and presented by those who are homeless. Being able to establish trust is a clear prerequisite for effective communication and to enable vulnerable clients to accept services that may have otherwise been declined. Having qualified, well-trained and well-supported staff enables service providers to offer and implement crucial services. (27)

3.8.4 Gender Issues

Many of the following points are from Health Canada's Drug Strategy Website:

- Studies of American programs targeted for women have consistently concluded that they result in more positive outcomes for women, especially in terms of program retention. Treatment approaches for women must take their unique issues into account, such as experiences with physical and sexual abuse and with motherhood. This is particularly important for dually-diagnosed homeless women; (70)
- Women experience huge grief and loss issues;
- Women use more medication and are attached to their medication;
- Women have fewer resources than men, including money, transportation, housing;
- Programming requires recognition of women's family concerns, and programs for the family as a family;
- Ensure women are safe in treatment facilities, both residential and non-residential, by attending to staffing, lighting, location, separation of residential sections, and so on;
- Implement and enforce strong sexual harassment policies concerning both staff and other clients, and discuss these during client orientation sessions;

- Respond appropriately to any woman who raises violent experiences as part of her substance abuse treatment. This requires, at minimum, acknowledgment of her disclosure, reassurance that she was not to blame, and referral to competent and suitable services.

3.8.5 Continuum of Care/System Development

- There is a need to improve linkages with the mental health community as well as with other referral options. Addiction treatment service planners and providers will need to consider the reforms underway in Ontario's mental health system. This may require working with the mental health community to develop responses for clients with both substance abuse and mental health problems. One example may be working with the mental health crisis staff stationed in hospital emergency rooms or with ACT or PACT teams¹⁴ that provide service to the seriously mentally ill. As well, the partnership potential with the (Canadian Mental Health Association (CMHA), Community Care Access Centre (CCAC), and Associations for Community Living regarding the developmentally delayed merits exploration. Assessment, treatment and case management and system coordination are at the forefront of providing timely care to clients with concurrent disorders. (10)
- Incorporate outreach to other services that may have first contact with women with substance abuse problems (e.g., doctors, mental health care services, shelters, sexual assault centres, child and family services) A combination of outreach services and a small-scale, low demand respite residence model has proven successful in bringing women with severe mental illness indoors. (50)
- There is sufficient research on the high-risk factors for homelessness to implement a triage system for preventing the discharge of vulnerable people from institutions to shelters and diverting them from shelters as they enter. High-risk persons should be provided a choice of supportive housing options that suit their needs and preferences. Those with serious addictions should be directed to harm reduction or residential treatment facilities and receive follow-up care, including supportive housing options. (50)
- Connect women who need them with appropriate community-based child care services.
- Advocate with local social service agencies, social assistance providers, child and family services, the courts, and other groups and individuals who can support women's treatment.

¹⁴ **PACT/ACT Teams** -PACT (Program of Assertive Community Treatment) and ACT teams are interdisciplinary community treatment teams with professional, clinical experience in Occupational Therapy, Psychiatric Nursing, Psychiatry, Social Work, Therapeutic Recreation, and Vocational Support. These teams assertively support clients who have a serious mental illness. On call coverage is provided 24 hours a day, seven days a week, with attention to clinical, housing and rehabilitation needs. Most of the contact between treatment team members and mental health clients takes place in their own home, workplace or elsewhere in the community.

- Ensure competent and appropriate medical assessments and health services, particularly gynaecological health, for women clients.
- Establish a roster of competent and knowledgeable mental health care providers to whom you may refer clients in need for assessment and consultation.
- Establish linkages (e.g., with police services) to ensure access to safety for any woman currently in a dangerous situation.
- Partnerships with other community agencies can explore the establishment of groups for special populations of women: mothers, lesbians, women who are pregnant, elderly, young, aboriginal, francophone, homeless, from ethno culturally-diverse groups, disabled, or women who have HIV/AIDS.
- Not every service will be able to provide specialized violence-related counselling services to women clients, and referrals to community services which have long waiting lists may be necessary. In such a case, comprehensive case management should be provided within the addictions system.
- The system members should engage in community education, directed at both the general population and at high-risk groups of women, to de-stigmatize women's substance use problems. There should be involvement with the medical community to provide addictions-specific information, especially regarding prescribing practices, screening and mental health.
- It is recommended that all Social Services Agencies needing to move clients throughout the continuum of care use the same basic referral form. If the referrals are made through an electronic system, the same basic data will be requested as those agencies moving people with paper copy only. In this manner basic data will be available and people will not be required to repeatedly supply the same information to every agency as they move through the continuum of care. Also--There is need for a secure facility to keep inebriates out of Police Service cells. These are the clientele that have not broken the law but are picked up by the police for their own safety. They have become a social problem rather than a legal problem. (46)
- A review of current literature on homelessness, women, and health, (32) with particular emphasis on Canadian sources identified the following possible models of service integration:
 - *Inter-agency coordination*: 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 client records).
 - *Co-location*: Also known as the *service hub concept*, this approach concentrates on the geographic co-location of services for homeless persons. 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.

- *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. 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. 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. There may be confidentiality and privacy issues related to the case management approach.

3.8.6 Housing

The literature identifies a need for housing that provides alcohol and drug free environments to accommodate individuals who are in treatment or recovery. At the same time, a need has been identified for housing where use is permitted, to meet the needs of homeless people who are not ready to enter treatment. (56 &60)

The following excerpts from an Australian study (7) about heroin users mirrors the current housing needs and situation for substance abusers in Canada:

- Safe and secure housing has the potential to increase the wellbeing and social capacity of heroin users. It can support choices about stopping heroin use or taking action to prevent a relapse. These decisions are more difficult in living environments which users do not control and heroin is readily available and where drug use offers temporary escape from deprivation;
- Homelessness and the lack of stable housing makes injecting practices high-risk and increases the risk of infection and the spread of blood-borne viruses such as HIV and Hepatitis C;
- There are a range of health benefits associated with secure housing, including better nutrition, adequate sleep and improved personal hygiene. Secure housing also has mental health benefits by addressing the alienation and depression often associated with an unstable housing environment;
- Access to secure and affordable accommodation enhances an individual's capacity to make use of the social opportunities offered by education and employment, opportunities that are often inaccessible to the homeless and transient;
- Public housing, the only affordable and secure housing option for low-income, dependent heroin users, on some public housing estates, is becoming a wasted resource. This is a consequence of an embedded and endemic drug trade in some public housing estates. The loss of amenity accompanying this drug trade often leads to public housing applicants being reluctant to accept tenancies on these estates and for significant number of existing tenants requesting transfers to other estates;

- There is a serious shortage of public housing. This constrains the work of service providers seeking to meet the needs of heroin users. For housing officers it means that they must allocate housing within an inadequate and constrained stock portfolio. This can negatively affect users seeking to avoid living near other users and existing tenants, both non users and users, by lifting demand for drugs in some areas. For other service providers it means that they are often unable to obtain secure and affordable housing for their clients even though it is necessary for their health and welfare.

Wet/Damp Housing

During the mid 1990s most housing options sponsored by mental health or substance abuse providers were “dry” housing or housing where alcohol and drug use is prohibited. Practitioners became concerned that without housing for people not willing or able to maintain sobriety or abstinence there would definitely be no hope of addressing the addiction. Practitioners began to suggest that perhaps a continuum of care should provide for degrees of dryness. It was suggested that “wet” housing or housing in which the use of drugs and alcohol is tolerated may be the only housing choice acceptable to the patient in the early phases of engagement and treatment. Some called for “damp” housing, where abstinence would be expected on the premises, but clients would not be required to be abstinent off site

Research from the American National Institute of Alcohol and Drug Abuse indicates that less than 5% of chronically homeless individuals with at least 15 years of chronic alcohol addiction, and multiple, failed attempts at publicly-funded conventional alcohol treatment ever become abstinent for the remainder of their lives. But before they die, they consume extraordinary amounts of public dollars in their utilization of emergency and hospital services, emergency transportation, detoxification services, court, jail and legal services. One study found that 123 individuals consumed over \$100,000 per person in ER costs alone in 1999. In comparison, a wet house facility costs approximately \$11,000 per resident per year to operate. Studies of 2 projects in Minneapolis have shown significant reductions in emergency room use (26%), jail (41%) and detox. facilities (32%). (41)

A study of Wet Centres in the U.K (19) provides the following information.

Engagement of excluded people - Wet centres play a vital and effective role in working with street drinkers and other groups of street people who are excluded from, or have difficulty accessing, existing services. They can link them into specialist or mainstream agencies, and can help them avoid antisocial behaviour and make constructive changes in their lives.

Managing the local environment - One particular challenge in setting up a wet centre is finding suitable premises and handling local opposition. Both before the centre opens and afterwards, service commissioners must hold ongoing, meaningful dialogue with the local community, including residents, local businesses, and voluntary and statutory organizations operating in the area. They must also ensure that clear procedures are in place to minimize the impact of the centre on the neighbourhood.

Involving specialist service providers - It is critical that complementary services, such as street outreach, health, substance misuse and housing support, are involved at an early stage in the development of the wet centre. Many clients have multiple and complex problems, including dual diagnosis of mental health problems and substance abuse, and need input from specialist agencies.

Staff training and support - Working with this client group can be intrinsically challenging. Aggression, non-compliance and rejection were relatively commonplace within the projects studied, and some had experienced problems in recruiting and retaining staff. Training, supervision and support are especially important in this field.

Issues of control - One of the tasks for wet centres is to work with people who have challenging behaviour while at the same time providing a safe environment for them. It is crucial that the centres are closely managed, that staff retain control, and that clear boundaries are set for service users.

The Seaton House Annex in Toronto is well known for its success in providing a wet house approach to accommodating men. Community groups in Canadian cities, including Halifax, Peterborough and Victoria, have conducted research and expressed interest in providing shelters that incorporate a harm reduction approach.

Independent Housing

Two approaches to addressing homelessness and substance abuse through the provision of housing are found in the literature. The first proposes that a continuum of care involving services, supports, programs linked to various forms of supportive/transitional housing involving emergency/wet shelters, residential treatment programs, etc. is the answer. The other identifies independent housing as the critical factor in stabilizing substance use, rather than a consequence or reward for control or abstinence. The American "housing first" approach is a good illustration of this. Martha Burt at the Urban Institute (U.S.) points out, "Paradoxically, doing more for homeless people by way of services, but falling short of providing housing, may actually draw more people into the official category of homeless while not affecting the homeless problem.

Preliminary results of a study comparing the continuum of care and housing first approaches strongly favour a housing first approach for individuals who are homeless and dually diagnosed. The findings also challenge commonly held clinical beliefs regarding the correlation between psychiatric disability and competence. Housing first, combined with a harm reduction approach to mental health and substance abuse problems virtually eliminates the barriers of access to housing for people with dual diagnosis and reduces the likelihood of their relapse into homelessness. (52)

An Ottawa based study found that there was an implicit understanding by respondents that 'a place to call home' is a basic requirement for good health and social welfare. In addition to this requirement, two major areas of intervention emerged:

1. *Addressing homelessness through the provision of services.* Respondents felt that the provision of shelter and basic needs, mental health services and addiction and rehabilitation programs were powerful preventive strategies.

II. *The role of service providers as "agents" of prevention.* These major areas of intervention also need to take into consideration an understanding of individual choice in modifying strategies and interventions. (27)

Appendix 5 provides an interesting description of how San Francisco approaches housing for its hardest to serve residents.

Housing for Homeless Women

There is little in the literature about appropriate housing solutions for homeless women, except for some indications that shared-unit, mixed-sex models are problematic. A pending study on "shared accommodation" commissioned by CMHC will contain more information on design and personal factors associated with successful sharing of living space.

Most homeless women express a desire for self-contained units, rather than shared accommodation, and favour having women as neighbours. Although there is a relatively small demand for sex-segregated buildings, sexual harassment by male residents is a common problem within Toronto projects designed for homeless people. Based on the input of homeless women, some new Toronto projects have adapted by designing exclusive women's spaces. (17)

A supportive housing strategy for women released from correctional services in B.C. documents that prisoners and ex-prisoners would like release housing to provide: peer support; a "clean and sober" environment; shared decision making among residents on household chores and rules; pro-active help to access educational upgrading and job skills training; transportation to medical services; basic life skills, including money management; and voluntary participation in counseling and healing circles. In the simplest terms, women said they need "a place to get away" from drugs and violence, and they want the help of others who understand their struggle to survive. (38)

Some long-term homeless women with mental health problems who have had opportunities to live in shared-unit supportive housing have returned to living in shelters. Reasons given by these shelter returnees point to a need for more staff support and intervention, at least within shared housing settings. For some, but not all, self-contained units are preferred, as is women-only housing. The minimum of rules and expectations in the shelters to which they returned suggests that these women might be better housed in a specialized women's single-room occupancy or bachelorette building with a high level of staff availability and support. (50)

The critical services attached to supported housing¹⁵ are negotiating with landlords and neighbours, handling situations of decompensation or "slipping off the wagon," ensuring that the rent is paid and the housing kept clean, and supplying tangible goods when necessary, such as furniture, transportation, and food. (50)

A literature review undertaken by students regarding housing for women who are homeless noted the following resident needs and policies and procedures: (21)

¹⁵ Supported housing involves portable support tied to the individual, not the housing site, as in supportive housing.

1. Residents

- For any program intending to address the needs of chronically homeless or marginalized people, it is essential to determine their values, lifestyle, survival mechanisms and community. For example, there is consensus in the literature on housing for Aboriginal women: they are better served in places where staff are sensitive to racial and cultural oppression and can provide culturally-appropriate support.
- It is also important to consider the transition women make in adjusting to their lives as new tenants. There will be both difficulties and ease in transitioning. For some the social environment may be more stressful than supportive, with some participants reporting deterioration in their physical and mental health. Positive examples of transitions for women document their sense of having “gained shared values, reduced isolation, mutual support and opportunities for participation and control”

2. Policies and Procedures

- Rules are contentious in housing projects. While rules tend to be constructed and implemented for the protection of women living in those communities, there seems to be some consensus that all too often those rules take too much away from an individual’s right to privacy and choices. It is suggested that policies like those around tenant selection, rules, and eviction would be better developed if they involved residents as much as possible. At StreetCity in Toronto, for example, residents cooperatively find solutions to their problems as “the homeless themselves are best qualified to generate solutions that address their needs”. Empowerment programs such as this are characterized as successful.
- Rules are most typically enforced by staff. Like rules, the power afforded to staff varies greatly from site to site; some staff can evict residents, while others have great difficulty in removing “difficult residents”. Levels and kinds of training, staff selection and provisions for staff safety vary greatly. Ideally, of course, all staff should be well trained, culturally sensitive, and know and trust each other.
- Privacy issues include physical privacy (homeless shelters tend to be overcrowded) and privacy for those with special needs (physical and mental disabilities) as well as the affordance of individual freedoms like showering and eating without being restricted by schedules and rules. Surveillance, of course, further restricts privacy, but is often characterized as a “necessary evil” to ensure residents are safe. Safety issues predominate in shelters and correspondingly invoke issues around regulation, restriction and surveillance. Regulations and surveillance of residents often reflects a presumption of blame; service providers blame the individual for her homelessness. Regulations can, furthermore, create insurmountable barriers for women. For example, in a study of a shelter for women and their children, it was found that shelter staff forbade residents to care for one another’s children and did not provide childcare, making it extremely difficult for residents to look for work, while nevertheless requiring all residents to spend 6 hours a day actively looking for work.
- A study of one exemplary women’s housing project, Sandy Merriman House in Victoria, B.C. provides the understanding of the need for project (board?)

members with skills and knowledge in the field of drug and alcohol misuse, and the necessity to establish a strong consultation/community accountability mechanism, to prevent the development over time of a traditional top-down/board-resident power structure.

Architectural Design

The recent climate of fiscal restraint and the de-linking of housing and support services have resulted in fewer new supportive/transitional housing residences. Emerging knowledge about the important relationships between private and shared space can, however, be used to rethink the use of existing housing for those requiring supports to stay housed..

A study (32) undertaken by the University of Waterloo involving psychiatric consumers/survivors in determining the relative importance of community and privacy in a supportive housing environment revealed the following when considering what qualities of housing environments promote well being:

- The spatial environment can both promote and limit social interaction;
- A sense of security is important when living with others. Privacy is associated with risk: having informal support from housemates-particularly in time of illness or need was considered both safer and an important part of supportive housing. Living alone also tended to be associated with loneliness – your best friend is a TV or stereo;
- A mixture of private and common spaces is important;
- Some residents will see their need for the support of housemates as temporary – a stepping-stone toward independence, other will value the security derived from defining their present supportive housing as permanent;
- Resident's privacy must be protected while informal social interaction is promoted.

Appendix 10 provides information about innovative housing designs in Toronto for formerly homeless individuals.

3.8.7 Governance

The literature provides several points relevant to governance for agencies providing women only programming and considering a harm reduction approach.

- Examine the presence and proportion of women as volunteers, board members, and among staff (not only as counsellors but in positions of leadership and authority). Examine recruitment and staffing policies and practices;
- Birchmount Residence in Toronto houses older men with mental/physical health issues including those with substance abuse problems. A Community Reference Board with representation from residents, service providers, councilors and staff has been instrumental in overcoming NIMBY; (59)
- A sample agency self-assessment tool can be found in appendix 3. Such an assessment can help agencies determine if they are prepared to provide harm reduction services;

- A key need will be the development of *Harm Reduction Policy*. (63) The following outlines the steps required.
 - *Clearly Define Harm Reduction:* The very first step is to agree on a clear and accurate definition of harm reduction that fits within the goals and mandate of your organization. Your definition should convey that the focus of this approach is on minimizing the harm associated with higher-risk behaviour, not abstinence, but that abstinence is a possible goal.
 - *Develop Your Policy/Position Statement.* Your policy should:
 - Include your definition of harm reduction;
 - Include a statement that commits your agency or department to the respectful treatment of your clients by applying harm reduction principles in service delivery;
 - Define what specific measures will be taken in the implementation of this approach;
 - Reflect an understanding of the continuum of harm along the risk scale and the flexibility in your programming to meet the needs of clients wherever they are along this continuum;
 - Ensure your policy adheres to the principles of harm reduction.
 - *Communicate Your Commitment to All Staff:* Make sure all staff are aware of your policy/position statement and of your commitment to this approach.
 - *Educate Staff:* All staff need to understand harm reduction as it relates to their practice. They need to be able to integrate these principles into the services they provide. Offer training to facilitate a comprehensive understanding of harm reduction as it relates to your agency.

A clear policy or position statement on harm reduction provides the frame work for an organization to incorporate this philosophy into their service delivery. A written policy will clarify your organization's position for all staff and will set standards for practice.

Consider the following when developing a harm reduction policy or position statement for your agency:

- *Clarify Actions to Support Harm Reduction:*
Identify specific harm reduction strategies that can be adopted within your regular practice based on your mandate.
- *Review the Effectiveness of Your Policy and Practice:*
Review your Harm Reduction Policy on an ongoing basis and ensure that your Policy has been integrated into your client services. Get feedback from staff and clients to see if this initiative is helpful from their perspective. Consider a formal evaluation of your harm reduction programming.

Appendix 6 provides sample harm reduction policies.

3.9 The Voices of Women

The following is an excerpt from the summer 2004 edition of the Toronto Harm Reduction Task Force Newsletter:

Here are some ideas. They are not mine. They have come from asking the people who are using drugs what they need.

First off, we need holistic harm reduction centres. Places where people who use illicit drugs can drop in and get the care and support they need, and all the equipment they need to use drugs safely - not just new needles; where they can get information and education; where they can stop for a conversation, to chill out, meet with resource people, doctors, nurses, welfare workers, mental health workers, housing workers, counsellors and others, who could provide services there or who could connect them with other service providers sensitive to their needs and situation. There would also be computers and voice mail, skills training, and opportunities to do creative things with music, art, writing, opportunities for employment and volunteering. Sort of like a combination of community health centre and community centre, but open and fair-minded.

We need safe drug use sites accessible to whoever needs them, without stigma or police observation. They would be best run jointly by users and dealers, sort of like clubs, where members would be able to get a fair deal on drugs and also at the same time be assured of quality. I have been told that places like this already exist in Rotterdam, with police sanction.

We need publicly funded local labs to assist drug users and syringe distribution programs in testing drugs for quality and strength, which would issue timely and accurate warnings when there are bad – or excessively strong – drugs out there, so people would not be dying from, say, adulterated cocaine, as three people did last year in Peterborough, or losing their brain and motor functions or dying because of toxic leuko-encephalopathy, as happened to 14 people in BC over the past two years – and apparently to two in the greater Toronto area this year.

We need user-run user groups, not just in Toronto but, across the country, reflecting the personalities and needs of their communities . . . and also connecting across the country to form a powerful civil rights voice for people who use illicit drugs. They already have this, to a degree, in Australia, funded by the government.

We need to ensure that club and rave drugs are properly labeled in terms of content and strength, so people will know what they are getting and be able to use them wisely and safely, because they are going to use them anyway.

We need honest drug education in schools. Young people must learn about the truth about drugs and the wisdom of harm reduction as well as of abstinence.

We need overdose prevention programs, with users and others provided with narcan and trained how to administer it. Edmonton is getting set to do this.

We need buyers' clubs for drug users, without fear of penalty.

We need peer programs that really develop peers' skills and that assist them in progressing into positions of responsibility. That pays them adequately, and helps them move from being paid through honoraria to receiving regular wages, so that they can receive benefits, same as other citizens – and yes pay taxes.

We need residents associations who "get it" about people who use illicit drugs and don't try to drive them away by denying them services – or who claim compassion for the users but, then, organize to drive out the dealers. Who will work together with people who use drugs to resolve neighbourhood issues. They are also stakeholders in the community.

We need researchers, scientists, treatment and harm reduction programs and people to give as much attention to harm reduction with cocaine and crack-cocaine as they do to opiates.

We need proper pain treatment for people who use illicit drugs. We need the stigma about drug use to melt into empty air.

We need to stop seeing friends getting sick with HIV, and Hep C, and TB, and cellulitis, and abscesses . . . and dying of overdose.

3.9.1. Focus Group and Questionnaire Results

Three focus groups were held and five questionnaires were completed by 38 women in Ottawa. All had experienced shelter life and had abused substances or had lived in a shelter with individuals abusing substances.

The responses of the women to the questions contained in appendix 7 are consistent with the findings of the literature review for this study and reflect the Toronto newsletter article above. Analysis of the information obtained provided the following information.

Women who have experienced substance abuse are familiar with the term “harm reduction”. Safety, education, self awareness, reducing harm by reducing drugs and alcohol, needle exchange, condom use, and methadone were identified as elements of a harm reduction approach.

When asked what services or agencies assist them in reducing harm, participants noted:

- Sandy Hill Health Centre programs and services;
- Addictions Anonymous (A.A.) programming, Homestead Treatment Centre (Toronto), Amethyst, addictions counselling, Methadone;
- Shelter services and drop in services;
- Needle exchange;
- Counselling, volunteer nursing;
- Canadian Mental Health Association (CMHA), Royal Ottawa Hospital (ROH), Assertive Community Treatment Team (ACTT), OASIS Ottawa Hospital – General Campus;
- St Mary’s Home, Youth Services Bureau (YSB).

Similar to findings in the literature, participants accessed shelters for safety, as a way to escape dangerous and abusive situations (mainly involving men), due to illness, and because of circumstances created by their own substance abuse. Supportive staff, access to private space, peer support, rules that normalize life, housing and employment help (Job Quest), on site child care and service providers were noted as positive aspects of shelter life.

When asked about the negative side of shelters and the need for “women only” shelters, respondents provided evidence corroborating best practices in the literature and identified service system gaps.

- The majority prefer “women only shelters” with some personal space that is private. Accommodation for couples also needs to be considered;
- Service delivery should respect cultural differences and gender preferences;
- Clear and consistent rules are required for safety and security. Barring women with challenging behaviour is a common practice but one that may not fit with a harm reduction approach;
- Well trained, supportive staff, who understand the drug culture, are in the best position to assist women who are abusing substances. Skills in conflict resolution, anger management and assisting those with mental illness, are particularly important;
- Separate accommodation for users and non users needs to be available.

- Discussions about how shelters could better support women with active addictions, and what harm reduction programs are needed, produced the following suggestions:
- Provide storage for alcohol and paraphernalia but not drugs;
- Have on site needle exchange, addictions counselling, MA, AA and NA meetings, concurrent disorder and peer support groups - especially in the evening;
- Have 24 hour crisis assistance available from staff knowledgeable about substance abuse and skilled in dealing with relapse;
- Provide separate accommodation for women when they are “under the influence”;
- Separate safe shelters/housing is also needed for women who are addicts and abusing alcohol. Such facilities need well trained, sensitive staff. Staff with previous personal substance abuse experience were described as the most helpful. Native women require their own residence where native practices such as smudging can be used. More 2nd stage housing is needed;
- Provide counseling for partners and harm reduction programs for teens;
- Provide assessment and assist women with developing transition plans;
- Provide support and services for pregnant women.

3.10. Key Informant Findings

Electronic surveys were sent to 20 agencies serving women involved with substances and 20 experts in the field of harm reduction. Detailed results are found in Appendix 8.

3.10.1. Agency Responses

Of the 20 agencies contacted, 11 opened the e-mail containing the survey and 6 responded – 5 from Canada and 1 from the U.S. Cornerstone should feel confident that a good response was received for this type of survey.

Agencies were asked to comment on what is in place for their agency, not what they would prefer to have in place. It is unknown what role the responding agency might have within a larger local continuum of services. The overall response is generally consistent with findings from the literature. Inconsistencies may be due to a lack of funding or policy/legislation restrictions resulting in program/service aspects different to what respondents would like to have in place.

A general analysis of the survey findings indicates:

- Women only harm reduction programs are most likely lacking in Canada. A gap may exist in harm reduction programming for women with children;
- A wide variety of housing, supports and programming is being made available across Canada. These should be reviewed when identifying existing services and gaps for the Ottawa area;
- The majority of surveyed programs allow intoxicated women to access premises, but only a few allow them to inject/inhale or ingest substances on site;
- Although most agencies house women singly, 50% also house several to a room. This may be due to lack of funding as the majority of respondents identified that access to private and shared living space is a priority;

- The majority of surveyed agencies house women involved in harm reduction programs with the general population in the same shelter or facility. It is unknown if this is a preferred approach;
- Harm reduction programs within surveyed agencies serve 20 to 50 clients with client/staff ratio of 1/10 being the most common. Most agencies have staff working 24/7. Staff “buy in” to harm reduction programming was identified as critical;
- Agencies require that staff have a sound understanding of homelessness and the issues affecting women. Skills in conflict resolution, mental health and addictions treatment and counselling, and harm reduction were identified as key requirements;
- Responding agencies did undertake some aspects of gender analysis to support program development;
- Reporting agencies have not engaged in rigorous evaluation of their harm reduction programming;
- The need for a full spectrum of programming including housing, detox and addictions treatment, not just harm reduction programming was identified by one respondent.

3.10.2 Expert Response

Of the 20 experts contacted, 10 opened the e-mail and 4 responded. All respondents reside in Canada and have expertise in homelessness, substance abuse, mental health, harm reduction and service systems. A fair response was received which is typical of surveys seeking expert opinion.

A general analysis of the findings revealed the following:

- Programs and services chosen for listing in the survey are consistent with expert opinion about what is needed for women who are homeless, at risk of homelessness and abusing substances. Expert responses also reflect the programs and services generally implemented by agencies responding to a similar survey and what agencies require in terms of knowledge and skills for staff.
- Expert opinions support a broader continuum of services than reporting agencies have been able to uniformly implement. For example; all experts support injecting/inhaling/ingesting substances on site or accessing premises while intoxicated, while only 1/3 of reporting agencies allow injecting/inhaling/ingesting substances on site. This may indicate a theoretical response from experts while agencies are bound by agency policies and capacity, and the reality of current drug legislation.
- Support for access to private personal space was supported but responses to the number of women that should be housed together were mixed. This may indicate the need for a variety of options within the service system.
- Expert support for housing women in a harm reduction program/service in a separate part or in an all together separate emergency shelter/facility was the exact opposite of what reporting agencies have been able to implement. Limitations of the agency survey prevent knowing whether agencies house women in harm reduction programs/services within the general population by choice or due to resource limitations. Similarly, while experts identify a smaller client/staff ratio of 1/5 as ideal, agencies are implementing programs and services with a ratio of 1/10 - most likely due to funding realities.

- The need for harm reduction programs/services specifically for women was identified by all.
- Improved mental and physical health, reduced illness and injury, better pregnancy, child custody/protection outcomes are indicators of success that a local initiative may be able to observe and track.
- Expert comments on what works are consistent with the literature re housing, continuum of service/community partnership approach, case management, client centred care, etc.

4. A FRAMEWORK FOR ACTION IN OTTAWA

Three tiers of action are required in Ottawa to effectively assist those women who are substance abusers and either homeless or unstably housed.

- The first requires situating harm reduction within a larger municipal drug strategy;
- The second - identifying a harm reduction continuum of services inclusive of a continuum of women only services; and,
- The third - individual agency requirements to provide harm reduction services/programs to women.

Action may occur sequentially or simultaneously, however, all are interrelated and depend on each other for success.

4.1. Develop a Municipal Drug Strategy

Addressing substance abuse requires cooperation between government, non-government agencies and independent practitioners to implement prevention, treatment, enforcement and harm reduction strategies. Geneva, Zurich, Frankfurt, Sydney (Australia) and other cities have been using such an approach (“The Four Pillars Approach”) since the early 1990’s with a dramatic reduction in the number of drug users consuming drugs on the street, overdose deaths and infection rates for HIV and hepatitis. Vancouver and Toronto are implementing similar approaches that should be carefully scrutinized for possible adoption by planners in Ottawa.

Vancouver’s Four Pillar’s Coalition (16) - In 1997, the City of Vancouver created the Coalition for Crime Prevention and Drug Treatment (now called the Four Pillars Coalition) - made up of business, government, non-profit organizations and advocacy groups – to engage the community in addressing Vancouver’s drug problem and drug-related crime.

In 2000, former Vancouver Mayor Philip Owen released the “Framework for Action: A Four Pillar Approach to Vancouver’s Drug Problems”, which outlined this integrated approach as a way to address Vancouver’s drug problem and open drug scene, particularly in the Downtown Eastside. To build support and receive public input on the four pillars, the City released papers, held community forums and worked with partner organizations and various levels of government to create an urban development body called the Vancouver Agreement.

In May 2001, the four pillars approach was adopted as policy by the City of Vancouver. The Four Pillars Coalition now includes over 60 organizations dedicated to implementation of the strategy throughout the city. The Mayor's Four Pillars Coalition continues to hold public meetings addressing such issues as the supervised injection site and approaches to treatment.

No one agency is responsible for implementation of the Four Pillars Drug Strategy. It is a co-operative project that relies on the coordinated efforts of the Vancouver Agreement, the City of Vancouver, Vancouver Coastal Health, the BC government, Health Canada, the Vancouver Police Department, Four Pillars Coalition members and the community, within their areas of responsibility.

Toronto's Municipal Drug Strategy (65) - In January 2004, the City of Toronto began a two-year process to develop a comprehensive municipal drug policy and strategy based on the four key "pillars" of prevention, treatment, harm reduction, and enforcement. Toronto has many programs, services and responses that span these four areas. However, there is not a unifying framework or strategy to guide or coordinate these efforts.

Toronto Public Health is leading this initiative on behalf of the City of Toronto in partnership with a broad range of community and institutional stakeholders including the Toronto Police Service, the Centre for Addiction & Mental Health, community-based coalitions and service providers, school boards, advocacy groups, substance users as well as representatives from the federal and provincial governments. Once a draft strategy has been crafted, the City will take it out into the community for broader input and feedback. The timing for these consultations is set for the winter of 2005.

Four committees have been set up to provide strategic advice:

- A Community Reference Group made up of community-based service providers, enforcement officials as well as traditionally under-represented groups including aboriginal people, ethno-cultural groups, youth and substance users.
- A Council Reference Group made up of five city councillors from across Toronto.
- A Strategic Management Team made up of senior management staff from the City of Toronto, the Centre for Addiction & Mental Health, the Toronto Police Service as well as representatives from local school boards, the justice system and designated community and substance user groups. Federal and provincial representatives are also represented in an ex-officio capacity.
- A Project Team made up of policy and research staff from the City of Toronto, the Centre for Addiction & Mental Health, The Toronto Police Service and community service providers.

Recommended next steps for a municipal drug strategy in Ottawa:

- Identify local champions in areas such as women's issues, local government, public health, police/corrections, etc. and provide them with evidence of need for tabling in political, funding and planning arenas.

- Approach knowledgeable and trusted individuals that can foster community buy in, and encourage them to become leaders and chairs of committees guiding planning processes.
- Ensure a gender analysis that can help guide the development of a harm reduction continuum of services.
- Make a connection with Ottawa's City for All Women initiative described in section 3.7.1 of this report

4.2. Map out a Harm Reduction Continuum of Services for Ottawa

A harm reduction continuum or service system typically includes low threshold support programs or day centres, employment and skills training, drop-ins, Methadone Therapy, harm reduction housing, wet/damp shelters, safe injection rooms or supervised consumption rooms plus system wide referral, assessment, coordination of care, consumer education and staff development functions.

The following principles are suggested to guide the development of a harm reduction continuum.

Integrated Services – Substance abusers have a wide spectrum of needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, housing and treatment/support services should be integrated and easily accessible.

Care Coordination – Research has demonstrated that coordination of care, particularly for consumers accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved outcomes.

Assessment – Frequent assessment of client status is essential for the appropriate delivery of services. Assessment allows for early intervention and client education aimed at preventing disease progression and/or transmission. Pregnancy and mother - child relationships are important aspects of ongoing assessment.

Referral – Referring clients to appropriate services and housing is a cornerstone within a continuum of care approach. Strong referral networks for this population provide a seamless process for clients who require different approaches and assistance at various stages of their relationship with substances.

Staff Education and Support – Continuous staff training, supervision, and evaluation enhances the success of reaching women and improves their health and housing outcomes.

Consumer Education/Information – Consumer education/information assists in reducing harm to women, their children and the community by providing accurate information geared towards reducing risk, preventing infection, and initiating behavior change.

Quality Improvement – Harm Reduction is a relatively new and inexact science/approach. Protocols are continuously evolving. Provider facilities must have quality improvement activities in place to continually measure the effectiveness of

their programs/services in improving health and housing outcomes for this population.

Confidentiality – Literature reveals that the stigma associated with women involved with substances remains pervasive and can become a barrier to reaching and assisting them. Written confidentiality policies, protocols, and practices can help alleviate client hesitation to reveal their status, particularly regarding pregnancy, parenting and sex trade involvement.

Gender Sensitivity and Competence – The reasons why women abuse substances, their experiences within the drug culture and the consequences of such abuse are different from those of men. Sensitivity in working with women who abuse substances helps to establish trust between provider and consumer, and is critical to engaging and supporting women.

Consumer Involvement - Consumer input and involvement is an important component of high quality care. Consumer preference must be a priority in making service planning decisions, as consumers are more likely to adhere to plans if their preferences and needs are considered. Consumer involvement helps persons with limited experience or ability in making independent choices, make decisions for themselves and/or assume increasing responsibility for making decisions.

Recommended next steps in the development of a harm reduction continuum for women:

- Establish an inter-agency coalition with a mandate to:
 - Exchange information and advocate on behalf of substance involved women
 - Undertake a needs assessment
 - Develop a common data collection system and set of core outcome indicators
 - Develop and implement training and education resources
 - Coordinate/integrate services
 - Develop interagency protocols
 - Seek shared funding/resource mechanisms

More specifically:

- Consider information contained in sections 3.8.5 and 3.8.6 of this report regarding continuum of care/system development and housing.
- Review reports¹⁶ to the former “Substance Use in the Homeless Population Working Group” in Ottawa);¹⁷ and implement “A Recommended Approach to Supporting Learning and Knowledge Development with Those who Work with People who are Homeless and Using Substances”. (69)

¹⁶ Allan B, Nolte I J. (2001) Background Paper to Support the Development of a Continuum of Service for Homeless Persons with Addictions in Ottawa Based on a Model of Harm Reduction

Myer M., Estabale, A. (2001) Homelessness and Substance use: Exploring Cross-sectoral Needs from the Clients’ Perspective.

¹⁷ Contact for documents is Marcia Gibson at CAMH in Ottawa

- Identify existing and missing harm reduction services/programs for women. Begin by reviewing harm reduction best practices noted in this report and work towards a range of services/programs that engage women at all stages of their substance involvement. Pay attention to the legal implications.
- Identify priority subpopulations of women in Ottawa who abuse substances and the services/programs they require such as access to culturally and GBLT appropriate programming; and, reproductive/neonatal health and child care services.
- Test the waters about what harm reduction programs/services are acceptable to the Ottawa Community and start there. Moving towards controversial priorities will need a sound business case approach and the involvement of local champions to achieve support.
- Where numbers permit, consider the establishment of women-specific services, programs and housing. Otherwise, within each sector of the care system, access should be provided to women-only groups and women counsellors for any one-to-one work. Ensure women who access mixed shelter/program options always have access to female staff.
- Ensure women striving for abstinence are housed separately from those actively using. At a minimum, provide a separate area for women during periods of intoxication and strict rules regarding abstinence when accessing shared housing/shelter facilities.
- Keep track of the evaluation of "housing first" initiatives. Should more social or market rent affordable housing become available, placing women dealing with substance use and/or mental illness in independent housing may be the better option to a continuum of care approach.
- Work with the Inner City Health Program to remove existing barriers for women accessing their services.
- Consider centralized intake, assessment, screening and case management that results in "wrap-around" services supporting women as they move from unstable housing or shelters into transitional or permanent housing. At a minimum, determine if a common referral/data collection form can be used to reduce repetitive intake.
- Develop strong working relationships with the drug treatment, mental health, developmentally delayed, hospital and corrections/legal sectors. Work towards integrated service delivery and discharge planning protocols. Determine the status of the development/implementation of an Ottawa "Drug Court" and its ability to assist women.
- Develop a "back pocket" resource for front line workers that lists services/programs for women abusing substances. Ensure it includes both low threshold and treatment oriented services.

- Develop education/information resources that assist in reducing harm to women, their children and the community by providing accurate information geared towards reducing risk, preventing infection, and initiating behavior change.

4.3. Determine Agency Capacity to Implement a Harm Reduction Approach for Women

Agencies considering implementing a harm reduction approach must carefully scrutinize their capacity to do so. A sound understanding of sex differences and gender influences is also required for proper development and implementation of women specific services. Governance, organizational structure, property management, facility design, and staff hiring & training will all be affected.

Recommended next steps include:

- Review sections 3.8.2, 3.8.3, 3.8.4 & 3.8.7 of this report concerning program/service development and implementation, staff requirements, gender issues, and governance. Ensure policies reflect a harm reduction approach and that staff understand how to integrate a harm reduction approach into their day to day work with clients.
- Determine if your facility/agency can house intoxicated women separately from the general population even if abstinence is expected.
- Provide private bedrooms as a minimum. Work towards several common spaces. Separate eating, food preparation, socializing, television watching, telephone, and quiet/reading activity as much as possible.
- Do advance work in the community and on the municipal political front to forestall objections to new programs/services/housing.
- Develop partnerships/agreements with other agencies, and consider development of interagency service teams to support clients. Include confidentiality policies.
- Consider risk management issues such as staff and client safety, and capacity to implement emergency protocols.
- Measure the effectiveness of agency programs/services in improving the health and housing outcomes for clients.

4.3.1 A Role for Cornerstone

Cornerstone Women's Shelter, in commissioning this report, is particularly interested in what changes it must undertake to better support its clients. In addition to assuring what is recommended in section 4.3, an interview with Wendy Muckle, Director of The Ottawa Inner City Health Project (ICHP), regarding the health needs of women revealed the following.

ICHP uses a harm reduction approach in the provision of its palliative care, short term medical care and Management of Alcohol Program. Services are available to men and women in mixed gender settings. The lack of a "women only" access point to ICHP services is an identified gap. Cornerstone Women's Shelter is the logical location, however, barriers exist to the provision of ICHP services at this site.

Cornerstone's current physical layout is prohibitive to the provision of good quality care. A design is needed that allows health care staff to see clients. A client on a separate floor does not work. Staffing changes are also required. The current staffing mix and roles prevent similar care to what is provided by ICHP in other locations.

6. REFERENCES

1. 519.org website: <http://www.the519.org>
2. AADAC/ Alberta Alcohol and Drug Abuse Commission. (2004). An Agency of the Government of Alberta. <http://corp.aadac.com/services/index.asp>
3. AIDS Care, Treatment and Support Program, Health Canada. (1997). Care, Treatment and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report.
4. Allan, B., Nolte, J. (2001). Background Paper to Support the Development of a Continuum of Services for Homeless Persons with Addictions in Ottawa Based on a Model of Harm Reduction. Ottawa, ON.
5. Aubry, T., Klodawsky, F., Hay, H., Birnie, S. (2003). A Panel Study on Persons Who Are Homeless in Ottawa: Phase 1 Results for: City of Ottawa Housing. Centre for Research on Community Services, Faculty of Social Sciences, University of Ottawa. Ottawa, ON.
6. B.C. Self Help Resource Association web site at: <http://www.vcn.bc.ca/shra/resources.php>
7. Bessant, J., Coupland, H., Dalton, T., Maher, L., Rowe, J., Watts, R. Heroin Users, Housing And Social Participation: Attaching Social Exclusion Through Better Housing: Final Report. On Line at: http://www.ahuri.edu.au/attachments/30056_final_heroinusers.pdf
8. Best Start Barrie. On Line at:
9. http://www.beststart.org/resources/anti_poverty/womens_drop.html
10. CAMH website at: <http://sano.camh.net/resource/pconcl.htm>
11. CAMH. (1996) Paper L2 of Ontario Addiction Treatment Services Rationalization Project: Guidelines for Restructuring Services (OSAB).
12. Canadian HIV/AIDS Legal Net Work Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Injection Drug Use & HIV/AIDS: The Facts. On line at: www.aidslaw.ca
13. Carey, K. B., Purnine, D. M., Maisto, S.A., Carey M. P., Simons, S. S. (2000) Treating Substance Abuse in the Context of Severe and Persistent Mental Illness; Clinician's Perspectives. Syracuse, NY.
14. Carter, C. Walton, M. (2000) Is Anyone Listening? A Gender Analysis of the Sex Trade Work, Status of Women, Canada.
15. Champlain District Mental Health Implementation Task Force. (2002) Meaningful Collaboration: Substance Use and Mental Health. Section 19.
16. City of Vancouver. Framework for Action: A Four Pillar Approach to Vancouver's Drug Problems. On Line at: <http://www.city.vancouver.bc.ca/fourpillars/>
17. CMHC. No Room of Her Own: A Literature Review on Women and Homelessness http://www.cmhc-schl.gc.ca/en/imquaf/ho/ho_015.cfm
18. Cochran, B.N., Stewart, A.J., Ginzler, J.A., Cauce A.M. (2002). Challenges Faced by Homeless Sexual Minorities: Comparison of Gay, Lesbian, Bisexual, and Transgender Homeless Adolescents With Their Heterosexual Counterparts. American Journal of Public Health 92(5), 773-776.
19. Crane, M. Wet Day Centre in the U.K.: A Research Report and Manual. On Line at: <http://www.kingsfund.org.uk/pdf/wetcentre.pdf>
20. Currie, J. (2001). Best Practices, Treatment and Rehabilitation for Women with Substance Use Problems. Health Canada.

21. deCastell, S. Jenson, J. (2000). Report for the Health and Home Project. On Line at: <http://www.google.ca/search?hl=en&ie=UTF-8&q=Savard%27s+a+descriptive+analysis&btnG=Google+Search&meta=cr%3DcountryCA>
22. Denning, P. (2001). Strategies for Implementation of Harm Reduction in Treatment Settings. *Journal of Psychoactive Drugs*. 33(1): 23-26.
23. Dinning, L. B., Podruski, A., Fox, D., Wright, A. (2004). *We Cares: Practical Skills for Front-Line Workers Working with Adults Affected by Fetal Alcohol Spectrum Disorder*. Ottawa ON.
24. Drake, Robert E. and Kim T. Mueser. 2000. Psychosocial Approaches to Dual Diagnosis. *Schizophrenia Bulletin*. 26(1): 105-118.
25. Garcia, B. San Francisco's Treatment on Demand Guidelines. San Francisco Dept. of Health.
26. Gender-Based Analysis: A Quick Guide for Policy-Makers | Status of Women Canada.
27. Guirguis-Younger, M., Runnels, V., Aubry T. (2003). A Study of the Deaths of Persons who are Homeless in Ottawa – A Social and Health Investigation. Report to the City of Ottawa Housing Branch. Saint Paul University and the Centre for Research on Community Services, Faculty of Social Sciences, University of Ottawa.
28. Haden, M. (2002). Illicit IV Drugs: A Public Health Approach. *Canadian Journal of Public Health*. Vol 93, #6.
29. Harm Reduction Coalition website: <http://www.harmreduction.org/>
30. Health Canada (2002). IDU in Canada. Hepatitis C Resource Library. Ottawa: Health Canada.
31. Health Canada's Drug Strategy website: [Women and Substance Abuse](#)
32. Hierlihy, D., Hwang, S., Whitzman, C. Hamilton, A. (2003). Models and Practices in Service Integration and Coordination for Women who are Homeless or at-risk of Homelessness: An Inventory of Initiatives. Ontario Women's Health Council. On line at: http://www.womenshealthcouncil.on.ca/userfiles/page_attachments/OWHCRReport-English.pdf
33. Howell, M. (30 August 2004) Mayor Says Legal Crack Smoking Room Is No Pipe Dream. Source: Vancouver Courier.
34. Hunt, N. A Review Of The Evidence-Base For Harm Reduction Approaches To Drug Use Document. On Line at: <http://www.forward-thinking-on-drugs.org/review2-print.html>
35. Johnson, L. (2001). The Community/Privacy Trade-off in Supportive housing: Consumer/Survivor Preferences, University of Waterloo, *Canadian Journal of Community Mental Health*, Spring.
36. Kappel Ramji Consulting Group. (2002). Common Occurrence: The Impact of Homelessness on Women's Health, Phase II Community Based Action Research - Final Report. On Line at: <http://www.sistering.org/issues.html>
37. Lang, C. Leong, T. (March 2004). Vibrant Communities - Gender Analysis in Poverty Reduction: A Report on the Gender and Poverty Project (Final Report). On Line at: <http://www.tamarackcommunity.ca/g2s321.html#progress>
38. Lasovich, M (1996). Release Housing Program for Women. A Supportive Housing Strategy For Prisoners Released From The Burnaby Correctional Centre for Women to British Columbia Communities. The Elizabeth Fry Societies Provincial Council. On Line at: <http://www.elizabethfry.ca/housing/Housing.pdf>
39. Lenoir, G. (2000). The Functioning of the Services Teams. *The Network: Health Housing & Integrated Services – Best Practices and Lessons Learned*, Corporation for Supportive Housing.
40. Little, J. (2001) Treatment of Dually Diagnosed Clients. *J. Psychoactive Drugs*, jan-mar; 33(1): 27-31.
41. Media release. Housing For Homeless Chronic Alcoholics Upheld By State's Highest Court. (2004). On line at: http://www.desc.org/documents/DESC_Media_Release-1811_SCrt_ruling030804.pdf

42. Mothercraft. Breaking the Cycle. On Line at: <http://www.breakingthecycle.ca/index.html>
43. Morse, G. (1999). A Review of Case Management for People Who are Homeless: Implications for Practice, Policy and Research. Practical Lessons: The 1998 Symposium on Homelessness Research. Eds.. Linda B. Fosburg and Deborah L. Dennis. U.S. Department of Housing and Urban Development and U. S. Departments of Health and Human Resources.
44. Mottet, L., Ohle, J. (2003). Transitioning Our Shelters: A Guide to Making Homeless Shelters Safe for Transgender People. The National Coalition for the Homeless and the National Gay and Lesbian Task Force Policy Institute. New York. On line at: <http://www.nationalhomeless.org/civilrights/transshelters.pdf>
45. Murphy ,S., Sale, P. Let's Get Real. Looking at the Lives of Pregnant Drug Users. On Line at:<http://www.harmreduction.org/news/spring01/sp01toc.html>
46. Newbury, R. Newbury, M. May, 2003. Homelessness and Addictions In Calgary. Calgary Inter Agency Committee Sub Committee on Addictions. On line at: <http://www.calgaryhomeless.com/images/products/documents/1223/06CAC4EF-CF8E-41CA-8617->
47. National Institute on Alcohol Abuse and Alcoholism (American) website: (NAPW) <http://www.advocatesforpregnantwomen.org/>
48. NIH. Alcohol: A Women's Issue. <http://www.niaaa.nih.gov/publications/brochurewomen/women.htm>
49. Novac, S. et al.(2002). On Her Own. Young Women and Homelessness in Canada, CHRA
50. Novac, S., Brown, J., and Gallant, J. (1999). Women on the Rough Edge: A Decade of Change for Long-Term Homeless Women.
51. OHPE Bulletin #316.1 (June 27, 2003). Integrated Health Services for Women Who Are Homeless and At Risk of Homelessness: The Situation in Ontario.
52. Pathways to Housing Website. <http://www.pathwaystohousing.org/html/housing-study.html>
53. PCAP. On Line at: <http://modelprograms.samhsa.gov/print.cfm?pkProgramid=134>
54. Practice Guidance for Delivering Outcomes in Service Coordination. On Line at:
55. <http://www.thecouncil.org/freeresources/ServiceCoordination.pdf>.
56. Raising the Roof Website. <http://www.raisingtheroof.org/lrn-home-index.cfm>
57. Randall, G. (2002) Drug Services for Homeless People – A Good Practice Handbook. <http://www.drugs.gov.uk/ReportsandPublications/Communities/1039175501>
58. Safe Injection Sites <http://www.ccsa.ca/pdf/ccsa-010657-2004.pdf>
59. Serge, L., Gnaedinger, N. (2003). Housing Options for Elderly or Chronically Ill Shelters Users. CMHC
60. (SPARC) Social Planning and Research Council of B.C. On line at <http://www.sparc.bc.ca/>
61. Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment. (1999). From the Revolving Door to the Open Door. Final Report of the Study Project on Homelessness and Alternative Addiction Treatment. Toronto.
62. Strachan. Tomlinson. (2003). Report on the Forum on Alcohol and Illicit Drugs Research in Canada. Kanata, ON. On Line at: <http://www.ccsa.ca/pdf/extl-009442-2003.pdf>
63. The Government and Public Awareness Task Group of NPNU Consortium. (2000). Harm Reduction Information Kit for Professionals working With At-Risk Populations. On Line at: http://www.hivedmonton.com/htm/harm_reduc/harmreduction%20kit%20-%20english.pdf

64. The Urban Institute (2003) Developing Community-Wide outcome Indicators for Specific Services. http://www.urban.org/UploadedPDF/310813_OutcomeIndicators.pdf
65. Toronto Drug strategy website: http://www.city.toronto.on.ca/health/toronto_drugstrategy.htm
66. Toronto Harm Reduction Task Force Newsletter, Summer 2004
67. Whitehead, B. (1997). Motivational Interviewing. SMMSP Newsletter # 8. On line at: SMMGP Newsletter No 8 - Dec 1997
68. Whitzman, C., Hierlihy, D. (2003). Models and Practices in Service Integration and Coordination for Women who are Homeless or At-Risk of Homelessness: An Inventory of Initiatives. On line at the Ontario Women's Health Council website: <http://www.womenshealthcouncil.on.ca>.
69. Wright, A. (2002). A Recommended Approach to Supporting Learning and Knowledge Development with Those who Work with People who are Homeless and Using Substances March 1, 2002
70. Zerger, S. (2002). Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature. On Line at: <http://www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf>

7. APPENDICES