

# Finding Home

Policy Options for Addressing  
Homelessness in Canada

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## Chapter 4.3

### Making the invisible visible: Canadian women, homelessness, and health outside the “big city”

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#### Introduction

This article is an exercise in “making the invisible visible” (Sandercock, 1998). “Invisibility” has not received the comprehensive analytical attention it deserves in spatial literature. However, invisibility is a common reference point, especially in feminist and postmodern literature on space and place. For instance, Sandercock (1998) refers to the historical and contemporary invisibility of racialized groups, women, and other subject peoples as well as the invisibility of radical ideas in her introduction to “insurgent planning historiographies.” Sibley (1995) also refers to exclusionary practices that have resulted in the invisibility of ideas and people, in both the past and present. Power is expressed by the monopolization of space, both in the literal sense and in the world of policy discourse (Sibley, 1995).

The notion that the lives of poor women are invisible to policy makers has been expressed in the feminist literature since the early 1980s. Hays, who writes about “invisibility and inclusion” in her book on low-income U.S. women, emphasizes that the women she spoke to “told their

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stories ... with the hope that they would be recognized not simply as a composite of clichés, but as whole persons ... citizens and social members" (2003, p. 139). What these references to invisibility have in common is a set of multiple meanings embodied in the term. Individual people's interior lives, their reasons for being at a particular place in their lives can be made invisible, misrepresented, or simply not cared about (for example, the "welfare queen" stereotype promulgated in the United States in the 1990s). Groups of people can be made invisible in both the spatial sense ("visibly" homeless people excluded from using public space) and in the policy sense ("hidden" homelessness not counted in statistics).

Although feminists have been providing a gendered perspective on housing and homelessness in English-speaking developed nations since the mid-1980s (McClain & Doyle, 1984; Watson & Austerberry, 1986), popular conceptions of homelessness in these nations still focus on the "visibly homeless" – those who "stay in emergency hostels and shelters and those who sleep rough in places considered unfit for human habitation" (Novac, 2001, p. 3). Less visible to public scrutiny and policy initiatives are women and men who face "hidden homelessness," those "who are temporarily staying with friends or family...and those living in households where they are subject to family conflict or violence," or who are at risk of homelessness because they are "paying so much of their income for housing that they cannot afford the other necessities of life such as food; those who are at risk of eviction; and those living in illegal or physically unsafe buildings, or overcrowded households" (Novac, 2001, p. 3). While men are more likely to be visibly homeless, sleeping rough or in shelters, women's homelessness is largely hidden from public view (Novac, 2001).

A second dimension to the "invisibility" of women and homelessness is the focus on visible homelessness in the centres of large cities. As Cloke, Milbourne and Widdowfield have pointed out in the British context, "the spatiality of homeless people is entirely encompassed by city limits" (2000a, p. 716). Soup kitchens, drop-ins, shelters for homeless people and other visible symbols of homelessness are concentrated in downtown areas of larger cities. Suburbs, small towns and rural areas share an idealized image of "old-fashioned" communities, "purified

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space” free from the lack of social cohesion and control that is assumed by some conservative commentators to breed homelessness (Cloke, Milbourne, & Widdowfield, 2000b, p. 715; see also Sibley, 1995).

In Canada, a growing research focus on housing affordability, on those who spend more than 30 percent of pre-tax income (or in a more extreme measure, spending more than 50 percent of pre-tax income) as an “indicator of changes in the risk of homelessness” (Moore & Skaburskis, 2004, p. 397, emphasis in original) has only recently shifted attention to “stressed households” living in suburban and ex-urban locations (Bunting, Walks, & Fillion, 2004). While there is a higher number of single-person households facing affordability stress in inner cities, single-parent households are spread more evenly across metropolitan areas. Local and senior government policy responses have not yet caught up with this demographic reality, leading to a mismatch between where housing affordability stress is “produced” and where services for the homeless and those at risk of homelessness are “consumed” (Bunting et al., 2004).

A third dimension, and a focus of this chapter, is the invisibility of the “landscapes of despair” (Dear & Wolch, 1987) *within* women who are homeless and at risk of homelessness. A recent literature review by the U.S. National Organization for Women concludes that the primary cause of homelessness among women in developed nations continues to be inadequate affordable housing and insufficient income, a situation which is often set into motion by physical abuse by a male partner (NOW Legal Defense and Education Fund, 2002). The World Health Organization’s landmark report on violence and health (Krug, Dahlberg, Lozano, Mercy, & Anthony, 2002) cites national and cross-cultural studies that show partner violence has huge impacts on physical, reproductive, and mental health, as well as economic impacts such as lessened ability to stay in paid employment and lower personal incomes. Given the links between domestic and sexual violence, poverty, and homelessness, it is hardly surprising that impoverished women often speak of extreme physical and mental stresses associated with keeping their lives and their families’ lives together. Recent Canadian and international policy approaches use WHO’s integrated, holistic and values-based definition of health, going beyond the absence of illness to describe a state of physical, mental, spiritual, and social wellbeing (Shah & Hodge, 1997; Thurston &

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O'Connor, 2002). While more affordable housing and better income and social supports are central to solutions of homelessness, the health care system plays an important role in preventing homelessness and in assisting women who are episodically homeless. As bell hooks says: "you can't effectively resist domination when you are all messed up" (1990, p. 218).

## Methods

This article aims to combine the policy-based and empirical work undertaken for a study in Ontario, with insights gained from post-structural theoretical literature, particularly from feminist geography, in order to illuminate the relationships between gender, health, homelessness, services, and space. It draws upon research conducted for an Ontario Women's Health Council (OWHC) report on integrated health services for women who are homeless or at risk of homelessness (Inner City Health Research Unit, St Michael's Hospital and Oriole Research and Design, 2004). The client organization was established in 1998 to "advise the Minister of Health and Long Term Care; ... advocate for improvements to women's health care in Ontario; promote, influence, and disseminate research into women's health issues; and to reach out and empower women across the province to make informed decisions that will contribute to improvements in their health."

In consultations with health-care providers across the province in 2000-2001, the OWHC heard that poverty was a key determinant of women's health. The OWHC commissioned a research study on the health issues of women who are homeless and at risk of homelessness (OWHC, 2002a) and also held a one-day "think tank" with health-care workers in November 2001 (OWHC, 2002b). At the think tank, the importance of providing integrated health care for women who are homeless or at risk of homelessness was a major theme.

While the initial terms of reference requested only a North American literature review and survey of health services across the province, the research team (of which I was a member) decided to organize four focus groups with female clients of health services, to elicit their opinions on quality of current health care and ideas for improvement. The locations for the focus groups were selected with the aim of speaking with a

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range of women across the province, and were organized in partnership with agencies serving low income women.

One focus group was held at the Parkdale Activity and Recreation Centre, a drop-in centre for homeless people in west downtown Toronto with an on-site health clinic. A second focus group was held in a community health centre in Oshawa, an industrial city 50 kilometres east of Toronto with a population of 150,000. The third focus group was held at a street health clinic specializing in services for substance abusers and/or people with mental health issues in Kingston, a city of a little under 100,000 people, 250 km east of Toronto, known for its prisons and universities. The fourth focus group was at a family services centre in Haliburton, a small town of 5,000 people 250 km due north of Toronto. Haliburton, adjacent to Canada's most popular outdoor recreation area, Algonquin Park, is heavily dependent on "cottage country" tourism.

The 40 participants in the OWHC focus groups ranged in age from teenagers to women in their late sixties. The women were also varied in their marital and family status, ethnic backgrounds, and physical and mental health histories. Many of the women in the Haliburton, Kingston, and Oshawa groups had custody of dependent children, although several had lost custody at some point due to housing crises. Several of the women in the Kingston and Parkdale groups spoke of not having custody of dependent children. All the women had direct experience of homelessness or being at risk of homelessness. Their experiences ranged from living on the street, to extended periods without secure private accommodation, to one woman who still owned the marital home, but was at imminent risk of losing it. Because of the small sample size, I was unable to break down responses by self-identified ethnicity and family status, but multiple burdens (e.g., low income combined with care of a mentally ill dependant) were referred to in the focus groups. In the sections below, I focus on the words of women in the three focus groups outside central Toronto to describe their own experiences of invisibility, and strategies for obtaining health services within these interlocking structures of invisibility.

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### Homelessness Inside and Outside the “Big City”

Homelessness is a growing crisis around the world, although the absence of systemic and comparable data makes quantification difficult. Demand for emergency shelter beds and other stop-gap services such as food banks is growing, even as the number of these services increases. However, a state of denial over the existence of homelessness and absolute poverty outside the centres of large cities continues to be fed by politicians and developers (for U.K. and U.S. examples, see Cloke, 1997). In 1991, the head of the London (Ontario) Development Institute, told the Commission on Planning Reform in Ontario to forgo “Toronto solutions,” such as a requirement to make 25 percent of all new housing developments affordable to low- and moderate-income households, as “affordability is not an issue in London.” (*New Planning News*, 1991) Ten years later, the City of London, Ontario, with a total population of 300,000, was serving 4,000 people per year in its shelters and had demand sufficient for over 2,000 more beds. In 1997, the successful candidate for mayor of the newly amalgamated City of Toronto said, “There are no homeless people in North York,” the suburb he had governed for 20 years. That same night, the body of Linda Houston was found in the washroom of a North York gas station, where she had sought shelter from the cold (“A Loving Mom,” 1997; “Remembering the Homeless,” 1997)

Homeless women are of every age and socio-economic background, but there are certain risk factors within the broad gender category of “women.” Gender, radicalization, ethnicity, physical ability, life cycle stage, sexual orientation, and access to income form interlocking “structures of constraint” that limit access to social goods and choices for individual women (Young, 2002; see also Jacobs & Fincher, 1998). For instance, the areas where housing affordability stress is concentrated in the Toronto region correlate with high levels of new immigrants and refugee claimants, above-average rates of unemployment, and a high proportion of single-parent households. There are two wedge-like arcs of social deprivation, which start in the east part of downtown and the northwestern inner suburbs and radiate outwards (Bourne, 2000).

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In Canada, census areas with a high proportion of Aboriginal people also tend to have high levels of housing affordability stress (Moore & Skaburkis, 2004). Almost three-quarters of Aboriginal single mothers live below the poverty line in Canada (OWHC, 2002a), housing conditions on many reserves are overcrowded, unsanitary and unhealthy (CERA, 2002), and Aboriginal women are more likely than other women to be sleeping rough in the centres of big cities (Novac, Bourbonnais, & Brown, 1999). Newcomers to Canada, particularly refugee claimants, are at risk of homelessness, and lack of credit and employment histories in Canada leads to difficulties in accessing private rental accommodation (Access Alliance Community Health, 2003; CERA, 2002).

Visible minority women are nearly twice as likely as non-visible minority women to live below the poverty line, and racial discrimination restricts access to housing (CERA, 2002; see also Informal Housing Research Network, 2003). Over two-thirds of women with disabilities or chronic health problems live below the poverty line (Chouinard, 1999). Young women form an increasing cohort of the visibly homeless, with almost a quarter of shelter admissions in Toronto comprising young people between the ages of 15 and 24 (CERA, 2002). As in the case of recent immigrants, the lack of credit and employment histories is a barrier to accessing rental housing (CERA, 2002). Lesbians are over-represented among homeless young women in Toronto, but there are no comparable data for Ontario or Canada (Novac, 2001).

The poverty rate for all single women, including mothers with young children, almost triples after divorce or relationship break-up, and many women who leave their spouses (including victims of wife assault) move in with relatives or friends immediately after separation, which may be the beginning of a spiral into long-term homelessness (Novac, 2001). Women over 60 years old are less likely than their male counterparts to own homes, and approximately half live below the poverty line (CERA, 2002). Chronic or long-term homeless women, those who have lived for more than a year in shelters or other short-term accommodations tend to be older women, many of whom have severe mental and physical health problems, often compounded by addictions (Novac et al., 1999).

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### **Women, homelessness, and health: The internal landscape of despair**

Homeless women in Canada are subject to nutritional deficiencies, exposure to pollutants and extreme temperatures, lack of access to basic services such as a telephone, lack of money for basic hygiene products (toothbrushes, soap, menstrual supplies, and so on), insufficient sleep and other by-products of extreme poverty and lack of stable housing. Because of these poor living conditions, homeless women are subject to higher rates of almost every disease and poor health condition, as compared to the general female population (Ambrosio, Baker, Crowe, & Hardill, 1992; Craft-Rosenberg, Culp, & Powell, 2000; Hwang, 2001; Novac, 2001). A recent literature review on the risk of death among homeless women in Toronto found that the mortality rate for homeless women under 45 years was about five- to thirtyfold higher than in the general population of housed younger women (Cheung & Hwang, 2004).

Along with health issues common to both genders, homeless women are canaries in the coal mine of gendered health concerns. Physical and sexual violence is a common experience in the histories of homeless women, both as a precipitator to homelessness and as a result. One Toronto study found three-quarters of a sample of 84 single homeless women in Toronto had been physically or sexually abused, usually by a male family member, prior to becoming homeless (Novac, 2001). Almost half the women in a 1992 Toronto street health survey had been physically assaulted in a 1-year period, with 21 percent reporting sexual assault (Ambrosio et al., 1992). In addition, North American studies have found that homeless women are at greater risk of abnormal pap smears, STDs, HIV/AIDS and unwanted pregnancy than the general female population (Ensign & Panke, 2002; Weinreb, Goldberg, & Lessard, 2002; Wenzel, Andersen, & Gelberg, 2001). Women who are assaulted by their spouses often report the abuse beginning during pregnancy, which suggests that the onset of pregnancy may be an instigator of abuse and subsequent homelessness among women (Weinreb, Browne, & Berson, 1995).

Unsurprisingly, given their greater risk for violence and poor physical health, homeless women are at much greater risk than homeless men or women in the general Canadian population for serious depression

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and other mental health disorders (Mental Health Policy Research Group, 1997). In all four focus groups, the difficulties of meeting basic needs for shelter, food, clothing and transportation led to a great deal of stress, depression, and anger, which in turn often resulted in physical illness:

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

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

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

Several women with dependent children were particularly affected by stress, compounded by their insecure living situations and their dependence on others for housing:

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

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

These quotes above suggest an internalized “reprivatization discourse” (Fraser, 1989). While some women were extremely aware of what external supports might help them in their present untenable situation (particularly housing and income supports), their day-to-day stresses were exacerbated by feelings of self-blaming. This was especially true among two women who described wealthier and more secure pasts, and who could not help wondering what they might have done to change their current situation:

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

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

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As Hays (2003) points out, the message that women's poverty is an outcome of personal "bad choices," a common trope in welfare rhetoric, has triumphed, not only within the policy realm, but also within women's perceptions of their own lives.

### **Invisibility Within the Health Care System**

Several recent North American studies have asked homeless women about barriers and enablers in relation to health care access (Acosta & Toro, 2000; Craft-Rosenberg et al., 2000; Ensign & Panke, 2002; Hatton, 2001; Kappel Ramji Consulting Group, 2002). One theme that emerges from these studies is that there are significant differences between homeless women and men in relation to comfort with emergency housing provision. Homeless women, whether single or with children, prefer strongly to avoid shelters, including shelters for abused women. This is because of legitimate concerns for their safety, and also because they wish to avoid the stigma and disruption caused by leaving their immediate environs, especially if they have children in school (Hatton, 2001). Several women in the Haliburton, Kingston, and Oshawa groups spoke of hiding their homeless status, partly because "coming out" as living in insecure accommodations would be harmful to their children:

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

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

This dilemma echoes the findings of other North American researchers, who have found that women often stay in an abusive relationship or double up with family and friends, rather than seeking refuge in a shelter, even if the shelter has access to health, housing, and legal services that are otherwise unavailable. The recognition that women's homelessness is largely hidden has important implications for access to health care services, and may provide one of the reasons why low-income women with dependent children and fewer social supports are

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so much less likely to utilize health care options than low-income men or higher-income people (Acosta & Toro, 2001). Given the extremely limited options available, women may “choose” to avoid giving control to potentially intrusive and insensitive health, judicial, welfare, and housing systems. For instance, several women in the focus groups described the measures that they took (credit card debt, appeals to welfare authorities) so that they could avoid moving from their original home, even though that home was no longer affordable to them.

As the Ontario Women’s Health Centre had already discovered, health services are often scattered in agencies throughout rural Ontario (with attendant transportation problems), and lengthy waiting lists for many services, such as free dental care, alcohol and drug treatment. There is a shortage of doctors in many rural and isolated areas, leading to closed patient lists. Simply not knowing about a service is a common barrier in all settings (OWHC, 2002a). Another Canadian study has found that physical access to appropriate services is especially acute among small town, rural, and isolated women, many of whom lack access to transportation, do not have family or social networks to rely on, and lack access to a telephone (Craft-Rosenberg et al., 2000). Several women in the focus groups complained of how local medical clinics provide inconsistent, incomplete and insensitive service:

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

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

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

There is never any help beyond the immediate crisis at [a local hospital]. (Oshawa)

Yet transportation costs to the “big city” are onerous:

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

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

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

In small towns and suburbs, overcrowded emergency rooms (a primary source of health services for many homeless women) and lack of money for public transit fares (assuming that there is public transit) are common concerns for women seeking access to health services (Ambrosio et al., 1992; Zabos & Trinh, 2001). One older woman in our focus group spoke about how:

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

Four low-income women in the focus groups who were not on government benefits said they could not afford medications or preventive services, the "benefits trap" described by a number of feminist researchers (Little, 2002, p. 110):

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

I don't have money to pay for prescriptions and food, rent and electricity, so I've stopped my medication. (Oshawa)

No dental care and my teeth are rotting. (Oshawa)

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

As Canadian research has shown, some women refuse to see physicians because of a past negative experience (Ontario Medical Association, 1996). Others report that medical staff are judgmental and refuse to treat symptoms and health issues adequately (Ambrosio et al., 1992; En-

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sign & Panke, 2002; Kappel Ramji Consulting Group, 2002; Zabos & Trinh, 2001). This was echoed by two women in the focus groups:

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

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

North American studies have shown that homeless women accessing health services, particularly new migrants and visible minority women, report linguistic barriers and cultural biases (Attala & Warming-ton, 1996; Kappel Ramji Consulting Group, 2002), while some people with histories of disruptive behaviour are barred from services (Ambrosio et al., 1992; Hatton, 2001; Novac, 2001). A few women in the focus groups described turning to alcohol or illegal drugs as a coping mechanism, which in turn, increased health and housing stresses:

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

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

Follow-up is difficult for homeless women, who may not be able to afford or access tests, pay for prescriptions, follow special diets or store medication at the correct temperatures. Medical follow-up is very difficult for women who live in temporary accommodations and do not have access to a telephone or mailbox. Frequent moves exacerbate the scattering of medical records, and the constant necessity to repeat symptoms and keep track of previous treatment suggestions (Hatton, 2001; Hwang, 2001; Novac, 2001; OWHC, 2002a; Wenzel et al., 2001). Homeless women's need for non-acute medical care is often balanced against more immediate needs, such as food and shelter, leading to chronic problems being neglected until they become emergencies (Luck et al., 2002). Almost every woman in the focus groups had a story of how she ignored ill health or medical instructions, simply because there were other financial or time priorities.

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### **Finding a Way Out of Invisibility: Homeless women's experiences and ideas on integrated services**

One U.S. summary of barriers to homeless women accessing services describes three common themes: “not knowing,” “runarounds” and “constantly starting over again” (Hatton, 2001; see also Jezewski, 1995). Given the frequent recurrence of these themes in the literature, almost every report on health services for homeless people stresses the importance of integrating health services in order to reduce barriers to access and provide continuous and coordinated prevention-orientated health services. However, there is no agreement about the meaning of the term “integrated.” In my review of the literature, integration was defined in at least four ways: (1) interagency coordination, (2) co-location of services, (3) case management approaches, and (4) holistic health.

Interagency coordination involves integrating service delivery among agencies serving homeless people. Methods range from coalitions that exchange information and undertake advocacy and/or needs assessments on issues of common concern, to service delivery teams that coordinate services and may undertake cross-training or develop interagency protocols and shared funding mechanisms, to management information systems that may track clients through shared record keeping, from intake assessment to patient records (Randolph et al., 1997). Interagency coordination can occur in any geographic setting, from the centres of large cities to rural areas.

Although interagency coordination has been a common recommendation of recent policy reports, the most comprehensive evaluation of integrating health services for homeless people suggests that it is not a “magic bullet.” From 1994 to 1998, the ACCESS project funded 18 centres in 15 U.S. cities serving hard-to-house men and women with severe mental illness to determine the effectiveness of strengthening linkages between agencies providing psychiatric care, and those that provided medical, substance abuse, housing and income support and employment assistance to their clients (Randolph et al., 2002). There was no significant impact on the housing or health outcomes of the clients in intervention sites, although the evaluation did find that cities with more community social capital, as measured by citizen involvement in organizations,

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projects, volunteer work and interaction with neighbours, also had stronger network strength (i.e., more effective coordination between agencies) and better housing outcomes for homeless individuals. The city's housing affordability, as measured by the proportion of households paying less than 30 percent of their income on housing, was also significantly correlated with positive housing outcomes (Rosenheck et al., 2001). The ACCESS evaluation suggests that a focus on agencies' formal linkages and policies may be less effective than a broader and possibly more diffuse community development approach. None of the women in the focus group specifically addressed interagency collaboration.

Co-location, also known as the "service hub concept," concentrates on the geographic co-location of services for homeless people (Dear, Wolch, & Wilton, 1994). Community economic development workshops and other employment-generating activities can be located next to or as part of shelter for abused women or an agency serving homeless people. Hospitals can have social services nearby, while mobile health units can visit shelters. Service hubs can be provided in suburban and small town locations as well as the centres of larger cities. In rural areas, the aim might be virtual co-location through a telephone network of organizations.

There was certainly some unprompted support for the service hub concept by women in the focus groups, either in one location or in the form of mobile health units:

Provide one-stop shopping: a combination of health and social services all in one building. OW [Ontario Works, i.e. government income support and benefits], food, clothing, health care all together. This would avoid the stigma of having to access the services individually. You could walk in the door and no one seeing you would know what service you were there for. It would cut down on gas costs and would be easier with kids. This type of facility would need to be available in different towns. (Haliburton)

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

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The need to integrate health services for children with help for parents was also brought up by most of the focus group participants who were single mothers:

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

There needs to be more suicide prevention for teens. My daughter needed to spend three months in a psychiatric hospital before she was assigned a therapist. (Oshawa)

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

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

In the case management approach, 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 (Attala & Warmington, 1996; Rosenheck et al., 2002). For instance, a pregnant woman who has been battered by a spouse might require assessment and treatment of physical and emotional injuries, continuous prenatal care (including screening for injuries which might have occurred to the fetus), referral to housing and legal services and income support information (Weinreb et al., 1995). 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 (Hatton, 2001). There may be confidentiality and privacy issues related to the case management approach, especially in smaller communities. Two women in the focus groups specifically mentioned being assisted by a case management approach:

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

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

A fourth element to integration has been identified by homeless women themselves: the importance of integrating women's physical, mental, emotional, and spiritual needs in a holistic health model (Kappel Ramji Consulting Group, 2002). Health services are seen as one strand of a comprehensive web of services that can seek to reverse the vicious circle of homelessness. For instance, women may become homeless because of low income exacerbated by a marital breakdown, which in turn may be related to violence in their past or present lives. Yet lack of decent, stable, safe, and affordable housing may lead to poor physical and emotional health, which in turn may prove to be a barrier to actions that might improve income prospects, such as employment or education. Obtaining housing may be the first step to better health prospects. North American research consistently shows that the further along a woman is in the good housing continuum (sheltered as opposed to unsheltered), the more likely she is to obtain adequate and appropriate health care (Lim, Andersen, Leake, Cunningham, & Gelberg, 2000; Nyamathi, Leake, & Gelberg, 2000). Alternatively, adequate and appropriate health and other social supports provided on the streets or in shelters can help women find more long-term housing options. In contrast to the three other approaches, which stress organizational structures, procedures, and locations, the notion of holistic health is based on respectful listening and choices provided to individuals.

Women in the focus groups stressed the importance of better informational and geographic links between services. However, their emphasis was on the quality of care provided. While staff in several walk-in clinics, including the one in Haliburton, were described as insensitive to women's needs and inconsistent in their services, other health care ser-

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vices, including the Oshawa Community Health Centre, were praised for their knowledgeable and empathetic staff:

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

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

In other words, the women found predictability, security, a sense of caring and useful information at the Oshawa Community Health Centre, a finding that echoes other studies of the community health care centre model in Canada and Australia (Warin, Baum, Kalucy, Murray, & Veale, 2000). The discussion on integrated health service tended to reinforce this holistic and woman-centred model. A common theme in the focus groups was that services should respond to women's stated needs. Women's Wellness, a weekly program where the theme is chosen by the participants, was praised by several Oshawa focus group members:

Women's Wellness made a huge difference to me. I felt it was okay to take care of myself. I got another message from Welfare!

Flexibility, empathy, and the need for a "harm reduction" approach were stressed:

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

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

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

Women told stories of how their lives had been transformed through appropriate health care, which they defined as responsive, empathic, continuous, and holistic:

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

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

It is worth noting that in both these cases, "the rules" were bent: in one case, a woman was not eligible to stay in a residence, and in the other case the length of tenure exceeded the regulations.

### **Conclusion: Locating invisibility and devising responses to it**

As Kearns points out, home is commonly a site where people feel "in place" (Kearns, 1991). If a secure home does not exist, or there is violence in the home, then where are the sites that people can begin to feel in place? And what is invisibility if not a condition of being "not in place"?

Women in the focus groups described struggling to survive within these interstices of spatial and policy invisibility. Physical and mental health problems resulted from the enormous stress of not having enough money to cover housing and other costs. Focus on survival meant little time to take care of the self. Fear of being stigmatized and of possibly losing child custody kept several focus group women from revealing the extent of their housing problems. Weak public transit infrastructure, social isolation and low-quality social services combined to create further barriers to seeking help. Walk-in clinics and hospitals, often the sole options outside the big city, were seen as emergency-focused and not providing any continuity of care. Some health care professionals were described as acting as barriers to women finding the help they need, and there was little choice as to health services in the suburban, small town and rural sites.

The possibilities of a space for healing are not limited to locations in the big city. When speaking about integrated health services, a focus on whole family and the whole individual woman was a common theme in the three focus groups, along with a client-centred approach that stresses

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choices and respect, and continuity of care. In other words, integration was sought within the individual bodies of women and within households, rather than at the policy level of inter-agency collaboration or service hubs. Community-based services, including health services, can be a space of at least temporary safety for otherwise invisible women: women who are marginalized, excluded, and isolated within the dominant discourse of neoliberal abandonment of social supports (Staeheli, 2003). The Oshawa Women's Health Centre served as a model for this kind of integrated health services, where women's needs were heard and responded to, instead of being met with standardized services and a call of "Next!" It is difficult to quantitatively measure the positive economic and social impacts of these good services, how they can save lives and improve health outcomes. However, the potential of integrated health services combating the individual and societal invisibility of homeless women should not be underestimated.

Homelessness is an issue which cannot be contained within the boundaries of the "big city," just as health cannot be contained within the boundaries of traditional medical services. At the edge of what is still a barely visible policy issue, the experts reside in shelters, motel rooms, and trailers, on couches and in sleeping bags. The question is how to tap into their considerable powers of observation and survival, in order to provide the best services in all settings.

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