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WOMEN FIRST: AN ANALYSIS OF A TRAUMA-INFORMED, WOMEN-CENTERED, HARM REDUCTION HOUSING MODEL FOR WOMEN WITH COMPLEX SUBSTANCE USE AND MENTAL HEALTH ISSUES

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INTRODUCTION

While estimating homelessness in Canada has been difficult, it is believed at least 200,000 Canadians experience homelessness each year (Gaetz, Donaldson, Richter, & Gulliver, 2013). What is often missing from research into homelessness in Canada is identification of the specific situations and needs of women experiencing homelessness. This paper identifies the complexity and specific issues for women experiencing homelessness, and presents two different supportive housing models offered by the Jean Tweed Centre in Toronto as responsive models to the needs of women. The two housing models discussed serve women experiencing homelessness and concurrent mental health, and/or substance use concerns.

Women and Homelessness

Women experiencing homelessness are often hidden from the public realm: A recent study by Sistering in Toronto has shown that women's homelessness is underestimated due to a lack of understanding of the ways in which women experience homelessness, which may include couch-surfing, trading shelter for sex, remaining in violent situations for housing, and other tenuous housing circumstances that take place outside of the public realm (2002). While male homelessness is often more visible in urban areas where men are more likely to sleep on the streets or in public spaces, women are less likely to be seen in public places when homeless due to the significant threats of physical and sexual violence they experience. Many women will therefore stay with dangerous and violent partners

rather than submit to the incredible risk of violence and exploitation on the streets (Gaetz, Donaldson, Richter, & Gulliver, 2013). The risks of violence associated with homelessness even extend into the shelter system for many women, which may also explain their avoidance of accessing these spaces and contribute to the relative invisibility of their condition. There is also a disincentive for many women to access shelters because their needs simply go unmet – the most recent Toronto Report Card on housing and homelessness found that women with substance use and/or mental health issues are not sufficiently supported by the shelter system (City of Toronto, 2003). For these reasons, homelessness for women is often more hidden than it is for men (Klassen & Spring, 2015; Novac, Brown, & Bourbonnais, 1996).

Not only is homelessness often more hidden for women than it is for men, but the experiences of women facing homelessness are also different than those facing men. For women in particular, domestic violence remains a leading cause of homelessness. In 2002 the World Health Organization found that 29% of Canadian women reported physical violence by an intimate partner, and in a study by Baker, Cook and Norris (2003), 38% of women reported becoming homeless immediately after separating from their partners, and up to 50% identified other housing difficulties, including loss of ability to pay their rent. Not only is violence a leading cause of homelessness for women, but it also continues when on the streets: when women become homeless, they are at increased risk of violence and assault, sexual exploitation and abuse (Gaetz, et al., 2010).

To add complexity to the issue, many women who are homeless are also struggling with mental health and substance use concerns – issues which affect women of all statuses, but which can compound the challenges faced by women at risk of homelessness. Each year, one in five Canadians experiences a mental health or substance use issue (CAMH, 2012). It is estimated that about two-thirds of women with substance use problems have co-occurring mental health problems (Finnegan, 2013) and more than 50% of women in shelters experience major depression (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). Mental health and substance use concerns can increase for women who experience homelessness, and they can also be precipitators to homelessness - women experiencing these difficulties often face challenges in maintaining employment, which can affect their ability to afford their housing, and maintaining tenancy can be difficult when experiencing significant mental health and/or substance use concerns, requiring treatment.

Women who are pregnant or parenting can also face increased barriers to maintaining housing. Women with children have been found to be at higher risk of living in substandard housing, and families have been identified as one of the fastest-growing homeless populations in Canada (Ritcher & Chaw-

Kent, 2008, Zabkiewicz et al., 2014). Women with children remain particularly vulnerable to homelessness as violence and poverty are identified as “the leading cause of homelessness for families” (Gaetz et al., 2013). Parenting women are not only at high risk of being precariously housed, but those who experience homelessness also report being scared to access emergency shelters and supports due to fear of apprehension of their children by child protection authorities (Cooper, Walsh, & Smith, 2009; Jones & Smith, 2011; YWCA, 2006). To add complexity to this issue, pregnant women who are homeless can experience increased vulnerability to substance abuse: the Canadian Perinatal Health Report found that 11% of pregnant women consumed alcohol in the past month and up to 5% reported using illicit drugs during pregnancy (Public Health Agency of Canada, 2008).

Not only is homelessness for women often hidden and under-estimated in the public realm and shelter system, there is also a paucity of research that specifically examines women’s experiences of homelessness. Therefore, for members of the public, social service workers, and academic communities the prevalence and nature of women’s homelessness is obscured.

With the causes and actual experiences of homelessness being different for men and women, policies and programs tailored to meet women’s needs are required, lest efforts to address homelessness fail to serve many women who are most severely affected. Given the barriers for women, there is a particular need for safe, affordable housing specific to women, and women with children, which is responsive to their needs. Stable, supportive housing has been linked to positive outcomes for those with mental health and/or substance use problems, including reduced substance use, improved mental health, and reduced use of costly services (i.e. hospital emergency departments) (Padgett et al., 2009). In addition, providing stable housing for families is crucial to promote well-being as it has been found that child homelessness is associated with poor health outcomes for children, and longer periods of homelessness among children is associated with worse health outcomes” (Sandal et al., 2015).

A GENDERED APPROACH TO ADDRESSING HOMELESSNESS

The Jean Tweed Centre (JTC) is a not for profit agency funded by the Ontario Ministry of Health and Long Term Care to provide services to women (and their families) across the province who are experiencing problems related to mental health, substance use and/or gambling. JTC offers a range of services including day and residential programming, out-patient counselling, trauma counselling, family support and continuing care. Outreach services are available in Toronto for pregnant and parenting women, as well as women with concurrent disorders and current involvement in the criminal justice system. Safe, affordable, permanent housing is also included in the range of services offered by the JTC.

In partnership with two housing agencies (Mainstay Housing and the YWCA Toronto), the JTC has tailored supportive housing programs for women experiencing

homelessness, problematic substance use and/or mental health concerns. These programs serve women who identify experiencing homelessness in keeping with the definitions of the Canadian Observatory on Homelessness, defined as: being unsheltered (e.g. living in public spaces or make-shift shelters), emergency sheltered, provisionally accommodated (e.g. couch surfing, trading sex for shelter), and at imminent risk of homelessness (e.g. experiencing violence in the home, unable to afford rent) (Canadian Observatory on Homelessness, 2012). The supportive housing programs described in detail below provide a stable place from which women can anchor themselves while engaging in supports to achieve their goals related to housing stability, substance use and mental health, thus increasing overall wellbeing.

Frameworks For Supportive Housing For Women

The JTC supportive housing programs are grounded in frameworks that take into consideration the context of a woman's life, the impact of her life experiences on her current situation, her strengths and coping skills, and her desire and readiness for change. Women-centered, trauma-informed, and harm reduction approaches are central to the services offered to women through these programs.

Women-centred Frameworks

Recognizing that women's experiences with homelessness, mental health, and substance use can be different than those of men, a women-centred approach has been incorporated into these supportive housing models. This approach takes into consideration the context of women's lives and how all areas are interconnected and contribute to her well-being. Women-centred care also emphasizes the importance of women's relationships, and supports connectedness among women. (Ontario Ministry of Health and Long Term Care, 2005). As described by Barnett, White, & Horne (2002) and based on the *Framework for Women-centred Health* (Vancouver/Richmond Health Board, 2001) the core of women-centred care is:

- a focus on women
- empowerment
- involvement and participation of women
- respect and safety

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In addition, Barnett, White, & Horne (2002) describe how women-centred services:

- address the complexities of women's lives
- are inclusive of diversity
- have integrated service delivery
- respond to women's forms of communication and interaction
- provide information and education

In the context of supportive housing for women with mental health and/or substance use concerns, a women-centred approach means creating safe spaces for women to reside, providing women's only spaces, encouraging women to participate in community-building and housing related activities, supporting women to live with increasing independence, and addressing all areas of women's lives that impact their well-being. Another important aspect of women-centred housing is to ensure that the woman is the lease-holder for her own apartment unit, which ultimately gives her choice and control over her own living space.

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Trauma-informed Approaches

A trauma-informed approach is also essential when working with women with mental health and/or substance use concerns. A number of studies have shown the connection between mental health and/or substance use and a history of trauma: a recent Canadian study looking at the pervasiveness of trauma among Canadian women in treatment for problematic alcohol use found that of the women interviewed, 90% reported childhood or adult histories of abuse (Brown et al., 2009). Experiences of trauma among women with substance use issues are linked to a range of mental health outcomes, including suicide and low self-esteem (Finnegan, 2013). One study has found that more than half of the women who report experiencing domestic violence also identify some form of mental health concern (Roberts, Lawrence, Williams, and Raphael, 1998).

Similar numbers have been found in large studies in the United States, including one that interviewed over 1,500 women and found that trauma was reported by over 95% of women who utilized both substance use and mental health services (Newmann & Sallmann, 2004, cited in Sturm, 2012). Likewise, the 2005 *Women, Co-Occurring Disorders and Violence Study*

The supportive housing models follow these core principles of Trauma-Informed Practice, as described in *Trauma Matters: Guidelines for Trauma-Informed Practice in Women's Substance Use Services*

1. acknowledgment of the prevalence of trauma
2. safety
3. trustworthiness
4. choice and control
5. relational and collaborative approaches
6. strengths-based empowerment modalities

found that of over 2,500 women who identified as having substance use and/or mental health issues, more than 91% reported a history of physical abuse and 90% reported sexual abuse at some point in their lives (Becker et al., 2005, cited in Sturm, 2012).

Traumatic experiences also have a negative impact on physical health and those with trauma histories commonly report such symptoms as chronic pain, central nervous system changes, sleep disorders, cardiovascular problems, gastrointestinal and genitourinary problems, among others (BC Centre of Excellence for Women's Health, 2009). These physical symptoms can have a detrimental affect on a woman's well being, particularly if she is also facing a mental health and/or substance use issue, is under-housed, un-/under-employed, and/or living in poverty. It has been well documented that those living with these issues have a difficult time accessing health care for a number of reasons including, lack of transportation and systemic barriers (e.g. not having an address to register with Ontario Health Insurance (OHIP), stigma related to mental health, etc.) (Canadian Mental Health Association, 2008).

Considering the significant impact and prevalence of trauma for women with mental health and substance use concerns, the JTC supportive housing programs have incorporated a trauma-informed approach to care. With this approach in mind, the support service providers work with women in a way that acknowledges how common trauma is and the wide impact it has, including the interrelationship between trauma, substance use and mental health concerns. This understanding is foundational in all aspects of women-centered service delivery. It also recognizes a wide range of physical, psychological and emotional responses that women may experience as a result of trauma and view these not as 'problematic behaviours' but as responses to difficult life experiences, which may reflect coping strategies that are (or were) survival strategies. It is acknowledged that these responses may help or hinder her in achieving her health-related goals. Service providers also develop safe spaces to support women with the challenges they experience, and seek to maintain safe therapeutic relationships with clients. They collaborate with women in non-judgmental ways to support them in identifying their own goals, and steps to achieve them. One concrete way this is done is by developing individual service plans with each woman, ensuring women experience choice and control in the development of their own care plan. In addition, service providers seek feedback in how services are being delivered, and are responsive to this feedback.

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Harm Reduction Frameworks

Harm reduction is another approach central to the JTC supportive housing models. The Canadian Harm Reduction Network defines this approach as “policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use” (Canadian Harm Reduction Network, 2014). In practice, this means that goals related to substance use (i.e. reduction, abstinence, and/or no change) are respected, and women are supported with respect to their choices and where they might fit on the abstinence/active use spectrum. As this housing is not contingent on abstinence, there is flexibility in supporting women to reach the goals they have set for themselves. Counselling approaches are also flexible and women are offered support (including referral to community resources) to ensure that their goals match external expectations that women may be facing (e.g. parole conditions, child welfare conditions, etc.).

Within these supportive housing programs, harm-reduction extends beyond substance use and takes into consideration all areas of a woman’s life. The women participating in the supportive housing programs are often confronted with the challenges of living in poverty, violence and trauma, pregnancy, mothering, single-parenting, discrimination, oppression, stigma, involvement in sex trade work,

involvement with the criminal justice system, and involvement with child protection authorities. The BC Centre of Excellence’s 2009 discussion guide titled *Women Centred Harm Reduction* describes the inter-sectionality of this approach:

In the context of women’s substance use, harm reduction cannot simply be about the intersection of one health determinant with the use of substances; it is instead about how many health determinants interact, and in turn amplify or influence the experience of women’s substance use (BC Centre of Excellence, 2009).

Harm reduction approaches are therefore also used to address mental health concerns, including medication management and referrals for on-going psychiatric care. Furthermore, the use of harm reduction approaches help women maintain their housing by addressing issues such as hoarding and interpersonal conflict with neighbours. In each of these instances, the counsellors seek to support women to identify their own goals in relation to their well-being, and facilitate mechanisms to increase safety and support. In many instances, referrals to other community services are made, with the intention of creating wrap-around support systems for women and their families.

PROGRAM MODELS

The JTC has partnered with two agencies to create two different supportive housing models, the Addictions Supportive Housing (ASH) model and the Elm model. Both of these housing programs offer low-threshold access to housing, in that entry into housing does not require women to provide housing references from previous tenancies, or to abstain from substance use. This is in keeping with housing-first philosophies which identify housing as a fundamental human right, and a cornerstone of overall health and well-being. As support from case managers/counsellors is integral to these models, a willingness to work with staff to address mental health, substance use, and other health concerns is required.

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Common Components to Jean Tweed Centre Supportive Housing Models

In addition to working from women-centred, trauma-informed, and harm reduction frameworks, another key component of both housing models is the provision of housing support for women who have historically experienced difficulties maintaining their housing. The JTC's housing partners (Mainstay Housing and the YWCA Toronto) employ housing support staff dedicated to helping women to identify and solve tenancy issues, which if left unattended, may lead to eviction. Examples of this work include discussions about tenant rights and responsibilities, payment plans for tenants who are in rental arrears, and mediated agreements between tenants and the landlord to address disruptive behaviours. The housing support is provided in tandem with counselling and case management support, however these roles are separated by workers and agencies to allow women safe spaces to discuss their personal concerns independent of issues related to their tenancy. If a woman loses her tenancy, the JTC counsellor remains connected to her and provides support to obtain other housing and access to other appropriate resources.

Finally, another important aspect of these housing models is the integration with larger social and health care systems. Women entering the housing programs

often present with a range of challenges that include mental health and substance use, physical health needs, criminal justice concerns, lack of food security, lack of transportation and income instability. Clients are able to connect with a Nurse Practitioner who provides weekly on-site support to clients in the housing programs, and is also available via the Ontario Telemedicine Network. Women are also often connected with other health care providers, therapeutic groups, food banks, residential programming, and government assistance.

Addiction Supportive Housing for Women

The Jean Tweed Centre's Addiction Supportive Housing (ASH) model is delivered in partnership with Mainstay Housing - a non-profit agency which provides housing for mental health consumer-survivors through government funded rent-geared-to-income subsidies. This model, which first began operating in the spring of 2011, hosts 32 self-contained apartment units, mostly located in the west-end of Toronto. This model originally had all 32 units in one residential building, with the staff located on-site. In recent years this model has been modified to 16 units being located in the same building (clustered housing model), and the remaining 16 units distributed throughout the city (scattered housing model).

This model is considered to be an “intensive-support” model with one support staff per eight tenants. The JTC employs three counsellor/case managers to assist clients with accessing appropriate health care, navigating the service system, and additional support in the areas of criminal justice, family law, etc. Mainstay Housing employs one housing support worker to assist clients with maintaining their tenancy. Staff hours are extended to provide support to tenants between 9am and 8pm. The counsellors also offer group sessions in the areas of relapse prevention, health and well-being, and mindfulness practice. A breakfast group is offered once a week to offer nourishment and opportunity for social interaction, and seasonal lunch celebrations are offered on a quarterly basis.

This housing program is intended to serve women with complex health care needs, including high use of emergency department and/or withdrawal management services. All tenants entering the

program identify being homeless at the point of intake, and also identify “severe and active” substance use concerns. In the four years of operation, this program has served 56 women. Ages of women in the program average 35 years old, with the youngest being 18 years old and the oldest 59 years old. Primary substances of concern are, in descending order of prevalence: crack, alcohol, cannabis, cocaine, heroin, and opioids. A high number of the women identify poly-substance use and/or high-risk behaviour associated with their use, with over 30% of women identifying a history of injection drug use. Over 30% of women also identify co-occurring mental health concerns, including anxiety, depression, and suicidality. Of the participants, 18% identify other physical health concerns, 14% identify criminal justice involvement, and 32% identify Children’s Aid Society (CAS) involvement with their children at the point of intake. The primary income sources for women in this program are Ontario Works (43%) and the Ontario Disability Support Program (39%).

Elm Housing

The YWCA Toronto Elm residential complex is a congregate housing model, with 300 units for women and their families, and is located in the downtown Toronto core. Of these 300 units, 150 are affordable units for women with low incomes, 100 are dedicated to women experiencing homelessness who also identify “severe and persistent” mental health concerns, and 50 units are dedicated to women of Aboriginal descent.

The JTC employs five counsellors/case managers to provide on-site support services to the 100 women living with mental health and concurrent substance use concerns, and two Aboriginal counsellors offering services to the 50 women of Aboriginal descent. The YWCA employs three community engagement staff for the Elm community, as well as a mental health specialist and an occupational therapist. Two housing support workers are also employed to help women maintain stable housing, and break the cycle of homelessness.

The 100 units that make up the supportive portion of this housing program are dedicated for women with significant mental health concerns, who also identify being homeless at the point of intake. The average age for JTC clients in this program is 43, with the youngest being 20 years old and the oldest 69 years old. While all of these women identify mental health concerns, 45% of women also identify co-occurring substance use, with the primary substances of choice being alcohol, crack, cannabis, and heroin.

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EVALUATION METHODOLOGY

The evaluation of these programs described in this section have been drawn from two main sources described below: 1) The Supportive Housing Performance Indicator Reporting, and 2) The Jean Tweed Centre Supportive Housing Evaluation. As these two sources are used for evaluative purposes and to monitor program quality and improvement, Research Ethics Board approval was not sought prior to data collection. This is in line with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* that states in Chapter 1, Section 2.5 that program evaluation does not fall within the scope of Research Ethics Board review, even with the presentation of the results in this Chapter, the anonymity of the information presented ensures the confidentiality of all participants (Government of Canada, 2015).

1. JTC Supportive Housing Performance Indicator Reporting

Performance Indicator Reporting is program-based data collection (used for both ASH and Elm Supportive Housing programs) with the purpose of demonstrating program successes and challenges by monitoring targeted goals. Program counsellors are responsible for collecting the data through discussion with clients (self-report) and observation, and report monthly on such indicators as Emergency Department (ED) visits, Withdrawal Management System (WMS) use, length of time housed, and a range of determinants of health such as income, housing, connection to primary care and community resources.

2. The Jean Tweed Centre Addiction Supportive Housing Evaluation

Recruitment

In 2012, all women in the ASH Program were invited to participate in either a focus group or an individual interview to explore the benefits and challenges they have experienced through their participation in the Supportive Housing Program. Recruitment was facilitated by face-to-face invitation and through the distribution of invitation/information flyers in residents' mailboxes.

Follow-up phone calls were made by the Evaluator and Counselors to ensure that each woman had the opportunity to participate in an interview or focus group if she was interested. In each recruitment method, it was stressed to participants that participation was voluntary and that their choice not to participate would not have an effect on their support services or housing.

Data Collection

All participants were interviewed on a one-on-one basis. With the aid of an interview guide, in-depth, semi-structured interviews were conducted by an internal evaluator, who was not a program counsellor. The interviewer maintained some structure within the interview while allowing for fluidity and reactivity within the interview process so that the interviewee could freely express her thoughts and feelings. In total, 12 interviews were conducted that ranged from 15 to 45 minutes in length.

Confidentiality Concerns

The evaluation team considered internal confidentiality (when individuals are identifiable to others in research reports) as a primary concern as the evaluation was conducted with a small network of women who know one another or know of one another.

To maintain confidentiality, the following strategies were used throughout the data collection process: individual interviews were offered, the names of participants were not recorded on audio-files or written recordings, consent forms were kept in a locked cabinet which was kept separate from all forms of data collection, all audio-recordings were deleted immediately following transcription, and all written documentation was kept on a password protected computer. Also, the informed consent process outlined to participants how their identity would be protected, how direct quotations and data might be used and the intent to share the findings publically. This process allowed respondents to make informed decisions about what they wished to disclose and who would eventually have access to the findings. Finally, no identifying information was included in the following report.

Analysis

Thematic analysis was used as a method of “identifying, analyzing and reporting” themes co-constructed from the qualitative data (Braun & Clarke, 2006). This involved becoming familiar with the data through transcribing the audio-recordings. Next, inductive analysis was used to code the transcripts whereby particular segments of data were considered meaningful and were given codes that represented their meaning. Relationships between codes were then examined and themes were developed that conceptualized their relationships. Themes were then refined until they were coherent and reflective of the patterns within the data.

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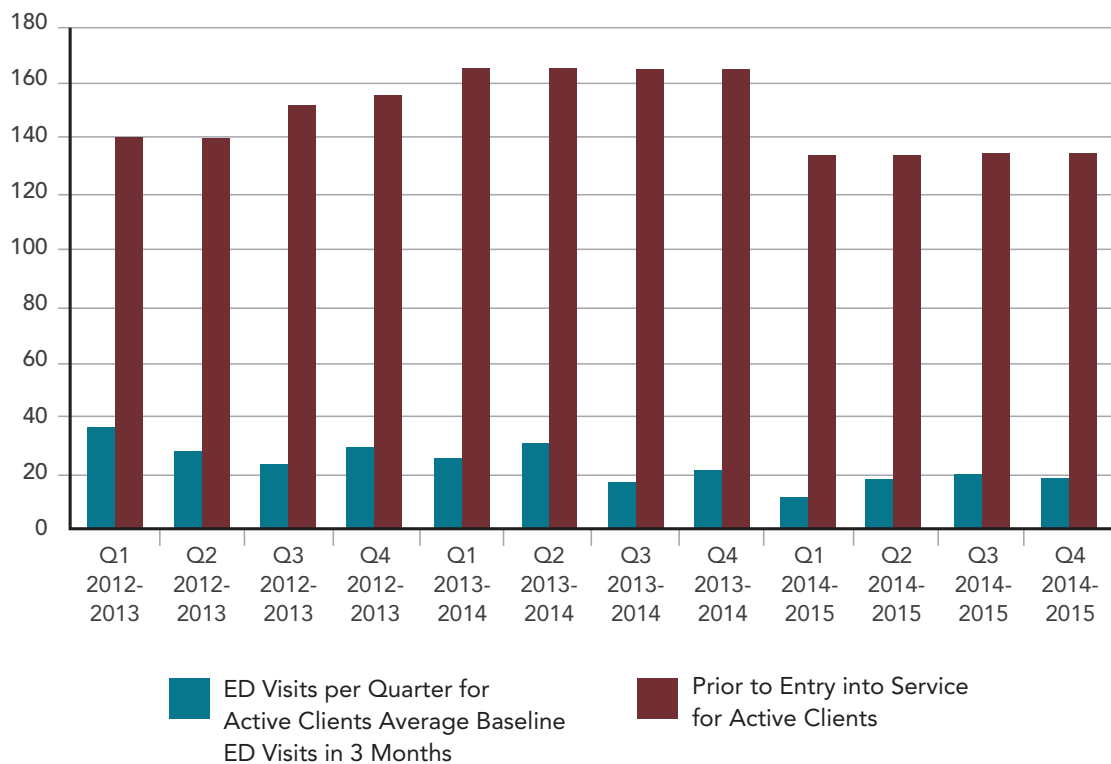
EVALUATION OUTCOMES

Impact on health system

The ASH model has shown considerable savings to the health care system through significant reduction in hospital Emergency Department (ED) visits and use of Withdrawal Management Services (WMS). Use of emergency services is extremely costly to the system with an average emergency room visit in the central Toronto area being \$219 (Dawson & Zinck, 2009). Data collected from participants in the ASH program through performance indicator reporting between July 2011 and March 2015 shows consistently an average quarterly decrease in Emergency Department use by 86% compared to ED use in the three months prior to entry into the program (see Table 1), and decrease in Withdrawal Management Services use by 98% compared to the three months prior to women entering the program. Furthermore, the focus on appropriate health care has led to the vast majority of women (100% in the ASH program, and 99% in the Elm program) now identifying a consistent primary health care provider, which is also cost effective (e.g. can decrease unnecessary visits and duplication of services if also using a walk-in clinic or ED) and improves continuity and coordination of care.

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TABLE 1 *Average Baseline Emergency Department Visits in 3 Months Prior to Entry into Service for Active Clients Compared to ED visits per Quarter for Active Clients*



Impact on women's health and well-being

Increased housing stability

Housing has been deemed to be a “fundamental condition and resource for health” by the World Health Organization’s Ottawa Charter for Health Promotion (WHO, 1986). Housing support has proven beneficial in helping women maintain their tenancy. Women have reported that the ability to enter into mediated agreements with the landlord to address behavioural concerns, and/or have payment plans to address rental arrears has meant they are able to maintain their tenancy for longer periods of time than ever before. The Performance Indicator Report, which tracks how long women remain housed, shows that the average time for women who are currently housed in the ASH program to have maintained their permanent housing is 3 years and 1 month. These findings are significant in that many women identify this being the longest amount of time they have maintained their housing in one place. In an interview conducted as part of the ASH Supportive Housing Program Evaluation in 2012, one woman shared the following:

“I love my house, it’s nice. I am definitely proud of it. Even my daughter called me and said “You’re still in the same place?” Like, there is pride. It has given me a lot of self-pride, knowing that I can do it on my own and that I chose to. I could have been one of those girls who got the boot for not paying their rent or whatever circumstance it was, I could have been one of them. And I have, at certain points for sure. So it also shows me that this is what I want, I do want a structured life, I want to be a normal person. I don’t want to have a place where it is used and abused and it had just given me that safe place where it’s a choice, it’s how do I want to live with it. I have had numerous housing where it has just been a party house, where it has been used and abused and then it’s gone. But this I’ve had for over a year because that’s what I chose. It’s wicked, it feels good”

Improved family life

With 32% of women in the ASH program and 6% of women in the Elm program involved with CAS and many women having become pregnant during their tenancy, reunification with children and apprehension prevention are important goals for many women. Addictions and Mental Health Ontario commissioned a report to help identify client outcomes for Addiction Supportive Housing across the province (Johnston, 2014). The study did not break down results for each program, but found that participants (both men and women) in this type of housing had a slightly increased chance of regaining custody of their child(ren) when participating in this program with 7% having custody of under-age children at admission while twelve percent (12%) had custody at the conclusion of the study (Johnston, 2014).

Women also report increased connection to family and some women who have previously had their children removed by the child protection system are now parenting from home. In data collected as part of the ASH Supportive Housing Program Evaluation, women shared how supportive housing was an important factor in re-establishing contact and care for their children. For one participant, having housing was essential in re-establishing contact with her children. Having the stability of safe and permanent housing was imperative for this to occur and she described her feelings now that she has care of her son,

“And it really is his time, and that’s what I am trying to remember as much as possible, it’s his time to be here with me and it is his time to really get to know me like I want him to know me. I want an everyday home life with my kids. I have that with my daughter and even though she is big now, she is...[omitted for confidentiality purposes], she is going to be coming this summer too so I am going to spend time with both my kids.”

Increased sense of safety and well-being

Women have reported increased ability to stabilize their health care needs, particularly with respect to their experiences of mental health concerns. One participant identified:

"What I have steadily noticed is that the number of my dissociative episodes I've had has severely decreased. And I do have panicked moments and I will come running down and will talk to whoever will listen and that's everybody here who's pretty supportive of me".

Other women have also expressed that their use of substances to cope has also decreased due to the stability offered by permanent housing. One participant described:

"I want to be more sober than I used to. Seeing other women in this building accomplishing things, so for some of the women actually getting their kids back, that has helped. And back in the day, I heard what was said but I wasn't listening and now I am listening and taking everything to heart. And I am taking the advice that I am receiving. Before it was like 'Yeah, okay, whatever, I just want to get out of here' but at the same time I wanted to learn but my addiction wasn't allowing me to. I believe that I have changed more than I expected, I didn't expect myself to realize the addiction and the fight and all the ups and downs that comes with it. And I have a desire to stay clean now and I didn't before and I believe that if it wasn't for here I wouldn't be feeling this way".

Women have also described their own increased sense of overall confidence and wellbeing:

"I feel a lot more confident than I used to be. And I understand my feelings a lot more and where they're coming from and I can pinpoint where they're coming from and what made me feel the way I felt. And it's amazing very, very amazing what one place, one little building would do for somebody".

"My self esteem is better now that I am not on the streets, prostitution can kill your heart and your mind and your spirit within. The street killed me, I was on the streets for a long time, and it hurt my body and my feet, so now my body is recuperating from that. The housing is helping me to get my body and my mind and my health back together".

OPPORTUNITIES FOR FURTHER DISCUSSION

Dedicated buildings versus scattered housing models

There remains on-going discussion about the benefits and disadvantages to providing supportive housing in dedicated housing versus scattered models. Women in these programs have identified the dedicated model to have increased their sense of community and safety; on the other hand, women have also identified increased stigma with respect to living in a dedicated supportive housing unit, and have also identified feeling triggered by the substance use of some of their neighbours. One model does not fit all and a women-centred approach would offer choice and provide different options depending on the needs and preferences of women entering the program. As a result of the attrition of units from the landlord, the ASH program shifted from clustered-model housing to a scattered model and when possible has offered scattered units for women who felt they would be better suited to be in a separate market-rent unit.

Staff support models

Another matter for further exploration is the offering of support on-site at the place of residence, versus an off-site support office. Whereas on-site staff support increases accessibility for tenants and provides a high level of responsiveness in times of crisis, questions remain about how best to structure staff responses in order to ensure support needs are being met, while simultaneously empowering women to develop their own coping mechanisms. While some tenants have identified they prefer the accessibility of having staff on-site, others have stated a preference to meet staff away from their place of residence in order to minimize the stigma associated with seeking support, and to maintain some distance between their own home and their counselling spaces.

Additionally, there remain questions about how best to structure support so that it is flexible and responsive to changing client needs. Typically, it has been found that

much support is required in the initial move-in phase; however, the longer people remain housed, the more stable they may become, and thus may not identify requiring the same level of support over time. For some, the cyclical nature of mental health and/or substance use leads to variable and changing support needs, and therefore some flexibility to increase and decrease support in response to presenting needs is required.

Intake and Assessment

Given the significant trauma histories, mental health concerns, substance use issues and other health care needs, women referred to the program are not always in a position to care for themselves without a high level of support beyond that of which these programs are able to provide. While both these programs offer low-threshold access for women who are experiencing homelessness, mental health and substance use concerns, an ability to live safely and independently is still required. In instances where there are concerns about a woman's ability to perform daily living tasks, it is the role of the counselors to connect women with additional resources. As part of the assessment process, it is often found that women being referred to the program are not connected to a primary health care provider, and so this is also a key part of the initial support provided to women looking for supportive housing. When women present with complex health care needs and counsellors are trying to assess her ability to live independently, inviting the Nurse Practitioner to be part of the assessment process has been beneficial. While counsellors currently make use of available screening tools to assess each woman's presenting needs upon intake, a mechanism to identify which women may be better served in more structured housing models (e.g. transitional housing and group home models with 24-hr staffing) would be beneficial.

CONCLUSION

Although there are areas that the two supportive housing models discussed above can be improved to better serve participants, it is clear that taking a gendered approach to housing has had a positive impact on women who have accessed these programs. It has offered choice where there is often very little, it has taken into consideration the intersectionality of substance use, mental health, and trauma and adjusted its model to address these issues simultaneously and with great care, and it has taken into consideration the context of women's lives (including experiences of violence, experiences of mothering and pregnancy, etc.). For many women, having a space that is safe and respectful has improved their engagement with services and their sense of security and independence in their own home.

Ideally, more supportive housing specific to women would be beneficial to those women and families who are struggling with the many issues discussed in this chapter, but at a minimum, all supportive housing should be designed with a gender lens and incorporate the trauma-informed and harm-reduction approaches that women have found helpful.

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