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Women on the Rough Edge

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

April 1999

by

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PURPOSE

This report constitutes a retrospective review of the changing patterns of women's homelessness in the Toronto area, with a focus on conditions and services for long-term homeless women, based on the observations and expertise of those who have worked closely with homeless women over the previous decade. Interview data from a small number of homeless women are included, along with a research-based profile of long-term homelessness among women in Toronto.

The report discusses distinctions in shelter and other service use patterns among homeless women (i.e., transitional, episodic, and chronic homelessness) and implications for housing and support service requirements. Women who are homeless for long periods of time face similar circumstances as other homeless women except that their personal resources are fewer, their state of physical and mental health poorer, and their individual capacity to cope is weaker. They are very likely to have severe mental health problems, and it appears that the prevalence of addictions is increasing.

EXECUTIVE SUMMARY

There have been significant changes over the past decade in the profile of women's homelessness and the service context. The proportion of women who use the emergency shelter system in Toronto increased from 24 to 37 percent from 1988 to 1996, and fewer of them are able to access subsidized housing. As more women become homeless and the existing social service and health system is less able to assist them, the most vulnerable stay homeless for longer periods. The emergency shelter system is not appropriate for long-term homeless women, but insufficient alternative housing and services are available for them. Most long-term homeless women have traumatic histories of abuse and are highly susceptible to revictimization, making personal safety and privacy primary concerns in any shelter or housing provision.

Due largely to inadequate resources, the shelter and related service systems have expanded to accommodate more homeless persons, but the level of services and staffing has diminished over the previous decade. We have relied on the observations and views of experienced service providers to explore the conditions for homeless women, especially long-term homeless women. A significant concern is the new tendency toward large-scale, mixed-sex minimal shelter provision which is considered generally unsafe for women and vulnerable persons.

Some long-term homeless women have become alienated and avoid using shelters with the result that more specialized efforts are required to reach these women, provide stable shelter for them, and re-establish their health and well-being. We describe one such innovative service, Savard's, which applies a philosophy of flexibility and reflexivity to accommodate the needs of women who are 'street survivors'. The need for supportive housing to accommodate vulnerable long-term homeless women is also discussed.

SOMMAIRE

Au cours de la dernière décennie, il y a eu des changements significatifs dans le profil des femmes sans abri et le contexte des services. La proportion des femmes qui ont eu recours au système des refuges d'urgence à Toronto a augmenté de 24 à 37p.100 entre 1988 et 1996, et le nombre de celles qui ont accès à des logements subventionnés a diminué. Tandis que davantage de femmes se retrouvent sans abri et que le service social et le système de santé actuels sont de moins en moins capables de les aider, les plus vulnérables restent sans abri pendant de plus longues périodes. Le système des refuges d'urgence n'est pas adéquat pour les femmes sans abri de longue durée, mais les logements et les services de remplacement sont insuffisants. La plupart des femmes sans abri de longue durée ont connu des histoires traumatisantes d'abus et sont très vulnérables face à la revictimisation, d'où l'importance d'assurer la sécurité personnelle et l'intimité dans toute disposition relative aux abris ou aux logements.

Étant donné l'inadéquation des ressources, les refuges et les services connexes se sont étendus pour loger davantage de sans abri, mais le niveau de service et le personnel ont diminué au cours de la dernière décennie. Nous nous sommes basés sur les observations et les points de vue des fournisseurs de service expérimentés pour explorer les conditions des femmes sans abri et particulièrement des femmes sans abri de longue durée. Une nouvelle tendance inquiétante fait surface, à savoir la création de refuges mixtes, à grande échelle, généralement considérés dangereux pour les femmes et les personnes vulnérables.

Certaines femmes sans abri de longue durée sont devenues marginales et évitent de fréquenter les refuges. Par conséquent, des efforts plus spécialisés sont requis pour rejoindre ces femmes, leur fournir un refuge stable et rétablir leur santé et leur bien-être. Nous décrivons Savard, l'un de ces services innovateurs. Il applique une philosophie de souplesse et de réflexivité pour répondre aux besoins des femmes qui ont survécu à l'enfer des rues. Nous abordons également le besoin de logements supervisés pour accueillir les femmes sans abri vulnérables à long terme.

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SECTION 1: INTRODUCTION

> *In some cities, the number of homeless is so large that hostels are turning some people away . . last year was touted as the worst since the Great Depression.*

The above excerpt appeared in a national newspaper more than fifteen years ago (Hickl-Szabo 1983) — the same message could have been repeated each year since then as the number of homeless and shelter beds have continuously increased. Canadians have become accustomed to witnessing evidence of visible homelessness, especially in urban areas. Not only the extent, but the face of homelessness has changed considerably. The proportion and absolute numbers of women, families, and youth among the visibly homeless are growing. And destitution is becoming entrenched for more of them.

Service providers in the Toronto area report evidence of change in the patterns of homelessness among women, with a higher incidence of long-term homeless women who have severe problems and multiple service needs that are very costly (e.g., heavy use of emergency hospital services). Despite extreme funding constraints, new shelter and health services have recently been initiated to address the needs of this group in innovative ways.

We will describe the current situation of long term women in Toronto and assess the similarities and differences in needs and services for this population over the previous decade. The focus of this report is to investigate the characteristics of women who do not use emergency shelters or remain in the hostel circuit for years, establish the factors that distinguish chronic homelessness, and address the ability of conventional and innovative services to effectively deal with long-term homeless women and to prevent an increase in their number.

The primary data source is the observations and assessments of 'seasoned observers', i.e., frontline and managerial workers who provide shelter-related services to homeless women. Interview data from a small number of homeless women are included, along with a research-based profile of long-term homelessness among women in Toronto.

Background Context

Over the past two decades, we have witnessed fundamental global economic restructuring that has altered employment patterns and prompted widespread changes in the welfare state including the collapse of housing supply programs. Canadian federal spending on social housing from 1984 to 1992 was reduced by $560 million, and the projected savings from the 1992 to 1998 period total a further 1.27 billion (Carter 1997). Canadian social housing policy is now argued to be less activist and progressive than that of the United States (Harris 1998).

High unemployment, and a decline in long-established manufacturing industries in favour of service-sector jobs that generally are lower paid, along with policies such as deinstitutionalization, have pushed an ever-larger portion of the population into poverty and a state of 'proto-homelessness' in the face of a crisis in housing affordability and availability. Adverse events can trigger an episode of homelessness for these people, and for some of them, a long-term period of homelessness (Dear and Wolch 1993). Culhane, Lee, and Wachter (1997) attribute the catalyst to shelter admission as a household crisis among the precariously housed, such as job loss, marital separation, benefit termination, utility disconnection, hospitalization, incarceration, and family conflict. Shelter use is also most frequent for those who have the least amount of familial,

social, or public support to buffer them when such a crisis occurs (Ibid.).

As the incidence and depth of poverty increases, there is a growing socioeconomic polarization of Canadian society that can be easily read in terms of the housing system. There is a more marked distinction between those who own and those who rent and a general residualization of the rental sector, with an increasing prevalence of low income households (Pomeroy 1998). This is evident in patterns of housing tenure and affordability, with significant changes for women-headed households. The housing situation for some women, mostly urban middle-class singles, is improving while for many others it is worsening to a crisis point. During the period 1980 to 1995, the rate of homeownership for women-headed households actually increased slightly from 37 to 40 percent, although still well below the rate for male-headed households which remains 71 percent.[1] During that same time period, the percentage of women-headed renter households in Canada with affordability problems (defined as those paying 30 percent or more of their income for rent) increased from 38 to 47 per cent. The comparable rate for male-headed households increased from 15 to 27 percent, reflecting a similarly large jump but from a much lower threshold.

As more female-led households are poor and have serious housing affordability problems, more women are in a state of 'proto-homelessness.' Wekerle (1997) has outlined how women's low incomes and cutbacks to social welfare programs affect women's housing status, including the range of restrictions faced by women living in subsidized social housing, where female-headed households are concentrated. In Ontario, funding for social service provision in abused women's shelters has been eliminated along with funding for shelter staff advocates and independent advocacy groups to challenge housing discrimination and violations of tenants' rights. At the same time, income assistance benefit rates have been severely reduced and vacancy-based decontrol of rents has been introduced, both factors affecting the jump in eviction rates.

Despite their greater vulnerability to homelessness, it is only since the mid-1980s that substantial numbers of women have become visibly homeless and their proportionate number as users of emergency shelters has increased. Acknowledgement of women's homelessness is a major indicator that distinguishes the 'new' from 'old' portrayal of homelessness (Rossi 1989).

Women's Homelessness

The housing literature has previously viewed homelessness as a male experience and problem, and women's homelessness has received little attention until fairly recently. Where gender is considered in the research, there is evidence of some gender differences, for instance, in precipitant causes. Most notably, violence against women plays a complex role as both a cause of women's homelessness and as the primary reason women avoid homelessness, especially visible homelessness. Women's strategies for dealing with homelessness differ from men's, and their homelessness is far more likely to be hidden from view, and from official counts (Novac, Brown, and Bourbonnais 1996).

Deinstitutionalization and withdrawal of services for persons with mental health problems are another significant factor in women's homelessness, especially long-term homelessness. It appears that the relationship among these main factors is dynamic, i.e., women with psychiatric disabilities who live in poverty are at very high risk of being abused and being homeless. Being abused

[1] Unpublished data from HIFE 1980 and 1995.

and being homeless also constitute traumas that exacerbate, if not cause, mental health problems. This has implications for housing homeless women. For example, in supportive and alternative housing projects for previously homeless men and women, women residents are subject to incredibly high levels of sexual harassment and abuse from male residents. In some cases, the harassers target women with mental illness (Novac, Brown, Guyton, and Quance 1996). And as women are spending longer periods of time homeless and on the street, the proportion of women shelter users who have mental health problems is rising.

There has been a dramatic increase in shelter use in the Toronto area during the 1990s by single women, women with children, and youth (Springer et al. 1998). The length of shelter stays is also increasing, placing more strain on the hostel system, and it is becoming obvious that there are women who remain in the hostel circuit, some for many years and despite opportunities for more stable housing. Although difficult to estimate, it appears that the number of long-term homeless women who resist using shelters is also growing. In general, long-term homelessness among women is a mounting problem, however, we understand little about it, what is needed to prevent the deterioration of their health, and what services are more appropriate than those generally available.

Our focus on chronically homeless women is apt not only because their situation is dire, but also because they constitute a disproportionate drain on the shelter system. Research from the U.S. has determined that "while the chronic homeless are only about 10 percent of shelter users, they consume 50 percent of the shelter system days" and that therefore, "the chronically homeless should clearly be the target of permanent housing programs" (Culhane 1997). The rate of health problems is extremely high among this group, and their lack of appropriate and stable housing contributes to their overuse of health services (Ibid.).

While primary prevention (i.e., eliminating homelessness) is clearly the fundamental and preferred objective, it is also quite costly. Secondary and tertiary methods of prevention involve targeting assistance to those at highest risk of becoming and staying homeless. Most of those who use emergency shelters do so for a short term and never return. Prolonged homelessness requires adaptations for survival and makes it increasingly difficult for people to reintegrate into mainstream society — such adaptations generally occur in as little as three weeks (Grenier 1996). Extended hostel living may result in a certain degree of institutionalization. It is important, therefore, to reach high-risk persons as quickly as possible once they become homeless.

The lack of Canadian research on homelessness promotes a reliance on use of U.S. research results, which may be inappropriate (Daly 1996). And widespread funding constraints, which necessitate the development of small local projects and low cost solutions, diminish opportunities for documentation and information exchange regarding the strengths and weaknesses of new projects, service innovations, and integration of multiple services. Innovative housing projects that are intended to address the special needs of long-term homeless women have been initiated in the Toronto area. There is virtually no documentation of how these services differ from those that are more traditional and conventional or their effectiveness with long-term homeless women.

Relevance

This research will provide an empirically-based description of long-term homeless women and their patterns of service use or avoidance over the previous decade, thereby identifying current needs and trends. It will establish what factors distinguish chronically homeless women from those who are transitionally and episodically homeless. A greater understanding of the threshold factors for long-term homelessness should facilitate service

planning and design and lessen the human and financial costs of this problem.

We will describe an innovative and successful residential project for long-term homeless women who are considered 'noncompliant' or who resist using conventional shelters. This and other examples of outreach services will be useful for service planning and provision and the development of specific projects and services that foster women's health and autonomy. Suggestions for better targeting of scarce resources should interest urban service providers and planners across Canada.

Methodology

Dedicated front-line workers and service developers are in a position to observe patterns in women's service use and follow particular women's histories, yet they rarely have the time to meet with their colleagues and analyse or document what they have learned. We believe that pooling the observations of those with many years of experience is a particularly effective method for learning about the experiences of long-term homeless women, many of whom are unlikely or unable to answer demanding questions for research purposes.

Our respondents have five to ten years experience providing and developing services for and with homeless women. They were chosen for their knowledge, analytical skills, and experience with homeless women and have been drawn from a range of service agencies in the Toronto area. The hectic and varied schedules of our respondents made it impractical to adhere to our original intention of relying primarily on a focus group format. While one group interview was conducted, and some respondents were interviewed in pairs, most of them were interviewed individually. In retrospect, this made it more likely that we would elicit a nonhomogeneous range of observations and views and added to the range of responses. In total, more than thirty service providers were interviewed. As individuals, their experience in shelter and related service for women ranged from five to 25 years.

We also conducted individual interviews with ten women who were homeless and had extensive experience of homelessness and precarious housing. These women were selected from various settings, i.e., street locations, shelters, and drop-in centres, and we made attempts to vary their characteristics in terms of age, level of service use, sexuality, racial status, and family history. We do not consider these women representative of long-term homeless women, and they specifically do not reflect the 'hard to reach' subgroup who, by definition, would be very unlikely or unable to effectively participate in a retrospective study.

A semistructured interview schedule was used. The respondents were not required to answer any questions that made them uncomfortable and were told at the start that they could terminate their involvement at any time. The homeless women were given a twenty dollar honorarium. We audio-recorded and transcribed all of the interviews where this was permitted and convenient (almost all of them), and subjected the responses to content analysis and summarization.

Interviewer selection
Our interviewers were chosen with almost as much consideration as our respondents. It was important that they understand the service providers' discourse and working conditions, as well as the context of homeless women's lives. Those who interviewed women who had been homeless for long periods had to know where and how to approach them, and to be able to quickly develop some level of trust and rapport. For these reasons, the interviewers were themselves current or past service providers.

Interviewee selection
Using interviewers who were also service providers strengthened our ability to reach long-term homeless women and to elicit their responses in a more understanding and respectful manner. It also presented some ethical concerns that shaped the selection of respondents. The interviewers did not approach women with whom they had a 'current' professional relationship; primarily this referred to women using an agency where the interviewers also worked. To some extent the caution extended to those with whom they had recently worked or expected to in the near future. For women who were heavy service users, the 'shield' could not realistically extend to distant past service relationships, especially since, to some extent, past relationships were relied on for establishing the requisite rapport and determining who had the experiential base and ability to comment on changes over the previous ten years.

Ethical concerns arose over any potential bias in women's ability to freely choose whether to participate in the study, unaffected by any sense of obligation or worry over implications for future service provision. The interviewers also wanted to avoid any future discomfort or regret over women's personal disclosures made to a worker in a position of greater power on whom they rely.

Organization of Report

There has been a spate of research reports on various aspects of homelessness in Toronto produced over the past couple of years. Those that shed light on the situation of long-term homelessness among women, along with relevant data from some local agencies, have been consolidated in the literature review. This is followed by an assessment of changing needs and services over the previous ten years for long-term homeless women based on the responses of service providers. The next section summarizes the input of women who have experienced long-term homelessness. The suggestions made by both service providers and service users are reviewed in the final section, along with some elaboration of the need for a range of supportive housing projects for long-term homeless women. A list of the service providers who were interviewed is appended to this report, along with the interview guidelines used for data collection from service providers and service users.

SECTION 2: LITERATURE REVIEW

Definitions of homelessness vary, usually according to political or logical considerations. Following the reasoning of Hopper (1997), we find it most useful to understand homelessness as a cultural term that reflects a condition of extreme poverty.

> [I]t makes both practical and historical sense to view the streets and shelters as but one variant of a class of informal or makeshift residential settings that increasingly characterizes the marginally situated (Ibid.: 9).

While the language and terms for destitute people have changed over time, the predominant image of a male experience has prevailed. Despite a "voluminous" literature on the history of homelessness, dating back to the late feudal period in Europe, there is very little available on the history of homeless women (Hopper 1997). And while the recent increase in homelessness among North American women over the past two decades has prompted some acknowledgement and investigation of women's experiences (see Novac, Brown, and Bourbonnais 1996), it is not extensive. More to the point, very little of it differentiates and addresses long-term homelessness specifically, and even less deals with appropriate services for this group.

Shelter Users and Gender Bias

The most common definition of homelessness, both for research purposes and in popular media discourse, has been pared down to those who are visibly without shelter, and those who use public emergency shelters. The latter group is spatially concentrated, subject to a degree of administrative control, and generally viewed as a problematic drain on municipal and other governmental resources. For these reasons, shelter users are most frequently the focus of research on homelessness. And so they have come to constitute our predominant understanding of what constitutes homelessness and therefore who is homeless.

The bias inherent in a focus on shelter users has gender implications. Despite the fact that women are more likely than men to live in extreme poverty and be unable to afford housing, they have not been as prevalent as men among shelter users. This gender pattern has been shifting recently — the proportion of female shelter users is increasing, and in New York City for instance, the largest group of users is female-headed families. It is still the case, however, that more single males than single females use shelters. What has not been investigated is the extent to which women's homelessness is hidden. In places where emergency housing is not even available, involuntary doubling up is the primary form of homelessness, as is the case in northern and small communities (Novac, Brown, and Bourbonnais 1996). To a large degree, women rely on their sexual and domestic roles to escape being without a roof over their heads.

The reasons for avoiding shelter use are not difficult to understand. Shelter environments have the characteristics of asylums or institutions (Golden 1992). They reflect a spatial regimen of austere need-fulfilment.

> [S]leeping arrangements are dormitory like with little or no privacy. Few visitors are permitted, and when they are, there is no place to entertain them, be they a relative, friend, or lover. This suggests that homeless people do not need privacy, self-expression, friendships, and sexual relations, or at least that these needs should not be taken seriously (Weisman 1992: 78).

There are generally attempts to provide women with dependent children more space and privacy, although rarely adequate to maintain their parenting role when their autonomy as adults is so constricted.

Women use various strategies to avoid using shelters. They may commit minor criminal acts that result in incarceration or they invent or exaggerate a medical problem to enter a hospital (Charlebois et al.1995). But the primary strategy is to attach themselves to men, even on a temporary or transient basis. Two studies of homeless adults, one conducted in Halifax and another in Vancouver, quoted women who commented on this commonplace strategy.

> *I bounced in and out of different places I only had a decent place to live that felt secure and safe when I moved in with a man, and that's probably why I've done it all my life. Because the system's set up that way, that women have to have that to feel safe and secure.* A woman quoted in Charlebois et al. (1995: 17).

> *You know there was once a time when I was homeless and I had to have sex with a man I just wanted a clean bed with sheets on it. I was homeless. I had no choice.*
> A woman quoted in Baxter (1991: 32).

Even within homeless or squatters' communities, women are more likely than men to enter into a lover/spouse relationship, in large measure to satisfy their immediate need for protection, although some of these relationships are themselves abusive or exploitive (Rowe and Wolch 1990).

The dilemma for women is that their dependence on men, for shelter or for protection from other men, does not necessarily make them less susceptible to violence or abuse and exploitation. The women's shelter movement was initiated to allow women to escape the homelessness caused by violence against them in their 'homes.' For women, homelessness is not resolved by simply having a roof unless their personal safety and some degree of autonomy is also assured. The dependency created by patriarchal relations within households as well as within state-controlled shelters are both indicative of homelessness for women.

> Homefulness must come to mean control, autonomy, self-reliance. In most cases it is not possible to achieve these ends if women return out of desperation to destructive relationships, or if they become recidivists to the hostel circuit (Harman 1989: 107).

Having found that homeless women frequently moved to avoid abuse, Tomas and Dittmar (1995) have suggested that for women, homelessness is the solution when (unsafe) housing is the problem. Homeless women have housing histories marked by a dependence on others to provide housing, coupled with residential instability arising from both abusive and disruptive episodes that began in childhood and continued into the present.

Families, Violence, and Homelessness

Men and women tend to stand in different positions in relation to their families. According to Wright and Rubin (1991, 1997) homeless men would like to return to their families, but know they would not be welcome, whereas homeless women have no wish to return in the first place. Estranged women are either family rejects who have exhausted the patience or resources of their kin networks or they are family leavers who have fled a domestic situation so troubling or so abusive that life on the streets is the preferred alternative.

Violence against women affects a very large number of women and is a significant factor in women's homelessness. For example, according to a national study, half of all women in Canada have been physically or sexually assaulted as adults, usually by male partners (Statistics Canada 1994). Over a quarter of those who live with violent male partners use medication, alcohol or drugs to help them cope. They are more likely to leave their abusive partners when they fear for their lives and when their children witness the abuse.

A number of studies have found exceptionally high rates of childhood abuse among homeless women. For example, Fischer (1992) found that, compared to homeless men, women are more than three times as likely to have been sexually abused as children and adolescents. Various researchers have also found that among homeless adults, women were much more likely to have been physically and sexually abused. Ritchy, La Gory, and Mullis (1991) found that 71 percent of women had been physically abused versus 28 percent of men, and 46 percent of women had been sexually abused versus 3 percent of men (Ritchy, La Gory, and Mullis 1991). Wright and Weber (1987) determined that homeless women are 20 twenty times more likely to be sexually assaulted than the general population of women in the United States.

While several studies have found higher rates of abuse among homeless than nonhomeless women, a couple have found no significant difference (e.g., Goodman 1991). In a recent comparison of homeless and housed women, Browne and Bassuk (1997) concluded that violence is a normative occurrence for women who live in poverty. Their study of 436 homeless and poor, housed single mothers in Worcester, Massachusetts revealed high levels of assault and injury experienced by both groups — only 17 percent of the combined groups had not experienced severe physical violence or sexual assault. Homeless women were more likely to have been victims of violence by intimates, but the rate of abuse was very high for all of the women. Nearly two-thirds of them reported physical violence by childhood caretakers. Forty-two percent reported childhood sexual molestation. And 61 percent reported severe violence by a male partner. There was an almost complete absence of any form of intervention to interrupt their life patterns of abuse.

Homeless women with mental illness are even more likely to have experienced abuse. Goodman, Dutton, and Harris (1995) found that the lifetime risk for violent victimization among episodically homeless women with serious mental illness is so high that rape and physical assault are normative experiences. Only three of their 99 respondents reported no experience of physical or sexual abuse in either childhood or adulthood, and for most of the 96, the abuse was severe. The risk for recurrent abuse was also extraordinarily high. A third of the women reported physical or sexual assault during an episode of homelessness.

Davies-Netzley et al. (1996) investigated the rates of childhood abuse among homeless women with severe mental illness and found that more than 75 percent of them had been exposed to either physical or sexual abuse between ages of six and 18. Women with histories of childhood abuse were much more likely to become homeless during childhood, and those who had been both physically and sexually abused during childhood were more than 15 times more likely than nonabused women to experience homelessness prior to the age of 18. The presence of childhood abuse and a lack of outside social and financial support is a combination that can put young women at extreme risk for homelessness as well as being precursors to mental health problems.

The impact of childhood sexual abuse is particularly powerful. Without appropriate counselling, there is a tendency toward revictimization among women who have been sexually abused in childhood (Wyatt et al. 1993). This has particular implications for women who

have few or no options to avoid dependence on men or close relations with them. And it is one of the reasons why sufficient sex-segregated housing options, especially at the level of emergency housing, must be available.

Women's Long-Term Homelessness: Toronto Profile

A 1977 report compiled by the City of Toronto Planning Board described the skid row community as almost exclusively male. Some writers have romanticized these men as part of a nonconformist male fraternity who reject regular work, family life, and private property — in short, a domestic life. On the other hand, women are closely associated with domesticity, and homelessness among women has tended to be ignored as an aberration. Women's shelters began to be developed across Canada in the early 1970s, many of them inspired by feminist philosophy, i.e., a political critique of male violence against women and an egalitarian spirit that fostered the feeling that those women working in the shelters shared a common cause with those women who were sheltered. There remains a noticeable thread of resentment over the fact that women's shelters are less austere then men's, and a belief that more sympathy exists for women than men who are homeless.

More recently, feminist goals and strategies of empowerment for homeless women are being lauded as better models for shelters by providing more than emergency housing — by enabling users to improve their access to housing and employment opportunities (Ward 1998). A major distinction between women's and men's shelter models and philosophy is the acknowledgement and significance given to women's experiences of violence and abuse and the relationship between violence and homelessness.

Childhood Abuse, Homelessness, and Street Youth

A few Canadian studies have found high rates of childhood abuse, neglect, and family disruption in the life histories of homeless adults and youth. The Mental Health Policy Research Group (1998) found that 49 percent of single female hostel users (vs 16 percent of males) had experienced childhood sexual abuse, and 58 percent of females (vs 38 percent of males) had experienced physical abuse during childhood. Most of the studies have not distinguished abuse that occurred during childhood and tend to combine various forms of abusive experiences. Breton and Bunston (1992) found that three-quarters of their sample of single homeless women (average age 25 years) living in Toronto shelters had been physically or sexually abused, usually by a male family member and commonly within the home, prior to becoming homeless. Over two-thirds of the users of a women's drop-in centre revealed experiences of sexual abuse and violence, although not necessarily during childhood (Laskin and Guberman 1991).

A study of Toronto street youth, who on average left home at the age of thirteen, revealed a similar pattern of familial violence and abuse (Hagan and McCarthy 1990). The families of street youth are more likely to have experienced unemployment and to have been disrupted (e.g., one biological parent, reconstituted families, youth living in foster or group homes). They are also more likely to have been violent — some form of force was used by a member of their families in 87 percent of cases, and for 60 percent of the youth, parental violence was sufficient to cause bruising or bleeding.

A third of street youth in Toronto are female. Although Hagan and McCarthy (1998) did not specifically investigate experiences of sexual abuse, 14 percent of the female respondents (and 6 percent of the males) disclosed this as a reason for leaving home.

Once the assistance of other family members and friends comes to an end, street youth adopt a nomadic roaming pattern that includes use of shelters and "squats" or abandoned buildings as places to escape inclement weather. Many youth respond to street violence by carrying weapons or staying in groups for protection. Sexual assault of females is frequent, and sex is commonly used in barter, for shelter, drugs, and even just the appearance of friendliness. Like adults, street youth tend to minimize relationships with other homeless persons or form short-term relationships, but their life on the street is often intensely social and they are more inclined to enter into group relationships.

Female street youth are more likely than older women to be members of street families, largely because of their concerns about safety. These concerns are warranted. According to a survey of 106 homeless women, appallingly high incidences of assault and suicidal ideation and attempts were reported within a one year period (Ambrosio et al. 1992). Many (46 percent) of them had been assaulted; 21 percent had been raped; almost two-thirds had contemplated suicide; and 30 percent had attempted suicide.

Shelter and Outreach Data

Various shelter and related agencies collect data on the people who use their services, but the information is rarely well-disseminated. We present here summary data collected by two women's shelters and a women's shelter outreach program.

Shelter A

One women's residence, whose policy is "to keep the least functioning, most ill, and most addicted," collected the following admission data on a total of 644 users during 1997. More than half of their service users were long-term.

- two-thirds of them were between the ages of 26 and 45; eight percent were younger, and 26 per cent were older
- over half of the women received income assistance (welfare); about a third of them had no income other than the 'personal needs allowance' given by the shelter
- half were mentally ill, but only 13 percent were taking psychiatric medication
- over a quarter (29 percent) had problems with substance abuse
- about a sixth (16 percent) exhibited violent behaviour at the shelter
- a quarter of the women had some kind of community or family support

A subsequent survey of 50 users showed that a high proportion of the women were circulating among various forms of institutions, hospitals, corrections facilities, and shelters:

- 42 percent had been in prison or detention at some point, almost half of them within the previous six months; a third were still on probation
- of those who had been incarcerated at some point, over half had also been hospitalized due to a mental health condition within the previous five years

Shelter B

Another women's shelter conducted a review of more than 300 admission forms during 1994 to reveal that a high proportion of their service users were immigrants (45 percent), with 24 percent coming from African or Caribbean countries, 10 percent from European countries, 4 percent from Central and South American countries, 3 percent from Asian countries, and 1 percent from the United States (3 percent unknown).

More than a third of the women had previously stayed at the shelter, and two-thirds had stayed at other shelters. At least half of their users were long-term. Their reasons for staying at the shelter included leaving a partner, parents, or friends, being evicted, being transient, or coming from another shelter.

The lifetime prevalence of physical abuse was 69 percent, and the lifetime prevalence of sexual abuse was 53 percent. Within the previous year, the respondents reported the following experiences:

- 31 percent had contact with psychiatric system
- 9 percent had been on probation, and 6 percent had been in prison
- 13 percent acknowledged abusing alcohol or drugs

Hostel Outreach

This profile is based on data gathered in 1997 on 99 clients of a women's hostel outreach program. Most of their service users have been homeless for over a year, and virtually all of them had a psychiatric disorder.

- 34 percent were racial minority (including 23 percent who are black); 37 percent were immigrants
- 57 percent were single, never married; and 39 percent were divorced, separated, or widowed
- 48 percent had completed high school or post-secondary education; 16 percent had never started high school
- most received income assistance (two women were employed part-time); nine had no income
- their ages ranged from 16 to over 65 years, but 79 percent of them are between 25 and 54 years
- 71 percent of the women had been diagnosed with schizophrenia; the rest had other psychiatric disorders
- 58 percent had been admitted as psychiatric patients at least once
- 19 percent had addictions

Summary of Shelter Agency Data

Although this agency data is not assumed to be representative of long-term homeless women, it covers a range of sources as one agency accepts women with the most serious problems, another serves a general population of homeless women and families, and the outreach program primarily serves women who avoid shelters and sleep rough.

The combined information from these three agencies suggests that a disproportionate number of women are African-Canadian; a high proportion of them have severe mental illness, perhaps half overall (although some are not receiving any psychiatric treatment); 13 to 29 percent of them have addictions; and 9 to 42 percent have had involvement with the criminal justice system.

Those women with severe mental illness or addictions have had great difficulty maintaining any housing they manage to get. This is primarily due to their own difficult and inappropriate behaviours, which are often violent or threatening. Or it is due to rent arrears caused by inadequate incomes and poor financial management (CRCT 1998).

Health Outreach Data

Homeless people face a significantly higher risk of premature death (Plumb 1997), and higher rates of infectious disease (including tuberculosis and HIV), gastrointestinal problems, untreated dental problems, and are prone to higher rates of injury and violence, higher risks of suicide, mental health problems, and substance abuse problems than the general population (Kushner 1998).

A survey conducted by an outreach health service (Ambrosio et al. 1992) and based on interviews with 106 homeless women and 352 men found that the incidence of emphysema, chronic bronchitis, arthritis, rheumatism, high blood pressure; asthma, epilepsy, and diabetes was significantly higher than in the general population. Yet, homeless people are less likely to maintain a relationship with a physician. They use emergency hospital services instead, which are poorly structured for ongoing

treatment. Some homeless people become alienated from the medical system for a variety of reasons, including stigma. Up to 40 percent of the survey respondents felt that medical staff discriminated against them, and more than a third of them had been discharged from hospital to a hostel or the street.

Another study based on a review of medical records (from 1994 to 1996) for homeless and socially isolated women who visited either of two drop-in centres in downtown Toronto revealed a very high rate of crack cocaine use, a relatively high rate of alcohol abuse, and a very high rate of Hepatitis C (Heyding and Pritchard 1997). Of the total number of drop-in users (444) whose files were studied, some were designated transiently homeless (TH), meaning that they did not have a fixed address for more than a month or two at a time, used shelters, or slept rough.

The records showed that during the two-year period:

- more of the TH women (27 compared to 17 percent of the whole group) used crack cocaine;
- 7 percent of the TH women abused alcohol;
- 14 of 16 TH women who were tested had Hepatitis C antibodies;
- 2 of the TH women died (one due to cardiomyopathy from cocaine; the other died by accident while intoxicated)
- 18 percent of the TH women were incarcerated;
- 7 percent of the TH women were pregnant (2 had abortions, 7 had their child apprehended by Children's Aid, 1 kept her child, outcome of 3 pregnancies unknown);
- 3 percent of TH women were certified as dangerous to themselves and hospitalized against their will (this means they were assessed for up to 72 hours in a hospital).

Common health problems included infectious diseases, especially tuberculosis; mental illness; chemical addiction; poor nutrition; poor hygiene; frostbite; leg ulcers; upper respiratory infections; and trauma (from mugging, beating, and rape).

Barriers to Health Care and Solutions[2]

There is a range of barriers and issues that impede the effective delivery of health care to homeless women (Heyding and Pritchard 1997). Many women are reluctant to be seen by a physician. For those who are willing, follow-up is very difficult with women who cannot be located, and continuity of care and success of treatment is difficult to assure. Many recommended preventive health measures are difficult to provide to homeless women (e.g., pap tests, mammograms, cholesterol screening, eye exams, dental care, blood pressure monitoring, and immunization) due to their transience. And regular dosage regimens are difficult for homeless women to follow (medication cannot be taken at prescribed times, or it may be lost or stolen). Accidental or an intentional overdose is a risk. Compliance with a daily medication like the birth control pill is similarly difficult, and unplanned pregnancies are common.

Access to health services is impaired due to institutional barriers and policy changes. For example, drug benefit cards are issued monthly to destitute people in Ontario, however, homeless people may be unable to obtain one, or may lose it, or it may be stolen. In an effort to prevent fraud, medical insurance cards are cancelled without warning if the Ministry of Health cannot locate the holders. Replacement costs for lost or stolen cards and identification are a barrier. The demand for card replacement assistance, as reported by Street Health, a medical service for homeless people, doubled from 1995 to 1997 (Kushner 1998). Besides not having valid insurance coverage,

[2] This section is based on Heyding and Pritchard (1998).

homeless women who are referred to a specialist may be too frightened to go to a hospital clinic, may forget about the appointment, or not have transit fare on the day of the appointment.

Mental illness prevents acknowledgment of other health problems, exacerbates coexisting medical problems, and interferes with the ability of women to care for their children. The new legislation, which is intended to make it easier for medical professionals to assist treatment-resistant, mentally ill people who are considered dangerous (Consent to Treatment Act), appears to be confusing and of questionable effectiveness.

Crack cocaine users are chronically malnourished; and intravenous drug users have a high risk of contracting Hepatitis C. Drug abuse and prostitution coexist, and sexually transmitted diseases such as gonorrhea, syphilis, and HIV are common. Drug use, prostitution, and violent behaviour combine in a pattern of behaviour for some homeless women. Continuity of medical treatment is affected by their involvement in the criminal system because there is little coordination between detention centres and the community health care system. Women's competence to care for their children is negatively affected by being homeless and more so by drug abuse. Most full term pregnancies result in the child being placed with a relative or taken into foster care. Some homeless women are very heavy users of the medical system, seeing multiple physicians and using emergency hospital services, in some cases to obtain narcotics or mood altering medications.

In order to improve health service delivery to homeless and transient women (and men), a range of adaptations in services has evolved. Medical teams go to various locations where they will reach this population (drop-in centres and shelters). They develop relationships with the staff as well as the patients, and in some cases rely on carefully informed staff members as communication intermediaries for women who refuse to consult physicians directly. Staff also keeps and distributes medications for some women, and they sometimes transport and accompany women to appointments with a specialist.

Both of the drop-in centres where Haying and Pritchard conducted their study have developed intensive drug and alcohol treatment programs and also work closely with women's detoxification centres. As much as possible, medical investigations are performed on-site to improve the likelihood of adequate follow-up. This is not possible, however, with certain tests, for example, HIV and tuberculosis. A notebook computer is used on visits to record diagnosis and treatment and facilitate continuity of care when a woman is seen again (for example, six months after a woman has been treated for syphilis, the notes remind the physician to take a follow-up blood sample to assure success of treatment).

Homeless Persons with Mental Illness and Addictions

Since there is a high prevalence of severe mental illness and addictions among long-term homeless women, appropriate health services play a critical role in assuring their well-being and stabilizing their lives. Preliminary findings of 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 to effective service use. 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.[3]

[3] Conversation with Calvin Kangara, Research Co-ordinator, Parkdale Community Health Centre.

Another review of health services for homeless people in Toronto identified several problems in the provision of services for those with mental health and addiction problems (Geyer Szadkowski Consulting 1998). Some of these problems are:

- *barriers to receiving services from addictions and mental health programs*

Extensive exclusionary criteria for various mental health programs (e.g., contact with criminal justice system, development disability, fire hazard, physically disability, self-abusive behaviour, inappropriate sexual behaviour, substance abuse, suicidal, violent behaviour) limit which services are available for multi-problem individuals and contribute to their further alienation.

- *lack of overall integration of service delivery*

There is not yet a coordinated service delivery system in the addictions and mental health fields, along with a lack of accountability regarding who is responsible for service delivery to the homeless population. The system is fragmented, with no single contact point for entry or referral within the system, and investments in community resources do not seem to be well-coordinated or anchored to the needs of the homeless population. Subsequently, homeless persons are quite likely to find the system confusing and not know who to contact for what assistance. Chronically homeless persons are required to endure repeated admission assessments for each organization's program, which is frustrating and constitutes a barrier to service.

- *problems with discharging patients to the community with no fixed address*

Provision of support services during and immediately following hospitalization or incarceration is critical for the prevention of homelessness, however, institutional downsizing and staff reductions that have led to fewer resources for discharge planning. A survey of hostel users found that 6 percent of them had received treatment in a psychiatric facility during the previous year (Mental Health Research Group 1998).

- *difficulty for this population to acquire and maintain proof of medical insurance coverage*

Acquiring and retaining identification and health insurance cards is difficult for homeless persons due to transience and susceptibility to crime. Up to 40 percent of them do not have health insurance cards, a serious barrier to overall health care provision.

- *problems with location of service delivery*

On-site service provision for users of shelters and drop-in centres is a primary requirement for homeless persons, one that is beginning to be addressed, but requires more development.

Hostel Use

An analysis of nine-years of administrative data on hostel use in Toronto[4] provides important information on patterns of homelessness in a major Canadian city (Springer et al. 1998). During the period 1988 to 1996, a total of 170,000 different individuals or 133,000 households stayed for at least one night in the Toronto hostel system (which consists of 3,874 beds at 68 locations). Most hostel users enter and exit the system quickly and do not reappear. More than 75 percent of all users are in and out of the system within four months, and 84 percent of them are out of the system in less than a year and do not return. About 17 percent are long-term users[5] who stay for one year or more (not

[4] The hostel database is a multi-variable data set collected by the Toronto Hostel Services Division covering all publicly subsidized hostels and shelters for the period 1988 to 1996. The unit of observation is the person or family group admitted and discharged. Individual heads of households can be identified by initials, date of birth, and gender.

[5] While many researchers, including Springer et al. (1998), and professionals use the term chronic to refer to those in the shelter system for a lengthy period of time (a year or more is acceptable as a general

necessarily consecutively, but in total). Nine percent have been in the system for one to three years, 5 percent for three to six years, and 3 percent for more than six years.

Only 6 percent of those from abroad are long-term users; they tend to need four days to two months to resolve their situation. For those who reported parental abuse as the reason for being homeless, the stay was usually one month to two years. Abused women and their children, if any, along with families, used the system for less that six months on average, and had uninterrupted stays. The proportion of families has increased quickly, and 10 percent of them are now long-term users.

Most women in the shelter system are transitional users, as are families, who stay on average for a couple of months. Men tend to either use a shelter for a very short time (stays of one night are quite common) or are long-term users. While those aged 18 to 44 are over-represented among the general population of shelter users, long-term users are more likely to be older — most are over the age of 35 years. Female long-term shelter users are very likely to have a mental illness.

In 1996 alone, more than 26,000 individuals used Toronto hostels, and 4,300 of them were considered long-term users. While constituting only 17 percent of shelter users, long-term users accounted for 46 percent of the bed nights. For this group, the hostel system functions as quasi-supportive housing (Emanuel and Suttor 1998). These people are caught in a revolving door. They need more than emergency shelter, and they are clogging the shelter system. More than 40 percent of them leave one shelter only to enter another. The longer they stay, the more they adapt to street life, and the more difficult it becomes to escape that life. Thus, the longer an individual uses hostels the greater the chance that they will continue to need the system (Springer et al. 1998).

As the function of other large institutions — psychiatric hospitals and jails — is contracting, people who were formerly, and those who previously would have been, housed in them are entering emergency hostels in large numbers (Ward 1998). And they are highly likely to be among the long-term homeless — hospital discharges have a 28 percent probability of spending a year or more in hostels, and those from corrections facilities have a 30 percent chance (Springer et al. 1998).

Several changes have occurred from 1988 to 1996. The proportion of women increased from 24 to 37 percent. The average age of users dropped. The number of people claiming their reason for using a shelter to be either spousal abuse, parental abuse, or family breakdown almost doubled, from 14 to 26 percent. And there are more families (increased from 9 to 18 percent), more single families (from 7 to 10 percent), and larger families (2.97 to 3.27 children).

There has been a dramatic drop in the ability of hostel users to find subsidized housing and an increased reliance on the private rental sector. In 1988, 22 percent of homeless households found subsidized housing, but by 1996, that figure had dropped to 8 percent. Even among persons listing spousal abuse as the reason for service, the number who obtained subsidized housing dropped by more than half, from 32 to 14 percent. And the number who obtained market units increased from three to 10 percent of cases.

The shelter system does not collect ethno-racial data. However, a recent study found that compared to the general population, Aboriginal (5%) and black people (15%) are over represented among the homeless population in Toronto (Mental Health Policy Research Group 1998). There is a

guide), we have chosen in this report to use the more generic term 'long-term' so that we can discuss an elaborated typology that distinguishes the categories of episodic and chronic homelessness as defined by Kuhn and Culhane (1998).

widespread lack of racial analysis in the Canadian housing literature, however, there are indications that racial minority and immigrant women comprise a disproportionate share of homeless women and shelter users (Novac, Brown, and Bourbonnais 1996).

According to the Royal Commission on Aboriginal Peoples report, the majority of Aboriginal migrants to urban areas are women, in large part to escape from physical and sexual abuse in their home and communities. Aboriginal persons are over-represented among the homeless in Toronto, with estimates ranging from five to 15 percent. They are more likely to use Aboriginal-managed shelters, yet federal and provincial governments have off-loaded funding support for existing Aboriginal housing program and projects, including a women's shelter and a transitional housing project (Obonsawin-Irwin Consulting 1998).

Service Use-Based Typology

Most of the research on homeless people, especially during the 1980s, has been based on cross-sectional samples, i.e., people who are using shelters or related services at one point in time to present a 'snapshot' of the population. This imposes a bias toward the inclusion of shelter users with longer stays. Those who are in the shelter system for only a few days, for instance, are less likely to be included. Such studies, therefore, are somewhat more likely to represent people with longer shelter stays, but they do not generally distinguish them.

Various researchers have developed typologies of homeless people. Those who have relied on personal characteristics of homeless people (e.g., in terms of mental health, substance abuse, social networks, employment, homeless history, and level of functioning) have elucidated the experiences of some subgroups, however, these models have also had limitations. Previous reliance on cross-sectional research methods can now be augmented by longitudinal studies on enumeration and composition. Sophisticated research techniques have been applied to elaborate a typology differentiated by the characteristics of shelter usage. Recent analysis of multi-year administrative data from major urban shelter systems appears to confirm the validity and utility of a model that profiles homelessness into chronic, episodic, and transitional patterns (Kuhn and Culhane 1998).

A primary benefit of such a typology is in program planning. Analyses of seven and nine years of shelter data for single adults in Philadelphia and New York have determined that the transitionally homeless (four-fifths of users) consume about a third of all shelter days; while episodically homeless persons (one-tenth of users) consume about 18 percent of shelter days; and chronically homeless persons (one-tenth of users) consume half of the shelter system days. It has been argued that appropriate programming would target the transitionally homeless with preventive and resettlement assistance; the episodically homeless with transitional housing and residential treatment; and the chronically homeless with supported housing and long-term care programs (Ibid., Culhane 1997).

Categories of users have been further described by Culhane (1997) and Kuhn and Culhane (1998). The chronically homeless group is a relatively older population with many special needs. Over half of them report significant health problems (physical and psychiatric illnesses as well as substance abuse), and they tend to over-utilize health services. Episodically homeless people are younger on average than chronically homeless people, but they have equally high rates of health problems. They are most likely to be 'street people' who experience trans-institutionalization, i.e., they enter various institutions (jails, hospitals, detoxification centres) between shelter stays. This group is considered less stable than the chronically homeless and is more likely to be 'difficult to

serve.' Transitionally homeless people are generally younger, and less likely to have mental health, substance abuse, or medical problems.

There are always some reservations about the quality and accuracy of any self-report data, which is commonly the source for data on previous use of services (Culhane and Metraux 1997). Kuhn and Culhane (1998) avoided this problem by matching the Philadelphia shelter system data with treatment records from other service databases to create a nine-year cross-service use profile. They found that there was no difference in the treatment level for severe mental illness between episodic and chronic shelter users, but there was a significantly higher level of substance abuse treatment history for episodic shelter users. It is important to note that this finding only applies to single adults, to systems or cities without limits on shelter stays, and does not track nor account for episodes of sleeping rough.

Substance abusing homeless persons are typified by stays in shelters that are frequently interrupted by stays in jail, detoxification centres, and hospitals. They also are more likely to be involuntarily discharged from shelters for violations of shelter rules, including 'clean and sober' policies. Based on these profiles, Kuhn and Culhane (1998) concluded that chronically homeless persons require alternative long-term housing options, such as supported housing, single room occupancy hotels, subsidized rental housing, and board-and-care or nursing homes. Episodically homeless persons have more complicated needs that require more structured housing opportunities with health and social support services, such as transitional housing and residential treatment programs. Kuhn and Culhane (1998) have suggested that the cost of these housing options will be offset by savings from other system costs, e.g., hospitals, jails, and street homelessness.

While research on long-term homelessness continues to develop profiles of the needs of various subgroups, there is a sufficient base of knowledge to design interventions that allow for strategic targeting of services and programs. It is counterproductive to wait while people struggle with homelessness for long periods of time and develop more severe health problems before effective assistance is offered. Lindblom (1997) has developed a list of characteristics that correlate with increased risk of homelessness and suggests that it be used prior to release from institutions to determine who is eligible for targeted assistance including supportive housing. A checklist based on these characteristics could also be used by shelter staff as a 'triage formula' to distinguish those persons who are most likely to stay homeless if not offered assistance.

i. few assets or resources and poor income potential (i.e., poor education or weak work history), indicating the likelihood of continued extreme poverty;
ii. history of prior homelessness;
iii. weak support network (i.e., few nonhomeless friends or close relatives);
iv. mental illness (e.g., history of psychiatric hospitalization);
v. alcohol or other drug problems;
vi. serious physical health problems;
vii. time served in prison or jail; and
viii. history of foster care or out-of-home childhood.

He suggests that extreme poverty along with at least one of the other criteria could be used to determine priorities for targeted assistance. This assumes that sufficient supportive housing is available, a matter that will be addressed later in this report.

Case Study of Low Demand Respite Residence

Chronically homeless persons are the heaviest users of the emergency hostel system and least well-served by it. There is evidence that a low-demand congregate housing model, combined with

aggressive outreach, has demonstrated positive outcomes for chronically homeless women who are considered 'noncompliant' and 'treatment-resistant' (Culhane 1992). These principles have been incorporated in a Toronto project (Savard's) which opened two years ago, and is now being proposed as a model for a new facility for chronically homeless men.

The model for Savard's was adopted from the Women of Hope program in Philadelphia which was initiated to serve 'noncompliant, treatment-resistant' homeless women with mental illnesses who have a history of living on the street. This model has been labelled a low demand respite (LDR) residence. It has an open door policy, few rules, and no treatment requirements. Lengths of stays are open-ended. Women of Hope was successful in bringing 120 women off the street from its formation in 1985 up to 1991. Many of the former residents (42 per cent) live in independent housing, and a substantial number live in moderately and highly structured housing (13 and 18 per cent respectively). The remainder has returned to the street (14 per cent), have died (10 per cent), or there whereabouts are unknown (3 per cent). The residents have generally shown a preference for normalized, independent living with some support services.

Savard's

A group of women service providers in Toronto began meeting in the early 1990s to discuss the particular problems they observed for long-term homeless women who were not being accommodated by the emergency shelter system due to their aberrant behaviour. They planned a new type of shelter service that would adapt to the preferences of women who avoided using shelters or were barred from them. Most hostels maintain barred and caution-alert lists. It has been estimated that two-thirds of both lists comprise those with psychiatric histories (Gerstein 1986).

The main problem appeared to be that shelters were too demanding, constraining, and frightening for some women, especially those whose behaviour was disruptive. Despite being highly vulnerable, these women were staying out on the street. The Women's Street Survivor Group, as they came to call themselves, evolved their thinking and planning over a period of several years, during which time some of them toured the Women of Hope project. The low-demand model that a group of nuns had originated for chronically homeless mentally ill women was greatly altered by the early 1990s, with the introduction of mandatory treatment, medication, and programming.

True to its original vision of being spatially and programmatically 'open and flexible' to women's needs, the Toronto project, now called Savard's[6] opened in January 1997, prepared to function as a shelter, residence, or drop-in centre for women. Several partitioned clusters of three-walled nooks forming semi-open cubicles were provided with beds and storage space for ten women, along with a communal kitchen, shared bathroom, and windowed, closed office. Two staff members were present at all times.

Savard's initiators were surprised that the facility was quickly filled to capacity and that its users proceeded to settle in and use the project as a residence.[7] Many long-term homeless women who sleep rough develop a reversed daily time cycle in which they are awake during nighttime hours to

[6] After Diane Savard, known by many of the original Savard's staff, who had survived homelessness and became a community worker. She died in 1993 at the age of 37.

[7] Funded as a pilot project for its first two years, researchers at Queen Street Mental Health Centre collected data on Savard's for eighteen months from its opening. The description of users' adaptations is largely based on their preliminary findings (Boydell et al. 1999).

avoid attacks. The initial cohort of residents gradually adapted from this 'night mode' to daytime wakefulness, a switch that signals a quickly developed trust in the staff and other residents and willingness to stay put.

While one of the early principles was described as one of non-intervention, it has been gradually acknowledged that quite a bit of intervention by staff occurs. The residents themselves began to insist on some rules, as they gradually developed some expectations of themselves and others. Other signs of community development have become evident over time, for instance, the quality of relationships among residents and with staff has improved, and there is more awareness of behavioural and spatial boundaries. Gradual and modest changes in the residents' behaviour, appearance, and physical health have occurred.

The staff continues to be self-reflexive about their 'soft' intervention. Behavioural expectations exist, but there are modest. Ranting, i.e., loud, angry verbalizations, is a common behaviour among many of the residents. Without effective intervention, only possible because of the high staff-to-resident ratio, rants can escalate into verbally or physically abusive behaviours. Staff members impose 'timeouts' of two hours to a week as consequences for the most extreme violations of the few rules — no substance abuse on the premises, no weapons, no violence. When a Savard's resident is forced to leave temporarily, staff members negotiate brief stays at other hostels. Since most of Savard's residents have been barred from the other hostels, they are accepted only on the condition that they will return shortly to Savard's.

After two years of operation, three residents have moved on to establish their own households in self-contained apartments, and two are back on the street, too fearful to stay. A few are making modest gains toward independence, and a few are highly dependent on this living arrangement. There are clear signs that the model is successful for long-term homeless women with mental illnesses who reject, or are rejected by, the conventional hostel system. But it is not clear whether the principles of the model can be maintained over a long period of time. For instance, funding uncertainties and work stress have contributed to a high level of staff turnover. The Savard's project is moving beyond its early stage of development and much remains to be learned from it.

Burt (1997) has argued that research to date has focused on describing the homeless population rather than documenting effective interventions to prevent homelessness. Even the research on remedies have addressed some subgroup, such as chronically homeless individuals with disabilities, more than others, such as episodically homeless individuals who are not well served by any of the systems with which they interact. Burt recommends the addition of more transitional services and supported housing for the latter subgroup. Low-demand flexible programs like that offered at Savard's provide a critical transitional service for long-term women who have high support needs but have become alienated from conventional shelters. Its ultimate success also depends on the availability of a range of supportive housing projects that match the abilities, needs, and preferences of homeless women.

SECTION 3: VIEWS FROM SERVICE PROVIDERS

This section is based on the observations and viewpoints of more than thirty service providers who have worked with homeless women in the Toronto area, most of them for at least ten years (the actual range was five to 34 years). Among them, they have worked in almost every shelter that accommodates homeless women, as well as in drop-in centres, community health centres, and street outreach services. Their range of experience includes innovative as well as more conventional service models, in locations across Toronto, as front-line workers, managers, and service developers. And they are highly dedicated. Many of them have served as volunteers on various committees and boards for agencies and community groups to direct, assist, and develop services for homeless women. Most importantly for this study, they are critical analysts with insiders' knowledge of the circumstances of homeless women spanning the period 1988 to 1998.

For the most part, there was a high degree of consensus in the observations of these service providers, and by combining the occasionally piecemeal viewpoints on certain aspects of the big picture, we have constructed a fairly cohesive general description and assessment of the situation for long-term homeless women.

Macro Level Changes and Issues

Service providers attributed most of the problems of women's poverty and homelessness to macro-level socioeconomic and policy changes, especially in the area of housing policy and allocation practices, social welfare policy and programs, and health policy and practices. Parallel to these changes there has been an increase in the use of shelters and food banks; a hardened focus on emergency housing and least-cost solutions rather than prevention; and greater law enforcement targeted to homeless people. Media attention to the growing numbers and 'new faces' of homeless people has increased public awareness that homelessness affects women, youth, and families. The lack of effective intervention and prevention, however, has led to a debilitating loss of hope and signs of increasing desperation among the homeless and those who work with them.

Housing, Income Support, and Health

- **an end to social housing development**

Until 1993, federal funds were available for building social housing. And provincial funds were available until 1995. Many Toronto social service agencies used senior level government supply programs to become involved in housing development for people who were struggling to stay housed in the private sector. A variety of supportive and alternative housing projects were built, some specifically designed for homeless people, and a few specifically for women. Transitional or second-stage housing projects were also developed to accommodate women's needs. By 1995, all of this activity had stopped.

Even while new social housing projects were being developed, there was a shortfall for those in need. Still, in the words of one respondent, "*there was some movement, now there's gridlock*" With no new social housing, and escalating rents in the private sector, the opportunities to rehouse homeless people have significantly declined. All of our respondents referred to the lack of new social housing supply as a fundamental problem for homeless women, especially for those who require

support services to obtain and maintain their housing.

> *Ten years ago a lot of nonprofit agencies were building — some shared, some self-contained units Stock was being created. At the same time, older boarding houses were disappearing. This happened at the same time as the big property boom. Now we are seeing a loss of stock again. It would have been good to have taken rooming houses into the nonprofit sector. Now the only money coming in is for boarding or rooming houses which will, unfortunately, go to private operators. The non-profit-managed projects are consistently nicer The staff are better qualified and better paid.*

Access to housing that is not only affordable but connected to support services is critical for many long-term homeless women. For example, women with severe mental illness require housing with support services to maintain their housing. When women cannot find safe housing and follow-up support after they have completed an addiction treatment program, they are re-immersed in a housing crisis and quite likely to return to old friends and old habits, thereby undermining all their efforts to improve their health and stabilize their lives. Local agencies have developed considerable expertise in designing and managing housing projects that suit various requirements, however, this sector no longer has access to capital funds.

> *We lack a variety of housing [forms and models] with varying levels of support for families, singles, couples, and youth. We need everything from independent self-contained housing to supportive self-contained housing to shared units and more alternative housing like Savard's and Strachan[8], and projects that are appropriate and culturally sensitive*

- **less access to subsidized housing**

> *The numbers [of people] in the shelters dropped dramatically when the Metro Toronto Housing Authority opened to singles [in 1986). In 1995, MTHA dropped the point system, and now it is inaccessible to most homeless people. In tracking the effects of the cuts, family numbers [in shelters] have gone up. Many need four or five bedroom units which are very scarce.*

The allocation policy for the Metro Toronto Housing Authority (MTHA) was changed from a point-based system to a chronological system with a smaller proportion of priority allocations. The waiting list for subsidized housing units is fantastically long (about 37,000), and it is taking much longer than before for women, including battered women, to be allocated a unit. Reference and background checks on applicants have become more rigorous. And guidelines regarding priority allocations for abused women have changed, for instance, women who have left abusive partners in other cities are no longer eligible. The overall

[8] Also called Streetcity II, Strachan is a Homes First project located in a new building that opened in 1996 and is managed with input from the 72 previously homeless men and women who reside there It offers individual rooms within clusters or 'houses' that include shared kitchens, bathrooms, and common areas. It is staffed 24 hours a day by 2 to 4 people.

effect has been to reduce access to subsidized housing.

> *Women who were fleeing abusive situations ten years ago could receive subsidized housing through MTHA within weeks Now they are forced to wait months in overcrowded shelters or stay with friends or family where possible.*

> *Metro Housing is getting harder to work with regarding battered women They want police reports. The 'priority' waiting list [for women who are leaving abusive partners] now takes one year. For large families, it is even longer.*

Other nonprofit housing providers also have longer waiting lists and are exercising more caution in screening applicants. Their various exclusionary criteria, while understandable, leave few or no alternatives for chronically homeless women who present serious behavioural problems.

> *The application process for nonprofit housing is not user-friendly There are gruelling interviews and references required. Even housing providers who house the 'hardest-to-house' want a two-year rental history. The waiting lists are very long.*

- **reductions in welfare levels, benefits, and services to low income people**

Public opinion regarding welfare provision has shifted toward a charity model which once again entertains questions of whom among the poor are viewed as more deserving and who are less so. The implementation of workfare, minus any provision of day-care facilities, support for families with children, or additional funds for transportation has reinforced the public perception of welfare recipients as a drain upon society. Discussion of systemic issues of unemployment, changing labour conditions, racism, tenants' rights, and the need for training and job creation programs has receded.

Most of the respondents said that the effects of the 21.6 percent reductions in Ontario social assistance benefit rates in October 1995, along with further restrictions to benefits since then, have been reflected in increased evictions and shelter and related service demand. Most welfare recipients rent in the private sector, and even low-end rents are beyond what they can afford. The maximum shelter allowance for a single person was reduced from $414 to $325, and from $663 to $520 for a parent and child. Welfare provision of first and last month's rent has been eliminated. And for those being discharged from an institution, fewer people are eligible for the discharge allowance to set up a household.

> *The cuts have had a big impact on [increasing] the numbers in the shelters. They are cutting preventive programs, food programs — cutting the possibility of people getting out of the system The message is if you are not working, you are not valuable Women should stop having babies, according to the government. The long-term effects are terrifying The stigma of being on assistance is very strong. People don't see assistance as a right.*

There have been so many changes to the regulations for welfare benefits that it is a challenge for service providers, let alone applicants and recipients, to keep track of them. The regulations and eligibility criteria have become more stringent. According to one respondent, only 5 percent of her clients' applications are approved,

and people with chronic addictions are no longer eligible as new recipients.

> *The bureaucracy is ten times worse in the last year and a half than it ever was. The questions that they ask are invasive and none of their business Women are essentially faced with going through the court process to get custody of their kids and getting a restraining order before they are eligible for welfare.*

English literacy problems exacerbate difficulties in access to welfare services. Documentation requests and notices of appointments are sent in printed form only. When pertinent information is not supplied or appointments are missed, benefits are discontinued.

The withdrawal of provincial government funding for a range of services used by low income women contributes to their marginal position and housing instability. For example, funding for tenants' groups and legal clinics have been reduced, and changes in landlord and tenant legislation have weakened tenants' security of tenure and effectively deregulated rents.[9] The management of MTHA (public) housing is gradually being contracted out to private sector firms who are unlikely to maintain the Community Liaison workers who intervene in conflict situations and attempt to prevent evictions. There are insufficient resources available to prevent an increase in homelessness.

- **reductions in health services**

Deinstitutionalization policies and reductions in the number of psychiatric hospital beds have not been complemented by sufficient investment in community and housing programs. It has become harder to get homeless women with mental illness into psychiatric hospitals due to a shortage of beds. When they are accepted, the hospital stays are much shorter and less can be accomplished; ten years ago the average stay was two weeks, now it is four days. Also, the number of beds in addiction treatment programs has not increased for several years.

Hospitals have fewer resources for discharge planning and more women are being discharged to shelters. Trans-institutional use between shelters and hospitals (for psychiatric care or detoxification treatment programs) is a pattern for many long-term homeless women. The distinctness of the health care system contributes to a lack of service coordination and continuity of care that keeps women with mental health problems bouncing from service to service.

> *It's a revolving door — women are referred to a hospital, but then they return. Hospitals don't initiate [income assistance benefits] They need to be more aware in hospitals and at higher levels in the bureaucracy Women are discharged with stupid recommendations such as taking so many pills every few hours*

The crackdown on health fraud has made it more difficult for long-term homeless women to replace lost or stolen provincial health insurance cards. Dental treatment for low income people has been restricted to emergency services, relying heavily on extraction. And there is a fear that eligibility for income assistance programs will be conditional on

[9] Since June 1998, there is no regulation of rent increases as units become vacant.

medication monitoring for those with severe mental illness.

Emergency Services, Least-Cost Investment, and Public Control

The widening gap between available resources and human need has caused the municipal government and local agencies to scramble in their attempts to address immediate concerns. Increasingly this has translated into emergency and temporary solutions to the pressing daily need for shelter and food. More least-cost, minimal shelter arrangements have been developed, leading to conditions that put long-term homeless women at great risk in terms of personal danger and deterioration of their physical and mental health. Some politicians and members of the public seem to be primarily concerned about risks to business development instead, and law enforcement mechanisms have been adopted and reinstituted to eliminate visible signs of homelessness and destitution.

- **focus on emergency solutions and least-cost service development**

> *Initially, it felt like the main problem was access to housing. Ten years ago, we didn't think poverty would exclude you from participating in society. Now homelessness is big and real for a lot of people*

The rallying cries of the "Housing, not hostels" campaign has become a hoarse whisper among those closely involved in working with the poor. In the vacuum of government leadership, a charity model of crisis service provision has been revived, as reflected with the Out of the Cold program initiated by a consortium of churches and temples or synagogues. In response to a growing crisis of homelessness, this volunteer-based program has responded by providing floor space for about 300 homeless people at more than 20 locations during the winter months. In the last five years, many young women, especially Aboriginal women, have begun to use Out of the Cold services.

> *Out of the Cold was an emergency measure. It's not anymore — it seems to be just an automatic thing If it can keep people alive, I guess that's important, but I think there should be better ways of looking at those situations*

A couple of respondents used a first aid metaphor to indicate that minimal, least-cost services not only do little to remedy the fundamental problems for homeless women, but actually contribute to them by allowing women's health and safety status to deteriorate — "*It's not just bandaid solutions, it's dirty bandaids now.*"

Mats on the floor and wall-to-wall bodies are now part of the municipally-managed shelter system as the newest shelters are designed to quickly accommodate large numbers of homeless people. Service providers commented on the deteriorating level of assistance.

> *There are more and more places for people to flop. Minimal provisions. People are having to become more dependent on this*

> *The whole system is eroding People don't have the time or the resources to work on solutions, and so what we have is typical of American cities There are large numbers of people who have no access to basic needs, so a whole culture develops which ends up being very costly in the long run. It isn't gaps in the system anymore — it's a giant hole There is no big*

> *picture analysis It won't be fixed by setting up a new service here and there.*

- **more use of food banks, especially by precariously housed women**

Initially intended as an emergency measure, food banks have become an entrenched part of the system for people living at the economic margins, acting as an income supplement for precariously housing women. More people are using food banks, including women responsible for feeding their children, so that food banks have expanded their range of provisions to include baby food and diapers. Some shelters have also started distributing bag lunches to homeless women on the move during the day.

- **more law enforcement directed to homeless people**

Homeless women are increasingly restricted from using spaces to which the general public has access.

> *Union Station is not friendly to the homeless One [long-term homeless] woman was handcuffed to a chair for several hours by Union Station security. She had been having coffee, bought by someone in the coffee shop, after she had been barred from the premises.*

> *About twenty people a night are sleeping in Nathan Phillips Square Most women who are on the street are sleeping out in the open It is too dangerous to be in alleys or under bridges, but being visible leads to harassment by police The [Toronto Transit Commission] also has very tough security now.*

Within the last couple of years, the Toronto Transit Commission has begun to enforce regulations against people found panhandling anywhere on their property and issue tickets with fines for loitering or trespassing. In part, the increased surveillance and forced removal by guards of visibly homeless people whose behaviour was in any way unusual were probably reactions to a single incident in which a mentally ill homeless man pushed someone into the path of a subway train.

Municipal politicians have debated the use of legal action and police enforcement to control the appearance and behaviour of homeless people in public areas. Homeless people with severe mental illness are especially likely to run afoul of the law. A mentally ill man was shot and killed by Toronto police after having an outburst on a streetcar. He had no weapon. More Canadian municipalities are developing and using legislation to regulate the visibility of homelessness, e.g., bylaws against panhandling and other behaviours of homeless people. For homeless persons this constitutes harassment and conflict over human rights and use of public space (see Mullen 1996).

Public, Political, and Individual Responses

While the general public and local municipal government have developed greater awareness that significant numbers of women, youth, and families are homeless, public sympathy toward homeless women may be declining, and the entrenched institutionalization of homelessness is leaving long-term homeless people in despair over any future improvements.

- **increased awareness of women's homelessness and long-term homelessness**

Over the past decade, there has been a significant shift in perceptions regarding who is likely to be homeless. The general public is more aware that women, youth, and families experience homelessness. It is no longer viewed as a problem only single men face. When a 1996 public opinion poll asked for reactions to the statement: *the homeless population in Canada is changing and now includes more young people, women and families than used to be the case*, 84 percent strongly agreed; two years later, 88 percent strongly agreed. Most Canadians believe that homelessness has a significant social cost. A high proportion of respondents (80 percent) either strongly or somewhat disagreed with this statement: *Homelessness really only harms the people who are homeless themselves, there is no real cost to the rest of society* (CMHC 1998).

To what extent senior level politicians and bureaucrats share these views is not clear, however, there is growing awareness at the municipal level. In Toronto, where there has been strong media, political, and research attention over the past year, awareness has extended to an understanding that long-term homelessness affects women as well as men.

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

- **decreased attention to women's issues and increased desperation**

At the same time that more women are affected by homelessness and poverty, the political and public profile of women's issues in general has attracted less attention and support. There has been a widespread reduction in funding for a range of women's services and advocacy organizations, making it less likely that any significant gender analysis will be incorporated into policy development or program planning and delivery. This has left homeless women especially vulnerable within a policy and service milieu whose dominant model has been based on the experiences of men.

While senior governments have long maintained an air of disinterest in dealing with the problems of homelessness, there are more signs of desperation and loss of hope among homeless women.

> *There is a hardening amongst the public and amongst politicians I fear that we will follow the example of New York and Chicago. We have gotten used to the changes and accommodated There was a sense of hopelessness after the cutback [in 1995] It might have been healthier to be angrier. The face of Toronto has been changed by the number of street people. Now there are people on the street in neighbourhoods that never used to have them — Yonge and Eglinton, St Clair and Bathurst, Jane and Bloor Mostly, they are white middle-aged Canadians*
>
> *There is less public sympathy for homeless women. There is still a stigma about them They scare the public, staff, and each other By*

> *the time a woman is on the street she has used all her resources. Women are angrier, have less hope, and fewer expectations At the Out of the Cold program, it is more silent and there is very little laughter*

Destitution is becoming entrenched, and so is resignation.

> *The situation of the homeless is different now, greater intensity. Ten years ago we knew most of the women Often they were looked upon as having eccentricities rather than major mental health problems. The stories were gentler. Now there are women for whom there is less hope, and they have less hope for themselves.*

Homelessness among Women

As more women, absolutely and proportionately, become homeless, greater diversity among them becomes apparent. Ten years ago, most homeless women were single adults, however, the number and proportion of homeless families, most of whom are headed by females, have increased tremendously in Toronto. The proportion of homeless youth has increased as well. Service providers also report an increase in the prevalence of severe mental illness as well as substance abuse over the past ten years. And while there is no basis on which to make a comparison over time, sexual violence is a pervasive problem for homeless women. Childhood abuse, previous victimization, and revictimization are all more prevalent among homeless women than among the general population.

- **more homeless women, more diversity**

Both the number and diversity of women who are homeless are increasing. The age range is broad. There has been an increase in the number of girls under the age of 16 who are homeless and on the street. And there are women over the age of 80 years in shelters. Aboriginal and black women are over-represented, and Asian women are under-represented.

There are more women who are new to the streets and hostel environments; they are less 'streetwise' or 'system-wise.' And there are more previously employed women using shelters, such as laid-off factory workers, and women with higher levels of formal education.

- **more women with children**

The number of women with children who were homeless for reasons other than domestic violence began to increase during the 1980s. They were first accommodated by shelters such as Family Residence and Nellie's, but gradually the numbers grew to such an extent that women and their children were housed in motels, heavily concentrated on the outskirts of the city. This concentration has overloaded the capacity of a small number of schools to deal with the needs of homeless children.

Single mothers are not generally on the street with their children, except for the recent emergence of a small number of pregnant teens and teen mothers who live on the street. Most of the latter use the services of a downtown youth centre, however, the centre has no accommodation for them.

> *Babies are being raised in squats — unheard of ten years ago.*

- **immigrant women**

Toronto is the primary reception city for immigrants to Canada, most of whom are able to settle with little or no assistance from social service agencies. Some women, however, become homeless due to economic hardship and family breakdown or abuse, frequently exacerbated by traumatic histories, especially among refugee women. Progressive immigrant waves have been reflected in the shelter population, although there is no evidence to suggest that immigrant women are more likely than Canadian-born women to be homeless for long periods.

> *At Women's Residence, there are more immigrant and refugee women, including those with mental health problems, for whom there has been a breakdown in the sponsor relationship Some of them are from Eastern European countries. Previous to this, there was a wave of immigration from Asian and African countries which began to slow down after the Somali immigrants arrived.*

One respondent remembered a cohort of refugee families who stayed at a family shelter where she worked ten years ago. Years later, some of the daughters from those families were homeless again.

> *There was a huge influx of refugees, primarily from Latin America and Ethiopia. People had extended families and came to Canada together. Later there were some serious problems of domestic exploitation and abuse. Now some of the younger women are ending up at [a shelter for young women]. Problems arise between the traditional ways and the new western ways.*

In some women's shelters, staff members have made extensive arrangements for language translators and worked on cross-cultural awareness and anti-racism. Deficiencies in federal support for settlement services have obligated them to fill service gaps, especially for refugee women.

- **visibility of homeless women**

More women are visibly homeless and more are sleeping rough. They sleep on park benches and over hot air grates. Youth are more likely to group together and form street families, so more young women stay in squats and mixed-sex shelters, or use makeshift shelters erected under bridges, on back streets, in parking lots, and in ravines.

More women are panhandling, and more young women have joined young men who squeegee (cleaning the windows of cars that are waiting for a green light at major downtown intersections in expectation of tips from drivers).

> *There are now single mums on the street [panhandling or hooking], but they won't say where they are living.*

- **abuse and violence**

Service providers reported more signs that homeless women have experienced abuse and more disclosures from them. It is not clear whether there is an actual increase in the incidence of violence against women or whether women are more likely to disclose.

> *More women have suffered from abuse than I remember ten years ago — very serious abuse. Fortunately, the abusers don't usually follow women to [our shelter].*

It is fair to say that the majority of women who suffer from mental illness are survivors of physical, emotional, and sexual abuse, including incest Symptoms of such trauma, once mistaken for mental illness, cannot be treated simply by medication. The unfortunate part is that there is minimal counselling or therapy available to low income women, and what is available has a waiting list.

The rate of abuse, within residential schools and families, experienced by Native women is astronomical.

Sexual abuse has sexualized a lot of the teens we see. A third to a half are sexual abuse survivors When people are forced to live in inadequate housing, they put themselves and their children more at risk [of abuse] Poor locks on the doors, men in rooming houses, having to leave children with unknown neighbours — it's all dangerous.

Some of the service providers said that domestic violence had increased along with poverty. Women living on the streets are certainly at great risk of exploitation and abuse, especially girls and young women who live in squats controlled by males.

There have been cuts in services for assaulted and abused women, and violence against women has receded as an issue with any prominence in the planning, development, and delivery of shelters and shelter-related services for homeless women. This leaves women without adequate support, and sexual assaults are generally unreported.

Despite all the education on violence against women, police and hospital staff still treat a homeless woman who has been raped with tremendous insensitivity. The system still fails her New, naive staff tend to trust the system, but soon they say they won't report a rape again because the system is as bad as the initial violation. This hasn't changed at all in ten years

Not all violence is directed to women by men. There is also violence by some women who "*have been through so much, they don't care about themselves or anyone else.*" In cases where women obtain drugs from their boyfriends and are highly dependent on them, some women resort to violence over access to crack cocaine and jealousy.

- **more mental health problems**

There are more homeless women with severe mental health problems, including more young women whose mental health problems are generally undiagnosed. Young women often have their first psychotic break in their early twenties, but may not receive appropriate assistance at that time. There are also more women who refuse medication and avoid all contact with the medical and psychiatric system. Some of them are quite socially isolated and alienated. They have rejected the primary or sole offer of assistance — pharmaceutical drugs.

The emphasis in the health field is on medication for people with mental health problems. While there are fewer lobotomies, there are more medications available and less choice about taking them — its social control through medication.

- **less alcohol use but more drugs, especially among young women**

> *Seems to me that ten years ago there was a fair amount of alcohol, but not the drug use there is now. We have 35 or 36 women [at our shelter], but only six to ten are not involved in some kind of drug activity Many of them are into crack.*
>
> *Drug use is on the increase Kids are starting very young. Squeegee kids fourteen to nineteen years old are on crack. They are leaving abusive families and living outside in parks, on the beach, in abandoned buildings, or on the corners where they squeegee*

Ten years ago, long-term homeless women were generally socially isolated women and older, alcoholic women. Now drug addiction has become a much more serious problem. Use of crack cocaine, which is relatively inexpensive, is more prevalent, especially by younger women. And deterioration from crack use, along with the new derivatives, is much more rapid than with the drugs in use ten years ago. All types of addiction treatment programs now have waiting lists.

Service Agencies

With the increasing number of homeless women and their range of needs, shelter and related services have expanded and altered and adapted their policies to accommodate longer shelter stays and the varied needs within the general homeless population. The lack of adequate funding, however, has shaped shelter provision toward minimal service provision and further compromised women's safety and well-being in the process.

- **more hostel capacity for women and changing regulations**

There are more hostels and beds for homeless women and youth, and their hostel stays are longer. The two-week stay limits that were widespread ten years ago have been eliminated in most shelters. A 'night out' system has developed to allow women to spend a night away from the shelter without losing their beds. Ten years ago, most hostels forced women to wake by a certain time and be out during the day. Many of them no longer have such rules.

On the other hand, several hostels are becoming more strict about women being 'high' or intoxicated. And some women's shelters are struggling to keep away pimps and drug dealers who 'hang around,' waiting for young women in particular. Ten years ago there was a general concern for women's safety and privacy, and women's shelters rarely had any male staff. In the struggle to provide more beds, and especially in the new, large, mixed-sex shelters, these issues have been sidelined.

- **changing models of service design and delivery**

Initially temporary shelter services, generally consisting of mats on floors, have become an entrenched part of the shelter system, as have food banks. Due to a lack of resources, the municipal expansion of the number of shelter beds now includes such minimal provision. And most shelters are operating with lower levels of staff in relation to the number of service users. While local agencies struggle to design services that are beneficial and well-suited for subgroups of the homeless population, budget constraints force them into difficult compromises. Changes in service design and delivery are being driven almost entirely by cost factors.

- **increase in number and use of drop-in centres**

Over the past decade, more drop-in centres have opened to serve the homeless and socially isolated. Two of them specifically cater to women. Drop-in centres provide a range of benefits for homeless women — coffee, meals, public transit tokens for designated travel, social interaction and activities, access to mobile health care, and help with replacing identification and health insurance documents. Some shelters and drop-in centres arrange trusteeships for women with chronic addictions or severe mental illness who cannot manage their financial affairs. For many long-term homeless women, drop-in centre staff offer companionship — it is one of the few services where staff members spend meaningful amounts of time with women.

Homeless women who work at night, generally in the sex trade, or who have no shelter and stay awake at night, use drop-ins to sleep on couches or bunk beds during the day. Because the centres are "*overladed and understaffed*," they have been staggering their hours of opening to cover the times when people cannot enter shelters. While generally helpful, the presence of drop-in centres can also draw attention to concentrations of vulnerable people and use of them may place women at risk of exploitation and abuse.

> *There aren't too many drop-ins that are really safe for women A lot of them are rough and a lot of them attract drug dealers, so people who are more vulnerable like those with mental health issues or developmental delays or women on the street are more susceptible to being taken advantage of.*

- **resources for service agencies**

Reductions in service provisions by other institutions, such as the health care system, have increased the demand on small agencies serving homeless people. For example, Street Health helps people to replace identification and health insurance documents, although when they run out of money, this service is terminated for periods of time. Similarly, at one drop-in centre, a tenth of a staff person's time is allocated to replacing these documents.

In order to stretch their resources for those in need, some food banks require evidence of residence (to determine jurisdictions), proof of need (e.g., social assistance recipient), and identification (to monitor and restrict frequency of use). These regulatory practices reinforce the abnormality of obtaining food assistance and alienate women who live in poverty.

Funds for housing workers have been lost from women's shelters and other agencies, and the remaining staff members generally have less time to assist women to find housing or provide the individual support that many require to reestablish stable households or to simply cope with their situation. The lack of such basic support services prevents some women from being able to secure housing.

> *We used to do advocacy, and we used to have housing workers who would liaise with new co-ops and secure housing. Because the money is cut, we don't do this anymore. We lost two housing positions because of the cuts in 1995 We don't know what happened to many of the teens who were housed at that time Before we were able to support women, but now we can only give names to the co-ops when there is*

> *a unit to fill. If it is a high risk person, she usually blows it.*
>
> *I think that most of us who work with women, we're overloaded. There's too much as a counsellor that you have to do. We need to be able to talk one-to-one with the women, check in on them, but we're understaffed and overworked. Then, you find that a lot of people slip through the cracks*

Shelter and agency staff members also have to spend more time trying to obtain alternate funding for their organization. This is time lost for cross-agency communication and coordination, or direct service.

> *We have to work harder and harder to get money. It is harder to keep abreast of what is going on in the community and to attend meetings. We process people more now and have less time for in-depth support.*

Human services workers are predominantly women, and those working in shelters and related services for homeless people are tremendously pressed. Along with an unsympathetic political climate, this contributes to agency isolation as each organization focuses on doing what they can with their limited or remaining resources. For example, many welfare workers are suffering burnout, and their attitudes are changing and becoming adversarial and hostile.

In some cases, diminished resources have prompted improvements in communication with health and welfare agencies, and a patchwork of coalition work has erupted at various times in response to anticipated or actual policy changes. The pattern of repeated agency funding reductions has also produced a 'chill effect' on women's protests against certain government policies. Organizations have become much more cautious about engaging in advocacy efforts.

> *I've worked in organizations that . when it's time to go out on protests against the government, they've warned me, "Do not go out as a representative of this organization." Because they're afraid. They don't understand that their silence does not protect them I think that for some women — there's too much coming at them at once. They don't even know where to start or how to name it And there's others who are fully aware of what's going on, but they won't speak out because they really think it probably won't affect them But it does, it affects us all. The government is really mean-spirited and attacks women and children — all the services [Premier Harris] cut, they affect women and children*

- **newer, fewer staff, and conflict and violence within shelters**

Due to the expansion of shelters, there are many new and inexperienced staff members working with the homeless population. Few of them have had training in gender or ethno-racial issues, and the ratio of staff to residents is much higher than in the past, so the ability of staff to monitor or intervene in situations of potential and actual conflict or violence is severely diminished.

Some workers are also staying in their jobs longer as there are few employment options, and the age and experience gaps among shelter staff presents various problems. There is a split between those

who have done the work for twenty years and learned on the job and new, young graduates. Some of the new staff members want more rules, have more expectations, and are less tolerant. They are more fearful over the violence and acting-out they witness.

> *So many people are now crammed in small spaces.*

Overt conflict and violence are less prominent within women's shelters than it is within men's shelters or those for youth, or anywhere that crack users form a critical mass. Nevertheless, tensions occur even within women's shelters and experienced staff members have learned how to handle potential and actual conflict. One of their methods is to create spatial barriers within and across shelters. For example, to prevent or diminish further trauma to women who have been recently abused or who are otherwise vulnerable, these women are steered away from shelters where the users may exhibit more violent and aberrant behaviour. Similarly, when one women's shelter began taking in more families, they avoided accepting as many women with severe mental illness as they had in the past.

When one of the mixed-sex shelters opened, a line drawn on the floor signified a barrier between the women's section and the men's section. Overcrowding gradually eliminated this simplistic system as homeless persons were placed on mats to sleep within inches of each other. 'Domestic disputes' are another feature of mixed-sex shelters. Male territoriality over female partners has erupted in conflict and violence among couples, and between men over women.

Most of the service providers reported that, except for younger women who want to stay with boyfriends or find them, most women, if given a choice, avoided the mixed-sex shelters. Most homeless women considered them a risk to their personal safety.

Long-Term Homelessness among Women

Women who are homeless for long periods of time face similar circumstances as other homeless women. However their personal resources are fewer, their state of physical and mental health is much poorer, and their individual capacity to cope is weaker. As the existing social service and health system is less able to assist women, the most vulnerable become and stay homeless for longer periods. This means that more concerted and costly services are required to reach these women, provide stable housing for them, and reestablish their health and well-being.

According to service providers, there are more long-term homeless women in Toronto than there were ten years ago. And long-term homelessness among families is an emerging phenomenon. As more women with children are becoming homeless and finding it takes longer to access subsidized housing, they are staying in family shelters for longer periods of time or are housed in housekeeping units in motels that are under contract to the municipality. Increasing homelessness among families is a serious concern because more of them in the future may experience long-term homelessness and create a generation of children who grow up homeless or at high risk of homelessness as adults. However, the vast majority of long-term homeless women continues to be single adults among whom there is a very high prevalence of severe mental illness, addictions, and very poor physical health.

- **more severe mental health problems and substance abuse**

Compared to ten years ago, more women are being discharged to shelters or the street from psychiatric hospitals. These women are virtually guaranteed to be among the long-term homeless. Some of these women will not use any services and do not want to use medications. Hospitals have recently

introduced multi-disciplinary, assertive community treatment (ACT) teams to reach such individuals. Several service providers expressed concerns about this treatment approach, especially since they continue to experience difficulties in obtaining hospital treatment that addresses women's preferences and needs.

> *It is very hard to get people admitted with the closure of Queen St. beds. Other times, people can't get out of hospitals. Hospital teams are doing studies on new medication, and people need to stay in hospitals longer while these are tried out. The new 'assertive community treatment' hospital teams are very drug-oriented. They follow people on the street and are very aggressive. They are not about choice.*

While alcoholism is far more prevalent among homeless men than women, there are some long-term homeless women who have alcohol abuse problems. Alcohol abuse is a prominent factor in death by exposure. Those who cannot afford liquor will drink cooking wine, disinfectants, and solvents, leading to many health-related problems such as blindness, kidney and liver disease, impairment of motor skills and bodily functions, brain damage, and ultimately death.

There was a strong consensus among service providers that drug addictions have become more prevalent among homeless women, and that the increased use of crack cocaine has contributed to women's inability to stabilize their lives. 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.

> *Because they have no housing and because of their drug use, they will not get to keep the babies They are reluctant to see doctors, because they don't want official interference. We have had three women deliver in the past three months. Their only use of health care was through the Health Bus. They had no other medical intervention until delivery. They don't want to stop smoking or cracking. The babies have been relatively healthy The Children's Aid Society has taken all three of these children into care*

- **health problems and issues**

A range of chronic health problems and infectious diseases are more prevalent among the long-term homeless population. This included dental and foot problems, the reappearance of tuberculosis, and sexually transmitted and intravenously transmitted diseases, such as syphilis, chlamydia, hepatitis B and C, and AIDS. Several respondents knew of homeless women with HIV infection, and they suspected that most women avoided testing or disclosure. Untreated minor injuries and illnesses become extremely serious, even life-threatening (e.g., cellulitis, gangrene, and broken bones). Provision of dental care has diminished year by year until no restoration work is provided, only extractions, which contributes to poor diets as women are less able to chew food. And poor diets contribute to high cholesterol, diabetes, and decreased energy levels.

Long-term homeless women face various barriers to the use of conventional health care services. For example, access to provincial health insurance has become more difficult.

> *Women often lose their identification in shelters. There is an eight to twelve-week wait for each piece plus cost. Health cards are hard to get. Even clinics give people a hard time.*

The severity of health problems among homeless women appears to have increased, especially for those who do not receive preventive health care. Some of the most common problems include upper respiratory and foot ailments, nutritional deficiencies, asthma, gynaecological problems, tuberculosis, lice, scabies, and dermatological problems, such as impetigo, boils, and infections.

Virtually all long-term homeless women have problems with severe mental illness or addictions, along with physical health problems, that keep them from staying housed unless they receive appropriate support services.

Services for Long-Term Homeless Women

As new emergency shelter models are designed to accommodate large number of 'generic' homeless people, the needs of long-term homeless women are ignored. These women, for the most part, avoid such shelters, along with drop-in centres and other services that do not create dedicated space for women with high service needs. On the other hand, some service differentiation has evolved to better address the needs of various subgroup, including long-term homeless women, and a couple of agencies have developed women's shelters to suit their needs. Outreach services dedicated to reaching long-term homeless women have also emerged to link these street survivors to appropriate shelters and other services.

- **changing shelter models**

Shelters conventionally accommodate either single men, single women, families, or single women and female-headed families. In fact, male youth over the age of 17 are generally not allowed to remain with their mothers and are sent to a separate shelter for single males or a youth facility. Over the past few years, more emergency shelters that are sex-mixed have opened. During the same period a couple of women's shelters designed specifically for long-term homeless women have opened with capacities of 15 and 38 persons.

The new, mixed-sex shelters are larger, accommodate many more people (60 to 100), have fewer material and staff resources, and address minimal, subsistence needs. People sleep on mats on the floor, and share blankets, along with one or two shower facilities. These shelters have been somewhat hastily planned and put into operation, largely in reaction to a mounting political crisis over visible homelessness. In the new mixed-sex model of shelter delivery, little or no consideration is given to the safety of women or particular individual needs.

> *Putting men from the street together with women who have left abusive situations or women with mental health problems can lead to further victimization of women Yet, this is precisely what is happening with these new hostels Men and women are sleeping in mixed accommodation, and new groups of people — refugees, abused women, women with mental health problems, teenagers leaving home, squeegee kids, crack addicts, older alcoholic men — are being placed together, with few support staff and few, if any, resources to address their individual needs.*

Many respondents believed these mixed-sex shelters do not provide adequate safety for women or vulnerable users.

> *It endangers the young and the really vulnerable, but it keeps politicians happy because people are not on the streets or dying from the cold.*

One respondent who regularly works at a variety of shelter sites compared the new mixed-sex shelters with one designed specifically for women who are chronically homeless:

> *I find that the Out of the Cold services that I work at — it's mostly men that you see there. The women are scared off. I think they need a space just for women. I work at [a shelter for long-term homeless women] right now and I think it's great. It's all women. At the other places where I work, the women see a lot of men. A lot of their bad experiences tend to be with men so they're not comfortable in that place. At [the women's shelter], I see that when women come in they feel that it's a safe place because when they look around they see that it's all women working there. Whether they have a boyfriend or not, that's someplace that they feel is safe. They can go out and see whoever, but they feel this is my space and they're not pressured by someone who says, "Come on, let me come home with you," because somebody else already said no — no men allowed in here — so it takes the responsibility off their shoulders*

In the Out of the Cold programs, as well as the new mixed shelters, there is little hope of assisting people to obtain housing and employment, or even to helping them to sort out daily problems such as lack of identification or difficulties involving welfare benefits. Instead we have a return to warehousing the poor. In fact, empty warehouses are considered ideal locations for this population as they are usually situated where neighbours will not object, and they offer ample space for dormitory accommodation where large numbers of people can be supervised in spaces easily observed by a limited number of staff.

- **service differentiation**

With the expansion of services for homeless women came increased differentiation or specialization in type of service provision. This has resulted in varying standards and types of service. For example, the staff at one women's shelter developed an expertise in assisting incest survivors and dealing with their related behavioural problems (self-mutilation and addictions). Another agency has services specifically for homeless people with psychiatric disabilities and deals with women in psychiatric crisis. There has been much discussion about how to best serve transsexuals within the shelter system. A few women's shelters will accept vulnerable men who feel unsafe in men's shelters. One women's shelter has developed an addiction case management program and places women in subsidized housing. This program that has been successful in keeping women stably housed, and some of the residents have returned to school or employment.

The two low-demand women's shelters for long-term homeless women cannot meet the existing need for such services, and both agencies struggle for adequate funding to maintain the requisite high staff ratio for this subgroup.

- **more outreach services**

Ten years ago, there were only two agencies providing outreach services to homeless persons. Such services have increased each year and now provide beverages and meals, warm clothing, and blankets and sleeping bags. There is an increased need for street outreach workers to connect chronically homeless women with services and

encourage those who are sleeping rough to enter an appropriate shelter.

As fewer physicians are willing to treat homeless persons, some homeless women are quick to use or overuse hospital emergency services, and others avoid the conventional medical system entirely. Both groups are being better accommodated by mobile health services that have developed to bring physicians, nurses and psychiatrists to shelters and drop-ins centres.

Models of outreach services vary. Many of our respondents said that case management services that are flexible and provide continuity or follow-up and non-mandatory assistance, including access to appropriate housing, are preferable to those that offer a particular set program that is limited to one type of support. The new medical outreach teams, for instance, are viewed with suspicion.

> *The new hospital [Assertive Community Treatment] teams follow patients and encourage [them to use] drugs. There is no safe home for people who don't want to take drugs. Twenty-one mental health teams are to be instituted. There is a big worry about 'public safety' Forensic beds are now a priority. 'Community treatment' means send drugs to the community. People are supported under the viaduct instead of getting housing. They think that treatment should be given in the community so that hospital stays are shorter. What are they saving if they have doctors and nurses working in the community? People get discharged from psychiatric hospital beds, and then readmitted since the funding rates change according to how long a person has been in.*

Most of the service providers stressed that homeless women need housing and support services within a context of individual choice. This assumes that options exist for women, but they do not.

Categories of Service Use

Those with long histories in the provision of services to women eventually notice patterns of homelessness that are based on seeing certain women use services over long periods of time or at particular points in their lives. While cautious about any violation of confidentiality, service providers can identify certain women who have been 'in the system' a long time, and can be seen to nod knowingly or smile at each others' anecdotes or references to an unnamed 'client' whom they recognize by unique or familiar characterizations. Workers' relationships with women who only use their services for a short, or single time are obviously short-lived, but may still offer information on the circumstances that precede, if not follow, these women's encounters of homelessness and crisis. We have drawn on their knowledge base to distinguish the following categories of female shelter users.

When asked to distinguish patterns of homelessness among women, our respondents portrayed one-time shelter users as women who are able to reestablish a household if given basic assistance, whereas long-term shelter users have special needs and require additional assistance to obtain and maintain a stable household. Distinctions among long-term homeless women were only meaningful to a minority of the service providers, but those who made such distinctions matched the service use profiles noted by Kuhn and Culhane (1998).

Transitional homelessness is characterized by a life crisis or turning point, such as leaving a spouse, entering the country as a refugee, or leaving the parental home for the first time. These are times when women may lack sufficient economic or social supports, yet they are able to stabilize their lives within short periods of time. With some targeted support, such as subsidized housing, counselling, welfare, legal aid, first and last months' rent, they are capable of carrying on independently.

Episodic homelessness is indicative of women whose lives are precarious and whose situation makes them vulnerable to repeated homelessness, e.g., very young women who have been sexually abused; older women living in cheap rooming and boarding houses who need to escape abusive tenants or landlords; women in abusive domestic situations; women who have addictions; and women in trouble with the law. These women are in and out of the hostel system, leaving it for periods when their lives are stable, but because they are economically and socially on the margins, they are more vulnerable to another period of homelessness. Their behavioural problems, especially those of substance abusers, cause conflict with neighbours and landlords, and these women have a pattern of repeat evictions. Women with chronic addictions are especially likely to exhibit a pattern of trans-institutional use (i.e., shelters, hospitals, and jails). Addictions are costly, so women with addictions frequently engage in sex trade work or theft and robbery, activities which increase their involvement with the criminal justice system and likelihood of being incarcerated. Addictions also require women to be sufficiently socially engaged to purchase or otherwise obtain whatever substance they crave. In other words, addictions foster some degree of social contact.

Chronic homelessness is most often the lot of middle-aged and older women who have severe mental health problems, usually schizophrenia or chronic delusional disorder, which may have worsened during the course of being homeless. These women are isolated and alienated, with few or no social supports. Some of them rely on extreme reclusiveness for protection and stay huddled in the corners of shelters. Others will not accept any assistance from service providers. Women with severe mental illness, most of whom spent much of their lives in psychiatric hospitals, are ill-served by the hostel system. They are at the bottom of the hierarchy within the shelter population and highly vulnerable to sexual abuse and robbery. Without specific assistance, they stay in the hostel circuit; some of them are barred even from shelters due to their bizarre behaviour, e.g., extremely poor hygiene habits and off-putting techniques, including loud yelling or screaming. Some of them have deep-seated fear or suspicion of government and refuse to carry identification or sign forms to receive financial entitlements (e.g., pensions). While this is the predominant profile of chronically homeless women, there are variations and evident changes. Younger women with undiagnosed mental health problems are a new group among the chronically homeless.

> *Ten years ago, we first starting seeing women with mental health issues on the streets that were older as they had been institutionalized prior to being discharged to the streets. We were seeing these women burnt out and heavily medicated and suffering from signs of intense electro shock therapy and lobotomies. Now we see women much younger who have not received any treatment and therefore have more energy, but need support that they can't get.*

In a sum, episodically homeless women may be easier to engage but are more likely to require residential treatment programs before they can be stably housed, with or without support services.

Chronically homeless women are more stable but may be harder to reach and are more likely to require appropriate supportive housing on a long-term basis.

Service Requirements

Our respondents made several suggestions to improve or expand existing services to better meet the needs of long-term homeless women. Most important, they stressed the need for more than temporary solutions. Permanent housing arrangements with complementary support services are required to establish and maintain long-term homeless women in stable households. In the case of both temporary and permanent housing provision, our respondents also stressed the need for additional women-only options.

- **fine-tuning of existing services**

- Increase the number of culturally-appropriate services for Aboriginal women (currently only a total of 20 beds).
- Increase the number of addiction treatment beds, including residential programs for dually-diagnosed women (i.e., women with mental illness and addiction problems).
- Increase resources for outreach and assessment services to prevent deterioration in homeless women's physical and mental health symptoms.
- Add more hostel spaces specifically for homeless couples (heterosexual and homosexual).
- Add more storage facilities (e.g., lockers) and shower facilities in shelters.
- Provide food allowances, community kitchens, and free cooking classes.

- **small-scale, low-demand, well-staffed shelter services**

Several of the respondents remarked on the success of Savard's in stabilizing the lives of chronically homeless women and suggested that additional, similar facilities are a better alternative than conventional shelters for women who have resisted, or been barred from, other shelters and whose behaviours make them difficult to place elsewhere. One respondent suggested that a specially-designed rooming house model with a low level of support services could assist women who are suited to semi-independent living.

> *Savard's has shown that if people can 'just be,' a lot of people would move into such a place In rooming house accommodation, soundproofing (for those who yell) and cleaning services would help more people to be housed.*

Harm reduction facilities for women with addictions might adopt aspects of the small-scale, low demand, well-staffed model exemplified by Savard's, especially as it appears that more long-term homeless women are substance abusers.

- **need for supportive housing**

Long-term homeless women generally require more than the provision of affordable housing to maintain stable households. Many of them end up re-hospitalized and back on the street because they are unable to manage the daily living requirements in the lowcost end of the housing system. One of the new services developed by a women's shelter, a case management program for women with addictions, has established that substance abusers are able to maintain their housing and even return to school or work if they receive a housing subsidy along with appropriate support services. Similar programs for women (including women with

children) who are leaving corrections facilities should be available.

Virtually all of the service providers pointed out the need for more supportive housing units for chronically homeless women.

> *Housing is a big thing for women. Each and every one of them, even if they have mental health issues, they'll tell you that they wish they had their own space. They need supportive housing for women so they know that even if they're living independently, there's a staff person or a counsellor downstairs that they can talk to or who will go and check in on them to make sure that everything is going okay.*

> *The percentage of mental health problems is very high — 60 percent. Sometimes they are diagnosed and taking medication, and sometimes not. Very few of the women do not need supportive housing For older women, they need support and cleaning services.*

Within the range of supportive housing models available, with varying levels and types of support services, several respondents suggested that those projects with low levels of support services (rather than high-support residential programs) were most appropriate for many homeless women who only needed occasional assistance and the reassurance of available staff. Several of the service providers also specified the need for more women-only projects and buildings.

> *Women-only housing is needed. Some women need a 24-hour house manager. They don't need [semi-institutional, large-scale boarding facilities], counselling, etc. People are able to manage as long as there is an intervener. They don't need mothering or a group home. Women are more interested in a rooming house rather than a boarding house model. There are no places that there aren't expectations for women to get better There is more change in the men's sector. They are looking now at harm reduction and palliative care. There needs to be harm reduction for women. Harm reduction for people all along the continuum, not just for the chronically homeless*

Several respondents noted that while most long-term homeless women prefer self-contained housing units, some find such housing too socially isolating and prefer shared units where they have the company of other residents. It is important that women have options from which to choose what will work best for them.

Summary

According to the observations of more than thirty service providers, there are as many similarities as differences evident in the circumstances for long-term homeless women over the past ten years. Basically, the scale and intensity of the problems have increased as government policies have not only failed to prevent homelessness, but have fuelled it by withdrawing funding for social housing, health services, and human service agencies. Consequently, the emergency shelter system and related services have expanded to accommodate more homeless people. And they have adapted in various ways — on the one hand to accommodate the greater demand by developing large-scale, least-cost, minimal service facilities

which increase the risk of victimization for homeless women, and on the other hand to provide greater differentiation or specialization of shelter services for various groups, including a couple of small-scale, low-demand shelters for long-term homeless women who avoid conventional shelters and sleep rough. The prevalence of mental illness and addictions have increased among long-term homeless women, and more outreach services have developed to reach those who avoid conventional services. Their physical health problems are severe, and outreach health services have somewhat improved their access by changing their locations of delivery.

The primary categorical distinction recognized by service providers is that between transitional and long-term hostel users. According to the few service providers who distinguished among long-term homeless women, their profiles of episodically and chronically homeless women approximate those described by Kuhn and Culhane (1998) with elaborations specific to women's experiences. Episodically homeless women are generally younger and are fairly easy to engage, but they are more likely to require residential treatment programs before they can be stably housed, with or without support services. Chronically homeless women are often middle-aged and more stable but may be harder to reach and are more likely to require supportive housing on a long-term basis.

Service providers' suggestions range from modest changes to the shelter system to the addition of small-scale, low-demand, and well-staffed specialized women's shelters, including harm reduction programs, and the development of supportive housing projects to accommodate women's diverse needs and preferences. Underlying all these changes are recommendations for more gender-sensitive, sex-segregated, and culturally-appropriate services and housing options.

Since the local context for developing such services has altered substantially within the context of no funding for housing development, it appears that the prospects are not strong for more shelter service or housing development that is gender-sensitive.

Local Context for Development of Women's Services

Throughout the 1970s and 1980s, progressive urban groups such as the Urban Core Support Network (UCSN), a national coalition of agencies serving the urban poor, the Single Displaced Person's Project (the Toronto branch of UCSN), and the Supportive Housing Coalition, a Toronto agency, put forth models for empowering the poor through their involvement in the development of housing solutions. The feminist community, through the work of individual shelters and the Ontario Association of Interval and Transition Houses (OAITH), focused on empowering women and raising public awareness on the issue of violence against women. All these groups, and many others, lobbied senior levels of government to fund the development of subsidized housing. Many nonprofit groups emerged to build and manage a variety of housing projects. Housing was considered a fundamental right as well as a necessary component to enable people to carry on with their lives in a dignified manner.

During the 1990s the pressure on the hostel system continued to increase, even though many new beds and shelters had been added to the municipal hostel portfolio. And the volunteer-based Out of the Cold program has gradually become institutionalized. Each member church or synagogue runs an overnight shelter one night per week during the winter months, offering a meal and a mat on a floor to up to 90 men and women. This measure, while well intentioned, has fostered a return to a charity model of social service provision.

Ten years ago, the shelter system for women in Toronto consisted predominantly of those shelters developed during the late 1970s and 1980s for women leaving abusive situations. Many of these were set up by women's groups with a feminist philosophy (e.g., Interval House, Nellie's, Emily Stowe Shelter, Women's Habitat, and Shirley Samaroo House). Most of them were located in large old houses and sheltered no more than 30 women. There was a deliberate attempt to make the atmosphere as home-like as possible, to provide supportive counselling, and to encourage women in making their own decisions. The women received individual attention. This was a stark contrast to the men's shelters, such as Seaton House, that provided dormitory accommodation for several hundreds of men each night.

Because the Toronto area feminist shelter system has been very much damaged through infighting and funding reductions, the women's shelters are not in a position to rise to the occasion, to advocate, lobby for, or open new shelters. These organizations are too much in chaos to take on new projects. As a result the more mainstream agencies are developing hostels which in previous years the women's community would have set up. The results are shelters that are far less gender-sensitive.

Out of the Cold has inadvertently made the provision of a very poor standard of shelter admissible. Before, there were no sex-mixed shelters (except for the Toronto Community Hostel which had some space for couples), and giving people mats on the floor was not tolerated. Now the city has opened a large facility that offers mats on the floor and mixed accommodation on a permanent basis.

Women's particular needs are being lost in the provision of large "gender-neutral" spaces. In fact, these new shelters are not gender-neutral but very much male-dominated. The new shelters are based on an economy of size, as the men's shelters have always been. Except for a few years when one church opened its doors to the homeless and allowed people to sleep on the floor (which ended when they developed two more substantial and permanent housing projects), there has never been such meagre provision of emergency shelter for women.

SECTION 4: VIEWS FROM THE ROUGH EDGE

This section is based on interview data from ten long-term homeless women. To introduce readers to the backgrounds and circumstances of our respondents, we have interspersed brief profiles within the text to indicate something of their housing histories and varied, but extensive, experiences of homelessness and precarious housing conditions. The age range of our ten respondents is from the early twenties to early fifties. Most of the women are 'white', two are Aboriginal women. All of them were born in Canada. Most of them are heterosexual. The names we have used are fictitious, and details have been omitted or altered slightly to prevent identification of the respondent, however, the substantive aspects of their stories are authentic.

One factor in our distinction between the categories of chronic and episodic homelessness, as noted in the previous section, is sociability. Some long-term homeless women are extremely insular and antisocial and unwilling to be interviewed, especially those who have spent many years in a psychiatric hospital. These women's voices are missing from our interviews. They generally have severe mental health, not addiction, problems. Even when they are willing to talk to an interviewer, what they say may be difficult to understand or interpret. For these reasons, we believe that our interview representation is somewhat skewed in that it reflects the experiences of women who are more communicative, socially connected, and willing to share their life stories.

Traumatic childhoods, poverty, abuse and violence, as well as residential instability, are the keynotes in these stories. Almost all the respondents revealed that there had been conflict and abuse within their families of origin that caused them to leave their parental homes during adolescence. A few of them also become mothers at a very early age, and there are scattered references to past partners who were abusive and violent toward them.

For the most part, familial living arrangements improved the women's access to stable housing conditions: living with parents as children, moving back in with mothers as adults, and living with sexual or marital partners. Seven of the ten respondents gave birth to at least one child and spent a number of years raising children. In some cases, this may have made it more difficult for the women to escape violent or abusive relationships or generally suppressed their ability to live as they wished. There are also indications that the responsibility of mothering motivated some of the women to try to maintain that role even when homeless and to constrain their use of drugs and alcohol. While some of the women with children attempted to continue raising them through periods of unstable housing and use of family shelters, others appear to have been less tenacious about their mothering role. Facing severe limitations in their ability to mother, they made responsible decisions to make other arrangements for their children. Eventually, most of the children of these homeless women were placed in care or sent to live with their fathers or other family members.

Although the dissolution of families as an outcome of homelessness has not received much research attention, one study has linked inadequate housing and the ability of parents to raise their children. Inadequate or lack of housing was identified as a factor in the decision to place a child in temporary care in more than one out of six Children's Aid Society of Metropolitan Toronto cases in 1992. In 9 percent of cases, the return home of a child was delayed due to a housing-related problem (Cohen-Schlanger et al. 1995). Since family disruptions are

characteristic among our respondents' childhoods, intergenerational effects become evident.

Few of our respondents referred to periods of sustained employment, and the employment that was reported was predominantly low-paid service jobs. Reliance on income support programs allowed the respondents access only to the worst of the housing market. For example, of those respondents who said they had lived in a rooming house at some point, the only elaborations they made referred to negative aspects — sexual harassment by a landlord and by male tenants; high turnover so that it was difficult to know who was actually a tenant in the house; high likelihood of drug use and dealing in the house; along with risky sex trade activity. Those who had access to subsidized housing, usually during periods of active parenting, criticized the neighbourhoods for being drug-ridden and unsafe.

At least four of our respondents have severe mental health problems, sometimes concurrent with addiction problems. In some cases, psychiatric hospitalizations and diagnoses occurred early in their lives. It is worth noting that, given the age of some of these women, they were likely to have been subjected to the first generation of psychotropic drugs and electroconvulsive therapy, with attendant severe side effects and perhaps some level of iatrogenic impairment.

Addictions are also prominent among our respondents. A few of them reported difficulties obtaining addiction treatment because they also had severe mental health problems. Of those who were able to enter addiction treatment programs, some resumed substance abuse once they were homeless again or in circumstances where drug use was part of their environment

As the oldest daughter, Tracy stayed at home to care for her younger siblings while her mother went out to work. She left her small town while an adolescent and came to Toronto more than thirty years ago, at first working intermittently as a waitress or salesclerk. Hospitalized at least once, probably as a young adult, Tracy was diagnosed as having schizophrenia. She has lived in rooming houses, and has a strong suspicion of men. Some of her fragmented, nervous remarks suggest previous experiences of abuse and violence. It was not clear to what extent she has used shelters in the past, but she has now somewhat settled in a low-demand women's shelter.

Personal Safety

Almost every respondent reported that some form of physical or sexual abuse during childhood played a part in their leaving parental homes at an early age. And many of the women referred to abuse from a partner later in their lives. These histories of abusive experiences in the home are counterbalanced by the risks of living in public places. The women reported various situations or people they try to avoid: drunk 'rowdies', crack users, parks and other areas where there is drug use and violence, and people whose behaviour is aberrant (unpredictable) or violent. For homeless women, protecting one's self-respect is a struggle as well, so that 'normal people' and 'white collar people' are avoided, too, because they exhibit contempt, disgust, superiority, or simply aversion. A couple of the women tried to stay indoors as much as possible. To feel safe, a few women said they go to their church, to women's drop-in centres, or talk to female friends, or to shelter staff. Some women obviously treasured the companionship they have established with certain service providers. And while half the women avoid

men, the rest have boyfriends or rely on relationships with men for protection.

Whatever the strategies for protecting themselves, attacks on the women were frequent and severe. Developing street smarts was an important lesson to learn as unseasoned women who are new to the street are noticed and treated more roughly by the men. Adaptations to street life require a reversion of the impulse to trust others. And working as a prostitute exacerbates the risks greatly, even if the conventional advice is followed: team up with someone, attend to 'bad dates' listings, and generally keep cautious. One respondent said she carried a knife while she was working.

Every respondent referred to at least one serious incident of violence during the time they had been homeless. It appears that all of the attacks were perpetrated by men. Six of the ten women reported having been assaulted fairly recently (to the extent that a time period could be ascertained, the assaults occurred within the previous few months to few years). Four of the women were beaten by men and received severe injuries, such as concussions and broken bones, and two of the women referred to recent rapes and rape attempts. One of these women exhibited signs of post-traumatic stress disorder.[10] This is undoubtedly not the full extent of the violence experienced by these women, but it indicates that long-term homeless women, especially those who sleep rough on their own or who have addictions for which they need to earn extra money, experience extreme physical and sexual violence.

While some long-term homeless women determinedly avoid any interaction with police officers or the medical system, being victimized by severe assaults and aggressive conflicts that occur in public locations is quite likely to draw them into such contact. Some of the respondents felt they had been treated well by police officers, either with specific reference to some of the violent incidents noted above, or as part of their general experience on the street, including their observations of how other homeless women are treated. Other respondents felt they had been subject to excessive surveillance and even harassment by police officers and treated with disrespect. This mixture of satisfied and highly dissatisfied assessments of interactions with the legal system is similar to the polarization of their responses to medical personnel.

Hilda left home when she was 17 because her stepfather was abusing her physically, sexually, and emotionally. As a teenage mother, her first two children were 'taken away,' and she went through an emotional breakdown which was diagnosed as manic depression. She was hospitalized twice, and tried to commit suicide. In her twenties she had three more children who are now being raised by her mother in another city. She attributes her homelessness to her former partner who "put [her] out on the street to work." She has used Out of the Cold services and stayed at various shelters off and on for ten years, with a more intensive three-year period that included sleeping rough.

Health Problems

None of our respondents, especially the older ones, enjoyed what could be called good health. The

[10] Post-traumatic stress disorder involves re-experiencing an extremely traumatic event for longer than a month. Symptoms include fear, horror, hopelessness, feeling numb or depersonalized, and experiencing flashbacks, along with anxiety or increased arousal, and avoidance of stimuli associated with the trauma (Kennedy, Parikh, and Shapiro 1998: 18).

onset of a few of their ailments may have preceded their homelessness, but most of their health problems are exacerbated, if not caused, by their living conditions:

- frequent colds, flu, undiagnosed coughs, bronchitis, pneumonia
- asthma, anaemia, migraines, arthritis, severe back pain
- diabetes, hepatitis C, AIDS, heart condition, liver damage, kidney problems
- epilepsy, hydrocephalus (head shunt), seizures
- schizophrenia, multiple personality disorder, depression, and addictions[11]

Given this range of health problems and their severity, access to medical services is of critical importance.

Use of Hospitals and Health Facilities

Half the women said they are well-treated by hospital personnel, and two are equivocal about their experiences with hospital staff. Three women reported that they have been treated poorly once when it was revealed that they lived in a shelter, or did not have an address or any next of kin for notification purposes. One woman reported that medical staff members have been patronizing and discounted her symptoms, attributing them to psychiatric rather than physical problems.

Wellesley Hospital, which has developed specific outreach programs and staff training for serving homeless persons, received a favourable assessment. A couple of the women relied strictly on mobile health services that are designed for homeless persons. Convenience may be the primary reason for this, but it also may be a way to avoid the risk of less-than-respectful treatment at conventional medical sites used by the general population.

Two women commented on situations when they were assaulted. One woman said she was treated well by emergency hospital staff and that the police were called to report the assault, while another said she was treated badly and the police were not called. A drop-in centre worker or advocate accompanied the first woman and this may have improved her chances of receiving equitable treatment.

Pat ran away from home at the age of 18 to escape physical, emotional, and sexual abuse. She has been in and out of several psychiatric hospitals, twice losing custody of her child. When she tried to enter a women's detoxification program, she was rejected because of her mental health problems. She lived on the street for years, washing herself in hospital bathrooms and alternately wearing and washing her two sets of clothes, before she tried a shelter for the first time. Since that time, she has stayed in several shelters, including family shelters when she still had her child. At two points, she lived in subsidized housing. For a few years, she lived in an alternative housing project for homeless people, but again found the drugs and violence intolerable. Her longest period of stable housing occurred when she lived in an apartment within a house owned by her mother. When the house was sold, she returned to using hostels. She is currently on a waiting list for a supportive housing project.

Use of Shelters

Perhaps due to the high rate of previous abuse and violence suffered, both as children and adults, or

[11] Regarding the high prevalence of substance abuse (including smoking) among our respondents, it is important to note that people who suffer from anxiety or depression commonly seek relief by 'self medication' by abusing various substances (Kennedy, Parikh, and Shapiro 1998: 21).

simply to avoid possibilities for male violence, most of our respondents used only women's shelters and avoided the newest or temporary emergency shelters that are mixed-gender. One woman, who said she had a "problem with men," used a mixed-gender shelter once on the condition that the staff assured her personal safety and discharged anybody who was violent. Mixed-gender shelters are appreciated, on the other hand, by those women, usually young, who want to remain with a male partner or friends.

Two respondents who had used both shelters for single women and for families said they preferred the latter because there is more privacy, generally a separate room. In the case of motel housekeeping rooms, extended stays are made more tolerable by the higher level of privacy.

Personal safety is a special concern in the choice of shelter. Youth shelters were reported to have a poor atmosphere, with too many aggressive youth. One woman said she left a women's shelter because of the mentally ill women who made her feel uncomfortable, giving this incident as an example:

> *Just one hour after laying down to sleep, I saw a woman standing over me with a fork.*

The high risk of being robbed and losing precious belongings, including identification documents, also keeps some women from using particular shelters, or any at all.

There are other reasons for women to reject the use of shelters — for one, they do not operate on the same schedules of homeless women who sleep during the day when it is relatively safer and stay up all night. In the words of one respondent — *Our night time is not the same as for the people running the shelter.*

Many of the respondents criticized the inflexibility of most shelters and their demeaning regimen of rules and curfews. Use of shelters is associated with high levels of control. One woman referred to it being prison-like. In one woman's shelter, there are mandatory in-house life-skills programs and housekeeping chores. Most shelters force residents to leave during set daytime hours; this is not appreciated, especially by women with health problems. And yet, some of the apparently easy solutions may not be as viable as expected. For example, because Marie drinks daily, she is not accepted in most shelters, yet she said she would not want to stay in a 'wet' shelter because, unlike herself, most drinkers are loud and confrontational, and she did not want to live in such an environment.

Vicki left home when she was 16 years old because she and her mother were not getting along. For a short time, she lived on her home reserve and helped to raise her cousin's daughter and cared for her cousin until her death from cancer. Returning to her mother's home in Toronto and finding their relationship unimproved, Vicki left for the street "with everything she could shove in a gym bag." Over the past several years she has generally stayed with friends. A couple of times, she and her boyfriend had a place of their own. She augmented their welfare cheque with panhandling, but they ended up in arrears anyway because he spent all their money on alcohol. She has been sleeping behind buildings under construction or in parking lots. When it got colder, she and her boyfriend, his brother, and another woman began staying at Out of the Cold[12] sites. The four of them stay together, whether sleeping rough or staying in a shelter, and look out for each other.

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[12] Out of the Cold programs are set up at several sites across the downtown area during cold weather. They are temporary 'winter' shelters that accept men and women and provide little more than mats on the floor and breakfast before forcing people out during the day. Curfews are set for admittance.

Related Service Use

Food Banks

All but two of our respondents have used food banks and are generally highly appreciative of this type of service, especially where the food bank staff members are respectful and where there is some choice allowed in which foodstuffs people want to take as well as the quantity (within acknowledged limits) — "just like shopping" in one woman's words. Normalization is obviously a very important quality of service provision. Food banks where the staff, or volunteers, are perceived to be patronizing, and where standard, stingy bags of food are handed out to all users reinforce feelings of being different and apart — recipients of anonymous charity.

No-cost food provision is clearly an aid to stretching an inadequate food budget and daily survival. Mothers were especially diligent about using food banks to supplement diets for their children. By relying on food banks for canned and dry food, they were better able to purchase some amount of fresh vegetables, meat, and fresh milk for their children. Vouchers for store purchases were also appreciated.

Veteran food bank users distinguished between various providers according to these various preferences. It was not unusual to hear that women would make long walking treks across half the city to use a favoured food bank.

Drop-In Centres

All of our respondents made use of drop-in centres or friendship centres and generally spoke of them warmly. Besides the basic provision of hot lunches, food banks, coffee, showers, clothing, emergency cash, housing referrals, and bunks for sleeping, there were other benefits, such as medical services, and use of computers. Of course, drop-in centres were also useful as escapes from lousy weather and to "kill time." But it was the personal support from staff members that was most appreciated. Several women referred to places where they especially liked the staff, giving examples of support they had received in times of crisis, but also referring to the overall friendly atmosphere.

One woman compared drop-in centres on the basis of how clean, well-furnished, and pleasant they were as well as the range of interesting activities. Another woman said she stopped using a particular drop-in centre where she believes she was "ripped off" by her public trustee and now prefers a women's drop-in centre where "*you don't have to posture for men, can play cards, and use a wood shop.*"

A few other services were mentioned by our respondents — addiction groups, a sexual abuse support group, and a harm reduction group for people with psychiatric disabilities. Aboriginal women made more use of shelter and related services that are managed by and for Aboriginal persons.

Dawn was given up for adoption when she was two weeks old and lived in a total of 14 different foster homes until, at the age of 17, she ran away because she was being physically and sexually abused. She left the Maritimes and 'hit the street' in Toronto where she began using drugs and slept on downtown rooftops. Over the next twenty years she has occasionally obtained more secure housing, usually in a rooming house, but never for very long. Her longest period of secure housing was when she lived in a public housing unit for eight years with an abusive male partner and their five children. This ended when she was evicted. Two of her older children went to live with their father, and the younger three were taken into care. For almost three years she and five others slept in a

park during the day and stayed awake all night keeping a watchful eye. She had another child who was apprehended at birth because of her drug use and homelessness. Over the next three years she stayed at various shelters or with friends, was incarcerated, and entered a detox program. She and her boyfriend are temporarily staying with a friend of his in a roach-infested, single room.

A Day in the Life

My life is boring.

According to one assessment, it takes 37 hours a week for homeless people simply to gain shelter, food, clothing, and other basic necessities, making surviving on the outside a full time job (Wolch and Dear 1993: 237). This contradicts the above quoted statement made by Dawn, but it may be that she felt resigned and saw little change in her life or nothing to look forward to. By her curt description of her daily routine, she wakes up, panhandles, hangs out, looks for work, then tries to figure out where she will *"lay her head for the night."*

Tracy spends her days inside, heavily dependent on the staff of the transitional housing project where she lives. And Rita stays inside most of the time, watching television to avoid the temptation to use drugs, or she goes to her various appointments. If she had to stay at a shelter where she was forced to leave during the say, she said she would be back on drugs in no time. Pat mentions going on a round of appointments.

Jill spends most of her day at her favourite drop-in centre, helping in the kitchen and hanging out. She also "works the streets and does drugs." At 4:00 a.m., Marie leaves the doorway by a major intersection that she calls home and walks to her favourite drop-in centre, located a couple of kilometres away; where she helps set things up, eats something, and goes to sleep in one of available bunks. When she wakes, she eats lunch, watches television, showers, uses an exercise bicycle, hangs out, helps the staff with cleaning, leaves at 4:00 p.m. and buys a bottle. She walks to Nathan Phillips' Square (city hall) to hang out, then back to her doorway between six and ten in the evening.

When still a teenager, Lee left her parents' home. Although she finds them quite unsafe, she has lived in rooming houses off and on. When she was a young adult, she sometimes lived with older, female partners, and some of these partners were abusive toward her. She has been incarcerated at least once and has entered drug rehabilitation programs a few times. The lack of adequate discharge planning has repeatedly left her without any means of support on release. She has used women's shelters extensively. Some shelters, however, exclude those who are not "clean and sober," so she has sometimes slept rough, especially when on an alcohol and crack binge. It's been five years since she slept outside, and for the last four months, she has managed to maintain a room in an alternative housing project designed for single homeless people.

Survival Strategies

Only half of our respondents received regular welfare benefits from income support programs. Even those who did receive such benefits supplemented their income by prostitution or panhandling. Prostitution, panhandling, and casual employment (e.g., cleaning, being paid by ticket scalpers to stand in line all night to purchase tickets for a "hot show") are the primary ways to earn

money for those who receive no regular welfare income. A couple of the women relied solely on emergency welfare funds or the 'personal needs allowance'[13] given at shelters. One woman regularly sold her monthly prescription for medication and sent half the money to help support her youngest child.

Prostitution can provide the most income, enough to pay for drug habits and even rent a room or apartment for a while. But our respondents appeared to engage only in subsistence prostitution, and a couple of the women who had stopped working in the sex trade were clearly relieved, as this woman explained — *Now that I don't feel so bad about myself, I can't do that job anymore. It was eating my soul.*

Among those of our respondents who had panhandled, some were frank, if not proud, about how much they and others they knew could earn[14] this way: twenty dollars in three hours; twenty to thirty dollars an hour "with a cute face and a nice smile"; and, even unsolicited, up to four dollars a day. One respondent said that it is easier for women to panhandle successfully: she knows a woman who has a sign with her daughter's picture on it and can make up to forty dollars an hour.

There are other ways to meet basic needs: one woman occasionally goes to the home of friends who will allow her to sleep undisturbed for up to two days. And other institutions take some of the pressure off shelters:

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

***One** of 11 siblings, Kim left home to escape her mother's alcoholism. She moved to the west coast and began using drugs. She later married and had three children, but her alcohol and drug use made it increasingly impossible for her to stay with her family. She has lived in rooming houses at various times, but for the last seven years she has stayed in shelters. During that time she has been incarcerated and entered detox programs. Two years ago she was roaming, going from shelter to shelter, but she is currently staying for longer periods of time in an alternative housing project for homeless single adults.*

Families and Homelessness

Talking about their families was difficult for some of our respondents, especially near a holiday season.

> *This time of year [Christmas] is very hard on me You'll probably see me sleeping a lot, crying a lot*

Several of the women are estranged from their family of origin or from their children. In other cases, there is still a flow of instrumental and social support between generations: one woman sends

[13] The personal needs allowance (PNA) was introduced in the early 1990s. All shelters residents who have no other source of income are eligible to receive $3.75 a day. Since 1995, this may include or consist of in-kind assistance as well as cash.

[14] For readers who do not view panhandling as a form of earning money, consider the opinion of one service provider that there is a benefit gained by those who give money to panhandlers — they get to "feel good" (i.e., compassionate) and assuage their guilt over the extreme destitution of some Canadians against their own good fortune.

money to help support her child; another has received money, visits, and offers of additional assistance from her siblings; and yet another has received occasional financial aid from her mother (without her father's knowledge).

While generally fraught with suspicion and social isolation, shared street life can also foster relationships, especially in the form of street families. There are also signs of quasi-parental relationships that are satisfying for older women who are no longer in a mothering role.

> *I get along with a lot of the younger people. I have a few kids on the street that call me mom, and I feel proud about that, cuz I musta done something right for them to call me mom.*

While one woman said that it was difficult to form relationships with other homeless women, most of whom prefer to maintain their privacy, another said that people on the street are "like family and look out for each other." The latter woman also said that young people on the street often ask her for advice and she always encourages them to give up the street life while they still can — she understands that it can seem exciting to them. Not asking for help nor accepting proffered assistance from family members may be a way of maintaining adult status and individual boundaries for homeless women. For example, one respondent said she does not ask her siblings for money because she would use it for drugs and she does not want to do that. Another woman appreciates the assistance she has already received from her family but wants to maintain her independence and not exhaust her family's limited resources.

> *I see my family, but they supported me long enough. I need to fend for myself. I hate going to my father and mother .... My sister has children, and my brother's in the pen. I hate to be a burden to them I had more support from my family than from any agencies or anybody else, but there is only so much a family can do.*

Until six years ago, Marie was employed and had her own apartment. When she was fired from her job, she began a wrongful dismissal complaint and applied for unemployment insurance. Once her savings were exhausted, the stress of the lawsuit and financial worries made it impossible for her to look for another job. She was drinking heavily and lost her apartment. She continued to pursue her lawsuit while living in a women's shelter for two months, but then gave up and left the shelter for the street. Since then she has stayed at only one other women's shelter, generally sleeping rough, and using drop-ins to sleep during the day. She used to spend all night in donut shops before finding a drop-in centre she liked. She avoids shelters because of her heavy drinking. Even when a shelter will accept her drinking, she finds it hard to make the curfew limits. On rare occasions she stays with a friend.

Changing Times

According to our respondents, there is a range of changes over the past decade that they have observed and that effect them or other homeless women:

- there is more risk to women's personal safety, more violence (partially due to use of crack cocaine), and more weapons on the street now (knives, brass knuckles, and guns)
- although there are more shelters, it is harder to get a bed

- shelter staff members have less time to talk to people, and they tend to be less pleasant or flexible, and more judgmental
- there are more food banks and drop-in centres and heavier use of these services
- access to medical services is more difficult and takes more time; there are fewer hospital beds available
- everyone's economic situation is worse; welfare benefits are lower, including emergency funds, so people more desperate — *People are robbing their own kind for a few dollars, doesn't feel like there are any rules anymore.*

Effects of Funding Cuts

Virtually all of the women were well aware of the climate of government funding cuts, reduced and eliminated programs, and the effects on themselves and other women living in poverty. They offered specific examples of these:

- the Native Centre "*used to have a lot of great programs*," but has drastically reduced their services
- Street Patrol used to provide transportation to far-flung shelters if they had time; now they are mandated to stay within the downtown area
- a popular art therapy group was cancelled
- reductions in funding make it harder to get assistance for psychiatric disabilities and treatment for substance abuse — *They expect us not to do drugs, but that's the only way we can cope.*

Some of the respondents had been directly affected by abrupt reductions in their welfare rates, with disastrous results (e.g., one woman was left with outstanding debts to family, friends, and shopkeepers, which she could not meet; another's teenage son began stealing to pay for his clothing).

With her two-year-old child, Jill first used a shelter for battered women when she was 18 years old. She stayed for two weeks that time, but on later occasions she used shelters to "take a break" from her husband's violent behaviour. At one point she moved in with her mother, but left with her youngest child to avoid her mother's heavy drinking and smoking. Jill had a drinking problem herself, but managed to work as a cab driver for a while. Years later, she was staying in a family shelter (a motel unit) with two of her four children (two had been placed in care by this time). After a year, she returned to her husband and the family of four had stable housing for about three years, until he left. Jill and her children then moved into a small two-bedroom basement apartment. Her homeless teenage nephew joined the household until the crowding became intolerable. Jill left with her youngest child to stay in one family shelter after another. By that time, Jill was using cocaine heavily and voluntarily placed her youngest child in care. Since then Jill has gone from hostel to hostel, stayed with friends sometimes, been in jail, slept rough, and returned to the hostel circuit. She's planning to move into a transitional housing project soon.

What's Wrong and What's Needed

Insufficient income support programs and rates were most often specified as a fundamental problem by our respondents, especially in terms of what kind of housing they are able to obtain.

> *You can't get first and last months' rent from welfare anymore, and the housing part [shelter allowance] is so small that it's impossible to get anything. I wouldn't live*

in what you can get for $325. It's better to be on the street than many of these places.

There were other problems that the women thought contributed to homelessness:

- violence against women, specifically abusive partners
- social isolation and loneliness
- unemployment
- substance abuse
- adaptations to street life, including resistance to rules and responsibilities

Their suggestions for change were logical extensions of their analyses of the problems. Some were framed as very modest changes in existing services (e.g., more women's shelters, transport between shelters and services, more flexible services and better access to them for people on the street). It is common to hear such suggestions from homeless people, asking for more of the same services that they criticize. This has been characterized as a reflection of their dependency, their inability to envision "more access to the larger society" (Homeless Persons Outreach Project 1990: 14). Reduced expectations may be an understandable coping mechanism and survival skill for those who feel a tremendous dissonance between what they control and what they require.

Other suggestions were definitely more bold and far-reaching:

- employment opportunities for the homeless to help each other, especially youth, off the streets
- more opportunities for education for homeless people
- restoration of health system funding and improved access for homeless people
- better help for those with mental health issues
- new residential programs with strong follow-up support to help people with substance abuse problems
- more mixed-gender services for transsexuals
- because some women require a fine balance between privacy and sociability, more housing options that provide private rooms along with communal areas

Many of the women specified the need for more affordable housing options, especially non-institutional, supportive housing models that incorporated models of community development or support and were sensitive to the needs of women with psychiatric disabilities.

As a child, Rita was sexually abused by an uncle and physically abused by her father. After running away from home at the age of 11, she received psychiatric treatment, living in an institution for over a year (cottage style residence). This was followed by life in the 'foster home circuit' until she was 18. For one year she had stable housing while she worked as a prostitute. Since then she has been HIV positive. Rita has the unique experience of having stayed in men's shelters (prior to her sex-change operation) as well as women's shelters. She found she was 'hassled' by the men and accused of being 'intimidating' by the women. Now staying in a women's shelter, she is waiting expectantly for a public housing unit.

Categorically Speaking

If we try to apply the categories of episodic and chronic as discussed earlier (Kuhn and Culhane 1998), it appears that about half of our respondents fit the criteria for chronic homelessness, especially the middle-aged women who have stayed in the shelter system for years. These women fit the

profile of semi-permanent residents of the shelter system. Episodic homelessness is also long-term but distinguished by intermittent use of other residential institutions (i.e., jails and hospitals, including treatment programs) that are especially associated with substance abuse problems and aggressive behaviour, a profile that more often applies to younger homeless women and those who self-medicate with illegal substances to deal with their intrapsychic suffering. A couple of the respondents appear to have shifted from one type to the other at different points in their lives.

Kuhn and Culhane (1998) were able to ascertain other institutional service use by linking their shelter data with that from large social service agencies (e.g., case management information) to determine these combined service patterns. While their shelter database reflects a maximum of nine years of service use, we were able to review longer histories for all but the youngest respondent. The interview method we used provided more individuated and in-depth stories of women's long-term homelessness. It also allowed women to offer their own views and opinions on the causes, dynamics, and solutions to homelessness. While these portraits convey more of women's lives, they are not the best method for measuring episodes of homelessness and length of shelter or other institutional use, partially because relying on memory, especially over long periods is not highly reliable. Consequently, it is not easy to position our respondents according to the categories the Kuhn and Culhane study have suggested.

It is possible that the primary distinction between the chronic and episodic homelessness may boil down to front-line assessments by social service providers that transinstitutional users are 'harder-to-serve' and require somewhat different intervention solutions. This issue will be discussed further in the next section.

SECTION 5: CONCLUSIONS

As the rate and depth of poverty has worsened, and the social safety net has been severely eroded, more women are subject to visible homelessness. This includes female children as young as twelve years of age and women in their eighties, a disproportionate number of Aboriginal and African-Canadian women, and women with dependent children. Most women and families are transitional hostel users who stay in the system for less than one year and do not return. For them, affordable housing is the primary key to preventing and ending homelessness.

Our focus in this report has been on women who are homeless for longer periods of time. According to analysis of nine years of administrative data, at least a sixth of the women who use the hostel system do so for a period of more than one year. These women are highly likely to have mental health problems. According to service providers' accounts, more long-term homeless women over the previous decade exhibit problems with addictions as well. The state of their physical health is very poor and they face significant barriers to receiving adequate health care due to their homelessness. Sexual violence is a predominant part of their life experience and cause of their homelessness.

The dynamic interrelationships among violence against women, mental illness, and homelessness have yet to be adequately explored and understood, yet it is becoming more obvious that women who are visibly homeless for long periods of time are extremely likely to have been abused as children and adults, are highly vulnerable to revictimization, and are virtually stuck in a pattern of hostel use, sleeping rough, and living in precarious and unstable housing conditions. The relationship between violence against women and their housing is complex; it both drives women toward and away from housing situations and living arrangements with men, depending on individual assessments of specific situations (Novac, Brown, and Bourbonnais 1996). This underlies a key distinction between women's and men's homelessness. Women require housing that is both affordable and safe.

Over the previous decade, the scale and intensity of homelessness has grown, yet services at shelters and drop-in centres have deteriorated due to decreased staffing and agency resources, so that workers are doing more with less (Ward and Tremblay 1997). We have relied on service providers' observations to elaborate on the factors that have contributed to these changes and what this has meant for women who have been homeless for long periods of time. There are several points of concurrence between the observations of experienced service providers and the findings of systematic research on homelessness in Toronto over the previous decade:

- more women, youth, and families are homeless
- as reasons given for shelter use, domestic violence and family breakdown have increased
- it has become more difficult for women, including victims of domestic abuse, to leave hostels and obtain subsidized housing
- long-term homeless women have experienced very high rates of abuse prior to and after becoming homeless
- there is a very high rate of mental illness among long-term homeless women
- more shelter and health outreach services have been developed for women, although not enough

Many of the service providers we interviewed were disturbed by the trend toward minimal shelter provision and the 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 or chronically homeless women, the trend toward large-scale, sex-mixed, minimal shelter facilities present great dangers 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. Such least-cost, minimal shelter conditions indicate a problematic direction for *de facto* social housing policy for the very poor. Ward (1998) has argued that the role and function of emergency hostels have changed, in concert with changes in other large institutions such as psychiatric hospitals and correction facilities, to become the 'institution in the community' and a long-term response to lack of housing for particular groups of the poor.

Almost all of the long-term homeless women we interviewed had left home as youth due to familial abuse. This speaks to a serious pattern for the future as the number of homeless youth increases in urban centres — will a sizeable proportion of them continue to be homeless throughout their lives, with only intermittent periods of relative housing stability? Hagan and McCarthy (1998) have suggested that a social welfare approach to service provision, rather than a law enforcement approach, improves the opportunities for homeless youth to find employment and more stable housing and make a successful transition to adulthood. More services and support should be directed to address the needs of homeless youth to break the intergenerational cycle of extreme poverty, homelessness, and family disruption.

Our homeless interviewees confirmed many of the observations made by service providers, i.e., income assistance programs are inadequate to secure modest, safe housing; the infants and children of homeless women are often apprehended by child protection agencies or raised by other family members; and the level and degree of physical and sexual violence abuse experienced by homeless women are very high. Homeless respondents reported severe physical and mental health problems, but mixed experiences in their use of hospitals and health facilities. Mobile health outreach services are well appreciated, and a couple of the women said they relied on them solely for health care. The women were quite cautious in their choice and use of shelters, with most of them using only women's shelters or sleeping rough. The changes they noted included greater concern for their personal safety, an increased level of street violence and use of weapons, less access to health services, and more shelter, drop-in centre, and foodbank services but less staff attention and assistance.

For women who have been homeless for a long time, affordable and safe housing is a necessary but inadequate solution to their situation. Most of them also require support services to help them maintain their housing and well-being. There is a subgroup of chronically homeless women, who are predominantly middle-aged, have severe mental illness, and are likely to have been institutionalized in the past. Some of these women avoid using shelters or are barred from them due to their aberrant behaviour. A combination of outreach services and a small-scale, low-demand respite residence model has proven successful in bringing these women indoors and allowing them to feel more secure and establish greater stability. Targeted services like this must be developed to prevent women from dying on the streets.

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 the 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.

Targeting Prevention

- *one-on-one workers*

Women's shelters have lost staff positions that previously allowed them to assist residents obtain permanent housing and to provide support service to help them establish households. This is only logical if the intention is to keep women housed in shelters, not if the intention is to help them move onto permanent housing. In an assessment of homelessness prevention strategies, Ward (1998) stressed the chronic shortage and important role of one-on-one support workers (i.e., case managers, housing workers, and community development workers). He estimated a current shortfall of 50 case managers alone and at least that many again of other types of support workers.

- *residential treatment programs for women with dual diagnoses*

There is a pressing need for treatment programs for women with concurrent diagnoses of psychiatric disorder and substance abuse. The general belief that treatment response is poorer for people who suffer from both problems at the same time is likely due to the lack of trained specialists and facilities to deal with both groups of disorders. Addiction treatments must be integrated with treatment for depression and other psychiatric disorders (Kennedy, Parikh, and Shapiro 1998).

- *harm reduction facilities*

After years of tension and vigorous disputes over drug use in a Cabbagetown neighbourhood east of downtown Toronto, the recently formed Illicit Drug Users Union of Toronto has been engaged in discussions about harm reduction strategies and programs, along with local service providers and the residents' association (Cash 1999). While needle-exchange programs are in operation, there are new plans to request funding to set up harm reduction facilities that would accept the use of drug and alcohol on-site (as recommended in the Mayor's Homelessness Action Task Force). Successful programs in twelve European cities based on the harm reduction model have been effective in limiting health risks to users and cleaning up surrounding neighbourhoods. There is a growing consensus that criminalization strategies (i.e., arresting users) have not been effective in stemming the flood of problems created by illicit drug use.[15]

- *need for low demand, high support facilities*

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. The reasons given by these 'shelter returnees' point to their need for more staff support and intervention, at least within shared housing settings (Novac, Brown, Guyton, and Quance 1996). For some but not all of them 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.

Supportive Housing[16]

The term supportive housing refers to any model that purposefully combines subsidized housing

[15] A non-judgmental approach towards alcohol consumption is already in force in a program attached to a large men's shelter (the Annex at Seaton House).

[16] The material in this section draws heavily on Novac and Quance (1998).

with supportive services designed to help people obtain and maintain their housing and well-being. The support services can include assistance with any of the following: service referrals, mediation and conflict resolution (with neighbours or landlords), community development, tenant input and management, employment, social activities and interaction, counselling, medical care, banking, cooking and meal preparation, laundry, and housekeeping. The types and levels of support vary considerably across projects. The settings include group homes, supervised apartments, and housing with independent supports, as well as self-contained or shared living arrangements. Shared living arrangements are fairly common, primarily to lower costs, but also to suit those individuals who are more comfortable living with others. Whether or not shared living is preferred by residents, it generally necessitates a higher level of assistance with problem-solving and conflict resolution.

Supportive housing has its origins in therapeutic and normalization principles. The majority of published research on supportive housing is found in the mental health literature and refers to projects that serve only people with psychiatric disabilities. Evaluative research conducted in the United States and Canada demonstrates that supportive housing keeps vulnerable people housed, reduces the inappropriate use of emergency services, such as hospitals and shelters, reestablishes residents' social networks and their ability to join and contribute to communities. There are also studies that indicate supportive housing has been effective in addressing the needs of other subgroup, such as people with developmental disabilities and youth.

Policies of deinstitutionalization have fostered the development of this housing approach, and newer projects are designed to accommodate persons who have been homeless. Project planning and management of supportive housing for homeless individuals is advancing beyond the early stage, yet the evaluation research literature on supportive housing models and programs that serve the homeless is still sparse and more descriptive than explanatory in terms of *how* housing and service components or combinations are correlated with effective processes and outcomes for residents.

According to Burt (1997), we have good program evaluation information on services for long-term homeless persons with severe or chronic disabilities (notably, mental illness, drug abuse, and alcoholism) and on programs that work to keep people in stable households, meet their needs, and create satisfying living environments with an overall 80 percent success rate. It is also clear that support services are critical to the success of supportive housing for these groups.

> The critical services 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 (Burt 1997: 365).

Novac, Brown, Guyton, and Quance (1996) conducted a survey of female residents living in more than twenty supportive and alternative housing projects managed by nine different agencies in Toronto and found the respondents to be well satisfied with the design and layout of their units, and with their neighbourhoods. Improvements in social and organizational skills, personal relationships, and practical life skills, including knowledge of social and political issues, were reported by the majority of respondents. The housing project staff members were viewed quite favourably by residents and considered responsive and helpful in providing support, advice, and problem-solving assistance. While there are many clearly successful aspects of existing projects, there are also areas that require improvement. One source of problems is shared living arrangements.

While some of the respondents who lived in shared housing appreciated its sociability, about a third of them were dissatisfied with the lack of privacy, having to share kitchen and bathroom facilities, and the irresponsible, annoying or frightening behaviour of other tenants. Even for women who have self-contained units, many are concerned about the adequacy of screening processes and management of troublesome or dangerous tenants. Connected to this basis for concern is another source of problems — gender relations among tenants.

Most of the supportive housing projects are sex-mixed, even when the units are shared, and a high proportion of the residents have been homeless. More than a third of the respondents indicated that they had been sexually harassed by male tenants, and up to half had been affected when witnesses to sexual harassment incidents were included. This is a much higher prevalence rate than for female tenants at large,[17] especially given the relatively short residency periods involved — on average less than two years and seven years at the most. In a couple of the buildings surveyed, women reported that rapes and sexual assaults by male tenants had occurred. Moreover, staff responses to complaints of sexual harassment were said to be generally poor. Especially because the prevalence of physical and sexual abuse is very high among homeless women and those who have lived in poverty, gendered patterns of violence must be understood and dealt with by supportive housing providers to prevent revictimization.

Several studies suggest that a sizeable portion (as many as a quarter) of women who are precariously housed, homeless, or living in supportive housing projects would prefer to live in sex-segregated buildings, including private sector rooming houses (Quance and Novac 1996, Novac, Brown, Guyton, and Quance 1996, and Novac, Brown, Gallant, and Sanders 1998). Yet only 6 percent of supportive housing units are designed specifically for women. There are very few women-only supportive housing projects or buildings in Toronto, and there are no private sector women-only rooming houses. In response to this demand, one nonprofit agency that monitors privately-owned boarding houses (Habitat Services), is adding three female-only rooming houses to its portfolio. The significance of the preference for sex-segregated buildings and projects is bolstered by the fact that women who live in them reported higher levels of satisfaction and fewer problems than those living in mixed-sex projects (Novac, Brown, Guyton, and Quance 1996).

According to a recent assessment of the supportive housing sector in Toronto, the current stock consists of more than 5,300 units.[18] The estimated shortfall to accommodate existing need is another 5,500 units. About half of these units are self-contained (Novac and Quance 1998). Among its many recommendations for preventing homelessness, the Mayor's Homeless Action Task Force has included the requirement that 5,000 units of supportive housing be developed as soon as possible and that programs to increase the supply of affordable housing are instituted (Golden et al. 1999). While there are no indications yet that senior governments will reinstate a national housing program to meet the crisis of affordable housing, there is some funding promised for supportive housing and related services through ministries of health and social services. It is important that a sizeable portion of any new supportive housing project be gender-sensitive — designed and managed according to women's needs and preferences.

[17] Based on an Ontario survey, about 25 percent of female tenants have experienced sexual harassment over their entire tenancy histories (Novac 1994).

[18] This excludes approximately 3,000 units designated for frail elderly people or those with development disabilities, both groups who are unlikely to be among the visibly homeless.

Projects designed by and for Aboriginal women are also required. Because too many Aboriginal people have lost even hope for improvement, a strategy to address homelessness for this population should begin by fostering hope through developing Aboriginal human resources and Aboriginal administration and service providers to improve Aboriginal health and social conditions (Obonsawin-Irwin Consulting 1998).
Cultural specificity in program design and delivery is critical to successfully meet the needs of Aboriginal women, men, and families. There are only a few Aboriginal supportive housing projects in the Toronto area. They are predominantly for Aboriginal families and older persons and have low levels of support. There is virtually none for homeless singles or couples who need medium or high levels of support, groups that are at high risk of homelessness.

For women who have been homeless for a long time, especially those who are alienated from the shelter and service system, it is of primary importance that the effectiveness of new services designed for them be monitored and the new knowledge integrated into shelter and outreach service adaptations and additions. We must not allow so many women to continue living on the rough edge of our society.

Appendix A: Key Informants

Eileen Alexiou, Jessie's Centre for Teenagers
Nancy Blades, Fred Victor Centre Women's Hostel
Nicki Casseres, Gerstein Centre
Suzie Edwards, Interval House
Dr. Heyding, Wellesley Centre
Anne Longair, City of Toronto Hostel Services
Robin Masterson, Strachan House
Annette McCurven, Homes First, Savard's, and 60 Richmond St.
Sheila Miller, City of Toronto Housing Department
Darlene Miner, Hostel Outreach Project
Susan Miner, Street Outreach Services
Marg Moores, Habitat Services
Louise Nimigon, Hostel Outreach Services, Community Resources Consultants of Toronto
Joy Reid, 416 Drop-in Centre
Josie Ricciardi, Regent Park Health Centre
Vicki Sanders, Streetcity
Eight staff, Community Housing Support Services
Denise Toulouse, Anishnawbe Health Street Patrol
Peggy Ann Walpole, Street Haven
Zell Wear, Toronto Hostel Services
Laurie Weiss, Public Health
Evodne Wilkinson, Out of the Cold
Annabele Wainberg, Women's Residence
Marie Zablonsky, Women's Residence

Appendix B: Questions for Service Providers

Informant Interview

Respondent's Name:

A: Relevant Experience

1. Please outline your relevant work history over the past ten years.

2. What would you say is your expertise in describing homelessness among women, and of what aspects are you knowledgeable?

B: Context of Homelessness among Women

1. With women in mind, how would you define homelessness?

2. Describe the general situation for homeless women over the past decade, pointing out the similarities and differences from ten years ago and today, or as things have changed during the past ten years.

   Probes: a) number of women effected, demographic profile (age, ethno-racial composition)
   b) *causes and patterns*

C: Factors of Chronic Homelessness among Women

1. Over the past decade, what has been the relationship between the following factors and chronic homelessness among women (note any demographic distinctions, e.g., by age, ethno-racial status, income, marital status, migration):

Health Issues:

a) general health
b) mental illness
c) substance abuse
d) alcohol abuse
e) physical abuse, sexual abuse, and incest

Survival Strategies:

How do the women?
a) find food and get money and other resources
b) find a place to sleep
c) protect themselves
d) relate to men, to other women, to service providers

Services:

a) What services have been available?
b) What are the gaps between needs and services available?

D: Chronic Homelessness among Women

1. How would you define chronic homelessness among women?
   Probe: distinguish among transitional, episodic, and chronic homelessness

2. What distinguishes the women who are more likely to remain in the hostel circuit for long periods?

3. Can you identify different types of lifestyles or circumstances of chronically homeless women?
   Probe: youth versus older women, drug users, health status, where they sleep

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Appendix C: Questions for Service Users

Questions for Shelter Users

Respondent's Background *[establish as much as possible, at any point during the interview]*

History and pattern of homelessness: *[Where are you staying now? For how long? Where were you before? When were you last well-housed? Any use of rooming houses? History of, and reasons for, evictions? History of, and reasons for, voluntary moves?]*

Age *[approximate]*? ________________

Experience with institutions? *[any experience of psychiatric services, hospital emergency services, detention or jails, detox centres, etc.]*

Family context: *[Any spousal relationships, recently or before? If any children, what are ages, and what is connection now? Any family breakdown related to homelessness or vice versa?]*

Other: *[whatever seems relevant, e.g., experiences of abuse, unusual or violent behaviour, shelter avoidance]*

Shelter and Service Use

1. How has the hostel and shelter system changed since you first used it?
   Have you used the newer shelters or co-ed places? *[be specific]* If so, how are they?

2. Have you used food banks? What do you think of them?

3. What other services do you find useful (e.g., drop-ins)? Why?
   What services have been unhelpful? Why?
   Have you noticed any changes in services?

4. Tell me how you spend your day *[where you go, what you do, who you see]*.

Support for Homeless Women

1. For how long have you been using shelter and hostel services?
   How did you become homeless?

2. What keeps you from getting and keeping a place to live?

3. Do you get any help from your family?

4. How have welfare/FBA cuts effected you, or women you know?
   How do you get money? *[welfare, PNA, temporary jobs, panhandling?]*

5. What kinds of problems do homeless women need help with?

6. How should services change?

Health Services

1. Where do you go when you need help with a health problem?

2. How's your health? *[Try to get a sense of her health problems, if possible, especially any mental health problems and substance abuse.]*

3. Is it getting easier or harder to see and talk to a nurse or doctor, or use emergency hospital services? How are you treated by medical people?

Safety Issues

1. How safe is it for you *(and other women)* on the street these days?
   Has it changed any?
   What types of people do you avoid? Why?

2. What are some of the safety issues for women on the street now?

3. Where do you go to be safe?
   Are there any places you used to go that you don't any more? Why not?
   Any new places that you go to?

4. How do you get along with men on the street?
   How do you get along with other women, and young people, on the street? In shelters?

[Check that the respondent is feeling okay after the interview and, if not, direct her somewhere for assistance.]

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