Models of Supportive and Tolerant Housing for Street-Involved Women

Prepared by the Prostitution Awareness and Action Foundation of Edmonton

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Executive Summary

The purpose of this study is to investigate options and models for developing a supportive and tolerant women's shelter for homeless women entrenched in street prostitution who are still active in their addictions.

The study examines eight shelter models which exemplify harm reduction practices and a 'housing first' approach to providing shelter for chronically homeless individuals with mental health, addictions and/or entrenchment in street prostitution. A total of 28 characteristics were compared.

The research also tapped the experience of local women still active in street prostitution. Specifically, the researchers held a focus group with nine women active in the street prostitution community, all of whom are effectively homeless. The focus group questions explored the pros and cons of the current housing options and what the women would want and need in a tolerant shelter.

Local shelter operators, addictions' specialists, outreach workers, parents and other professionals concerned with service delivery to women involved in prostitution participated in a focus group. They gave input regarding key features of a possible tolerant shelter in Edmonton.

The stakeholders affirmed that an ideal model should be highly tolerant and employ harm reduction strategies. The target clients should include women and transgendered individuals entrenched in street prostitution that may have addictions issues. There should be minimal assessment or entrance criteria.

Both groups advocated allowing individuals to use the shelter if they are actively using drugs or alcohol, and agreed that drugs or alcohol should not be allowed in the facility. There was agreement about having guidelines for behaviour for residents of the shelter. However, the housing and support services providers maintained that evicting a person from the shelter for violating the rules should be a last resort, while the potential user group advocated for eviction.

Considerations when dealing with women involved in street prostitution included not having a curfew and allowing people to stay in the shelter for extended periods of time (six months to unlimited). Both stakeholder groups said that many resources that should be available at the shelter. Although many resources were listed, health providers, and addictions and trauma counselling were most important. They also agreed that information and resources should be readily available at the residents' request.

Both groups also discussed the possibility of having two facilities: one for those who are actively using drugs or alcohol and one for those who are not. The housing and support services providers cited a need for a "dry" shelter for individuals who need housing before and after participating in a drug treatment program.

The potential user group was specific about several key points: their ideal facility should be small with private rooms, there should be a drop-in component, and staffing should include peers. Both stakeholder groups agreed that shelter staff should be supportive and non-judgemental and should employ de-escalation techniques when dealing with extreme behaviour.

The issue of location requires further examination as the potential user group favoured locating the shelter close to their street resources, whereas the housing and support services providers favoured a location that is away from the area of street prostitution.

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Introduction

The Prostitution Awareness and Action Foundation of Edmonton (PAAFE) initiated this study. The study arose out of the need for 75 additional emergency housing spaces for homeless single women, as identified in the Edmonton Community Plan on Housing and Support Services.[1] A detailed housing analysis conducted by PAAFE shows that there are no shelters that accommodate women who continue to use drugs and/or alcohol and are active in street prostitution.[2] Moreover, there is chronic overcrowding in existing emergency shelters.

The purpose of this study is to investigate options and models for developing a supportive and tolerant women's shelter for homeless, street-involved women who are still active in their addictions.

Methodology

1. The researchers undertook a literature review (web based) to find examples of "wet shelters" and "tolerant housing". Six projects from Canada and two from the United States were explored in depth. All of these projects offer "housing first"[3] and employ harm reduction strategies in their service delivery. Four of the projects are specifically geared to sheltering women involved in street prostitution. The research includes examples of "Safe Haven" shelter models for chronically homeless individuals who may have both a mental illness and substance abuse issues. Additional information on the case studies was obtained through interviews and written materials provided by senior managers of the housing projects. (See Key Research Questions on page 4.)

2. The research also tapped the experience of local women still active in street prostitution. Specifically, the researchers held a focus group with nine women active in street prostitution; all of whom are effectively homeless. The focus group questions explored the pros and cons of current housing options and identified what the women would want and need in a tolerant shelter. (See Appendix 1: Focus group question guide for potential user group, page 24.)

3. Local shelter operators, addictions' specialists, outreach workers, law enforcement officials, parents and other professionals concerned with service delivery to women involved in prostitution participated in a focus group. They were presented with an overview of the case studies and the input from the women's focus group, and identified the key features of an ideal model for a tolerant shelter in Edmonton. (See Appendix 3: Focus group question guide for housing and support service providers, page 27.)

All of the written materials reviewed for this study have been compiled and retained by PAAFE. Included are a number of practical guides and manuals concerning the planning and operation of the housing projects examined in this study. A complete listing is in the bibliography.

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[1] Edmonton Community Plan on Housing and Support Services 2005-2009, Edmonton Joint Planning Committee on Housing, p. 19

[2] Inventory of Current Housing Supply in Edmonton: Gaps in Supportive, Transitional Housing, Prostitution Awareness and Action Foundation of Edmonton, 2005

[3] "Housing First is an approach that centers on providing homeless people with housing quickly and then providing services as needed." National Alliance to End Homelessness, www.endhomelessness.org

Key research questions

The following questions were posed to the operators of the eight shelters highlighted in the report:

Who is housed in the project? (Specific client description)

1. What are your assessment/entrance criteria?
2. Does the program accommodate transgendered individuals? Are there any special practices you've initiated to accommodate transgendered individuals?
3. Does your program accommodate lesbian couples sharing a bed?
4. What age group do you work with? Do you encounter legal issues with clients who areunder age? Can women bring their children? If so, what do you have set in place to guarantee the safety and well-being of the children and the mother?

How does the building operate?

5. Number of units in the project. Type of units provided (shared, self-contained, mat). Is this what you would recommend if you were starting new? What is optimum?
6. Who owns the building? Who pays for operations?
7. Can you provide an income and expense statement/budget on operations?
8. What is the average length of stay? (Are there any limits on the length of time residents can stay? If yes, is this an internal policy or a funder-imposed policy?)

Policies and practices

9. What are your building policies? (hard drugs, marijuana, alcohol, smoking use on-site)
10. What are your policies and practices around safety? (For example criteria for expulsion, weapons check upon entry, ask for drugs or alcohol to be turned over for safe-keeping?)
11. How do you deal with drugs and alcohol? Can residents actively use/consume while there or do they use/consume elsewhere and come back to safely come down?
12. Support services: Who, how and where are they provided? (For example nursing services, addictions counselling, etc. Are people given help to get clean on site or referred out to detox? Or is it "just" a place to come down safely?)
13. How do you address transition planning? (Where do you send women after they come down, if they want to leave the street?)
14. Do you dispense medicine (For example Atavan, cough syrup) to help people come down?
15. What is your staffing/volunteer model? (Specifically – involvement of peers and health professionals, and other staff. How many staff on at any time?)
16. What emergency situations/crises have occurred and how have you handled them?
17. Do you have special considerations when dealing with women involved in street prostitution?
18. What input do current residents have for decisions about daily life in the facility; about entry of a new resident, determination of residency – either for themselves or other residents?
19. What input did the potential user group have into designing the building? Into designing the policies and practices?

Community partnerships

20. Who are your key partners – Child Welfare, addictions agencies, health providers, housing providers, others?
21. How is your relationship with neighbours/property owners?
22. Describe your relationship with the police.

Other research questions

23. Do you know of another best practice or model that we should explore?
24. Can you recommend any valuable research papers or reports?
25. Any words of advice as we explore developing a similar project here in Edmonton?

Section One: Case study findings

Overview of case studies

Each of the eight subjects of the study (six Canadian and two American) provides emergency shelter or a safe haven[4]. Four of the projects have an accompanying drop-in program that offers practical resources and other supports, which may be accessed on a volunteer basis. All of the projects are part of a continuum of housing services, which may include outreach, transitional and/or other permanent housing options.

The primary service offered by these projects is a place to live versus a place to receive treatment. All of the informants identified harm reduction as a primary service delivery strategy. They characterised their approach as making few demands i.e. not requiring residents to abstain from drugs and alcohol use or prostitution. Similarly residents do not have to take their mental health medications, enrol in detox or participate in other programs. While making positive changes is encouraged, opportunities to access programs or other supports are offered only when the individuals request assistance. The projects are highly tolerant of the behaviours and lifestyles of the residents.

Most of the projects are restricted to women and transgendered individuals who identify as women. Only one project is open to both women and men, but individuals are housed according to sex. One project serves women with minor children. See next page for a complete overview of the projects.

[4] "A Safe Haven is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who are on the street and have been unable or unwilling to participate in supportive services." Frank Rice Safe Haven, www.lampcommunity.org

Table 1: Overview of case studies

Atira: Bridge Women's Emergency Shelter, Vancouver, BC The Bridge Women's Emergency Shelter, located in Vancouver's Downtown Eastside is staffed 24 hours a day. Staff provides emotional support, referrals, resource information and advocacy.
Lamp Community: Frank Rice Safe Haven, Los Angeles, CA Open seven days a week, Lamp Community's Frank Rice Safe Haven has a day center and a shelter component. The day center offers a high-tolerance, low demand environment with drop-in services. The shelter provides thirty crisis respite beds, offering a safe place for men and women in urgent need. The new Women's Wing at the Safe Haven provides privacy, comfort and a home for the growing number of homeless women on Skid Row. Safe Haven is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who are on the street and have been unable or unwilling to participate in supportive services.
Fred Victor Centre Women's Hostel, Toronto, ON The Women's Hostel is a safe accessible shelter for women who require emergency shelter. The women may have been recently evicted, unemployed, victims of domestic violence, have mental health or substance use issues, or be sex trade workers. Hostel staff work with the women in a flexible and respectful manner, using a harm reduction approach. They help the women identify and meet their individual needs, link them with appropriate support services, and help them access safe, affordable housing to end their cycle of homelessness. Services include a Women's Day Program, a safe and welcoming place for women that addresses poverty and homelessness, social isolation, substance use and mental health issues.
Project H.O.M.E. Women of Change, Philadelphia, PA Project H.O.M.E. Women of Change provides 25 Safe Haven beds in the Center City area of Philadelphia for women who have a severe mental illness and a history of homelessness. Services are provided on a 24-hour basis, including case management, supportive services and on-site medical care.
Sandy Merriman House (Victoria Cool Aid Society), Victoria, BC SMH serves women who are homeless, have concurrent disorders, and/or are active in the sex trade. It is unique in that it is not a transition house, and does not have the usual mandate to serve only clients who are leaving abusive relationships and not using drugs or alcohol. Sandy Merriman House (SMH) started as an emergency shelter program of the Women's Shelter Society (WSS) in 1995. It is open throughout the day for drop-in services, and for shelter stays of up to ten days.
Savard's, Toronto, ON This hybrid model, used as shelter, drop-in and safe haven, has been an incredible success and remains unique in the City of Toronto. Savard's, established its new home and expanded services in 2003. This hostel contains 30 beds and is designed for women with a long history of homelessness who are also living with a severe and chronic mental illness. Initially developed by Homes First and the Women's Street Survivors Resource Group, Savard's was designed as a high-tolerance, low-demand environment targeting women who could not manage in traditional emergency shelters, and as a result remained on the street.
Powell Place Shelter (St James Community Service Society), Vancouver, BC Powell Place has the capacity to serve 26 single women at any given time. The vast majority of women accessing Powell Place are dealing with a number of major challenges in their lives, including addiction, mental health, physical illness and the dangers that come from working in the survival sex trade. Lack of supports in these areas often leads to a revolving door of substandard hotels and emergency shelters. Powell Place works with women to link them with the services that are available and support them in their quest to survive the harsh realities of their lives.
St. Elizabeth Home Emergency Shelter (St James Community Service Society), Vancouver, BC St. Elizabeth has the capacity to shelter 32 women and children. St. Elizabeth's addresses the need for short-term emergency shelter while working to support women to find safe affordable housing in a difficult housing market. Women and their children access services during times of crisis. Shelter workers work with them to provide support to find better housing and connect to with appropriate services. Staff advocate when necessary whilst providing a safe and secure setting

Who is housed

All of the projects provide shelter for individuals who are homeless, have substance abuse issues, and/or mental health issues. Additional descriptors of the key client group are those in poor health, unemployed and/or victims of domestic violence.

All of the informants reported that some or all of their residents may be involved in prostitution. There is however a distinction between those who engage in prostitution as a primary or secondary survival strategy. Half of the projects view those with mental health and concurrent addictions as a primary client group. These individuals tend to engage in prostitution only occasionally as a means of obtaining food, shelter or drugs while homeless. Four of the projects specialize in sheltering women who are more deeply entrenched in the sex trade and are active in prostitution on a daily or regular basis.

At Savard's, the key informant provided advice about mixing women with chronic mental health with women who engage in prostitution: "[It] has not worked well in the past. We find that this can't be the easy place to stay for prostitutes to stay because they can stay out all night. It is also problematic to mix prostitutes with women with psychiatric issues. It's better if you don't try to mix it too much."

Table 2: Client description

	Women	Men	Trans-gender	Children	Sub-stance abuse issues	Mental health issues	Working in sex trade
Atira: Bridge Women's Emergency Shelter, Vancouver	Yes*	No	Yes	No	Yes	Yes	Yes*
Frank Rice Safe Haven, Los Angeles	Yes*	Yes*	Yes	No	Yes*	Yes*	Yes*
Fred Victor Centre Women's Hostel, Toronto	Yes*	No	Yes*	No	Yes	Yes	Yes*
Project H.O.M.E. Women of Change, Philadelphia	Yes*	No	Yes	No	Yes*	Yes*	Yes
Sandy Merriman House, Victoria	Yes*	No	Yes	No	Yes	Yes	Yes*
Savard's, Toronto	Yes*	No	Yes	No	Yes*	Yes*	Yes
Powell Place, Vancouver	Yes*	No	Yes	No	Yes	Yes	Yes*
St. Elizabeth Home Emergency Shelter, Vancouver	Yes*	No	Yes	Yes*	Yes	Yes	Yes*

* denotes a key target group and/or special expertise

Assessment or entrance criteria

Most projects have minimal assessment and entrance criteria, apart from a homelessness requirement. All of the projects serve those who are chronically homeless, at risk of becoming homeless, and have substance abuse and/or chronic mental health issues.

Project H.O.M.E. requires a referral from an outreach worker. Assessments are made by the outreach team members who make first contact with the homeless. Staff use the HUD definition of a chronic homeless person as someone who has one or more years of street or shelter stay, or four episodes of homelessness in the past three years. The outreach workers also do informal mental health assessments.

Sandy Merriman House in Victoria does not admit women who are under the influence of drugs or alcohol *if* their behaviour is violent and might endanger others staying at the shelter.

Fred Victor Centre employs the Safe Haven model which sees its members (residents) as part of a life long community. They state that: "once a person is screened into the Community Model, they are part of it for life. They are welcome to come, go, and return as they choose, with no time limits on healing or recovery. Such flexibility responds to the cyclical nature of mental illness and the likelihood of relapse and periods of acute mental illness."

At Savard's, informal assessments are done through observation at intake in order to determine how to pair up clients. While they will admit everyone at intake, if the individual does not have a mental health issue, they help them find another shelter.

Transgendered individuals

All of the projects accept transgendered individuals and house them either according to the sex with which they identify or in single rooms.

Three of the projects offered information and training sessions for their staff and residents to raise awareness of issues facing transgendered individuals. One informant noted: "My advice is to make sure staff are okay with them (transgendered) as will they have to stand up and advocate for them."

Project H.O.M.E. is planning on minor renovations to the communal bathrooms in order to provide more privacy, in part due to a city-wide enactment of a transgendered inclusion policy.

Fred Victor Women's Hostel is geared to serving transgendered individuals. This organization also facilitates "T-Girls", a support and educational group for transgendered and transsexual individuals[5].

Lesbian couples

Five of the projects do not accommodate couples. Two of the projects consider lesbian couples a family and will accommodate if a double room is available.

One project will accept lesbian couples only at intake. The key informant reported: "There are some cautions: sometimes people will claim to be couple in order to use together. If they meet and start a relationship within the hostel, we are reluctant to allow them to share a bed because very often the relationship ends in a couple of weeks and they ask to be separated again. Sometimes we ask that new relationships wait a couple of weeks before they begin sharing a bed together."

Age groups served

Seven of the projects house individuals who are 18 or 19 and older. (See Table 3: Age of residents, children.) Two projects noted that they have accommodated individuals well into their 70s and 80s. Powell Place shelter will take individuals as young as 16 if no other facility is available but staff must inform the Ministry of Housing (formerly Social Services) when a person under the age of 18 is staying there.

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[5] Fred Victor Centre produced *Creating a Space Where All Are Welcome: Investigation and Direction Concerning Access to the Toronto Hostel System for Transsexual and Transgender People (*Strang & Forrester, 2004).

Fred Victor Women's Shelter notes, "Initially we did accept youth (16 and up) but found that our model did not work well with youth. Our model works for adults. Youth need more structure and there is the danger that they may become even more entrenched in street life staying with an older population. In exceptional circumstances, we may house a youth for short stays who has been barred from youth shelters."

Women with children

Only one project, St. Elizabeth Home Emergency Shelter, accepts mothers with minor children. The informant notes, "With new shelter, we were able to design for the kids. Kids have their own play space. Women who are heavily using and not well tend to stay away from the kids' spaces. It all works out. These kids have seen a lot – we find that the women who are using are quite respectful around the kids."

Table 3: Age of residents, children

Shelter	Minimum age	Children accepted
Atira: Bridge Women's Emergency Shelter, Vancouver	18	No
Frank Rice Safe Haven, Los Angeles	18	No
Fred Victor Centre Women's Hostel, Toronto	18	No
Project H.O.M.E. Women of Change, Philadelphia	18	No
Sandy Merriman House, Victoria	19	No
Savard's, Toronto	18	No
Powell Place, Vancouver	16	No
St. Elizabeth Home Emergency Shelter, Vancouver	18	Yes

Building operations

Number and type of units

These projects tend to be modest in terms of size and number of beds. The number of units ranges from as small as 12 beds to as large as 50 beds (not including overflow cots). The average number is 30 beds per building.

The type of unit includes private rooms with washroom, semi-private (2 to 5 people to a room) and dorm-style. All but two projects have a combination of private, semi-private and dorm-style accommodation. Atira has private rooms with washroom only, while Savard's has dorm-style only. In most cases, washrooms and bathing facilities are shared.

Atira notes, "Private rooms are really important. The women say that it's really nice to close the door and have private space, take a shower, use the washroom, etc."

Table 4: Number and type of units

	# of units	Type of units
Atira: Bridge Women's Emergency Shelter, Vancouver	12	Private rooms with washroom
Frank Rice Safe Haven, Los Angeles	80 (total)	30 bed shelter (dorm style) 50 village/transitional housing (semi private, divided according to sex with shared shower facilities)
Fred Victor Centre Women's Hostel, Toronto	40	Single rooms, double rooms, rooms with 3 beds, 4 beds and dorms with 6 beds
Project H.O.M.E. Women of Change, Philadelphia	25	Dormitory style, 25 beds in one in one room
Sandy Merriman House, Victoria	25	One single room reserved for women with profound mental health issues, recent assault or trauma or otherwise vulnerable. Remainder are 2 bed, 3 bed, and 5 bed
Savard's, Toronto	30	8 semi private beds (2 beds to a room) and a 22 bed dorm
Powell Place, Vancouver	26	Rooms with 2 beds
St. Elizabeth Home Emergency Shelter, Vancouver	32	Private sleeping areas are arranged in pods that are geared to families

Building ownership

Half of the buildings are owned by the housing operators, the remainder are owned by other non-profit housing providers or by government. (See Table 5: Building ownership and operations funding.)

One key informant said, "I strongly suggest owning your own building. The neighbours could make it difficult for us if we have to go to council to make changes to the building or to our programs."

Funding for operations

The Canadian projects are funded by provincial or municipal housing programs. Some projects access additional operating dollars through the Ministry of Health and the Ministry of Children and Youth. Similarly, the American projects are funded through HUD as well as the Office of Mental Health. They also access local grants, foundations and private donations. (See Table 5: Building ownership and operations funding.)

Table 5: Building ownership and operations funding

Shelter	Building ownership	Operations funding
Atira: Bridge Women's Emergency Shelter, Vancouver	Atira	B.C. Housing
Frank Rice Safe Haven, Los Angeles	Frank Rice Safe Haven	Substance Abuse and Mental Health Services Administration (federal), Dept of Mental Health, AIDS funding, HUD, Private foundations/donors
Fred Victor Centre Women's Hostel, Toronto	Fred Victor	Toronto Hostel Services
Project H.O.M.E. Women of Change, Philadelphia	Columbus Property Management (a low-income housing provider).	HUD Office of Mental Health Local grants, foundations and private donations
Sandy Merriman House, Victoria	BC Housing	B.C. Housing
Savard's, Toronto	Savard's	Toronto Hostel Services, Ministry of Health, United Way
Powell Place, (St James Community Service Society) Vancouver	St James Community Service Society	B.C. Housing
St. Elizabeth Home Emergency Shelter, Vancouver	BC Housing	B.C. Housing, Children and Youth Ministry

Cost of operations

Most of the key informants provided an approximate total operating cost for their project. The average annual cost per bed is $31,524.

Table 6: Operating costs, annual costs per bed

Shelter	Number of beds	Annual operating cost	Cost per bed per year
Atira: Bridge Women's Emergency Shelter, Vancouver	12	$400,000	$33,333
Frank Rice Safe Haven, Los Angeles	80	$1,752,450	$21,905
Fred Victor Centre Women's Hostel, Toronto	40	$1,000,000	$25,000
Project H.O.M.E. Women of Change, Philadelphia	25	$ 817,810	$32,712
Sandy Merriman House, Victoria	25	$800,000	$32,000
Savard's, Toronto	30	$1,135,000	$37,833
Powell Place, Vancouver	26	$985,000	$37,884
St. Elizabeth Home Emergency Shelter, Vancouver	32	Not available	Not available

(All costs are in Canadian dollars, where 1 USD = 1.1683 CAD)

Length of Stay

Three projects have limits on the length of stay. These are imposed by a funder. For Atira and Powell Place, the limit is 30 days. At Sandi Merriman House, the limit is 10 days, but staff may apply to extend the stay to 30 days. The remaining projects which have no imposed limits. The average stay ranges from six months to four or five years.

Sandy Merriman House noted: "Realistically, about 20% of residents have been here for years. We did a study and found out that when women leave SMH, they did not access other shelters. This stat helped us to rationalize and find funding for our drop-in, which is now part of our core funding."

At Frank Rice Safe Haven, the drop-in centre plays an important role: "Some go back out, come back again, and go out again. The key that helps is the drop in centre which is the primary point of engagement.

For some, success is walking in the door. We work at building relationships and trust. Once they're ready they come back, some take two weeks, some five years, but the door is always open."

Table 7: Length of stay

Shelter	Maximum length of stay	Average length of stay
Atira: Bridge Women's Emergency Shelter, Vancouver	30 day limit imposed by funder	
Frank Rice Safe Haven, Los Angeles	No time limit	From short stays of several nights to as long as 10 years.
Fred Victor Centre Women's Hostel, Toronto	No time limit	3-6 months for most, but street involved clients usually have 2 weeks of continuous stay, are gone for a week and back again
Project H.O.M.E. Women of Change, Philadelphia	No time limit	Average is about one year.
Sandy Merriman House, Victoria	10 day limit, may apply for extension from funder for a stay of up to 30 days	
Savard's, Toronto	No time limit	20 or 30 clients have been there more than 6 months. 12 clients have been here for more than one year.
Powell Place, Vancouver	30 days	
St. Elizabeth Home Emergency Shelter, Vancouver	Short term – families are there until permanent housing can be found	

Policies and practices

Policies (hard drugs, marijuana, alcohol, smoking use on-site)

All of the projects are tolerant of residents who actively use drugs and alcohol. However, there are varying levels of tolerance regarding the use of drugs and alcohol in the shelter. Two projects tolerate drug use in private areas within the building. The key informant at Frank Rice Safe Haven explains, "If you are doing it (hard drugs, marijuana, alcohol etc) behind closed doors that's okay, as long it does not affect community and others. We feel that what goes on behind closed doors is their business, just as the rest of the population can do what they want in the privacy of their own homes."

The other six projects have policies that prohibit drug and alcohol use on site. While Powell Place and St. Elizabeth discourage drug use on site, they do have a needle exchange and sharps containers in the bathrooms. The key informant clarified by saying, "I don't want to kick anyone out because of drugs. We try instead to have the talk and build relationships and steer away from shame. We may direct to a nearby safe injection site, but some women will use in the bathroom. Some women are more vulnerable and get caught, but I don't want to jeopardize their stay because they get caught and others don't. We try to look at addictions as medical issues as opposed to shame."

At Sandy Merriman House, "[We] ask that people not use street drugs on site. If this is breached, we talk with them and may elect to a short term barring of perhaps two weeks. Will negotiate, but always have a conversation about maintaining an atmosphere of safety inside the shelter."

No project allows cigarette smoking on the premises, as mandated by local bylaws, but all offer a designated smoking area (often private) outside the building.

Role of drugs and alcohol

While Frank Rice Safe Haven does allow residents to use on the premises in private, the rest of the projects allow people to come in high or intoxicated, but not to use on the premises. Atira explains: “It’s okay for women to come in high and go to their rooms to come down.”

Most of the projects were realistic about on-site drug use: “Sometimes women use in their rooms. We don’t encourage it, but it does happen. We focus on safer use of drugs and have a supply of needles for the women. Staff uses precautions: gloves, sharps containers, etc”.

Fred Victor Women’s Shelter is concerned about the safety of people who are coming down from drugs: “We do allow people to come in high or intoxicated. We only monitor their behaviour and for bad trips. In this case we try to keep them in common areas in order to provide assistance. We do house rounds about once an hour. We check in all of the rooms to see if people are okay. If we are worried about someone, we may check their breathing or even wake them every hour. For instance, those using Methadone are at high risk of overdosing. Fortunately we have not had a resident die here.”

Policies around safety and criteria for eviction

A) Safety

All of the projects have some general policies in common. None of the projects keep street drugs or alcohol in safekeeping for residents. All ask residents to turn in anything that is dangerous (weapons, sharps, medications) for safekeeping. One key informant described how it works, “Women on the street do have weapons. We ask to hold on to them for them and when they leave, they can have them back. This works well, it’s a thing of trust that we build with the women.” Another key informant pointed out that crack users usually have knives that they need in order to use drugs.

At Sandi Merriman House, residents are asked to “turn in cell phones for safekeeping (so that women are not dealing, arranging dates etc on site).”

B) Eviction or barring

Eviction policies reflect a harm reduction approach. Seven of the projects have policies around expelling residents for violent behaviours. “We only expel if they have severe conflict (threatening behaviour) with another resident or threatening and they can’t manage it.” These policies provide a framework for safety within the shelters. In practice however, eviction was rare. In these cases, barring was short in duration (from a few hours to two weeks) and only temporary. All of the key informants reported that ‘housing first’ is a central goal of their projects. Ultimately, the goal is to offer opportunities for residents to become permanently housed. (See Transition planning, p. 14.)

In some cases, a project may suspend service for a short time if a woman is caught with a dangerous item, such as a weapon, or with street drugs. “If they are caught it will result in suspension of services. [A woman] can appeal the barring. We try to deal with these issues from a lifeskills development process. The approach is to provide a sense of stability, consistency, respect and dignity. The guidelines were developed with service users and reviewed one year ago. The women are apt to be more rigid about the guidelines than we are.”

One key informant summed it up by saying: “Our whole model is around not asking them to leave. We try instead to have an honest discussion about what is happening and to problem solve.”

Support services

All of the projects offer support services on site. The key providers of service are the shelter staff. Their role is to provide informal counselling and support to the residents of the shelter. They do not prescribe support services, but are ready to offer information and referrals when the residents’ requests information. The informants emphasized while access to other supports is open to all residents, participation is not a requisite for staying in the shelter.

To a large degree, the availability of in-house supports is limited by funding. For this reason, the projects form partnerships with other agencies in order to make services available to the residents. In common with all of the projects is the presence of a health provider such as a practical nurse, psychiatric nurse or doctor, addictions counsellor and/or harm reduction worker. In all cases, these professionals are health providers who provides services to residents of the shelter on an outreach basis.

Atira advises: “I recommend an outreach worker for when women leave. Sometimes they may find a place to live, but have trouble with landlords, paying bills etc, and end up back on the street again. They need long-term support and follow-up.”

All of the projects either operate, or are closely affiliated with, a drop-in program, which is open to their residents during the day. The drop-in programs also have harm reduction mandates. Three of the drop-in programs specialize in offering supports to women involved in prostitution.

Transition planning

Frank Rice Safe Haven employs a non-linear, flexible approach to transition planning: “The Community Model recognizes that the recovery of mental illness or substance addiction is a cyclical process. Individuals with mental illness and substance addiction may experience many different periods of full functioning and de-compensation or relapse throughout their lives. It is not a linear process where recovery moves only in one forward direction. The Community Model recognizes that the pace of recovery varies among individuals and time constraints and deadlines for “full recovery” are avoided. Furthermore, the Community Model provides an array of housing and service options that can meet individual need "where the client is at". The housing is on a level field — shelter, residential program, permanent housing — there is no hierarchy to the housing. One does not have to "earn" their way into a housing component. This is contrary to the traditional treatment and housing models that are based on a linear process, where clients must begin their recovery in a fixed format and must move on to the next “stage” within a preset amount of time.”

The rest of the projects all have either hostel redirect workers, case managers or housing workers. All have access to other housing supports.

Sandy Merriman House had this to say about second stage housing and detox for women who want to leave the streets, “We do case management as much as possible. However with 60 women here during the day drop-in and 25 in the shelter, this is limited. The housing situation here is horrible: there are no vacancies, and what is available is expensive. Victoria has an estimated 2500 – 3000 IV drug users and only 8 detox beds. We try to practice harm reduction without a lot of tools.” This situation is complicated further by the limit of stay at the shelter (30 days) imposed by the funder. (See Length of Stay, page 11.)

Dispensing medicine

The key informants were asked if they dispensed medicines like Atavan or cough syrup to help people come down from being high. None of the projects dispense medications to help people come down. No project offers on site detoxification but will refer to local resource if a resident requests help. Most of the key informants pointed out that dispensing medicine and supervising detoxification would require them to obtain a license and to hire qualified medical personnel. A typical medical model (which prescribes treatment) would not work with the harm reduction (high tolerance, low demand) model employed by these projects.

All of the projects will keep residents’ medications for safekeeping (such as medication for mental health illness). Most do not dispense the medications, but may offer to help residents keep track of their consumption.

Staffing/volunteer model

Except for Atira, each program has at least two staff on at all times. Atira has one staff person on at all times, because it only has 12 beds in the project. Frank Rice Safe Haven recommended an ideal staffing ratio or 15:1 or better, although they have a ratio of 20:1 at most times because of funding shortages.

Four projects have volunteers who help on a regular basis with activities such as reception, cooking, organizing donated clothing, poetry, and personal grooming. Some volunteers are on student practicum assignments. Three of these projects actively encourage former residents to participate as volunteers.

One key informant cautioned: "[There is] lots of testing with the clients – we are cautious about having [volunteers] in when the women are here because some volunteers do not have reasonable expectations of the women."

Emergency situations/crises

The key informants described dealing with a variety of emergency situations which fall into two categories: medical (overdose, illness, acute mental illness episodes and bad dates) and violence (hitting, shoving and yelling). Most informants report that violence is rare or infrequent. The response to these situations is consistent across all of the projects, "If it is medical we have lots of policies and procedures and get help as appropriate (call 911, mental health response team etc.)"

In situations of violence, all of the projects have staff trained in de-escalation techniques: "Most emergencies are around managing conflict like yelling and screaming – rarely for worse situations. We may ask someone to leave. The biggest thing is de-escalating a situation and not engaging."

Considerations when dealing with women involved in street prostitution

Given that the projects employ harm reduction strategies, most offer some form of support for women who continue to engage in street prostitution. For example, staff help with making safety plans, providing access to condoms etc. At Frank Rice Safe Haven: "We work more on people's trauma issues."

Three of the projects provide special consideration to women who work at night. These allow either overnight absences or late admission to the shelter. Powell Place said, "[There is] no curfew – women often work at night. We do say that if we haven't heard from you in 24 hours, we may give away your bed."

Fred Victor Women's Shelter had to make a special arrangement with their funder to accommodate women who are still working as prostitutes: "We were not supposed to let them come and go, but got permission from our funder to allow this as a harm reduction strategy (for those involved in prostitution). This is based on a woman's individual plan. Usually we say that she can't be out (of the shelter all night) for more than two nights in a row. She can have 3 overnights per week, but not back to back. We may negotiate a late curfew for the alternate nights. The City also does allow us to make exceptions around holidays, so women can be away for longer periods (some do visit their families) and still have a bed when they return."

Sandy Merriman Shelter is open only at night. The building is used for the operation of their day program during the day. "They can still be working in prostitution while staying here. We develop contracts with women who work at night. For instance, if they expect to come in late (i.e. 3 am) we may contract with them that they get up at a certain time (8:00 am) as that is when the other women are getting up and the shelter is preparing for the drop-in hours. Although they can be here during the day we really need a space for women to lie down during the day to rest (the bedroom areas are not supervised during the day)."

Input of residents about daily life in the facility

Residents' input into decisions about daily life ranges from informal (suggestion boxes, sign-up sheets, house meetings) to formal (appeals and complaints process).

Resident participation is always voluntary. Three of the programs have at one time or another consulted residents about general program design and/or guidelines and policies.

Input of user group into building design, policies and practices

While three of the projects inherited their buildings, the remainder did involve the user group in designing the building by way of consultation into program design, policies and practices. Sandy Merriman House found a novel way of involving former users in the design of the shelter: “The original renovation of this heritage building was partly funded through an EI training program. We were able to involve 12 former addicts/sex trade workers who worked with the trades to do the renovation. As such they had a lot of input into the design, from creating the sizes of bedrooms to picking colours.”

The key informant at Fred Victor Centre advised: “Canvass the women and ask what they need – what is out there, and what is missing?”

Community partnerships

Key partners

All of the programs had close partnerships with other agencies. Most notably, health organizations were at the top of the list followed by addictions agencies and other housing providers. Many of these partners provide outreach services to residents of the shelters.

Relationship with the police

Responses to this question included: ‘brilliant’ (two), ‘okay but could be better’ (four), and ‘challenging’ (two).

Several key informants encountered problems with individual police officers who demand to know who is staying in the shelter. Central to this situation is protecting the privacy of women staying at the shelter. The most extreme example comes from Powell Place, “Often they just want to barge in. Some are better, but some are worse. Our shelter is on the 2nd level. When police come we don’t say who is here unless they have a warrant. We have worked out a protocol with the police department. We meet them at the front gate and keep the conversation light and friendly. One cop forced his way in on the weekend. This is intimidating for women and the staff. This is not the norm but I know we can stand up to them due to the protocol.”

Another example comes from Fred Victor Women’s Shelter, “We have had some cops demanding information from staff and even telling them: ‘You’re going to need us sometimes so you should play ball (by providing information)’. It is harder still if this is a missing person complaint. Very often the person who is looking for them is the one who they are fleeing.”

In contrast, some relationships with police are extremely positive. Two informants indicated that they sometimes provide mental health education to police officers. Sandy Merriman House works closely with local police. “There has been a transition over the past 10 years. Initially there was conflict. Now we see the police are part of the continuum of care. Police are welcome to come in. We do adhere to privacy legislation but when police make enquiries, we ask why. If a woman has a warrant or other legal issue we can work with the police and others to help her deal with it. As such, the police let us intervene and mediate a bit more. We try to help the woman to make the transition (deal with her legal issue) and in most cases she is not taken down in handcuffs.”

Relationship to neighbours

Four of the shelters report that they are located in unique areas that have other social service organizations or shelters but no market residential buildings. Neighbourhood tolerance is high.

The remainder are located in or near areas that contain market residential housing (often condominiums). Key informants report that they are proactive in maintaining relationships with their neighbours and have made concessions to neighbours: “When we first came here there was only one condo, now we are completely surrounded by condos. The condo we have most difficulty with is the one that was here before we came. They have a front entrance that has nooks and crannies and there are street people who loiter and use drugs etc. The condo tends to blame us for this problem, so we agreed that if they see a female we are willing to come and ask the person to leave the property. Our staff check the condo every couple of hours. If they see a male street person, we ask them to call the police.”

Sometimes projects make other concessions to neighbours. Sandy Merriman House asked the women not to congregate in front of the building to smoke, but to use the smoking balcony provided on the premises of the shelter instead. Project H.O.M.E encountered a more extreme situation and ended up not using the front entrance to the shelter. “A concession was made for the women and staff to enter and exit the facility at the back of the building. The back door is off a side street and involves going down a set of stairs to the main door, and once inside, climbing up a set of stairs to the shelter. However, if a woman has a physical disability, by law she has right to access the main door (which is accessible and does not require her to use the stairs).”

Two key informants pointed out that neighbourhood tolerance varies. “It also depends on what the neighbourhood can bear. Our neighbourhood has no problem with prostitution or drugs – they are used to this as a daily activity.”

Words of advice from key informants

The key informants interviewed were invited to give general advice about developing a tolerant shelter in Edmonton. Key informants reinforced the notion of housing first and harm reduction. All agree that shelter that is not dependant upon program participation criteria is the key to stopping the cycle of homelessness.

While all of the projects aim to provide residents with opportunities for permanent housing when they are ready, Frank Rice Safe Haven, (whose primary target group is chronically homeless, mentally ill and addicted individuals) advocates eliminating emergency and transitional housing and to only provide permanent housing with supports.[6]

Atira
As workers we are fearful sometimes for the women. The women have survived for a long time and know what they are doing. They know how to survive. I tell my staff not to be fearful or worry.

Another thing is don't assume that someone who is using and has mental health issues will become violent. This is not true. Everyone is capable of becoming violent, not just addicts and those with mental health. Don't assume the worst about these women.

The private rooms are really important. It's nice to close the door and use the washroom in complete privacy. The number (12 units) is good but this would work if you had two floors of 12 rooms each.

Frank Rice Safe Haven
Patience – everything is a process. Think outside the box. Think housing first then harm reduction strategies and philosophies. With this population, it works. Permanent housing is most important to making people not homeless. We need so much more here. Band aids work but don't last.

Housing can be the answer for even the most the disruptive, hard core person. They can really get it together and stay housed. It is way less expensive. It works and it's cheaper than band aids.

If we could, we would take out emergency and transitional housing and make it all permanent housing (with supports) as much as possible. Even people who are actively using or not taking their meds are successful with this model. Work on behaviour where they are at and provide supports. We are working on getting more permanent housing with supports.

Fred Victor Women's Shelter
Build meaning full partnerships especially around health providers.

Project H.O.M.E
Make sure that the people you hire want to be there because it's hard – physically and emotionally. Staff must be people committed to the cause and want to help break the cycle of homelessness.

Sandy Merriman House
Call if you need support! Sometimes these things are put together by persistence and determination. Just keep at it. Our experience is that it usually takes 5 years to get from an idea to a building.

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[6] Pathways to Housing (New York, NY) provide immediate access to scattered site permanent housing for chronically homeless individuals with mental illness and addictions. This program was contacted in the research phase of this study. Upon learning that the aim of this study was to examine program models for street-involved women, the key informant said that he would not recommend the model for the intended target population. He advised that while their model works extremely well for chronically mentally ill individuals, the street-involved individuals would do better in a supported and supervised setting.

Savard's
Be practical. Try and work on developing staff that will create a space to live in that feels normal. This lets "crazy people feel a bit less crazy".

Women who are living with a severe and chronic mental illness and women with addictions do not mix that well. Be careful. It can be good to house them in separate areas. Crack addiction is the worst; this is not a good combination with women (with mental health issues) who can't defend themselves.

If the primary issue is addiction, then an open structure has a way of fanning the flames of addictions. Don't require people to be in all night, especially if they are planning on using (drugs).

Drinkers do not tend to want to hang out with people with mental health.

Have at least a few double rooms. We also like the dorm style in the open – it is a good way to assess (via observation) where a person is at. A combination of semi-private and dorm style accommodation is ideal.

Don't take someone from a dorm-style shelter to an independent apartment. Stage the transition as much as you can. We have problems when an "episode" occurs. They can't come back into shelter because they are housed.

Powell Place and St. Elizabeth Home Emergency Shelter
Be aware of the issues. This is so do-able. It seems for a lot of people they think: how do you do that? It's not the norm but it works. You need some protocols but don't try to enforce a lot of rules. Its rich and its hard and its great work and the women really appreciate the caring. The key thing is to provide housing. Staff should not be rule-oriented and should have a good sense of humour.

Other best practices or models recommended by key informants

Both Powell Place and Fred Victor Women's Shelter were recommended by informants and subsequently interviewed for this study.

Additional best practices/models recommended were:
519 Drop-in Centre, Toronto
Haven society in Nanaimo, BC (permanent housing for street involved women)
FROST'D, New York, NY

Summary of the typical model

The following is a summary of the typical or generic model based on common denominators found across the eight case studies.

Table 8: Generic shelter model

Client Description	Women, transgendered individuals (who identify as female), lesbian couples (if rooms are private or semi-private) May have a mental illness May have an addiction Entrenched in street prostitution
Age group served	18 years and older
Assessment or entrance criteria	Minimal to none
Number and type of units	Average 30 units, semi private
Building ownership	Half of operators own the building
Funding source	Multiple sources
Cost of operations	Average of $31,524 per bed annually
Length of Stay	Not limited
Policies (drug use)	No using on site May be at the facility when high
Policies around safety and criteria for eviction	Guidelines for behaviour Temporary eviction for violent behaviour
Support services	Access to drop in centre
Transition planning	Case management/referral upon request
Dispensing medicine	Personal medications kept in safekeeping only
Staffing/volunteer model	Two staff on at all times
Emergency situations/crises	De-escalation technique for handling emergencies
Considerations when dealing with women involved in street prostitution	No curfew
Input of user group into building design, policies and practices	Consult with user group
Community partnerships	Strong linkage to health providers

Section Two: Input from potential user group

A focus group interview was conducted with a group of nine women still active in street prostitution. All of the women consulted were effectively homeless and regular users of local shelters. They were asked for their advice on what is needed to create a supportive and tolerant women's shelter for individuals involved in street prostitution. (See Appendix 1: Focus group question guide for potential user group and Appendix 2: Data from focus group with potential user group.) Several key themes emerged from the interview.

The women reported a lack of personal control when using the shelter resources currently available. Much of this is due to the overcrowded conditions present at local shelters, which reduces access and privacy and requires many rules. The women did, however, put forth the idea that rules and guidelines would be needed to ensure the personal safety and respect for women who might use a new shelter.

There was agreement regarding who should be served in such a shelter: women or transgendered individuals only. This shelter should be for adults only (versus youth and women with children) however, there was disagreement about the minimum age requirement. Most thought that it should be for those 18 and older. A few individuals said that it should be for those who are 30 and up, based on the perception that most resources were geared for youth aged 18 – 30 years of age.

Another key issue was around drug use. The women said that they were often not in control of their use of drugs and that being high was sometimes a barrier to accessing safe shelter. The women discussed the merits of having "one shelter where you can use, one where you can't".

The women listed a number of ideas for on site support services and referrals with the view of having services that would help them to get off the streets. One way to do this is to have a drop-in component (a local drop-in resource was cited by the women). The women listed many ideas for building design, amenities and safety features. There was agreement regarding keeping the facility relatively small, with private rooms. Staffing was another key concern. The women recommended having peer staff form part of the staffing model. The women also expected to pay room and board for accommodation and meals.

Table 9: Generic model as developed by potential user group

Client Description	Women, transgendered individuals (who identify as female) Entrenched in street prostitution
Age group served	18 years and older/30 years and older
Assessment or entrance criteria	Minimal to none
Number and type of units	Small (not specified) private rooms
Building ownership	Not stated
Funding source	Not stated
Cost of operations	Not stated
Length of Stay	At least 6 months to one year
Policies (drug use)	No using on site May be at the facility when high
Policies around safety and criteria for eviction	Guidelines for behaviour Eviction for violent behaviour
Support services	Access to resources, drop-in component
Transition planning	Case management/referral upon request
Dispensing medicine	Not stated
Staffing/volunteer model	Staff should include peers
Emergency situations/crises	Not stated
Considerations when dealing with women involved in street prostitution	No curfew
Input of user group into building design, policies and practices	Consult with user group

Section Three: Input from housing and support services providers

Local shelter operators, addictions' specialists, outreach workers, law enforcement officials, parents and other professionals concerned with service delivery to women involved in prostitution participated in this focus group. These individuals all have experience with providing services to women involved in street prostitution and were well aware of the implications of the current shortage of emergency housing. (See Appendix 3: Focus group question guide for housing and support service providers and Appendix 4: Data from focus group with housing and support services providers.)

A central theme that emerged from this discussion was gaps in existing services. The participants in this focus group reported that women either fail to make it to drug treatment because they have no supported housing while waiting for a treatment bed, or fail after completing a drug treatment program because they have no safe permanent housing.

As with the potential user group, this group discussed the possibilities of two models: one for people who are trying to stop using and working the streets, and one where people can use and work the streets. Location was another key theme. The participants advocated for having a facility away from the area of street prostitution. They advocated for a personalized, home-like, well designed facility with a number of amenities. (One participant said that they preferred dorm-style rooms.)

This group recommended that the shelter have a high tolerance for people who are actively using, as long as they are not using on site. Rules and guidelines should be developed to ensure safety for the individual and for others at the facility. Participants recommended avoiding barring people from the shelter.

As for services, the stakeholders wanted a supportive, non-judgemental staffing model that includes health services, trauma counselling and addictions counselling (perhaps delivered on an outreach basis). They also wanted opportunities for residents to develop life skills.

Table 10: Generic model as developed by housing and support services providers

Client Description	Women, transgendered individuals (who identify as female) Entrenched in street prostitution
Age group served	18 years and older
Assessment or entrance criteria	Minimal to none
Number and type of units	Small facility, private rooms
Building ownership	Not stated
Funding source	Not stated
Cost of operations	Not stated
Length of Stay	Open ended
Policies (drug use)	No using on site May be at the facility when high
Policies around safety and criteria for eviction	Guidelines for behaviour Avoid barring
Support services	Access to resources (health, trauma, addictions)
Transition planning	Not stated
Dispensing medicine	Not stated
Staffing/volunteer model	Staff should be tolerant and non-judgemental
Emergency situations/crises	Not stated
Considerations when dealing with women involved in street prostitution	No curfew
Input of user group into building design, policies and practices	Consult with user group

Conclusion

The stakeholders affirmed that an ideal model should be highly tolerant and employ harm reduction strategies. The target clients should include women and transgendered individuals entrenched in street prostitution that may have addictions issues. There should be minimal assessment or entrance criteria.

Both groups advocated allowing individuals to use the shelter if they are actively using drugs or alcohol, and agreed that drugs or alcohol should not be allowed in the facility. There was agreement about having guidelines for behaviour for residents of the shelter. However, the housing and support services providers maintained that evicting a person from the shelter for violating the rules should be a last resort, while the potential user group advocated for eviction.

Considerations when dealing with women involved in street prostitution included not having a curfew and allowing people to stay in the shelter for extended periods of time (six months to unlimited). Both stakeholder groups (potential user group and service provider group) said that many resources should be available at the shelter. Although many resources were listed, health providers, and addictions and trauma counselling were most important. They also agreed that information and resources should be readily available at the residents' request.

Both groups also discussed the possibility of having two facilities: one for those who are actively using drugs or alcohol and one for those who are not. The housing and support services providers cited a need for a "dry" shelter for individuals who need housing before and after participating in a drug treatment program.

The potential user group was specific about several key points: their ideal facility should be small with private rooms, there should be a drop-in component, and staffing should include peers. Both stakeholder groups agreed that shelter staff should be supportive and non-judgemental and should employ de-escalation techniques when dealing with extreme behaviour.

The issue of location requires further examination as the potential user group favoured locating the shelter close to their street resources, whereas the housing and support services providers favoured a location that is away from the area of street prostitution.

Appendices

Appendix 1: Focus group question guide for potential user group

PAAFE is trying to figure out how to house women who are live (involved in street prostitution) and who are using drugs and alcohol. We looked around and found out that there are new ways of housing homeless people. No matter what they are doing, whether that's using drugs and alcohol, working the streets or even if they have a mental illness, these places do not ban people, and they always have a place to stay. We want your advice about what works and what doesn't work with the housing that we already have in Edmonton, and what you want and need for housing.

Questions:

1. Where do you go now when you need a place to stay? (WEAC, Spady, etc.) What is missing for you when you stay there? Why don't these places work for you?
2. Given where you are at right now, what do you need? If you were designing the kind of housing you needed, what would that look like? What would make it a good, safe option for you?
3. Is the housing you need for a short time (a place to crash for a few days, weeks or months) or is it permanent (a room or apartment of your own with your own key)?
4. If it's a temporary place, how much privacy do you need? (Dorms, 2 or 4 to a room, etc) What happens if there's not enough or too much privacy?
5. Who can stay there? Should it be for women only? What about trannies, couples, lesbian couples, women with children, women with mental health problems?
6. What can you do in there and still not get booted out? Should you be able to get in if you are using? Can you keep on using if you stay there?
7. Should there be rules? What should they be? How would you deal with people who are bothering others?
8. What do you need to feel safe there?
9. What kinds of services/help do you think should be available e.g. medical help (HIV, STD's Hepatitis, Needle exchange), addictions treatment, detox, counselling for trauma or sexual assault, mental health nurse, social worker, housing worker, clothing exchange, parenting, life skills classes, art classes, etc?
10. Should detox or drug treatment be optional or mandatory?
11. Can you come and go as you please? Should there be set hours?
12. Should the place have a kitchen, dining room? Should they provide the food or do you make your own?
13. What about the staff? What would they be like? What kind of training should they have?
14. What about other things like bathrooms and showers (private or shared), laundry, lockers, etc?
15. Where should this place be located? On or off track?
16. What else is important?

Appendix 2: Data from focus group with potential user group

What is not working?

- At [the shelter] I have to wait till 1 am to get a bed, have to get up at 7am, then I need 12 hrs sleep to come down, others screaming and flipping out
- Going home and getting my ass kicked because I don't have any other choice

What works?

- Bosco homes before staff took over
- Elizabeth house set up
- Duplex almost perfect-but, too many rules
- Calgary has lots of places, you move on when you're ready
- Taking baby steps

Rules/guidelines

- No warrants- should be taken care of
- No tolerance for dates, no overnight guests at all
- Some people need structure
- Kick out for total disrespect for housemates, coming home smashed
- Give 3 chances
- No weapons
- Have a housekeeping schedule
- Being able to use keeps anger down- people get anxious, grouchy
- Have one place where you're clean/ one where you're not
- Where can I go when I'm coming down that is safe?
- No TV after a certain time
- Still be allowed to go out but check in at a certain time so people know you're ok
- Pay room and board
- Visitors OK

Intake criteria

- 18 and up
- 30 and up
- Women/transgendered only
- No couples
- No men
- Time limit- 6 months to a year (but can extend)
- Deal with peers by being straight up

Staffing

- Peers should be part of the staff to help us know that "if you can change, we can change"
- Same staff as Kindred House
- Staff should have first aid, counselling

On site services/activities

- Help with taxes, I.D., and voting
- Individualized
- People would respect house more if there is staff there
- Smokes
- Staff should cook- but residents should also be able to cook sometimes
- Computers, internet
- Medical- people should learn to take care of themselves

- Courses- budgeting/ life skills
- When you do change you're going to want to move on because you're going to want more
- Psychologist, psychiatrist
- Detox program
- Pets are good (2 dogs and a cat)
- Camping trips, skiing (Banff)
- Make it like Kindred House- open 24 hours
- Monthly "family" meeting
- Groups- to talk about how you feel, discuss your own problems, everyone can know where you're at

Building features and amenities

- Fire alarms, elevator
- Gate
- No signs, anonymous
- Security cameras (to see who is coming)
- 25 people at the most- not too many in one place
- Room with locked door
- Stereos- in rooms with headphones built into wall
- Like a cottage that is part of a bigger picture (housing continuum)

Amenities

- Phone with privacy for talking to friends, business, long distance to call home
- Lockers, showers, laundry, lock-up room
- Clothes
- Makeup room
- Little room (like a detox room)
- TV in common area

Location

- Far away off track (so you can't see it) but close enough to access our street resources
- Out of downtown (like the Duplex)

Appendix 3: Focus group question guide for housing and support service providers

We need your advice about what works and what doesn't work with the housing that we already have in Edmonton. We also want your advice about what is needed to create a supportive and tolerant women's shelter for individuals involved in street prostitution.

Questions:

1. What is working with what we have now?
2. What is missing with what we have now for women involved in street prostitution?
3. Who should be able to access this shelter? (Women only, transgender, couples, women with children?)
4. Length of stay: Should it be short term or permanent (long term)?
5. What tolerance would there be around drugs and alcohol?
6. Can people come in high?
7. Can people use on site?
8. Should there be rules?
9. What should they be?
10. How would you deal with people who are bothering others?
11. What would it take to bar someone from the shelter?
12. What measures need to be in place to ensure safety for residents and staff?
13. What kinds of services/help should be available on site?
14. What is ideal?
15. What must be available?
16. Addictions: Should detox or drug treatment be optional or mandatory ?
17. Can residents come and go as they please? Should there be set hours?
18. How would women involved in prostitution be accommodated?
19. What kinds of amenities or features should this shelter have?
20. Is location important?
21. What else is important in terms of providing tolerant shelter for women involved in prostitution?

Appendix 4: Data from focus group with housing and support services providers

What's working now in Edmonton?

- Henwood is good about getting high risk people directly from Detox to Henwood

What is missing with what we have now for women involved in street prostitution?

- Big gaps
- Shelters are a holding place for the chronically mentally ill, it's a social shame
- You're banned 30 days for nothing.
- Can't get IS if you're at a shelter
- Need wire cutters to take the locks off lockers at the shelters
- No place to store stuff
- Let us not think that what we have now is an answer – it's too bad that's the best we have to offer women.
- Women are hungry
- There is overwhelming demand on the resource – things have shifted over the years
- Wrong mandate or no resources for current shelter
- Are current shelters just enabling people to stay homeless?
- How long do you have to stay at WEAC to access Elizabeth House?
- Currently people can't "work", but can't be on IS, and have to come in by a certain time
- Women with addictions have huge barriers – there's only McDougal House. The big gap is the lack of transition housing – the in-between place for people waiting to go to detox
- The Duplex was that before and after place. That's what missing!!!!!
- The women say 'Why go through the detox when there's no place for me to go afterwards? Why bother?'
- Counsellors at detox try to plan for the next step. If the client doesn't want to go to residential treatment, then, we try other things.

If we were able to construct a model – what would it look like?

- Is it a BED, or a HOME? That's where the difference in "success"
- Servants Anonymous – model
- We need the "in-between" spaces for those who are waiting for detox, waiting for treatment. (Note: AADAC is looking into transition beds)
- Continuum of beds
- Start in a 6 room dorm, then transition into single rooms
- Depends on how women are coming into the shelter – what kind of crises and health challenges they have
- I'd rather see 50 beds of shelter, than 12 private rooms.
- There's a need for the private rooms after the detoxing, transitioning –they need the private space so they can dialogue with staff.
- Shelter component and drop-in component
- Two different things: A model where people are trying to stop using and working. And a model where people can continue to use and work
- First step and second stage housing

Who should be able to access this shelter? (Women only, transgender, couples, women with children?)

- Currently, there's more for men in Edmonton
- My ideal is that every person who is homeless should have a home – a private room where you can lock the door, be safe, be able to know that you can leave and come back and your belongings would still be there. A place to decorate, make your own, but, most of all know that your stuff will still be there.

- All are multi-challenged – it's best to keep the group fairly small so we're not warehousing.

What tolerance would there be around drugs and alcohol?
- It's unfair to kick people back on the street if they slip up.
- It has to be open-ended so you keep trying

Can people come in high? Can people use on site?
- People in the regular community do drugs, drink to excess – for the most part, they get up and go to work.
- Kindred – some can come when they're high – we don't allow using on-site. It's on an individual basis, we know those who are more violent and we ask them not to come when they're high.
- If you're a staffed model and allow people to use on site, you're looking at a different set of regulations and rules, legislation, etc.
- If you tolerate use on site, you'll invite more police attention, you'll attract litigation, and you will invite criminal control – not a good idea at all!
- Maybe we need two places – for when you're using and when you're not.
- A safe place to come down when I'm been up and using

Should there be rules? What should they be? How would you deal with people who are bothering others?
- Safety for the individual and safety for others. The implementation is the challenge – you can implement in a military style, or, with a fair bit of reviewing and good judgment.
- Visitors – that can be a safety issue for people living there. People have a practice of taking care of each other – but, that can be a volatile situation depending upon the visitor.
- No curfew – they are adult women and should be treated like adults.

What would it take to bar someone from the shelter?
- Have to keep the door open!!!!
- Compassionate, non-judgmental staff – no power tripping!!!!
- Separate the behaviours from what the vision is for the home
- Manageability of behaviours around safety.
- Some consequences for violent behaviours – immediate consequences that isn't barring.

What kinds of services/help should be available on site? What is ideal? What must be available?
- Staffing – most situations can be de-escalated if you have caring, trained staff. Very seldom do we have to evict someone - they usually respect the environment when they are respected.
- Working with chronically homeless women, who've never been parented – they just want a home with a staff person. Living in the moment –spending money right away. They'd like in-house programming – budgeting.
- Health services: create partnerships with health facilities to assist with medical support for people who need it – refer out to hospitals, medically supervised detox.
- Need to provide Outreach nurses that come in – assist with HIV, STDs, pregnancy, Health for Two
- Get hooked up with an outreach worker who supports them along the continuum – provide a link to help them with outstanding warrants and other needs.
- Staff – good capacity to listen with compassion, a non-judgemental manner.
- As there is more staff, there will be fewer crises to generate attention from staff. For example a program in Chicago demonstrated that people get well having a place to go.
- Passenger van and driver.
- Trauma and addictions component.
- Earnestness and harm reduction
- Need mental health stream for regular women

Should detox or treatment be optional or mandatory?

- OPTIONAL
- In the first stage – the choice to use isn't a choice when it's running through the body. When I was relapsing, I'd walk for miles to get drugs, sometimes more than once a night

Can residents come and go as they please? Should there be set hours? How would women involved in prostitution be accommodated?

- In the example given, the women had to call in, becoming accountable for their own choices. I liked the accountability factor – accountable for their actions – this is healthy, initial therapy. They can begin to look at their own behaviour, become healthier
- You're an adult – adults phone when they're not coming home – it also makes you feel cared about. Many haven't been parented – there are many "13-year-olds" walking around in adult bodies

What kinds of amenities or features should this shelter have?

- Need storage!
- EICHS design features – e.g. not having closet doors, but having closets
- Need a 'ginormous' kitchen!!!! People are frantic about eating, frantic about being hungry!!!
- A SNUG participant told us that: After detox – I'd like a place where I could have my own room and there would be a common area
- Utilitarian, and warm and inviting
- Won't have an oak bedside table, something that will stand up; sinks don't have ridges so that they're easy to maintain
- Build into the budget – replacement of furniture and items!!!!
- Bathtubs for relaxing!
- Storage for keeping their stuff! Locks with a combination and a key, so they don't have to cut through locks if the key is lost

Is location important?

- Removal from the area – not on track – get away from the city, the draw of the street – as we know, the street itself is an addiction. Location is critical.
- I agree – remove the accessibility to the street.

What else is important in terms of providing tolerant shelter for women involved in prostitution?

- Supportive staffing component is the most important
- For multi-barriered people it can be difficult to live independently without support
- Support is imperative – it's the biggest downfall of all the programs we have, it's the lack of staffing
- FASD support – it's expensive and it always will be. We just have to face that fact
- In a shelter you should be able to sleep and eat at anytime you want - if you sleep through supper, you shouldn't have to go hungry. Need flexibility!
- Is there a way that this type of shelter could help the women, facilitate some support – for the days while waiting for treatment – a place to come back to after treatment? Safe House offers before and after support for those waiting. For adults there is no place like this. Maybe someone with addiction background to give support
- The fear is about the physical detoxing – education around that re: coming down from opiates and what medications they can give
- We under-estimate that the individuals have experience (For example: their familiarity is with the using lifestyle. They often have great fears about being successful – and no skills. Programs take on the assumption of recovery. Sometimes clients can't move that fast – have to take baby steps)
- Women Building Futures – help with the building of more transitional housing for women
- Check out Sage House, Servants Anonymous
- Remember the need for palliative care for those who are dying
- How big a population should this serve? There are 75 in the community plan

Appendix 5: Additional input from potential user

(These notes were provided to PAAFE by a woman who was not able to attend the focus group at Kindred and who was homeless and active in addictions and street prostitution at the time.)

What is 1st Step Housing?
To me it's a crash and burn place. I disagree with the idea that women would be allowed to still use while in the house. I think that a nurse or qualified nurse's aid would be delegated to give downers and pain killers (cough medicine, etc.) This is an essential! Something would have to be negotiated with the Alberta Health Care Act.

Another pro would be helping Project KARE present and observe with a much more substantial access to the women's life styles.

It would also help ("johns" schools and "girls" schools) to grow at a greater success and help women get their life back on track.

But, what about the young men? Don't they need help to? Aren't they just as stuck?

First Step Housing – What Would It Look Like:
1. Safety
2. Warmth
3. Shelter
4. Food
5. Laundry
6. Hygiene
7. Phones
8. Opportunities
9. Unit

I believe First Step Housing needs to support a person to take the next step in getting life stable again, even though a person may not do this the first, or the tenth time around.

Need to be aware that using while crashing is not allowed in the home, although it will still happen!

The bonding that happens between us will and can have a domino effect – one goes straight and others follow.

The home should be open on a 24 hour basis and the home needs a certain amount of supervision, and this needs to have a person who won't represent a threat or authority figure.

The setting should be comfortable and safe. There should be beds available, food and toiletries. No one would live there – it would be a place to crash! Although, if planning on straightening out, maybe it can be an address in order to get onto assistance or be on a resume to apply for a job.

It is my prayer that in all the locations where the women work, there may eventually be a first step house available.

Drug dealers are not to be phoned from the home or come to the address (go to the drug den or using place).

Confidentiality is very important.

God be with all of us involved in creating the first step home!

Additional notes- (original visioning for the Home For Healing):
House 1 – Coming Down
House 2 - Developing Routine, meetings
House 3 - Commitment, education, employment
House 4 – staying until they were ready to become a beautiful butterfly

Appendix 6: Additional input from service provider

(Notes provided to PAAFE from an Edmonton Police Service Vice Detective who could not be at the Focus Group.)

What would First Step Housing Look like?

It would provide safety from pimps, dealers, boyfriends and it would be secured to the outside – people could leave of their own free will, but would be safe from those who would harm them.

The housing would be designed to accommodate these needs:

- Detox
- 1 -3 night emergency shelter
- 30+ days – short-term stabilizing housing – residents could begin to access community programs
- There needs to be sequence planning for transitioning

There would need to be quick access to health care (e.g. if in NE Edmonton – establish a relationship with the NE Health Centre.

Staff:

- Must be knowledgeable about detox and health issues
- Must have 24 hour staffing model
- The staff must want to be there and be willing to develop healthy relationships with those who come – this is not just a job, it's for people who care about the women.
- Sufficient staff ratio to create safety for everyone
- Need to be able to call EPS or EMS if needed

Location:

- Away from the street activity, but less than an hour away so that there is easy access to health and other needed resources.

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