Street-involved Women with Co-occurring Disorders:

Development of Policy and Practice Recommendations for Street Connections.

by

Diane Heywood, R.N., B.N.

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Abstract

Street-involved women with Co-occurring Disorders experience distinct and overwhelming health and social issues, while facing considerable barriers to appropriate and helpful services. Street Connections, a Population and Public Health program, provides services to this and other street-involved aggregates using Harm Reduction and mobile outreach to prevent sexually transmitted infections and blood borne pathogens. Three conceptual frameworks, Gender-based Analysis, the Comprehensive, Continuous, Integrated System of Care, and Harm Reduction guided the practicum. The purpose of the practicum was to develop policy/practice recommendations for Street Connections regarding service enhancement for this aggregate. Literature-based best-practices were compared to three agency case studies of programs providing services to this aggregate including Street Connections, the Program of Assertive Community Treatment, and Dream Catchers. Data, consisting of agency documents and person-centered interviews with nine staff, were analyzed using open coding to identify themes. Recommendations incorporate gender-based analysis, recovery, access, engagement, screening, integrated services, and staff development/support.

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Dedication

I dedicate my practicum to my young daughters

Rachel and Mary,

who are growing up to be strong and wonderful women.

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Chapter One

Introduction, Statement of the Problem, Purposes

Co-occurring mental illness and substance use disorders (CODs) are now recognized as common among individuals who experience either substance use disorders or mental illnesses. Individuals with CODs also tend to have a greater degree of health and social issues with enormous financial costs to multiple service systems (Centre for Addiction and Mental Health, 2001; Substance Abuse and Mental Health Services Administration, 2002). Particular aggregates within this population experience even further challenges because of poverty and unstable housing. Street-involved women with CODs is one such aggregate with added vulnerabilities including their gender and the social context of their lives (Weiss, Kung, & Pearson, 2003).

With the increased attention to the development of health and social services for the care of CODs, the concern then turns to best-practices recommended for street-involved women with CODs, and the current services which are offered to them in Winnipeg. The purpose of the practicum was to explore best-practices and existing services for the aggregate of Winnipeg women. In particular, findings concerning policy and recommendation are suggested for Street Connections. Chapter One begins with background regarding the above issues and then sets out three objectives for this practicum. Chapter Two is a literature review of current best-practice recommendations in relation to street-involved women with CODs. In Chapter Three, guiding models are presented followed by a description of the proposed case study methodology. Chapter

Four presents findings for three case studies. Finally, Chapter Five compares these case studies and puts forth policy and practice recommendations for Street Connections.

Health and Social Issues of Co-occurring Disorders

Mental illnesses and addictions are serious public health issues in and of themselves. They are associated with significantly higher mortality rates and lower life expectancy rates when compared to the general population (Hannerz, Borgå, & Borritz, 2001; Harris & Barraclough, 1998). When individuals suffer with both mental illness and substance use disorders at the same time, referred to as CODs, their health and social problems are compounded. Mental illness refers to psychiatric or emotional problems that are classified, according to the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*, as psychotic, mood and personality disorders (American Psychiatric Association. Task Force on DSM-IV, 2000). Substance use disorders include either dependence or abuse of any number of psychoactive substances such as alcohol, cocaine and innumerable other drugs. In reality, individuals with CODs may also experience more than one mental illness and/or substance use disorder at the same time. Moreover, their problems can then become the concern of other social services. In turn, this adds enormous financial costs to multiple systems such as primary health, child welfare, homeless shelters and justice (Centre for Addiction and Mental Health, 2001; Hood, Mangham, McGuire, & Leigh, 2004; Rothbard, Metraux, & Blank, 2003).

People living with CODs are prone to higher risks of several health problems including sexually transmitted infections (STI), blood borne pathogens (BBP), psychiatric symptom exacerbation, poorer prognosis and suicide, (Drake, Mueser,

Brunette, & McHugo, 2004; Kelly et al., 1998; Meade & Sikkema, 2005; RachBeisel, Scott, & Dixon, 1999; Stoskopf, Kim, & Glover, 2001). For example, research conservatively estimates that populations with CODs experience HIV rates from 3-6% and hepatitis C rates from 16-30% (Cournos & McKinnon, 1997; Klinkenberg et al., 2003; Rosenberg, Drake, Brunette, Wolford, & Marsh, 2005; Rosenberg et al., 2001). These rates are associated with several factors including increased risk-taking related to sexual behaviors, substance use and psychiatric symptoms (Butterfield et al., 2003; Essock et al., 2003; Meade, 2006; Meade & Sikkema, 2005). CODs are also associated with higher rates of social issues such as poverty, homelessness, violent behavior, violent victimization, childhood trauma, work problems, unemployment, criminal activities, child abuse and neglect as well as other family problems (Friedman et al., 2005; Gearon & Bellack, 2000; Lundy, 1999; Opler et al., 2001; Stuart & Arboleda-Flórez, 2000; Swartz et al., 1998). Hence, in addition to the enormous financial costs, CODs are associated with devastating consequences which can impact not only on the individual, but also their families, communities and society as a whole.

In the past 20 years, with increased recognition of and attention to people with CODs, this population's size and issues are no longer considered marginal or even minor. In the general population, large-scale surveys conducted in Canada and the U.S.A found rates of CODs from 10% to 30% (Grant et al., 2004; Kessler et al., 1996; Offord et al., 1996; Regier et al., 1990). In samples of individuals with mental illness, Canada and other countries around the world repeatedly show the rate of substance abuse to range from 30-70%, which is significantly higher than the general population (Cantor-Graae,

Nordström, & McNeil, 2001; Drake et al., 2004; Offord et al., 1996; RachBeisel et al., 1999; Regier et al., 1990). Conversely, individuals seeking treatment for alcohol or other substance use disorders also have a prevalence of psychiatric disorders, from 50-100%, again significantly higher than the general population (Cuffel, 1996; Martens et al., 2004; Nadeau, Landry, & Racine, 1999; Regier et al., 1990; Ross, Glaser, & Germanson, 1988). These results make it clear that individuals with CODs are widespread in the general population and have higher rates of health problems, notably STI/BBP. This should be anticipated when individuals seek services related to either mental illness or substance abuse disorders.

Street-involved Women with CODs

Trends toward negative outcomes are apparent for the population of persons with CODs, but consideration must also be given to aggregates within this population who exhibit different characteristics, issues and service priorities. Street-involved women with CODs are one aggregate that tends to experience even greater vulnerability to negative health and social outcomes than the population with CODs as a whole. Because literature specific to this aggregate is limited, it is useful to first examine the pertinent research related to all women with CODs.

At 35-70%, prevalence estimates for women with CODs are just as high as for men with CODs (Weiss et al., 2003; Zilberman, Tavares, Blume, & el-Guebaly, 2003). However, several prominent differences from their male counterparts emerge. First, women with CODs tend to seek help from primary health or mental health services before substance abuse treatment. They also report for mental illness symptoms, most

commonly Depression, Post Traumatic Stress Disorder. Men with CODs tend to seek substance abuse treatment first and report it, instead of mental illness, as the primary problem (Zilberman et al., 2003). Next, psychiatric symptoms and overall prognosis for females with CODs is worsened to a larger degree with abuse of substances. This finding is particularly notable for Schizophrenia and Post Traumatic Stress Disorder (Brunette & Drake, 1997; Gearon & Bellack, 2000). Then, women with CODs who get pregnant take on additional risks that affect the fetus too. There are higher risks of Fetal Alcohol Spectrum disorders, adverse drug effects on the fetus, low birth weight, abortion or premature delivery. Finally, there is also the fear of custody loss of this baby or other children in their care (Tait, 2000; Weiss et al., 2003). These are just some of the most notable differences between women and men with CODs.

Beyond these differences, street-involved women with CODs experience additional vulnerabilities. When women turn to street-involvement, it is frequently for one or more of the following reasons: to earn money illicitly or illegally; to buy, sell or use drugs on the street; or the absence of a stable place to stay. They may work in the sex trade, smoke crack cocaine, inhale solvents, inject drugs, use crystal methamphetamine, panhandle, deal drugs, have no fixed address or even shelter for the night. For each of these reasons, there are additional health and social risks (Alexander, 1996; Baker, Case, & Policicchio, 2003; Beaudoin, 2004; Meade, 2006). Furthermore, street-involved women with CODs experience higher rates of sexual assault, domestic abuse and other violent victimization when compared to men with CODs (Friedman et al., 2005; Gearon & Bellack, 1999; Goodman, Rosenberg, Mueser, & Drake, 1997; Weiss et al., 2003).

Data reveals the proportion of HIV diagnosed in women from Winnipeg continues to increase over the past several years. In addition, Winnipeg has among the highest rates of Chlamydia and Gonorrhea for 15-24 year old females in Canada (although Manitoba Health does not collect the necessary data to indicate street-involvement, substance abuse or mental illness in women diagnosed with STI or BBP). Unprotected sex and injection drug use are predominant risks reported by women diagnosed with HIV/AIDS (Beaudoin, 2005).

Research also shows that the street-involved mentally ill aggregate tends to take risks at significantly higher rates than the general population. Street-involved mentally ill populations report the same high-risk behaviors, including unprotected sex with multiple and casual partners as well as sharing needles and other drug equipment for injecting drugs (Davidson et al., 2001; Mandell, Kim, Latkin, & Suh, 1999; Meade & Sikkema, 2005). Women with serious mental illness take notably more sexual health risks than men such as unprotected sex and trading sex for money, drugs or a place to stay (Butterfield et al., 2003). All together, the data suggest the probability of very high levels of risk taking, STI/BBP rates, as well as other health/social problems in Winnipeg's street-involved women with CODs. The morbidity and mortality associated with street-involved women with CODs make it paramount that services must reach out to this vulnerable aggregate. The STI/BBP risk for this aggregate is of particular concern to Street Connections, whose services primarily extend to Winnipeg's street-involved population with the purpose of STI/BBP prevention.

Barriers

The presence of a number of barriers, however, limits access to appropriate and helpful care from either the health care or substance abuse systems. First, mental illness and substance abuse are historically stigmatized disorders. The extent and quality of care for these disorders has always been lower than physical diseases which are typically viewed more sympathetically by the public (Hood et al., 2004). Second, individuals with CODs tend to have health problems and social issues that are more complicated than individuals experiencing only any single disorder, leading to the idea that CODs are difficult and complex (Centre for Addiction and Mental Health, 2001).

Third, the mental illness and substance abuse service systems have developed in isolation of each other. Separate service systems increase the burden on individuals who then have to seek help at least twice, retell their story, deal with additional transportation, attendance and follow through issues (Drake et al., 2004). There are often competing treatment perspectives between different programs. For example, one program advises abstinence from all drugs while another prescribes psychoactive medications and takes a harm reduction approach toward illicit drug use.

Beyond the above influences, additional obstacles exist for street-involved women with CODs. Perhaps foremost is added stigma from society's attitude toward women for either street-involvement or substance abuse. Stigma is often internalized by women and linked with considerable shame and guilt. As a result, they all too frequently avoid or hide their problems from services instead of seeking assistance (Cormier, Dell, & Poole, 2004). In addition, women often hold multiple and simultaneous caretaking

responsibilities for family, leading to missed appointment and premature cessation of treatment when treatment programs do not address their practical needs such as childcare, parenting, transportation or other concerns.

Relationships are another important issue for women with CODs that should be addressed in treatment because of the numerous ways that a relationship directly or indirectly impacts on substance abuse (Alverson, Alverson, & Drake, 2001; Meade, 2006). Women who continue a relationship with a boyfriend who is not seeking to change his substance use is just one of many common examples. Research shows that addressing such issues and developing relationship skills increases treatment outcomes for women (Weiss et al., 2003). All together, these factors combine to lessen the likelihood that this aggregate will successfully seek, find, follow through and benefit from mental illness or substance abuse treatment.

Co-occurring Mental Health and Substance Use Disorders Initiative

A review of the research shows that engagement of, access to care, and retention in treatment is more effective with the population of individuals with CODs when there is integration of mental illness and substance abuse service systems, programs and interventions (Drake et al., 2004; Substance Abuse and Mental Health Services Administration, 2002; Ziedonis et al., 2005). To improve care for CODs in Winnipeg, the Co-occurring Mental Health and Substance Use Disorders Initiative (CODI) was started by the Winnipeg Regional Health Authority (WRHA), Addictions Foundation of Manitoba and Manitoba Health (Winnipeg Region CODI, 2004). CODI has based its operations on principles from the Comprehensive, Continuous Integrated System of Care

model (Minkoff & Cline, 2004). CODI itself does not provide direct service to the population of individuals with CODs, but consists of the three above named organizations along with a number of additional stakeholders who do provide mental health/illness and addiction services (Winnipeg Region CODI, 2003). The goal of this initiative is to create a coordinated addiction and mental health service system operating from a number of evidence-based and/or expert consensus best-practice principles (Winnipeg Region CODI, 2004). Changes in service systems are expected to occur in steps and build momentum over time as more programs and service providers develop their capability in working with people who have CODs, and as interagency coordination progresses. Clinical training guidelines were developed to guide this progression along with ongoing courses offered to service providers in the addiction and mental illness service sectors.

Missed Opportunities

With the influence of CODI as described above, service systems for mental illness and addictions are changing, although its impact on services for street-involved women with CODs is not yet fully apparent. A large number of street-involved women, many of whom have CODs, continue to hide important aspects of their situation if accessing traditional services or choose not to seek these services at all. A portion of this aggregate is, however, connecting with Street Connections, a mobile outreach program. Street Connections, a WRHA Population and Public Health Communicable Disease Control program, offers service to Winnipeg's street-involved population with the goal to prevent STI/BBP transmission. Given the program's mobile nature, the Public Health Nurses and

Outreach Workers operate predominantly out of a van and provide condoms, sterile needles, safer crack use kits, STI/BBP tests, vaccinations, health counseling, prevention information and referral to other programs as necessary. Operating for over 15 years, the program is based on a Harm Reduction approach whereby it does not negatively judge street-involvement but rather works with clients toward reduction of health risks (Winnipeg Regional Health Authority, n.d.). Street Connections' outreach and approach does develop a considerable degree of trust with street-involved people and can act as an entry-point to other services (F/P/T Advisory Committee on Population Health, 2002).

Yet, Public Health Nurses and Outreach Workers actually lose opportunities to better serve the street-involved women with CODs they contact. Street Connections is not a direct part of the mental illness, or addiction service systems. Staff do not routinely screen for CODs, especially mental illness. The prevalence of CODs that is expected with street-involved women is not recognized and consequently other interventions or referrals that may be useful are not offered. Even when individual women with CODs are recognized, staff may have less than the optimum knowledge or experience regarding the care of CODs and additional services available to them in Winnipeg. Moreover, there are no formal associations between Street Connections and mental illness, addiction or other programs providing services necessary for individuals with CODs. Thus, the trust potential between staff and street-involved women who have CODs is not fully realized and opportunities to overcome the enormous barriers they face are lost once again.

Integrated treatment between mental illness and substance abuse service systems is recognized as essential, but this likely should also extend to other service providers

who regularly connect with this aggregate, including Street Connections. Significant costs to multiple service systems unmistakably reveal the need for further service system enhancement and interconnections. Because Street Connections is already a trusted and established service provider to individuals within this aggregate, it can be an important access point for women with CODs to engage with addition services. The inclusion of Street Connections into integrated services has the potential to decrease barriers and improve health/social outcomes for this aggregate, which can ultimately have positive impact on STI/BBP prevention (Hercus, Lubman, & Hellard, 2005; Rothbard et al., 2003; Willenbring, 2005).

Purposes

With this context in mind, the three purposes of this practicum are:

1. Determine best-practices for street involved women with CODs with an examination of the research and consensus-based best-practice recommendations;
2. Determine current practices in Winnipeg for this population through completion of case studies of Street Connections as well as two Winnipeg-based CODI stakeholders; and
3. Develop policy and practice recommendations that are both relevant for this aggregate and feasible for Street Connections to consider.

Chapter Two

Review of Best-Practice Recommendations

In recent years, with the heightened recognition of CODs, its associated negative outcomes and high costs, there is also recognition of the need to improve services and adequately address the health needs of this population. Of late, there has been greater attention in the literature and research regarding service developments including practice recommendations published by Health Canada (Centre for Addiction and Mental Health, 2001) and the Substance Abuse and Mental Health Services Administration (Center for Substance Abuse Treatment, 2005). Because this area of research is emergent, recommendations are based on the evidence and expert-consensus with the primary focus on addiction and mental illness treatment. This strays from the focus of Public Health outreach programs such as Street Connections whose primary focus is prevention of STI/BBP, not treatment of addiction or mental illness. Also, recommendations in the literature tend to address the whole population of people with CODs, instead of the specific aggregate of street-involved women with CODs. With these limits in mind, a review of best-practice recommendations is presented to address the first purpose of this practicum. Wherever possible, recommendations applicable to the context of Street Connections and street-involved women with CODs are included. Recovery, access, screening, engagement, services and staff are the major areas addressed.

Recovery Orientation

A recovery-based orientation in relation to service provision is a primary recommendation because it incorporates principles that have wide-ranging impact across

all service systems (Appendix A). Recovery acknowledges the necessity of self-direction, personal responsibility, active participation and ongoing hope for individuals with CODs. For women, who usually experience stigma and shame related to either substance abuse or mental illness, recovery-based approaches that are strength-based, respectful and supportive are more effective than traditional substance abuse services (Ashley, Marsden, & Brady, 2003; Center for Substance Abuse Treatment, 2005; Cormier et al., 2004). This approach is recommended for all women but it is particularly relevant to mothers and pregnant women who most acutely experience shame and stigma related to street-involvement and CODs (Tait, 2000).

A recovery-based orientation takes a long-term perspective that fits with the lifelong nature of CODs. It views that both recovery and personal change occur in stages over time. This perspective enables the application of Prochaska and Diclemente's (1984) stages of change, including precontemplative, contemplative, planning, action and maintenance stages. Aiming for services and techniques to match with each individual's current stage of change as well as continuing throughout the recovery process has the potential to improve individual outcomes (Centre for Addiction and Mental Health, 2001; Center for Substance Abuse Treatment, 2005; Hubble, Duncan, & Miller, 1999; Prochaska & Diclemente, 1984).

Access

It has been established that when this aggregate does seek help, they more frequently experience refusal and the direction to go elsewhere for assistance, only to be sent elsewhere again. The literature supports the need to enhance access to treatment for

all individuals with CODs, including street-involved women (Amaro et al., 2005; Ashley et al., 2003; Centre for Addiction and Mental Health, 2001; Ziedonis et al., 2005). The Center for Substance Abuse Treatment (2005) recommends that all service systems implement a 'no wrong door' policy to facilitate every individual with readily available access to services regardless of which 'door' or service she first contacts. For example, if an individual seeks assistance in an addiction treatment facility, she will not be told to first get mental illness treatment, or vice versa. The place she first chose to begin access is considered the right place for her to start accessing services. Moreover, to further promote access for individuals in precontemplative and contemplative stages, including many street-involved women with CODs, outreach is recommended.

Best-practice recommendations acknowledged that it is not realistic for every program to provide all necessary services for this population (Center for Substance Abuse Treatment, 2005; Centre for Addiction and Mental Health, 2001). For 'no wrong door' policies to work in practice, continuity between and among services is necessary whereby clinicians, programs and whole service systems are willing and able to communicate and collaborate with each other and create smooth transitions between services.

Engagement

Engagement is the next focus of recommendations. While this is separate from access which was reviewed above, it is actually facilitated by access to services that are readily available. Engagement is vital to encourage individuals with CODs to remain in contact with clinicians for screening, assessment and treatment. Ongoing engagement is strongly recommended regardless of each individual's time-length in or progress-level

with change because CODs are life-long, and remaining in contact long enough to facilitate change is needed (Hubble et al., 1999). This process is particularly relevant for street-involved women with CODs who do not progress smoothly into or through treatment. It is not uncommon for this population to terminate then reconnect with services several times before any significant progress is observable (Center for Substance Abuse Treatment, 2005). A welcoming, nonjudgmental, empathic approach is suggested (Minkoff & Cline, 2004). Other helpful skills include acknowledging the individual's view of problems and solutions as well as showing sensitivity to the individual's gender, sexual orientation, culture and history of trauma (Centre for Addiction and Mental Health, 2001; Center for Substance Abuse Treatment, 2005).

Another recommended approach to strengthen the engagement process is to address specific problems closer to the beginning of contact (Center for Substance Abuse Treatment, 2005). Assistance with housing is particularly beneficial for homeless street-involved individuals who are homeless or living in unstable living situations. The research states that working with individuals to obtain and maintain housing leads to improved outcomes such as decreased psychiatric symptoms and hospital admissions (Sacks et al., 2004; Skinner, 2005). Then, women seeking substance abuse treatment commonly experience additional difficulties with childcare, transportation, safety, STI or BBP. Assistance will strengthen the process of engagement because it begins with provision of assistance that the individual may both need and want (Ashley et al., 2003; Center for Substance Abuse Treatment, 2005).

Screening and Assessment

Screening is crucial to boosting entry to treatment because service providers must first notice that individuals might have CODs before assessment and treatment can proceed. Because the rate of CODs is high in both mental illness and substance abuse populations, the literature strongly recommends that screening for CODs become a routine practice in settings where any individuals with either problem are encountered (Centre for Addiction and Mental Health, 2001; Center for Substance Abuse Treatment, 2005; Ziedonis et al., 2005). Brief screening tools are more realistic to use than lengthy tools and such tools should have a high positive predictive value. There are a variety of screening tools available with varying extent of research validation. Examples of available screening instruments include the CAGE-AID (Cut-down, Annoy, Guilt, Eye-opener-Adjusted to Include Drugs) (Appendix B) which screens for alcohol/drug use (Brown & Rounds, 1995) and the Mental Illness Screening Form III (Appendix C) for mental illness (Carroll & McGinley, 2000).

However, if use of a screening tool is not suitable in a specific situation, then it is also recommended to ask a few brief yet straight-forward questions about previous problems with substance use and/or mental illness This recommendation is tempered with the awareness that some individuals, including street-involved women with CODs, can be mistrustful of questioning and may provide socially desirable answers. Therefore, it is suggested that service providers to continue engagement, develop a relationship, and then complete screening over time. As well, it is advised that service providers also screen

based on assessment of the individual's appearance, behaviors and/or mental status in addition to questioning (Centre for Addiction and Mental Health, 2001).

After the engagement process begins and screening is completed, an in-depth assessment is essential for determination of diagnoses and development of treatment plans. Thus, it is crucial that screening guidelines not only set out what constitutes a positive screen, but also what process is to be followed to both offer and access assessment and follow-up services (Center for Substance Abuse Treatment, 2005).

Integrated, Comprehensive, Continuous Services

The research evidence and expert consensus both support the provision of integrated, comprehensive, continuous services for individuals with CODs (Centre for Addiction and Mental Health, 2001; Center for Substance Abuse Treatment, 2005; Ziedonis et al., 2005). Comprehensive services are those that address the range of health and social problems experienced by individuals with CODs including prevention and/or treatment of STI/BBP (Zilberman et al., 2003). The evidence supports improved outcomes for women in addiction treatment, with the presence of comprehensive services that address substance abuse, mental illness and additional problems including poverty, housing, trauma, violence, relationships, parenting, child custody, loss and self-esteem (Ashley et al., 2003; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

Integration refers to an approach to service-delivery that merges all the services required for substance abuse, mental illness and health or social issues into a unified whole. Integration of services can take place within a variety of programs although the initial preference may be all services to be integrated into one program. However, this

expectation is not realistic or necessary for all programs or service providers across the total health and social service system. A significant level of integration can be achieved by communication, cooperation and collaboration between programs and service providers regardless of which organization they come from. It requires that both administration and service providers value and prioritize the time and effort such integration will require (Centre for Addiction and Mental Health, 2001; Center for Substance Abuse Treatment, 2005).

Continuity of service is recommended because individuals with CODs usually require long-term assistance from more than one service provider and over more that one service episode. Improved outcomes and added effectiveness are found when there is continuity that is characterized by seamlessness when individuals move between programs; consistency between service providers; and coordination between previous and present service episodes (Adair et al., 2005; Center for Substance Abuse Treatment, 2005).

Staff Development and Support

Finally, best-practice recommendations focus on staff development and support. Ongoing professional development and staff supervision are essential to develop and maintain competencies in working with individuals with CODs, particularly the aggregate of street-involved women with CODs. Basic competencies for staff include communication, engagement, screening, referral and crisis management skills. To provide integrated care across services, it is also necessary for staff to be able to

communicate with other services and provide care that is consistent with, not negating of, other service providers' efforts.

Finally, strategies to mitigate the effects of staff burnout and turnover are recommended given the challenges associated in working with this population. A variety of strategies suggested include:

- clear, consistent opportunities for staff communication about client progress, feelings and program issues;
- opportunities for consultation between staff who work with the same client;
- working in teams to decrease isolation;
- manageable caseload size; and
- healthy support networks with separate professional and personal time.

Addressing these issues will assist in decreasing staff turnover and burnout, which in turn will increase the competency and consistency of services for this population (Center for Substance Abuse Treatment, 2005).

Summary

In this chapter, I reviewed best-practice recommendations related to the CODs population. Recovery, outreach, ongoing engagement, practical assistance, regular screening, commitment between service providers to provide integrated, comprehensive, continuous services and strategies to increase staff development and support were found as summarized in Table 1.

Table 1

Summary of Best-practice Recommendations

- Use a Recovery-based orientation.
- Enhance access via ‘no wrong door’ policy and outreach.
- Continually use engagement techniques.
    - Welcoming, nonjudgmental, empathic, sensitive.
    - Facilitate practical support such as housing.
- Complete regular screening with all clients.
    - More contact and time may be needed.
- Comprehensive assessments for all positive screens.
- Provide integrated, comprehensive, continuous services with one or more programs, as necessary.
- Make staff development and support available.

Chapter Three

Models and Method

Herein, I describe three models, which guided this practicum. Gender-based Analysis, described as a tool based on a model, has focused this practicum to consider the effects of gender and street-involvement (Women's Health Bureau, 2003). The Comprehensive Continuous Integrated System of Care model was developed to guide the improvement of service for populations with CODs (Minkoff & Cline, 2004). This model is currently utilized by CODI and thus is already influencing Manitoba's mental health and substance abuse service systems (Winnipeg Region CODI, 2004). Next, the Harm Reduction model is essential to consider because of its pragmatic approach to engaging street-involved populations and perhaps, most importantly, because it is a key approach used by Street Connections (Phillips & Labrow, 2000; Winnipeg Regional Health Authority, n.d.). Finally the case study method used for this practicum is presented.

Gender-based Analysis

The primary goal of Gender-based Analysis is to ensure that a substantive gender equality perspective is integrated into research, policy and/or program development. Substantive equity refers to equal outcomes between genders, which is different than equal opportunities. To achieve equal outcomes, each gender may actually need different opportunities or treatment. Gender-based Analysis, described as a tool that is based on a framework, recognizes that female and male gender each impact differently on health status. Gender is a determinant of health that also intersects with other determinants of health such as socioeconomic status. Gender-based Analysis also recognizes the need to

assess the impact of determinants of health that create additional diversity within each gender such as socioeconomic status, culture or any other number of factors (Donner, 2003; Women's Health Bureau, 2003). Gender-based Analysis has focused this practicum to consider substantive equity for street-involved women with CODs and the development of relevant recommendations for Street Connections policy and practice.

Comprehensive Continuous Integrated System of Care Model

The Comprehensive, Continuous Integrated System of Care (CCISC) model endorses system level change that goes beyond the provision of a set number of specific programs to improve services for individuals with CODs. The rationale for system level change is that CODs are significantly prevalent in all health/social service settings, experience significant negative outcomes and create higher financial costs in these service systems, thus a select number of programs would be grossly inadequate for the needs of this population. It is vital that whole service systems develop capacity to recognize and work with CODs (Minkoff & Cline, 2004). This model is used by CODI, described previously, for its goal to improve the services in Winnipeg available to the population with CODs.

The CCISC model is based on a recovery orientation. As described previously, a recovery orientation emphasizes self-direction, personal responsibility, individualization and hope. Predetermined interventions or outcomes are not put forth by this model as these need to be developed for each individual according to her/his diagnoses, level of functioning, external supports or limitations, stage of change and/or phase of recovery. Comprehensive, continuous, integrated treatment is also fundamental. Next, the CCISC

model focuses on improvement of existing services. While new resources and funding would be welcomed and utilized, they are not required for implementation of the model's recommended practices. This focus on improvement of existing services supports the integration of existing programs that already have regular contact or trust with individuals who have CODs. All of these features are incorporated into clinical training guidelines put forth by CODI in Table 2.

Table 2

Features Incorporated Into Clinical Training Guidelines

Welcoming, Empathic and Hopeful Stance:	Demonstrate a welcoming, empathic and hopeful attitude in the provision of services to persons with CODs.
COD Population Needs and Barriers:	Demonstrate a working knowledge of the needs and concerns of persons with CODs as a special population.
Mental Health and Addiction Clinical Knowledge and Best Practices:	Demonstrate basic knowledge of etiology for mental health and substance use disorders and best practices in treatment/rehabilitation for CODs.
Change and Recovery Models:	Demonstrate an understanding of change and recovery models use in the treatment/rehabilitation of mental health and substance use disorders.
Crisis Response:	Demonstrate practical knowledge on a range of crisis prevention, intervention, and resolution approaches.
Screening and Assessment:	Demonstrate ability to complete basic screening for CODs and an integrated, longitudinal, strength-based assessment.
Integrated Treatment/ Rehabilitation Plans:	Demonstrate the ability to design, implement and ensure highly individualized, integrated treatment/rehabilitation, discharge and continuing care plans.
Coordination of Services:	Demonstrate knowledge and skills to facilitate the client's experience of integrated, continuous and coordinated service.
Facilitation of Recovery:	Demonstrate ability to facilitate client learning and recovery

Used with permission from Winnipeg Region CODI on May 31, 2007.

(Winnipeg Region CODI, 2004, p. 3)

The CCISC model offers a broad framework for services to the population of individuals with CODs, which is enhanced by the Harm Reduction model as described next.

Harm Reduction Model

The reduction of harm is viewed as one of many legitimate incremental outcomes according to the CCISC model (Minkoff & Cline, 2004). The Harm Reduction model's goal is just that, the reduction of harm. Stated another way, the goal is to decrease the negative health, social and economic outcomes associated with risk-taking. Risks are usually related to substance use but essentially can be any of a wide range of behaviors. A predominant characteristic of Harm Reduction is its nonjudgmental approach with individuals who use substances and its recognition of each individual's inherent worth. Harm Reduction recognizes that all individuals have self-determination and take risks; criticizing or expecting individuals to stop all risks leads to social isolation, which in turn leads to further harm (Cheung, 2000; Manitoba Harm Reduction Network, n.d.). Harm Reduction seeks to engage individuals and encourages them to start reducing harms wherever they are able, thus it supports minimal requirements of clients in order to provide services. Providing relevant information and supplies facilitates individuals to make informed choices to lessen harm for themselves, their families, friends and communities. These interventions to decrease harm also fit within the CCISC model's guideline for individualized plans and interventions. While recovery is not explicitly stated in the Harm Reduction model, its principles correspond with a recovery orientation.

As described previously, Harm Reduction is a predominant approach used by Street Connections. Therefore, it is both appropriate and critical to incorporate this model in the development of policy/practice recommendations that Street Connections can consider for adoption.

Method

Design. A multiple case study design was used for this practicum. Case study is a research strategy that "investigates a contemporary phenomenon within its real life context especially when the boundaries between the phenomenon and context are not clearly evident" (Yin, 2003). In other words, this practicum examined programs that were currently providing service to street-involved women with CODs. Three different programs, Street Connections, the Program for Assertive Community Treatment (PACT) and Dream Catchers, were examined to address the second purpose of this practicum, to determine current practices in Winnipeg for the street-involved women with CODs aggregate. Each program's services were offered in different environments thus increasing the breadth of collected data and adding to the element of data triangulation. This strategy was most appropriate because examining the context of service provision while not controlling behaviors was vital to understanding what practices were currently provided, where they were provided and why.

Setting. Health care services within the City of Winnipeg provided the setting for this practicum. Winnipeg is a midsized Canadian city with a population of over 600,000 people. The size of its street-involved population was not available although it is known that the Point Douglas and Downtown areas of the city are significant areas of street

involvement. The majority of health care services in Winnipeg are funded by Manitoba Health. The WRHA is the major health care service provider although others, such as Nine Circles and Klinic Community Health Centres, are funded by Manitoba Health as well. For substance abuse, the majority of services are funded separately by the Manitoba Government's Healthy Living Department. The Addictions Foundation of Manitoba is the largest service provider although there are other addiction service providers such at the Native Addictions Counsel of Manitoba.

As mentioned previously, CODI is a project whereby the Addictions Foundation of Manitoba, Manitoba Health, WRHA and a number of additional stakeholders such as Mount Carmel Clinic and Klinic partnered to improve services for the CODs population (Appendix D).

Sample. A purposive sampling strategy was used to maximize the opportunity to study services currently provided to street-involved women with CODs and three programs were chosen. The team leaders of the three programs were approached to establish cooperation with this practicum. In addition to Street Connections, PACT and Dream Catchers were included in the practicum. PACT, a WRHA Community Mental Health program, provides treatment and rehabilitation services for individuals with severe and persistent mental illness. Many of their clients have co-occurring disorders (Manitoba Health, n.d.). Dream Catchers is offered by Klinic Community Health Centre and works with women and transgender women who are in the process of leaving the sex trade. The program aims to support them while overcoming addictions and dealing with childhood/adult trauma or sexual abuse. This program serves women who are street-

involved and many of the participants have CODs (Winslow, 2005). These three programs differ in their primary goals, service delivery strategies and several other variables. Case studies of each program served to illustrate the assortment of health services available to women living with CODs (Yin, 2003).

From each of these programs, a convenience sample of three to four administrative or front line staff were recruited for a total of nine participants. Inclusion criteria of participants were: current employment by the case study program, practical knowledge in working with women with CODs, and willingness to participate in an interview.

Recruitment. Upon approval from the Education-Nursing Review Ethics Board (Appendix E), access was sought from the WRHA Research Review Committee (Appendix F) and the team leaders of each of the three programs (Appendix G). With the team leaders' agreement, participants for person-centered interviews were recruited with letters of invitation distributed by the team leader of each program into each staff's mail slot in their mailbox at the work site of the three programs. To protect the privacy of staff, letters of invitation were not personally addressed; instead each letter was just addressed to 'staff' (Appendix H). Administration and staff were invited to contact the principal investigator directly if she/he wanted more information about this practicum and/or was interested in participating.

Data collection. Data were collected from various sources to increase the accuracy and credibility of the findings. Agency documents and person-centered interviews were the primary sources of data. Documents included mission and value statements, program descriptors, annual reports, discussion papers, and position statements as well as any

available statistics on client usage or satisfaction. Then, person-centered interviewing was used as a method of dialogue where the individual is questioned both as an informant, who has expert knowledge of a program's practices, and as a respondent, who has personal reactions to the practices within the program. The differences between informant and respondent modes distinguish this method (Levy & Hollan, 1998). From each program, there were one to four participants for a total of nine participants. Each participant met for an audio-recorded interview that lasted between 50-90 minutes. Notes regarding overall impression of the interview were made by the interviewer after, not during the interview. Person-centered interviewing offered additional data as to what current practices are provided and why. See Appendix I for the interview guide.

Data management. Data were managed as follows. Documents collected were filed according to program for later access as needed. Notes made by the interviewer about potential themes were also kept and filed. Interview tapes, once transcribed verbatim, were accorded an ID number. The transcriptionist signed a confidentiality pledge (Appendix J). The tapes were stored in the principal investigator's office in a geographically separate location from the consent forms. A master copy of the transcripts was placed in the principal investigator's office. All data (documents, tapes, consent forms, transcripts) were stored, locked, secured and will be kept for at least five years after completion of the study at which time the data will be disposed of as confidential waste.

In this way, a chain of evidence was maintained to be able to show that the analysis did result from the evidence. Thus, an audit of the data is possible and both

confirmability and dependability of data are increased (Yin, 2003).

Data analysis. Analysis occurred concurrently with data collection. The data from interviews were critically read to gain an understanding of participants' narratives. The process of open coding was applied to identify patterns, merge into categories, then aggregate into themes which were made up of one or more categories. Then, the original text was referred to so that meaning and context were maintained.

Documents were examined to corroborate, contradict and/or add new data to the interview findings. The process went back and forth between the interview findings and program documents until themes were completed.

Member checking with interview participants was done to assess for accuracy of their responses. Two participants from two different programs were approached initially and a written summary of the findings was presented. These participants were selected because their comments were not as straightforward to identify patterns or themes as other interviews. No issues regarding misinterpretation of their intended meaning was identified by these participants. Next, prior to the final draft, all participants were approached to request they check my analysis of all of their direct quotes used in Chapter Four. Seven of the nine participants agreed to member checking and each of the three programs was represented. Again, no contradictory issue was identified by the participants although two participants added context to one quote each.

These findings were compared to the best-practice literature to scrutinize similarities and differences between best-practice recommendations and current practices, then develop policy/practice recommendations for the Street Connections program.

Ethical issues. An ethical constraint of case studies is that program anonymity is impossible, as each of the programs is already identified. Particular care was taken to maintain privacy and confidentiality of interview participants. Participants signed consent forms and provided their names. These forms were stored, locked and secured in the principal investigator's office separate from any data. Given the small sample size, absolute confidentiality could not be guaranteed. However, no participant names are used in the presentation of the findings whether in written or verbal modes. All participants first provided written, informed consent which consisted of the purpose of the practicum and interview, time commitment, potential risks and benefits (Appendix K). Participants were told they could withdraw from the practicum at anytime without prejudice. I was available for questions after data collection.

Furthermore, member checking, as described above, was done with participants before public release to protect identity and clarify meaning. Although no issue arose during member checking regarding the potential for identification of a participant, if such an issue had come forth, I would have negotiated with the participant regarding alteration of quotations (findings) so as to protect speakers' identities without compromising the data.

Timeframe. A 6 to 8 month timeframe was proposed for completion of this practicum. Recruitment for person-centered interviewing occurred through out the time-line with emphasis on the beginning months.

Feedback. In addition to this practicum report, findings were available to individual participants on request through a one-page summary of results. Also, a presentation by

the principal researcher will be made to interested administration and staff from each of the three programs.

Limits. The case studies were completed during a time-limited period in the spring of 2006. Documents available did provide historical context. However, each of the three programs can potentially evolve and change after data collection. As well, the findings are intended for the development of practice and policy recommendations for Street Connections and thus the collection of data is aimed in this direction. It is the reader's discretion regarding the transferability of findings to other programs or aggregates of service areas.

Chapter Four

Findings

In this chapter, the second purpose of this practicum is addressed: to determine current practices in Winnipeg for the street-involved women with CODs aggregate. Findings arising from the case studies of Street Connections, PACT and Dream Catchers are presented.

Street Connections

Context

Street Connections is a core-funded mobile outreach program within WRHA's Population and Public Health Communicable Disease Control. Even with changes in name, administration and 'ownership' of the program, the staff of Street Connections has always utilized mobile outreach with a Harm Reduction approach to prevent HIV transmission among street-involved individuals and injection drug users. Mobile outreach refers to the practice of driving a vehicle, cruising and stopping to offer services. As described previously, Harm Reduction accepts that people take risks which can harm their health, but the goal is to lessen the consequences of their behaviors, specifically STI/BBP transmission, without judgment or requirement to stop all risky behaviors before these services are provided. While Street Connections has guidelines referring to the distribution of harm reduction supplies and pamphlets describing its Harm Reduction approach, there was no guideline or policy specifically referring to Harm Reduction as a model for the program. Also, recovery is not explicitly stated in Street Connections

guidelines although many of the following findings that represent Harm Reduction also exemplify principles of recovery.

The program started in 1990 as Street Links, a two-year demonstration project administered by the City of Winnipeg Health Department. The name changed to Street Station and continued within this department until 1995. At Manitoba Health's suggestion, Mount Carmel Clinic applied and received core funding to run and amalgamate the program with POWER (Prostitutes and Other Women for Equal Rights). The two programs became Street Connections and offered services until 1999 from a mobile vehicle as well as two fixed locations in Winnipeg's inner city, 820 Main Street and 50 Argyle Avenue. Then, in 1999, evaluation of the program by Prairie Research Associates brought forth the following issues. The program's lease at 820 Main Street was terminated as the building had been sold. There was staff who expressed safety concerns, as well as complaints from surrounding businesses. Another site was not sought. The other site on Argyle Avenue had always been designated for women and transgender women only. Then, Mount Carmel Clinic's Board took the position that HIV prevention was a public health issue affecting all of Winnipeg, not just the geographical area served by Mount Carmel Clinic. After this external evaluation, the decision was made to the transfer of the mobile outreach portion of Street Connections to the WRHA Population and Public Health Communicable Disease Control in 2001.

Since that time, Street Connections is co-located at 705 Broadway Avenue alongside the STI and BBP Prevention and Control team, another WRHA Population and Public Health Communicable Disease Control program. These two teams recently

amalgamated into the “705 Broadway” team. For consistency on the street, the Street Connections name, along with its mobile outreach and Harm Reduction approach continued. Despite these changes, the provision of continuous mobile outreach using the Street Connections name allowed Winnipeg’s street-involved population to develop familiarity and trust with the program. As one participant observed, “One of the great things that [staff] did that really helps and one of the big keys I think is that we developed such a long history with clients that we do have that trust.” Familiarity and trust with street-involved populations were found to be important elements of Street Connections that continue to this point in time.

Goals

Street Connections’ goal began with HIV prevention and expanded to include prevention of additional STI (chlamydia, gonorrhea, syphilis and chancroid), and BBP (hepatitis C and HIV). The target population is street-involved individuals including crack users, sex trade workers, injection drug users, street-involved youth, solvent users and the homeless who are often, but not always, living in the Downtown and Point Douglas areas of Winnipeg.

These populations are often disadvantaged with respect to the determinants of health and participants discussed the impact of poverty and unstable housing. As one participant noted:

> Often people that have co-occurring disorders seem to often have basic needs that aren’t being met, housing is often a problem. The access to food, you know. Access to safety sometimes too. So I mean those things. A lot of the basics have to be addressed in order for people to address the other stuff because the basics are the most important things

> to anybody. So for, for instance, for a person to talk about their mental health issues, well what I need is a place to stay. That's what I need right now.

Participants know the importance of addressing determinants of health and working holistically with clients, but they are also cognizant of their limits, given the reality of the program's goals and their ability to work with the large number of clients seeking service. When there are "competing priorities, [communicable diseases] take precedence unless someone's life is immediately in danger."

Services

Pamphlets and program descriptions show that services typically provided include:

- supplies to reduce harm (sterile needles, condoms, safer crack use kits, lubricant, biohazardous containers for needle retrieval, alcohol swabs, tourniquets, filters and sterile water);
- BBP/STI counseling and education including distribution of the weekly 'Street Sheet' (Appendix L);
- verbal and written safer injecting information (Appendix M);
- wound assessment and minor dressing changes;
- crisis counseling, support and advocacy;
- referral to other health/social agencies;
- vaccinations against hepatitis A, hepatitis B and influenza;
- gonorrhea and chlamydia testing and treatment;
- HIV, hepatitis and syphilis testing; and

- case/contact management for reportable BBP/STI under the *Public Health Act*.

Note that case follow-up is limited to those Street Connections' clients who were tested for STI/BBP by Public Health Nurses in the program. Given the difficulty finding contacts, follow-up of contacts is limited to those individuals named by clients of Street Connections. Also, Street Connections nurses will assist the other Public Health Nurses with the 705 Broadway Team, who do the vast majority of case/contact follow-up, by attempting to find and follow-up with contacts who are known to the program. This aspect of work is different from other Street Connections outreach activities because staff seek out specific individuals identified as cases or contacts, instead reaching out but allowing each individual client to ultimately decide whether to access service. The challenge is building a trusting relationship with individuals who are reluctant for case/contact services.

Operations

Street Connections currently operates Monday to Friday from 9:00 am to 12:30 am, and Saturday from 5:00 pm to 12:30 am. During outreach, staff drive at approximately 30 kilometers per hour in a large white van with "Street Connections" and its phone number printed on the side. The bulk of client services are provided during outreach after 6:30 pm. This van was equipped to provide services that require additional privacy and space. Vaccinations, blood draws, wound assessment, minor dressing and interviews can take place in the cargo portion of the van, where curtains can be drawn to provide some level of privacy. The West end, North end, Downtown and Osborne Village are traveled and staff stop whenever street-involved individuals are seen. Staff

acknowledge the individual but it is the street-involved individual's decision if she/he will come to the van or approach staff. Staff also make 'home visits' city wide to meet with individuals for needle distribution/retrieval or for STI/BBP testing/treatment. For staff safety and client privacy, staff do not enter clients' homes, but instead the individual clients come out to the van for service. Two staff, usually Outreach Workers, work 9:00 am to 5:00 pm and two other staff, usually a Public Health Nurse and an Outreach Worker work from 5:00 pm to 1:00 am.

Access

To decrease the threshold for individuals to seek services and thus, to promote access, a number of the following strategies are in keeping with a Harm Reduction approach.

Mobile outreach. Only a very small portion of Street Connections' clients go to the 705 Broadway office. This office is not in the immediate area where street-involved individuals are found, and it is located next to a community police station and also shares its entrance with other health programs at Nine Circles Community Health Centre. As one participant noted, most clients are encountered during mobile outreach

> because you're going right to where they're at…our service is mobile and we're out there where the women are working, the strength is that we're connecting with their home territory. We're not trying to get them out of there and send [them] elsewhere for services."

Every contact with clients on the street serves as an additional opportunity to develop trust. All the participants emphasized the role of outreach with harm reduction strategies as paramount to Street Connections.

Anonymous services. Street Connections guidelines explain that a significant portion of services provided do not require names or other identifying information, but are instead anonymous encounters. Because many of the activities associated with street-involvement lead to criminal justice system conflicts, more clients do approach the van knowing that their names are not recorded when they only receive health information, harm reduction supplies or supportive counseling. Allowing clients anonymity decreases the threshold to obtain services and also facilitates trust development When other services are provided, in keeping with the *Personal Health Information Act*, individual records are confidential with only as much information as necessary for appropriate treatment and follow-up.

Data on client access. Data on client usage gathered by Street Connections staff from April 2005 until March 2006 show the large number of contacts with individuals made by Street Connections staff. Staff made over 17,000 client contacts, distributed over 10,000 safer crack use kits and 310,000 needles while retrieving just over 230,000 needles. There was a variation in the number of contacts between warmer and colder months with an average of 70 contacts per day. Participants confirmed that each individual seen during a shift is recorded as one contact. If a same individual is seen later in a same shift by the same staff, this is considered a continuation of the previous encounter and not recorded as a new contact. This also means that the exact number of different individuals is not known. Some clients have contact with the program daily while others may only contact the program once. Although staff get to know clients who repeatedly contact the program, given the anonymous and fast paced nature of the

service, a significant portion of the following data about characteristics are estimated but not verified. The top three client profiles in this data are crack users, sex trade workers and injection drug users. Data on mental illness were not collected. As well, approximately 70% of clients self-identify as Aboriginal and there is close to an equal female to male ratio. Also, only 0.04% of client contacts are identified as youth less than eighteen years old. Data on client satisfaction with Street Connections were not found.

It is significant to note that mental illness is not captured by the statistics kept by the program staff. Thus, the proportion of street-involved females with substance CODs who access the program is not verifiable. However, the data reveal the large number of clients who access this program.

Timing. The number of contacts with clients presents a tremendous opportunity for service. On the other hand, mobile outreach within the clients' environment also means that clients are first interested in their own work or personal activities. For example, one participant noted that women in the sex trade are watching for their next customer or "date".

> [Staff] are meeting up with someone on the corner. And even though they may want to talk [about health or safety], we've got [time for] a little blurb. If a car drives by and they have a date, then that's a priority right there. So it's kind of catch 22 because we're there but the timing's not always right for that person to be there.

While access is made easier with mobile outreach and harm reduction strategies, timing is an issue for Street Connections staff. Clients want services in their community on the street, but meeting with a client exactly when she/he wants to take the time for all her/his concerns is difficult to arrange.

Engagement

The previous findings on access and outreach are closely related to engagement of clients. The subsequent findings illustrate a variety of strategies to engage clients that were applied.

Communication techniques. First, all participants identify the importance of using a variety of communication techniques that develop trust specifically with street-involved clients. Examples include recurrent brief contact, initial use of minimal nonthreatening statements, casual dress code, humor, repeated offering of additional services and "respecting the right [of clients] not to answer questions."

One participant described another important skill to engage clients, body language assessment:

> Their (client's) body language. Like if they don't want to hear it, like they just tell us, like they shut us down, so that's a good sign. They shut us down. Their body language. They're in a rush. They just have no time for us.

A quick assessment of every client's body language assists staff to adjust their interaction style to suit the client. Then, participants also spoke about the use of straight-forward questioning with clients who already have some rapport or trust with the program and staff.

> Being straightforward. You know for me I find that works well because I'm even shocked with some of the things I can say and get away with the clients. Like they don't go meow at me. Like it has happened sometimes, but 90% of the time, I don't know, I just think being straightforward with the client and just being honest. Honesty is a, is a good approach with them I think.

Newsletter. Another strategy used to engage clients that all participants highlighted is Street Connections' weekly newsletter, currently called the "Street Sheet" (Appendix L). Every week a different newsletter is put together by frontline staff containing health information, reports made by sex trade workers of abuse by customers ('bad dates'), messages for clients and a variety of jokes. Participants describe its strength in offering information and an opening to address "personal issues in a nonpersonal [nonthreatening] way." It affords the opportunity to reach out to individuals who do not want to take the time right then to stop and talk at length with staff. The newsletter's language, topics and format are specifically aimed to get the attention of street-involved individuals. Street Connections' staff offer every client a copy and the vast majority of clients take one. Many clients comment that they read the newsletter and like it. Each week, 200 to 300 newsletters are distributed by Street Connections staff to clients; approximately 40 newsletters are emailed to selected agencies who also work with street-involved individuals, and approximately 20 copies are left in the waiting rooms at 705 Broadway Avenue.

Health information in the newsletter is regularly based on STI/BBP prevention but will also include any pertinent health or social issues. One participant explained:

> In [the newsletter] are a number of articles on harm reduction pretty broadly defined…but occasionally we also talk about a loss…And although it doesn't really address the issue of severe and persistent mental health disorders. It opens, in some ways it opens the door to what really happens on the street…And I know we talked about that in the van as well directly face-to-face with people so, [we also] kind of hand out information that is relevant in small packages, not in a way that scares people. Hopefully in a way that people can understand. So maybe we are in some

> ways laying the groundwork for, for those small changes that people are ready to make.

Thus, the majority of client interactions are fast paced, but the newsletter provides an opportunity to inform clients of relevant health and social information in a way they can accept.

Gender and culture. On yet a different level, gender and culture are potential areas of commonality that participants also use to engage clients. Some participants discussed the benefit of using different approaches depending on clients' characteristics, particularly with pregnancy.

> Definitely prenatal. This is a good time to engage with us…I find people are more willing at that point to get help if they're wanting it. And are a little bit more open to services…It's a great window of opportunity.

However, other participants stated that gender did not influence how they worked with clients. They continually sought to establish an inclusive, nonjudgmental approach with all clients, regardless of gender or other characteristics.

> I haven't found anything, any difference by gender that I can say. I mean as far as [what] we use to work with them or stuff like that. I don't see that. Each person is treated as them self.

When asked about culture, interview participants more readily discussed the benefits of using cultural awareness to engage clients. "It's good to know different cultures because it can be a point of entry for people to understand each other or get to know each other." All participants agreed that engaging clients was enhanced when clients saw similarities between themselves and staff, whether this was based on gender, culture or any other characteristic.

Respect. Perhaps most importantly, participants deliberately demonstrated respect for their clients.

> [W]hen you're engaging with someone you have to be very respectful of their right to live how they want to, without treatment.
>
> [Clients] respect someone who sees themselves as an equal. Like we don't see ourselves as being better than them. And I think that gives us a good understanding also and it makes the client feel more comfortable with us at that point.

Participants identified the challenge in "having the opportunity to ask" yet "to not ask that question that'll scare them off." They know the importance of "offering, not pushing" to maintain at least a minimal level of connection because "we're there on the long term in the sense that we'll be back the next day, and the next day, and the next day."

Overall, any service that the client may find valuable such as vaccination or STI testing is used by staff to engage clients. "[Y]ou have to work on that and continue to draw them in somehow. Either with the nursing stuff or educating and, or advocacy. Let them know what we offer." The development of trust through a variety of communication techniques is a principal strength of the program that occurs simultaneously with mobile outreach. As another participant observed, "Much of the success is so contingent on the relationship that people have and are able to develop…a very strong foundation of trust which without which you can do nothing."

Screening and Assessment

Screening, not to determine if individuals were eligible for Street Connections services, but rather for the potential presence of CODs, was a challenge for all

participants. They identified a lack of knowledge and comfort in addressing mental illness issues. However, the regular provision of needles and safer crack use kits, clients' drug use, and addictions were readily apparent and, thus, more apt to be addressed by staff. One participant stated. "I have a sense that we're more comfortable as a team dealing with issues around substance use than around mental health…I think [staff] focus more on the addictions part."

Participants do acknowledge the value of contact with clients over an extended time period to better enable them to screen clients for CODs. As one participant stated,

> It takes time. I mean, sometimes when we run into people they may seem like they have a disorder. And right off the bat we may assume that because of the way they present. And they may be new. But, um, once again, it's kind of hard to say because it depends on what they're using, you know, and what they're like…But I don't necessarily believe that they have a disorder right away. I'm still open to whether or not they do.

However, another participant stated that overall, "We don't necessarily screen for co-occurring disorders." A general lack of focus on mental illness was revealed throughout the interviews which in turn led to decreased identification, planning and services for street-involved females with CODs.

Comprehensiveness, Integration and Continuity

Given the fast-paced and anonymous nature with much of Street Connections' services, issues did come forth that challenged the level of comprehensiveness, integration and continuity of services, particularly to those individuals such as street-involved women with CODs, who are reluctant to access services or develop trust. First, all participants identified time constraints as an ongoing issue. Time constraints arise

from the volume of clients contacted each shift, the number of clients approaching the van at any one time, or from difficulty timing contact with clients when they are ready for additional services. Privacy, motivation and interagency relationships were additional issues as presented below.

Privacy. Participants found that privacy is an issue that is associated with time constraints. Frequently at least one additional client approaches the van at the same time and/or interrupts another client. At certain locations, it is not uncommon for more than ten clients to approach the van at the same time. Even when additional clients stand back from the van, the first client will often then say that she/he only needs harm reduction supplies and other concerns can be addressed later. A client could choose to get into the van where there is less opportunity for other clients to see or hear the remainder of the interaction. But participants identify that the issue continues when the first client comments that being seen to get in the van could imply a problem or vulnerability. Another participant explained that some clients openly say "I don't care" if other clients see them or know their concerns, but most clients will say they do not want others to know "my business." Thus, the protection of privacy is an ongoing issue which in turn influences clients' motivation to obtain additional services.

Fluctuating motivations of clients. The comprehensiveness of services is challenged by clients' fluctuating motivations. Staff accept that each client has the responsibility for her/his own care even though clients' motivation to seek care fluctuates repeatedly. One participant spoke of the problem with "assuming [clients] are going to still want that service the next day. And that they are wanting to follow through." Having

interactions and providing interventions that match with clients' fluctuating motivations is a challenging skill to apply. For example, clients repeatedly request STI/BBP testing yet not at the moment they meet with staff. Often, services that require additional time must be offered several times before an opportunity arises whereby the client wants to proceed and staff are available for that service. While staff were mindful of challenges with follow-through related to street-involvement, they were also aware of their limits to provide all clients with timely, comprehensive services and assist progress toward changes.

Interagency relationships. Participants affirmed that integrated relationships with other health and social service agencies could potentially increase the comprehensiveness of services available. A number of professionals and programs were identified by participants as having unmet potential for integration with Street Connections staff including, but not limited to, the Mental Health Counselor with the 705 Broadway Team, the CODI consultation team and the Addictions Foundation of Manitoba. However, they also affirmed that consultations and referrals with other social service programs is challenging. First, participants found consulting about issues for clients difficult when staff did not yet know a client's name given the anonymous nature of services.

Then, most other service providers rely on daytime services while the majority of Street Connections' client interactions occur late in the evening. When staff meet or speak directly with the consultation/referral source, clients were more likely to feel comfortable following-through with referrals. However, additional issues such as unstable living situations, addictions, stigma, and other social issues mean that a

significant percentage of clients did not follow-through. Follow-through with referrals was also undermined when Street Connections' staff could not arrange for staff to drive and stay with clients at the referral appointment. With the volume of client contacts and the mobile nature of Street Connections work, having the time to connect and develop relationships with other agencies was difficult.

Staff Development and Support

All participants expressed the need and desire for more ongoing support and training related to the provision of services to this vulnerable yet challenging population. They were aware that within the WRHA, ongoing staff development and training was available. For example, participants articulated the value of additional training or resources from WRHA programs such as Co-occurring Disorders Initiative (CODI) and the general Population and Public Health team.

> We're connected to a larger system. That we're only beginning to hook into some of the CODI training, that's positive…I think there's a strength in opportunity as well in being connected to Public Health, in that if we can address some of the, some of these other issues with relative ease, that can also help.

Participants stated that staff meetings are held approximately once monthly from 4:00 pm to 6:00 pm to encourage attendance of staff from both shifts. However, not all staff attend any single meeting as part-time staff may not be scheduled for work on the day of a staff meeting. Communication between staff cannot always occur in person, thus emails and voice mails are frequent.

Summary

Street Connections is a WRHA Population and Public Health Communicable Disease Control program with the goal to decrease STI/BBP transmission, particularly among Winnipeg's street-involved population. Services range from harm reduction supplies to case/contact follow-up for reportable STI/BBP. The findings show that most services with this program are broadly aimed at the street-involved population as a whole, and are not targeted specifically at the aggregate of street-involved women with CODs. Access for the street-involved population is enhanced by mobile outreach and anonymous services even though timing of service to individual clients can be difficult. With the aim to develop trust, clients are engaged through a variety of strategies including communication techniques, newsletter, gender and/or cultural similarities and above all, respect.

Given the volume of client contacts compared to clients' needs, challenges do exist for the program. Screening and assessment for CODs is not a routine process. Even though the research demonstrates that upward of 50% of this aggregate will have CODs, data from the program to confirm this are not available. Additionally, there are limits to the level of integration and comprehensiveness of services that Street Connections staff can provide. Then, interagency relationships are seen as an unmet opportunity to increase the level of integration and comprehensiveness of services. Finally, some staff development and support practices were in place.

Program of Assertive Community Treatment

Context

The PACT model is a service delivery model for a team of mental health professionals to provide comprehensive and integrated treatment, support, and rehabilitation services for individuals with severe and persistent mental illness. This model was first implemented in 1972 in Madison, Wisconsin, and is now operated in several cities, towns and rural areas across Canada and the USA. Since 2000, Manitoba Health has provided core funding to the WRHA Community Mental Health program to operate a PACT team. Winnipeg's PACT team shows a high degree of fidelity to the principles and standards put forth for PACT such as teamwork, shared governance and responsibility, long-term individualized services, and recovery-based orientation (Appendix N). The following findings exemplify principles of this PACT team.

Goals

Documentation shows that PACT's goals are:

- treatment for clients to feel as healthy as possible while lessening symptoms and minimizing acute episodes of mental illness;
- support for clients to live in the community instead of hospital or institution; and
- rehabilitation with clients to meet their own goals such as work, education or greater independence in daily living.

Services

Documentation also shows that typical services provided by PACT include:

- symptom assessment, treatment, and education including provision of medications;
- counseling and support;
- outreach;
- skill teaching for activities of daily living, money management, shopping, etc.;
- twenty-four hour crisis response;
- development of and support for social activities and relationships;
- employment counseling;
- substance abuse services;
- advocacy; and
- support and education for families and other natural supports.

Operations

PACT ensures client services are available 24 hours a day, every day of the year. The majority of staff work Monday to Friday daytime hours. As well, Service Coordinators and Support Workers rotate to work day, evening and weekend shifts to ensure two staff are available for clients on the evening and weekend shifts. These staff also rotate such that one staff-person is available to provide on-call overnight services every day of the week.

The PACT model supports the importance of an accessible office space for clients and their families. Thus, since the program was started, PACT's office is located close to

the inner city at 492 Hargrave Avenue and has its own entrance and waiting room. Just as significant, the office is set up with a large, common, central workspace to facilitate easy interaction for staff. However, the PACT model also endorses assertive outreach and staff go out to meet clients instead of expecting clients to always come to staff. Thus, the majority of client services are provided in the community.

Teamwork. Teamwork is another important element of the PACT model. PACT employs a Team Leader, Psychiatrist, Administration Assistant, eight Service Coordinators and four Support Workers who all work together as a team. The Team Leader has a key role for clinical consultation and one-to-one supervision of staff. Having a Psychiatrist on staff is essential for readily available psychiatric assessment, crisis intervention, pharmacologic treatment and hospitalization if necessary.

Service Coordinators and Support Workers have work and/or life experience with mental illness and/or rehabilitation services. Service Coordinators have health-related professional backgrounds such as nursing, social work and psychology. Support Workers educational backgrounds vary and may not have additional post-secondary education. Participants confirmed that staff have expertise with substance abuse or vocational development but this PACT team does not have designated Substance Abuse or Vocational Specialists. Also when peers, individuals who have personal experience with mental illness, are hired onto the team, it is into any of the positions listed above, as there is no specified Peer position.

In keeping with the service-delivery model, all staff are willing and able to implement unregulated services for each client. All staff bring their own personal and

professional expertise to the team but continue to function within the limits of professional licensing bodies. For example, any of the staff will help a client clean her/his home if necessary. As one participant observed, “What works really well for PACT is that we do it as a team. And that is the thing that works best…so it’s not like you’re ever doing something by yourself.” Staff may see clients individually but the whole team is aware of the recovery plan. While team members function with differing levels of responsibility according to her/his professional licensing body, any team member is able to step in to provide unregulated services as necessary.

However, to foster relationship development between clients and staff, each client has a “mini-team”, composed of three to five PACT staff, which provides the majority of services for that particular client. On the mini-team, there is a designated “Primary”, either a Service Coordinator or Support Worker who is the contact person if external agencies are involved with the client. The Primary also has the responsibility to monitor all aspects of the client’s status and services. Thus, the Primary and the mini-team see the client more often but any staff member can and will provide services.

Access

Many individuals with severe and persistent mental illness would profit from PACT’s services but Winnipeg’s capacity is limited with only one PACT team. Referrals to PACT are accepted from a variety of sources including health care professionals, hospitals, family members or the individual as well. Referrals first go through a centralized intake process for the whole Community Mental Health Program and those who fit within PACT’s criteria are referred to PACT. Clients must have an axis I

diagnosis according to the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV (*American Psychiatric Association Task Force on DSM-IV, 2000), PACT policy on admission criteria requires all the following:

- inability to consistently perform practical living skills;
- ongoing difficulty acquiring and keeping adequate housing;
- inability to consistently function in major life roles such as work or parenting; and
- failure to make use of existing mental health services.

Clients must also have at least two of the following:

- severe and persistent symptoms of mental illness;
- co-occurring substance abuse disorder; and/or
- high-risk or recent history of criminal justice involvement.

Those individuals who meet eligibility criteria meet with PACT's psychiatrist and team leader or designate to assess whether the individual will be admitted to PACT. Thus only those individuals with the highest level of needs are admitted. As one participant stated,

> PACT gets the sickest of the sickest. So I think other PACT programs, when there's more PACT programs in [another] city. You have people that are better and people that are worse. So you can spend more time with people that may need your services and less time with people that are more independent. Whereas we get people and most of them are really, really sick…So they require a lot of services.

PACT does have street-involved women with CODs admitted although only those women with persistent and severe symptoms of mental illness and an ongoing functional disability would meet the criteria for admission.

In the fall of 2006, this PACT team had over 70 clients. They are aiming to serve 90 to 100 clients with a client:staff ratio of fewer than ten:one. PACT has not yet reached its client capacity as admissions to the program were paced to allow the team to establish a close relationship with each client and ensure comprehensive treatment, support and rehabilitation. The current goal is to admit 2 clients per month and reach 80 clients by year-end. Participants confirmed that approximately 35% of clients are female and 5% of females are street-involved or incarcerated.

As for discharge criteria, PACT's policy is that both the staff and client must mutually agree that the client is able to function with minimal input from PACT in all major areas of her/his life including self-care, work and social life. Discharge may also happen if the client permanently moves out of Winnipeg. Accordingly, only five PACT clients have been discharged, moved or passed away since the program's inception in 2000.

Engagement

For clients who are determined to be eligible for PACT's services, deliberate efforts are made to engage clients into the program. These findings illustrate outreach, long-term services, communication, harm reduction and client responsibility as elements of engagement.

Assertive outreach. Assertiveness and outreach are central ingredients of engagement. One participant stated,

> [T]rying to see them on a regular basis. The other thing is that we are quite assertive. So if we don't see someone, we'll actually actively look for them. Spend lots and lots and lots of time looking for them. So I think that's a big

> plus because we're able to engage with these individuals as opposed to other programs who, are typically, not nearly as assertive. So this person doesn't actually come to their office or meet their meeting times, then they just don't get seen. And they fall through the cracks. Whereas we'll actually go and cruise the low track. If they're in between tricks and I can, we can actually meet with them…You have to do that, persistence. Assertiveness is same thing.

Going out to meet a client in her/his own community also facilitates staff to become engaged with and assess the client's social and physical environment.

Long-term service orientation. Engagement with clients is enhanced because the PACT model accepts that both the disability and recovery from mental illness are long-term processes. Once a client is admitted into PACT, services are provided indefinitely. Another participant stated that this allows staff "the time and the goal in this program of being able to work with people and not have them discharged from the program because they're uncooperative."

Participants noted that long-term services assist them to "build close relationships", "find out what their dreams are", "plant the seed and make plans" and "do things with them" which can encourage clients to progress toward positive changes.

> Making change can be very hard for people and some women who are with our program have been involved in this lifestyle for a long, long time. It's really ingrained in how they live their lives and it's, sometimes it's hard to show or to give them possibilities that there's other, there's a different kind of life out there if they want it.

Other benefits of long-term services are that staff are better positioned to "respect [client's] goals" and match the client's readiness for change, instead of setting unreachable goals for the client. Other participants observed that when clients do make

small changes, this progress can be noted and acknowledged by staff. Examples of progress may appear as minimal as the client's expression of frustration with ongoing street-involvement or one additional week in an apartment without eviction. Thus, long-term services facilitate staff to engage with clients and work at the client's pace toward change.

Communication techniques. Participants also identified the utility of a nonjudgmental, straight-forward communication in connecting with clients. One participant commented,

> We openly question them. We ask them. We don't beat around the bush.

Another participant added,

> One thing that's good I think for lots of our clients is that they're pretty, not all the time, but lots more are pretty honest with us. And they share with us. That we know that we try not to judge, be judgmental, so that they know that they can talk to us about, what they're doing…I mean I shouldn't say they all tell sort of thing. Obviously they don't…So they know that we're not going to judge them.

Participants illustrated that staff use a range of communication techniques with the goal to build rapport with clients.

Harm reduction. In conjunction with communication techniques, staff apply harm reduction principles. A participant commented, "I guess maybe that's another benefit of our program is that we take more of a harm reduction approach as opposed to preaching abstinence. Which I think that allows us to build a real trust with people." Staff reach out to meet and align with clients in their own environments without demanding the client achieve abstinence or other unrealistic expectations. In practice, assertiveness, outreach

and nonjudgmental acceptance are all used together to enhance relationship development with clients.

Client as responsible individual. Documentation from the PACT manual puts forth the need to, above all, relate to clients as responsible individuals with the same responsibilities and rights as any citizen. While participants always demonstrated this attitude, they also did discuss the difficult balance between client responsibility and finding clients during scheduled appointments. Even with the application of the above strategies, participants stated that clients are frequently difficult to locate, particularly street-involved women with CODs who are often abusing substances daily and not staying at any fixed address.

> But not everybody is as intensive as individuals with co-occurring disorders. They're living on the street. That's where a lot of [staff] time is involved. Either a lot of time or no time. And that's where it makes it really difficult to schedule…You can't find them for their appointment. Or they do come in sort of out of the blue and you have to use that opportunity to the best of your, as best you can. You can't just say, you know, it's not our scheduled appointment, go home.

Participants spoke of trying to be as flexible as possible with respect to appointments with street-involved clients. One participant found that "with this population you have to be a little bit more flexible." However, staff's daily work assignments do not usually allow open time slots for unexpected clients. Instead, staff will "juggle" by rescheduling appointments with other clients.

This was not always possible as it affects other clients in the program and adds to staff workload. As another participant explained,

> But one thing that has helped with that though I think is that we have to realize that we can't be rescuing people out of [chaos] every day…I guess that's one way [of] trying to get through the chaos in their life and putting some structure so. And not to think that we have to rescue them every time they come in.

A participant described the need to assess the client's situation and either "seize the opportunity" or "set limits and hold [clients] somewhat responsible" for her/his actions. Instead of responding immediately to provide all services to the client whenever the client asks, participants aimed to work with clients. For example, Winnipeg's shelter options are scarce due to a lack of safe, affordable, accessible venues. While this is a frequent issue, there is a benefit to working with the client to secure a place to stay instead of responding to their demands to get them a place to stay.

> I mean we could jump in and possibly find them housing. And we do. Often, find housing over and over and over again. But they need to do a lot of the legwork for that. And take some ownership for their housing. Reason being otherwise they're just not going to maintain it.

This approach may mean the client lives without a fixed address while staff and the client work together on this issue. It also means that the client may then develop motivation and skills to keep her/his housing longer. While challenging to achieve, the client is given the opportunity to develop responsibility.

Screening and Assessment

Screening and assessment for CODs occur for all clients in the initial assessment process. Careful comprehensive assessment and treatment planning are fundamental to PACT. For every client who is accepted, staff conduct concurrent assessments in the areas of mental illness/health, physical health, activities of daily living, housing,

vocational, substance use, social supports and family interactions. While the *Personal Health Information Act* is respected, participants emphasize the value of collateral information from family, friends and any external agencies associated with the client. These assessments are brought to PACT's Recovery Planning meeting as described by one participant,

> Every [staff] has to come to the recovery plan meeting and so it's a very expensive two hours. We take everybody's brains, which are really good, and sort of put them together…we go through the issues and then, everybody on the team presents. Let's say that I'm the prime for somebody, I'll write down the issues that we have, mental health, physical health, housing, vocational, education, employment, substance use, legal issues, that sort of thing.

As the name suggests, recovery planning is based on Recovery principles. Staff also apply recovery principles by using assessment and planning as opportunities to align with the client and involve her/him in PACT's services. Another participant explained, "We meet with the client, we try and get them what they want and we get them to come. So we have a really high success on having the clients come to the Recovery Planning meeting."

With respect to planning services, the importance of considering consequences associated with each individual's gender and culture was acknowledged by participants.

> Well I think that, what is happening with all of our women that are in that boat, they all end up working the street…And the men don't. A lot of the men panhandle. And I think that all, yeah; all of our women that have co-occurring [disorders] end up working the street. And so then that puts them in much more vulnerable position because they're, they're in a dangerous situation and the men that panhandle [are] much safer…Violence and, you know, STDs [STI]. And getting kicked out of whatever housing they have because they bring people in there, is higher for women than it is for men. And that is one of the,

> that is one of the big challenges…More, they're much more vulnerable than the men.

However, participants tended to place more focus on the client as an individual, regardless of gender or culture. As one participant summarized, "every [recovery plan] that we have here, everything is so individualized if you look at their recovery plan. They're very tailored."

After the Recovery Planning meeting, the recovery plan is written then submitted to the Team Leader to review and ensure the written plan is realistic and relevant to the client's issues.

> And then the team leader reviews the plan after you've done it. And sees whether or not you have some realistic, attainable goals and he signs it off and the client signs it off and you sign it off. And then they (participant) get a copy and you get a copy. And it's in the file and it's on the charting so that you can see in six months. Have we attained this goal or haven't we attained it?

As a result, this process enhances the communication of the plan to all individuals involved as well as sets the stage for a review of the services and goals in 6-months. A participant noted that while the whole process of screening, assessment and planning appears time-consuming, the total team's involvement strengthens the likelihood of successful follow-through with services.

Comprehensiveness, Integration and Continuity

Documentation shows that the PACT model espouses the team to assume responsibility as primary provider of services for its clients. The objective is to ensure its services are comprehensive and integrated. Participants stated that the team makes every effort to provide as much service as its team members have the capacity to provide.

> One stop shopping. PACT is like a one stop thing. So we try to be very holistic and look after all aspects of a person's life so that we don't have to send people there for that service. We can't do everything but we're not restricted just to one certain area of their lives.

PACT itself maintains primary responsibility for its clients, responsibility that is shared among all team members. Participants value their capacity to provide this level of service.

> It's amazingly nice when you have a full complement of staff and then you can do work with people. You can work on employment goals; you can work on harm reduction stuff and substance abuse. You can work on housing. You can work on budgeting, whatever.

As well, this approach makes it less complicated to know who has responsibility for which service and to decrease service gaps or fragmentation.

However, while participants are mindful of the time and capacity they have for their work with clients, client characteristics and needs are such that staff still do not always have as much time as they need to provide the most effective client services. One participant described the effect of each admission on workload.

> Most of the people that we accept are homeless…I'm giving the example that she's been evicted from Manitoba Housing. She has a history of drug use. You have to find her housing. We had to get her hooked up with, again, with Social Assistance. Get her re-established on some sort of pattern so that she'll eat food and keep herself clean, the basics. See whether or not whether we can keep her stable. So the people that we get are, most of them, floundering with no housing, nothing. I already have clients. So if I get another one, as a nurse I'm responsible for all their physical health concerns, getting them to a doctor, getting them to a dentist, getting them to an eye doctor…Making sure that their medications are ready, prepared and that they're taking them. There's a lot of other things that we do. Twice

> a year we do a physical on them where we weigh them, do their vital signs, take their blood work. There's quite a few challenges, as well as the social stuff, liaison with their EIA worker, Corrections, or whatever else, plus the day-to-day stuff that they're needing…One more [client] can be busy.

The tension between the capacity to offer comprehensive service yet wanting more time to provide even more comprehensive services was evident with all participants.

Interagency relationships. Even though PACT staff aim to provide their clients with all the necessary services, external agencies are still often involved with clients. Some of the external agencies which are involved with PACT clients include Employment and Income Assistance, the Public Trustee, Winnipeg Police Services, Corrections, Crisis Stabilization Units, Child and Family Services, general practice physicians, and inpatient psychiatric units. All participants recognized the importance of maintaining positive relationships with both external agencies and individuals involved with PACT's clients.

However, external agency involvement does add complexity to services because other agencies have additional expectations of the client as well as different processes and rules. One participant gave an example "[external agency] don't want to release [the client] from jail until she has a treatment program. See that's a challenge."

Despite these expectations, all participants found that working with external agencies can be successful. For example, consider that the team's psychiatrist provides PACT clients' community psychiatric care while working 0.85 EFT (equivalent of full time) without inpatient admitting privileges to psychiatric beds. When this psychiatrist is not at work, the team does have psychiatric care available 24 hours per day in the

community with a WRHA's Community Psychiatrist On Call Consultative Service (CPOCCS). Then, if a client needs inpatient psychiatric care, staff aim to work with the hospitals' bed manager and psychiatrists to ensure an adequate level of continuity in psychiatric care. Another participant observed, "If they need to go to hospital because they're acutely psychotic, we can do that immediately. That's a non-issue any time of day or night, we're twenty-four hour service." Overall, PACT staff actively maintain a strong link with other services.

Another participant described the process of PACT's systems meetings for individual clients, which involves all the external health and social service agencies that have contact with a particular client.

> We had systems meetings. We really try to have systems meetings so that we can all sit down together and problem solve together. So we do that. It's really quite nice that you can get input from everybody what they think the problem is and what they think would be solutions and we can all come up with a plan. So that you're not arguing with services, you're not fighting with them, you're not saying, well you're not doing this and you're not doing that. And so, we really eliminate a lot of that stuff because we work together with them. I think that's probably why we don't run into a lot of problems. We coordinate and, we're good at that.

The findings reveal that the staff's success is a consequence of having the time, responsibility and commitment to problem solve and coordinate services with the client and external agencies.

Substance abuse. All participants find that one particular challenging area is clients' substance abuse. Participants confirmed that a significant proportion of PACT clients do abuse substances and virtually all of PACT's street-involved women have

substance abuse issues. In keeping with PACT's model, an integrated approach is applied and all participants stated that they provide clients with substance abuse counseling including motivational interviewing and harm reduction approaches.

> We do a lot of work on their substance use and we use motivational interviewing techniques. Try and get them to curb their pattern of use. Try and get them to change their environment.

Other participants spoke of practical interventions such as grocery shopping or paying bills with clients on pay-day, and even budgeting for alcohol/drugs with client's who chronically continue substance use. Participants also spoke of supporting clients' decision to use less addictive and/or expensive drugs.

Participants explained that another difficult issue arises when the client needs substance abuse treatment beyond what PACT is able to provide. First, Winnipeg does not have options for "damp" supervised housing where an individual can live in a supervised setting with the encouragement, not the expectation, for abstinence. Secondly, PACT clients, including street-involved women with CODs, behave in ways that limit their access to other services such as inpatient withdrawal or residential addiction treatment. As one participant explained about addiction treatment facilities attempts to work with PACT clients,

> We haven't had a great experience actually with formal [addiction] treatment programs…our clients are pretty wild and challenging and the treatment programs don't want them. Pretty much. And they [additional treatment programs] try. I shouldn't say they haven't tried. We had one client who went to [addiction treatment program]. And she lasted; I don't know how long she lasted. Maybe a week. Maybe two.

Thus, while PACT actively strives to provide comprehensive, continuous, integrated services, all challenges in the implementation of this level of integration have not yet been met.

Staff Development and Support

Team communication is an essential component of PACT's model. Every weekday morning, the team meets at 8:00 am to review the status of all clients and update daily work assignments for staff. In addition, all staff participate in the previously described weekly Recovery Planning meetings. Each week all staff are also expected to attend an additional meeting time for either the Education meeting, the Program Administration/Operations Meeting, or the Team Culture Meeting which addresses team issues and team building. The expectation to attend facilitates all PACT staff to communicate regularly, problem solve and work as a team.

Summary

PACT is a WRHA Community Mental Health Services team whose goal is to provide treatment, rehabilitative and support services which are community-based, continuous, comprehensive and integrated. Long-term services are available twenty-four hours per day and 365 days per year. Staff aim to work as a team by sharing responsibility and decision for client services.

Access is limited to those individuals with severe and persistent mental illness who are prioritized for PACT's services. Street-involved women with CODs are not specifically prioritized for service with this PACT team but, depending on the level of need and disability, some women within this aggregate meet PACT's admission criteria.

Assertive outreach, harm reduction principles, relating to the client as a responsible citizen plus additional therapeutic communication techniques are all used to engage and maintain clients in PACT. Comprehensive screening, assessment and planning are fundamental components of services. Participants emphasize their capacity and commitment to individualizing client services based on a variety of characteristics, of which gender and culture are relevant, but not the only features.

While a goal of PACT is to maintain responsibility for its clients' care and provide for as many clients as capable, it does actively involve external agencies as required. Positive relationships and outcomes appear to be associated with having the time, responsibility and commitment to work with the client and these external service providers. Housing and substance abuse treatment are two areas that continue to present challenges. Finally, PACT regularly meets together as a team which facilitates this team's development and support of each other.

Dream Catchers

Context

Dream Catchers, a program for women and transgender women who are in the process of exiting the sex trade, started in 2002 at Klinic Community Health Centre. This program has always operated out of Klinic's 870 Portage Avenue site. Initially Dream Catchers obtained one-year funding from the Federal Department of Justice's Community Mobilization Program, and then in the following years, the program received funding from The Winnipeg Foundation and Winnipeg Housing and Homelessness Initiative. Year-to-year funding meant that each year, there was uncertainty if the program would

continue the next year. One participant observed the effect on the development of trust between clients and staff.

> Well certainly going for funding every year was a huge obstacle because it created a lot of stress. It created a lot of stress for the participants as well because they didn't know year to year whether we were going to continue.

Since the spring of 2006, Dream Catchers has received core funding from Manitoba Health which, as one participant stated, "makes a huge difference" in terms of decreased stress on staff and increased investment into the program by clients.

The following findings illustrate that Dream Catchers is guided by the principles of recovery, inclusion and harm reduction.

Goals

A participant summarized the goals of Dream Catchers:

- support clients to transition out of the sex trade;
- support clients to recover from symptoms of post traumatic stress related to sex trade work and childhood sexual abuse;
- support clients to abstain from drugs, maintain sobriety and prevent relapse;
- model healthy relationships and effective interpersonal skills for clients;
- assist clients with links to appropriate community resources;
- assist clients to obtain safe and stable housing; and
- assist clients to improve general living conditions.

Services and Operations

The principal services offered by Dream Catchers include a weekly support group for clients and weekly individual counseling. Other services include group cultural activities (e.g. Aboriginal sweats), opportunities for training, volunteer experiences, as well as assistance with or advocacy in negotiating with other health/social service agencies. Intake occurs thrice yearly in January, May and September.

Dream Catchers employs two staff members, a Counselor and a Peer Mentor, each on a part-time basis for a total of 28 hours per week. The Counselor provides individual counseling, group facilitation, outreach by telephone, advocacy with clients' social service agencies and assistance with cultural or empowerment activities by the group. The Peer Mentor's role is to provide support during groups and outreach. In the previous year, Dream Keepers played an integral role in Dream Catchers, as described below.

Dream Keepers. Dream Keepers was a program into which Dream Catchers clients could transition. Dream Keepers offered its clients training as peer mentors. In turn, clients could then volunteer to attend Dream Catchers' groups and provide support and mentoring back to Dream Catchers clients. However, the funding for Dream Keepers did not continue this year.

One participant described how both the staff Peer Mentor and the Dream Keepers' peer mentors were a resource to the program given their insight, empathy, modeling and encouragement that was both valued and trusted to clients.

> Peer mentors can say, 'Hey, I did the same thing, you know, and I'm still here. It doesn't mean automatic failure

> just because, you know, you're still with an abusive guy'. So, yea, the inspiration and the wisdom of the peer mentors is, I think, the hugest strength of this program.

Access

Documentation shows that Dream Catchers applies the principle of inclusion as staff and the program strive to welcome, include, and provide service to any women or transgender women who are at any stage of exiting the sex trade. There are no criteria regarding attendance, alcohol or drug use that would lead staff to exclude or ask a client to leave a group. As one participant stated, "No one's ever screened out of this program…they've had way too many experiences of being screened out and told that, you don't want it bad enough." There are no rules regarding drug use or abstinence, yet one participant noted that clients abide by the expectation to not be disruptive when coming for counseling, groups or any other services. Clients can be at any stage of the process of exiting including contemplation about their life in the sex trade, preparation to change, taking actions toward leaving, or maintaining success with exit from the sex trade.

> Some aren't even sure whether they want to stop using [drugs] when they come in. Basically if they are asking for that help, and they have some idea that they want things to change and they just need that support, they're in. If they want to come, they're in.

Documentation shows that over 40 clients have participated in the program and more than 30 clients have completed six-months with the program. One participant stated that clients usually stay with Dream Catchers for a year then move on to other programs. This can be a long process of leaving and returning as clients "cycle" back into Dream

Catchers as needed up to 2 or 3 years. The majority of clients heard of the program through word-of-mouth and has worked on the street in the sex trade although some of the clients do engage in sex trade work “inside” with escort services or massage parlors. Thus, street-involved women are one of the aggregates but not the only aggregate served by this program.

A participant noted the challenge that does arise for the program is that clients “screen themselves out by not showing up.” In response, staff continue to reach out to clients and welcome them back regardless of how many appointments or groups they have missed. Clients’ absence also affects other clients, particularly when the group size gets small. When clients who are currently attending groups get frustrated, the suggestion has come forward to enforce attendance requirements. However, to demonstrate the principle inclusion, clients can continue to be a part of the program without attendance requirements, while staff actively express hope that absent clients will begin to make changes at some point. A participant also explained that staff will also use this to reinforce to those who are currently attending the program that before they started regular attendance, staff felt the same hope and the program still included them.

Access is also facilitated by another Klinic program, Stepping Stones, which provides street outreach to women in the sex trade as well. This is significant because Dream Catchers’ Peer Mentor works for both programs and thus there is some crossover when potential clients are contacted.

Engagement

Staff actively work to engage and maintain clients in the program by demonstrating caring, developing trust, modeling healthy relationships and performing outreach activities. First, interactions are based on caring and empathy. One participant emphasized the importance for clients to develop a close, trusting relationship with staff. Examples given include supporting clients through extremely negative events such as apprehension of a child or a death of a child. As one participant stated, "you better be there" with clients who often have "very few ties to family and very little sense of belonging anywhere."

At the same time, staff also model healthy relationships by having healthy relationships with clients. Setting limits while maintaining the relationship is an important element.

> [A client] comes in here and they're all demanding. [I ask] 'What are you willing to do about this? This is the 4th time you've come in and you've said that you want this and you messed it up.' Instead of saying, 'Well, you know, you can't come back or you shouldn't do this.' Its like, 'We're going to discuss this and work out what's going on'. And I think that again models for them what it's like to have, you know, it's the best way to teach someone how to have a healthy relationship.

Thus, staff set limits as to how they will interact and work with clients while demonstrating caring, not rejection from the therapeutic relationship.

As well, telephone outreach is a component of Dream Catchers to engage clients. Staff regularly phone clients and encourage program attendance. This aspect of the program is especially significant for those clients who are not regularly attending the

group or individual counseling. For those clients without phones, staff will leave a message at Sage House (Appendix O), pass a message through Stepping Stones street outreach, and/or assist clients to access free community voicemail with Connect 2 (Appendix P).

Screening and Assessment

While addiction and mental health or illness issues are not part of Dream Catchers inclusion or exclusion criteria, one participant noted that virtually all clients have substance abuse and mental health issues that become apparent as the client attends individual and/or group counseling. The majority of clients are also suffering issues related to trauma including Post Traumatic Stress Disorder. One participant also stated there is a complexity that takes time to assess in separating symptoms of mental illness from symptoms related to withdrawal or substance use.

Comprehensiveness, Integration and Continuity

For clients who access and engage in Dream Catchers' services, initial counseling mostly focuses on trust development and feeling management, especially pain related to post-traumatic stress. The program takes an integrated approach towards substance abuse and mental health/illness working with both issues as necessary during counseling. Also, one participant explained that they can offer clients access to the medical staff with Klinic who both are willing to assess the client and treat her with medications. As presented below, Harm Reduction and interagency relationships also impact Dream Catchers' services.

Harm reduction. Harm Reduction principles are clearly found with Dream Catchers. While the program's goals are to support clients to exit the sex trade, to abstain from drugs, to maintain sobriety and to prevent relapse, a participant emphasized that it was "not mandatory" that clients reach these goals.

> Our philosophy is definitely harm reduction. No one's ever asked to leave our program basically. So certainly [staff] don't see relapse as a sign that person's not serious about recovery…if their goal is to cut down to one joint a day and cut out other drugs, you know, we go with where they're at in their contemplation. We go with their goals.

Any steps clients take toward healthy changes are encouraged and celebrated.

Recovery. Recovery is another guiding principle that is evident throughout the findings. For example, clients have the responsibility and authority to determine what direction they take during counseling. As one participant stated "I take my cue from [clients]." Next, staff know that clients will take a nonlinear path while making changes in their lives and may even need to start portions of the program over again. "[Staff] have realistic expectations of what addiction recovery looks like…With us, relapse is just seen as, 'OK, that's part of the deal. And, you know, just don't give up. Keep trying'." Empowerment is evident as clients have the opportunity to train for and then assist with providing workshops to professionals on the issues for women working in the sex trade. A holistic approach is promoted and clients can participate as a group in various cultural and spiritual activities. Peace marches, drum making and sweats are just three of several examples. The program also hosts an annual "graduation celebration" to acknowledge progress and honor clients who feel ready to make use of other programs.

One challenge concerns the effect of any one client's relapse on other clients. As one participant observed, "We [staff] don't say, 'Oh well then you're kicked out of the program'. So while they're out there using, they're doing really inappropriate things, and their lives are messy and they're not great poster children for the program." Instead of excluding clients, they are included on an ongoing basis because as this participant continued,

> [I]f that person keeps coming back and keeps getting more ideas about what they need to do better to change their lives, and they eventually are not in that crack shack any more, that speaks really loud volumes. And it speaks really loud volume since that person can keep coming back and can keep getting a second and third and forth chance. Because that's the kind of hope that people need to hear when they're on the streets.

Perhaps, most importantly, hope is a valued aspect of the program that is repeatedly referred to. "It's basically just letting [clients] know, 'hey, we didn't give up on you, you know. You may have given up on yourself. You may have gotten scared and overwhelmed but we're holding a place here for you'." Staff will continue to express hope for clients regardless of a client's own feelings, thoughts and behaviors. As well, one participant emphasized that "recovery is a life-long thing" so services are available long-term "because it takes a long time to build up that sense of hope. To get past all the fear and all the hopelessness and all the trauma."

Interagency relationships. Dream Catchers' goals do involve program staff to advocate for or work with clients to negotiate with external social service agencies. Employment and Income Assistance, Manitoba Housing, and Child and Family Services are just some of the more common agencies contacted by staff. A participant stated that

this work is challenging due to a number of factors such as lack of time for interagency contact as well as lack of understanding or appreciation of the issues and problems faced by clients. Thus, while staff aim to provide comprehensive services and work with external agencies as necessary, limits do exist in relation to time and resources.

Staff development and support

Staff have ongoing training time and funds available to themselves each year for courses and conferences relevant to their work with this clientele. Dream Catchers staff meet once weekly for case review and program planning. The staff also meet once monthly with an Advisory Board to ensure coordination of services.

Summary

Dream Catchers is a core program of Klinic that works with women and transgender women who are at any stage of exiting the sex trade. Many of Dream Catchers' clients work street sex trade, experience addictions, as well as mental illnesses such at Post Traumatic Stress Disorder. The principles of inclusion, recovery and harm reduction guide this program. Services include individual counseling, group counseling, training, cultural activities as well as advocacy with external service agencies. While this program's staff strive to provide integrated and comprehensive services, limited time, particularly for advocacy and problem solving with external service agencies is an ongoing challenge.

Chapter Five

Discussion

The findings in the previous chapter reveal the strengths, challenges and limits for the improvement of services to street-involved women with CODs. Most importantly, there are a number of opportunities for Street Connections' service with this aggregate. This discussion will compare findings from the case studies with each other as well as with best-practice recommendations. Recommendations that are relevant to the street-involved women with CODs aggregate, and practical for Street Connections to consider, will be put forth, thus addressing the third purpose of this practicum. For consistency and clarity, similar subheadings used to present the findings are applied although, in practice, there is fluidity among the areas discussed.

Context, Goals and Services

The findings show that all programs studied in this practicum have different goals, provide varied services, and operate within diverse parts of Winnipeg's health care system. Street-involved women with CODs make up a portion of the clientele for each program. Street Connections is a WRHA Population and Public Health program for STI/BBP prevention that meets up with a considerably larger number of clients who frequently want brief and/or anonymous interactions. PACT is a WRHA Community Mental Health program that follows a specific service delivery model to provide treatment, rehabilitation and support to a consistent caseload of persons with severe and persistent mental illness. Dream Catchers originates from Klinic Community Health Centre with the purpose to support women and transgender women who are exiting the

sex trade. In making comparisons and developing recommendations, it is paramount to be cognizant of this diversity and its impact on capacity to implement changes.

Gender-based Analysis

Gender-based Analysis can assist to increase equality in outcomes for the street-involved women with CODs aggregate by bringing social and biological differences between genders to the foreground. Not only are there difference between genders, but Gender-based Analysis acknowledges there are also differences within genders based on characteristics such as socioeconomic status and culture that must also be considered (Donner, 2003; Women's Health Bureau, 2003). Research does reveal considerable differences in risk-taking, health/social consequences and different effects with therapeutic processes for women compared to men (Alexander, 1996; Ashley et al., 2003; Butterfield et al., 2003; Meade, 2006; Zilberman et al., 2003). For street-involved women with CODs, the negative impact is compounded as the number of issues they face increases (Brown, Huba, & Melchior, 1995).

With Street Connections, some participants acknowledge the additional and unique needs of street-involved women, particularly during pregnancy. Other participants stress the importance of ensuring all Street Connections' clients are treated equally as individuals without exclusion. PACT promotes an individualized approach to service provision whereby gender is relevant but not the only factor influencing the assessment, planning and provision of services. Dream Catchers was developed specifically for women in the sex trade and has incorporated processes that can increase treatment outcomes for females, such as peer support and promotion of bonding between women.

It is recommended that Street Connections consider a tool such as Gender-based Analysis as this could assist staff to explicitly consider how its services can have different impacts on its clientele who come from different genders and cultural backgrounds. Before implementation, it is essential that staff receive an orientation to the value for this tool and its process, particularly with respect to increasing substantive equality for all clients, and not to exclude any one segment of the program's clientele.

Recovery Perspective

A recovery-based perspective (Appendix A) is a best-practice recommendation that is especially pertinent for the aggregate of street-involved women with CODs who experience stigma and shame along with mental illnesses and addictions that can last a lifetime (Center for Substance Abuse Treatment, 2005; Substance Abuse and Mental Health Services Administration, 2006). All three programs incorporate many principles of Recovery. Participants from PACT and Dream Catchers clearly discuss the influence of Recovery on their practice. Individualized focus, self-direction, strengths, hope and acceptance of nonlinear progress are just some of the features exemplified in the findings. PACT's written treatment plans are called Recovery Plans which further reflects the influence of a Recovery perspective. The findings from Street Connections do not explicitly refer to a Recovery perspective although this program uses a Harm Reduction approach that does reflect Recovery-based principles. For example, Street Connections' participants spoke of respect, clients' personal responsibility, self-direction and long-term services, which are all features of Harm Reduction and Recovery. It is also significant to note that participants from each program expressed the significance of applying Harm

Reduction approaches with street-involved women with CODs. Thus, it is apparent that Recovery and Harm Reduction are compatible perspectives.

It is recommended that Street Connections consider the incorporation of Recovery-based principles to enhance the values and principles upon which its services are based. Articulation of Recovery with Harm Reduction would be useful to provide a foundation of values for the program to utilize as it continues to evolve and augment services.

Access

The literature strongly recommends increasing access for street-involved women with CODs (Amaro et al., 2005; Ashley et al., 2003; Centre for Addiction and Mental Health, 2001; Ziedonis et al., 2005). Outreach and a 'no wrong door policy' are two broad approaches recommended to increase this aggregate's access to health and social services (Center for Substance Abuse Treatment, 2005). All three programs include outreach as a component of service. PACT does not use outreach to increase access for individuals who are not admitted to this program, but rather outreach is applied to engage and maintain their current clients. Dream Catchers does use outreach to increase client access.

Street Connections provides outreach as a predominant feature of service. Outreach is closely associated with issues of privacy and anonymity. The anonymous and fast-paced nature of contacts makes it challenging to accurately determine rates of CODs with Street Connections' clientele. Staff do not collect data on rates of mental illness among its clients. However, the research does show that upwards of 50% of street-

involved women can be expected to have CODs (Weiss et al., 2003; Zilberman et al., 2003). With this awareness in mind, it is recommended that Street Connections periodically measure rates of CODs among its clientele and determine if this research-based estimate is reasonably accurate. Such data could reveal gaps or success in reaching out to this vulnerable aggregate.

Apart from challenges in measurement, the findings confirm that a considerable number of street-involved women access Street Connections' services. This is a tremendous opportunity for this aggregate to begin with Street Connections' services and potentially go on to access other necessary health and social services available in Winnipeg. Knowing that Street Connections does facilitate access, it is recommended that the program consider the development of a 'no wrong door' guideline to further enhance access for this aggregate to other services in Winnipeg's health and social services systems. Best-practice recommendations describe such a policy to ensure that no matter which program the individual first contacts, this individual will have straightforward access to comprehensive, integrated, continuous assistance (Center for Substance Abuse Treatment, 2005; Winnipeg Region CODI, 2004). Assistance can begin with the first program the individual contacts, but further assessment and/or treatment may actually require 'seamless' referral to another service with the required expertise and capacity (Center for Substance Abuse Treatment, 2005). A 'no wrong door' guideline for Street Connections would mean that street-involved women with CODs could then have the opportunity to access services with other relevant programs. To make a guideline with 'seamless' referrals work for Street Connections, additional revisions in its capacity to

work with other services will be discussed in a subsequent section on continuous, integrated comprehensive services.

Engagement

The strength of Street Connections, PACT and Dream Catchers in reaching out to engage street-involved individuals must be acknowledged. This feature is especially relevant for street-involved women with CODs who face challenges regarding trust and relationship development. Research reveals that development of ongoing trusting relationships with clients is one of the primary features of therapeutic relationships that can successfully encourage personal change (Cormier et al., 2004; Hubble et al., 1999). Street Connections demonstrates several invaluable aspects such as nonjudgmental acceptance, anonymity and its newsletter. Dream Catchers' welcoming, empathic caring approach is among the most valuable components in their work (Center for Substance Abuse Treatment, 2005). For PACT, the acknowledgment of mental illness and addiction as long-term issues, along with the subsequent use of long-term and regular contact are just some of the important features of their success with engagement. It is recommended that the agencies continue to incorporate these aspects, along with consideration of opportunities to develop notable strengths such as Street Connections' newsletter.

All participants from each program spoke of keeping street-involved women with CODs connected with their services. Flexible appointments or suitable timing of contacts, while still recognizing that the clients are ultimately responsible, is an on-going challenge. Participants' approaches fit with best-practice recommendations for extended use of engagement techniques with individuals who are hard-to-reach and in

precontemplative or contemplative stages of change (Center for Substance Abuse Treatment, 2005). To increase engagement of clients, it is recommended that Street Connections consider use of Motivational Interviewing, which incorporates these stages of change while engaging with clients' to increase their motivation for change. Motivational Interviewing has been implemented for HIV prevention in various settings where client contact is brief including commercial venues and public sex environments (Harding, Dockrell, Dockrell, & Corrigan, 2001; Rutledge, 2006). Single-session Motivational Interviewing has been shown to be effective in research with street-involved, substance-using sex-trade workers (Yahne, Miller, Irvin-Vitela, & Tonigan, 2002). For successful implementation, adaptation to the context of Street Connections is necessary. Additional training for Street Connections' staff, along with direct, practical supervision would potentially increase staff's skills to assist clients with personal change. Motivational Interviewing, along with continued focus on the role of Harm Reduction approaches, can build upon this program's strengths.

Screening and Assessment

Differences among programs are noted with respect to screening and assessment of CODs. PACT's staff completes the most comprehensive written assessments and all clients are all assessed for CODs. Dream Catchers' also assess all clients as staff understand that the vast majority of clients will have addictions and mental illness symptoms, usually related to post-traumatic stress. Street Connections' staff do not routinely screen or assess clients for CODs, although participants commonly interact with

clients regarding substance abuse issues and will become aware of mental illness in clients with whom they have more in-depth contact.

However, without screening and recognition of CODs, opportunities to begin assessment and treatment are lost. While PACT's and Dream Catchers' ability to screen and assess do not have anonymous encounters with their clients, both programs do incorporate regular screening and assessment into their work with clients. It is recommended that Street Connections' staff consider regular screening. Successful screening might be attained in asking brief, but focused, questions.

Below is a list of potential screening questions suggested by the Centre for Addiction and Mental Health (2001, pp. 32, 37):

- Have you ever been given a mental health diagnosis by a qualified mental health professional? (yes/no)
- Have you ever been hospitalized for a mental health-related illness? (yes/no)
- Have you ever harmed yourself or thought about harming yourself but not as direct result of alcohol/drug use? (yes/no)
- Have you ever had any problems related to your use of alcohol or other drugs? (yes/no)
- Has a relative, friend, doctor or other health worker been concerned about your drinking or other drug use or suggested cutting down? (yes/no)
- Have you ever said to another person "No, I don't have [an alcohol or drug] problem, when around the same time, you questioned yourself and FELT, "Maybe I do have a problem?" (yes/no)

These questions are concise and designed to begin screening clients for presence of either mental illness or substance abuse. It is acknowledged that many interactions with Street Connections' clients are so brief that it is not possible to complete screening during one

interaction. This process must also include the need to screen clients over a period of contacts while staff continue to engage and build relationships with clients.

Next, it is not feasible to expect Street Connections' staff to have the capacity to conduct complete assessments for CODs within the context of their service priorities for STI/BBP prevention. Accompanying the screening would be a guideline that outline a practical process for positively screened clients to connect with assessment and treatment from an appropriate service provider (Center for Substance Abuse Treatment, 2005). This guideline would need to be developed. Within this process for referral, consideration must be given to the challenges identified with follow-through of Street Connections' clients. Street Connections could develop a strong connection and ongoing consultation with the consultant source while they also maintain contact and assist clients to develop motivation to meet for assessment and/or treatment. Potential service providers who could be consulted include the Mental Health Counselor from the 705 Broadway Team, or the WRHA CODI Outreach team as they already have experience with mental illness and addictions in marginalized populations.

Comprehensiveness, Integration and Continuity

Another noteworthy difference between the cases studied in this practicum is their capacity for comprehensive, integrated, continuous services as recommended in the literature and the CCISC model (Centre for Addiction and Mental Health, 2001; Center for Substance Abuse Treatment, 2005; Minkoff & Cline, 2004; Ziedonis et al., 2005). The three programs demonstrate that there are different programs available across the health care system that already connect and work with this aggregate. This fits within

visions and goals for CODI which aims to develop capacity across the entire health care system (Winnipeg Region CODI, 2004).

Before comparison of the findings, another initiative also needs to be considered, the Winnipeg Integrated Services Initiative (WISI), which is another partnership between three organizations: the WRHA, Manitoba Health, and Manitoba Family Services and Housing in this instance. Similar to CODI, this initiative also has integration as a key concept which is described as a process where fragmented services can develop through a process involving communication, cooperation and collaboration. The significance of WISI is its vision to create community-based health/social services that are seamless, efficient, effective, holistic, individual/family focused within the principals for primary health care and population health (Winnipeg Integrated Services Initiative, 2003). Access Centres (Appendix Q) are being developed to decentralize and locate health/social services closer to their communities, although Street Connections continues as a centralized service that is not located within an Access Centre (Winnipeg Integrated Services Initiative, 2003; Winnipeg Regional Health Authority, n.d.). Within this framework, the three programs may each be part of the Winnipeg's health care system but do appear fragmented from each other. Thus, the whole system can benefit from one program's development toward integrated services, i.e. Street Connections.

Turning to the examination of the findings, PACT has the greatest capacity for comprehensive, integrated and continuous services with its retention of responsibility for total client care and lower client:staff ratio. PACT's participants also spoke of having the time and commitment to problem solve with external services for client care. For Dream

Catchers, integration of care was identified as useful by participants, predominantly with respect to substance abuse and mental illness. However, this program's capacity for comprehensive, integrated, continuous services appeared more limited in large part because of the available staff hours for the program (28 hours/week) compared to their clientele's needs. There was less capacity for connecting to and problem solving with external agencies than Dream Catchers' staff know is most beneficial.

Findings from Street Connections demonstrate their capacity to provide additional services concerning of CODs is limited because of a variety of reasons such as the volume of client contacts and anonymity. Additionally, it is apparent that their success with referral and follow-through of clients to other agencies has not yet reached its full potential given the time constraints that participants experience. As stated previously, it is unrealistic to consider that Street Connections itself could deliver the comprehensive array of services required by street-involved women with CODs. However, it is advantageous for Street Connections' staff to develop its capacity to integrate with other services as staff refer women with CODs for assessment and treatment. To develop their capacity in moving toward integration, it is recommended that staff be given additional support and direction to make both the commitment and time that are necessary to begin the process of increased communication, collaboration and cooperation with external services. One such mechanism to begin this process is to build in regular consultation with other Community Mental Health and Addiction services, possibly in the latter portion of Street Connections' team meetings to maximize the use of time when the majority of staff are already available. Not only will Street Connections benefit with the

development of increased integration, but clients can also benefit with the reciprocal opportunity to educate and encourage external services of the priority to incorporate STI/BBP prevention, screening and access to treatment into their services (Brunette, Drake, Marsh, Torrey, & Rosenberg, 2003).

Staff Development and Support

The literature on best-practice recommendations puts forth the need to develop staff support and competency in working with individuals who have CODs (Center for Substance Abuse Treatment, 2005). The findings show that participants from the three programs have access to various amounts of development and training via their parent organization. For example, they can access training with CODI, which has developed yearly staff development sessions regarding its clinical guidelines (Winnipeg Region CODI, 2004, p. 3). Staff may not require all of the nine CODI training modules, but are able to access the modules that are relevant to their program and services. This training is a significant endeavor because of its direct relevance to the development of Street Connections' expertise in the area of service to street-involved women with CODs. It is noted that administration continues to support and encourage staff to complete the relevant CODI training sessions. After each training session, and on an ongoing basis, it is also recommended that staff have the opportunity and direction to incorporate this training on a practical level within the context of Street Connections' day-to-day services.

Next, best-practice recommendations include strategies to mitigate staff burnout and turnover with opportunities for staff to communicate about program issues, client progress, and individual feelings. Other useful strategies include consultation among staff

who work with the same client; working in teams decreases isolation, makes caseload size manageable, and potentially establishes healthy support networks (Center for Substance Abuse Treatment, 2005). It is notable that PACT's model emphasizes the value of teamwork and staff support (NAMI - National Alliance on Mental Illness, 2006). This team has built-in mechanisms for staff support such as daily meetings that the whole team is expected to attend. Dream Catchers also has weekly time for case-review and program planning. Street Connections holds team meetings less frequently. Scheduling can pose a challenge as staff need to alter their hours to attend staff meetings. However, Street Connections does benefit from regular staff contact and it is recommended that the program consider additional strategies that can increase staff competency and decrease burnout. This would potentially strengthen services offered by the team.

Conclusion

In conclusion, CODs are widespread difficulties which should be expected in street-involved females. This aggregate encounters numerous barriers to accessing health/social services, and experiences tremendous negative outcomes, not the least of which are higher STI/BBP rates. This practicum reviewed best-practice recommendations found in the literature, and then completed three case-studies of Winnipeg-based programs that currently provide service to street-involved women with CODs. A comparison of best-practice recommendations and the case-study findings resulted in opportunities for Street Connections as summarized in the following recommendations.

- Consider the use of a Gender-based Analysis tool to assist staff in explicitly considering how its services can have different impacts on its clientele who

come from different genders and cultural backgrounds. Before implementation, it is essential that staff receive an orientation to this tool's values, benefits and processes, particularly with respect to increasing substantive equality for all clients, and not to exclude any one segment of the program's clientele.

- Consider the incorporation of Recovery-based principles into Street Connections' approach to enhance the values and principles upon which its services are based. Articulation of Recovery with Harm Reduction would be useful to provide a foundation of values for the program to utilize as it continues to evolve and augment services.
- Periodically measure rates of CODs with Street Connections' clientele and determine if research-based estimates are reasonably accurate. Such data could reveal gaps or success in reaching out to street-involved women with CODs.
- Consider the development of a 'no wrong door' guideline for Street Connections to enhance access for this aggregate to other services in Winnipeg's health and social services systems.
- Continue to support Street Connections' strengths around the engagement of clients with a focus on opportunities to further develop strengths such as Street Connections' newsletter.
- Consider use of Motivational Interviewing. For successful implementation, adaptation of Motivational Interviewing to the context of Street Connections is necessary. Additional staff training, along with direct, practical supervision, is also required.

- Consider the implementation regular screening for CODs with brief, but focused questions. Include the need to screen clients over a period of contacts while staff continue to engage and build relationships with clients.
- Develop and implement a guideline that outlines a practical process for positively screened clients to connect with assessment and treatment from an appropriate service provider (Center for Substance Abuse Treatment, 2005). Also develop a strong connection and ongoing consultation with the consultant source while they also maintain contact and assist clients to develop motivation to meet for assessment and/or treatment.
- Provide staff with additional support and direction needed to make both the commitment and time that is necessary for the process of integration.
- Continue support and encourage staff to complete the relevant CODI training sessions. It is also recommended that staff have the opportunity and direction to incorporate this training on a practical level within the context of Street Connections' day to day services.
- Increase investment in strategies that can increase staff competency and decrease burnout to strengthen the team as a whole.

These changes have the potential to position Street Connections to subsequently influence programs within the Addiction and Mental Health service systems to prioritize the need to integrate prevention and screening and even referral treatment of STI/BBP into their own practice (Brunette et al., 2003).

References

Adair, C., McDougall, G., Mitton, C., Joyce, A., Wild, T., Gordon, A., Costigan, N., Kowalsky, L., Pasmeny, G., & Beckie, A. (2005). Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services, 56*(9), 1061-1069.

Alexander, M. (1996). Women with co-occurring addictive and mental disorders: An emerging profile of vulnerability. *American Journal of Orthopsychiatry, 66*(1), 61-70.

Alverson, H., Alverson, M., & Drake, R. (2001). Social patterns of substance-use among people with dual diagnoses. *Mental Health Services Research, 3*(1), 3-14.

Amaro, H., Larson, M., Gampel, J., Richardson, E., Savage, A., & Wagler, D. (2005). Racial/ethnic differences in social vulnerability among women with co-occurring mental health and substance abuse disorders: Implications for treatment services. *Journal of Community Psychology, 33*(4), 495-511.

American Psychiatric Association. Task Force on DSM-IV. (2000). In American Psychiatric Association (Ed.), *Diagnostic and statistical manual of mental disorders: DSM-IV-TR.* (4th ed., text revision ed.). Washington, D.C.: American Psychiatric Association.

Ashley, O. S., Marsden, M., & Brady, T. (2003). Effectiveness of substance abuse treatment programming for women: A review. *The American Journal of Drug and Alcohol Abuse, 29*(1), 19-53.

Baker, L., Case, P., & Policicchio, D. (2003). General health problems of inner-city sex workers: A pilot study. *Journal of the Medical Library Association, 91*(1), 67-71.

Beaudoin, C. (2004). *Results from phase II of the enhanced surveillance of sexually transmitted diseases among Winnipeg street-involved youth study.* Retrieved November 29, 2005, from http://www.gov.mb.ca/health/documents/phase2report.pdf

Beaudoin, C. (2005). *Summary of communicable diseases for the month of September 2005.* Retrieved December 2, 2005, from http://www.gov.mb.ca/health/publichealth/cdc/surveillance/scd/sept05.pdf

Brown, R., & Rounds, L. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: Criterion validity in a primary care practice. *Wisconsin Medical Journal, 94*(3), 135-140.

Brown, V., Huba, G., & Melchior, L. (1995). Level of burden: Women with more than one co-occurring disorder. *Journal of Psychoactive Drugs, 27*(4), 339-346.

Brunette, M., & Drake, R. (1997). Gender differences in patients with schizophrenia and substance abuse. *Comprehensive Psychiatry, 38*(2), 109-116.

Brunette, M., Drake, R., Marsh, B., Torrey, W., & Rosenberg, S. (2003). Responding to blood-borne infections and persons with mental illness. *Psychiatric Services, 54*(6), 869-865.

Butterfield, M., Bosworth, H., Meador, K., Stechuchak, K., Essock, S., Osher, F., Goodman, L., Swanson, J., Bastian, L., Horner, R., & Five-Site Health and Risk Study Research Committee. (2003). Gender differences in hepatitis C infections

and risks among persons with severe mental illness. *Psychiatric Services, 54*(6), 848-853.

Cantor-Graae, E., Nordström, L., & McNeil, T. (2001). Substance abuse in schizophrenia: A review of the literature and a study of correlates in Sweden. *Schizophrenia Research, 48*(1), 69-82.

Carroll, J. F. X., & McGinley, J. J. (2000). *Mental health screening form III.* Project Return Foundation Inc. Retrieved October 1, 2006, from http://www.asapnys.org/Resources/mhscreen.pdf

Centre for Addiction and Mental Health. (2001). *Best practice concurrent mental health and substance use disorders*. Ottawa: Health Canada.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders. Treatment improvement protocol (TIP), Number 42.* No. 05-3992). Rockville, MD.: Substance Abuse and Mental Health Services Administration.

Cheung, Y. (2000). Substance abuse and developments in harm reduction. *Canadian Medical Association Journal, 162*(12), 1697-1700.

Cormier, R., Dell, C., & Poole, N. (2004). Women and substance abuse problems. *BMC Women's Health, 4* (Suppl. 1), S8-S17.

Cournos, F., & McKinnon, K. (1997). HIV seroprevalence among people with severe mental illness in the United States: A critical review. *Clinical Psychology Review, 17*(3), 259-269.

Cuffel, B. (1996). Comorbid substance use disorder: Prevalence, patterns of use, and course. *New Directions for Mental Health Services,* (70), 93-105.

Davidson, S., Judd, F., Jolley, D., Hocking, B., Thompson, S., & Hyland, B. (2001). Risk factors for HIV/AIDS and hepatitis C among the chronic mentally ill. *Australian and New Zealand Journal of Psychiatry*, *35*(2), 203-209.

Donner, L. (2003). *Including gender in health planning. A guide for regional health authorities*. Winnipeg, Manitoba: Prairie Women's Health Centre of Excellence. Retrieved January 3, 2006, from http://www.pwhce.ca/pdf/gba.pdf.

Drake, R., Mueser, K., Brunette, M., & McHugo, G. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*(4), 360-374.

Elliott, D., Bjelajac, P., Fallot, R., Markoff, L., & Reed, B. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Essock, S., Dowden, S., Constantine, N., Katz, L., Swartz, M., Meador, K., Osher, K., Rosenberg, S., & Five-Site Health and Risk Study Research Committee. (2003). Risk factors for HIV, hepatitis B, and hepatitis C among persons with severe mental illness. *Psychiatric Services, 54*(6), 837-841.

F/P/T Advisory Committee on Population Health. (2002). *Reducing the harms associated with injection drug use in Canada.* Retrieved October 20, 2005, from http://www.hc-sc.gc.ca.proxy2.lib.umanitoba.ca/ahc-asc/pubs/drugs-drogues/injection/preface_e.html

Friedman, S., Shelton, M., Elhaj, O., Youngstrom, E., Rapport, D., Packer, K., Bilalai, S., Jackson, K., Sakai, H., Resnick, P., Findling, R., & Calabrese, J. (2005). Gender differences in criminality: Bipolar disorder with co-occurring substance abuse. *The Journal of the American Academy of Psychiatry and the Law, 33*(2), 188-195.

Gearon, J., & Bellack, A. (1999). Women with schizophrenia and co-occurring substance use disorders: An increased risk for violent victimization and HIV. *Community Mental Health Journal, 35*(5), 401-419.

Gearon, J., & Bellack, A. (2000). Sex differences in illness presentation, course, and level of functioning in substance-abusing schizophrenia patients. *Schizophrenia Research, 43*(1), 65-70.

Goodman, L., Rosenberg, S., Mueser, K., & Drake, R. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*(4), 685-696.

Grant, B., Stinson, F., Dawson, D., Chou, P., Dufour, M., Compton, W., Pickering, R., & Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the national epidemiologic survey on alcohol and related conditions. *Archives of General Psychiatry, 61*(8), 07-816.

Hannerz, H., Borgå, P., & Borritz, M. (2001). Life expectancies for individuals with psychiatric diagnoses. *Public Health, 115*(5), 328-337.

Harding, R., Dockrell, M. J., Dockrell, J., & Corrigan, N. (2001). Motivational interviewing for HIV risk reduction among gay men in commercial and public sex settings. *AIDs Care, 13*(4), 493-501.

Harris, E., & Barraclough, B. (1998). Excess mortality of mental disorder. *The British Journal of Psychiatry, 173*, 11-53.

Hercus, M., Lubman, D., & Hellard, M. (2005). Blood-borne viral and sexually transmissible infections among psychiatric populations: What are we doing about them? *Australian and New Zealand Journal of Psychiatry, 39*(10), 849-855.

Hood, C., Mangham, C., McGuire, D., & Leigh, G. (2004). *Exploring the links between substance use and mental health.* Retrieved November 28,, 2005, from http://www.hc-sc.gc.ca.proxy1.lib.umanitoba.ca/ahc-asc/alt_formats/hecs-sesc/pdf/pubs/drugs-drogues/mental-mentale_discussion/discus_e.pdf

Hubble, M., Duncan, B., & Miller, S. (Eds.). (1999). *The hearth and soul of change what works in therapy.* Washington, D.C.: American Psychological Association.

Kelly, B., Raphael, B., Judd, F., Perdices, M., Kernutt, G., Burrows, G., Burnett, P., & Dunne, M. (1998). Psychiatric disorder in HIV infection. *Australian and New Zealand Journal of Psychiatry, 32*(3), 441-453.

Kessler, R., Nelson, C., McGonagle, K., Edlund, M., Frank, R., & Leaf, P. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*(1), 17-31.

Klinkenberg, W. D., Caslyn, R., Morse, G., Yonker, R., McCudden, S., & Ketema, F., Constantine, N. (2003). Prevalence of human immunodeficiency virus, hepatitis B, and hepatitis C among homeless persons with co-occurring severe mental illness and substance use disorders. *Comprehensive Psychiatry*, *44*(4), 293-302.

Levy, R., & Hollan, D. (1998). Person-centered interviewing and observation. In H. R. Bernard (Ed.), *Handbook of Methods in Cultural Anthropology* (pp. 333-364). California: AltaMira Press.

Lundy, J. (1999). The burden of comorbidity among the homeless at a drop-in clinic. *JAAPA*, *12*(4), 32-47.

Mandell, W., Kim, J., Latkin, C., & Suh, T. (1999). Depressive symptoms, drug network, and their synergistic effect on needle-sharing behavior among street injection drug users. *The American Journal of Drug and Alcohol Abuse, 25*(1), 117-127.

Manitoba Harm Reduction Network. (n.d.). *Harm reduction principles and practice.* Retrieved November 1, 2006, from http://www.harmreductionnetwork.mb.ca/principles.html

Manitoba Health. (n.d.). *Guide to the mental health system in Manitoba.* Retrieved January 31, 2007, from http://www.gov.mb.ca.proxy2.lib.umanitoba.ca/health/mh/system.html

Martens, P., Fransoo, R., McKeen, L., Burland, E., Jebamani, L., Burchill, C., De Coster, C., Ekuma, O., Prior, H. Chateau, D., Robinson, R., & Matge, C. (2004). *Patterns of regional mental illness disorder diagnoses and service use in Manitoba: A population-based study*. Manitoba: Manitoba Health.

Meade, C. (2006). Sexual risk behavior amoung persons dually diagnosed with severe mental illness and substance use disorder. *Journal of Substance Abuse Treatment, 30*(147), 157.

Meade, C., & Sikkema, K. (2005). HIV risk behavior among adults with severe mental illness: A systematic review. *Clinical Psychology Review, 25*(4), 433-457.

Minkoff, K., & Cline, C. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *The Psychiatric Clinics of North America, 27*(4), 727-743.

Mount Carmel Clinic. (2004). *Program and services.* Retrieved November 1, 2006, from http://www.mountcarmel.ca/programs.community.htm

Nadeau, L., Landry, M., & Racine, S. (1999). Prevalence of personality disorders among clients in treatment for addiction. *Canadian Journal of Psychiatry, 44*(6), 592-596.

NAMI – The National Alliance on Mental Illness. (2006). *PACT model fidelity review.* Retrieved May 2 2007, from http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=29079

New Life Ministries. (n.d.). *Connect 2 community voice mail.* Retrieved November 1, 2006, from http://www.geocities.com/wccia/voicemail.html

Offord, D., Boyle, M., Campbell, D., Goering, P., Lin, E., Wong, M., & Racine, Y. (1996). One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age. *Canadian Journal of Psychiatry, 41*(9), 559-563.

Opler, L., White, L., Caton, C., Dominguez, B., Hirshfield, S., & Shrout, P. (2001). Gender differences in the relationship of homelessness to symptom severity, substance abuse, and neuroleptic noncompliance in schizophrenia. *Journal of Nervous and Mental Disease, 189*(7), 449-456.

Phillips, P., & Labrow, J. (2000). Dual diagnosis - does harm reduction have a role? *The International Journal on Drug Policy, 11*(4), 279-283.

Prochaska, J. O., & Diclemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy.* Homewood: Dow Jones.

RachBeisel, J., Scott, J., & Dixon, L. (1999). Co-occurring severe mental illness and substance use disorders: A review of recent research. *Psychiatric Services, 50*(11), 1427-1434.

Regier, D., Farmer, M., Rae, D., Locke, B., Keith, S., Judd, L., & Goodwin, F. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. results from the epidemiologic catchment area (ECA) study. *Journal of the American Medical Association, 264*(19), 2511-2518.

Rosenberg, S., Drake, R., Brunette, M., Wolford, G., & Marsh, B. (2005). Hepatitis C virus and HIV co-infection in people with severe mental illness and substance use disorders. *AIDS 2005, 19*(Suppl. 3), S26-233.

Rosenberg., S., Goodman, L., Osher, F., Swartz, M., Essock, S., Butterfield, M., Constantine, N., Wolford, G., & Salyers, M. (2001). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. *American Journal of Public Health, 91*(1), 31-37.

Ross, H., Glaser, F., & Germanson, T. (1988). The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry, 45*(11), 1023-1031.

Rothbard, A., Metraux, S., & Blank, M. (2003). Cost of care for Medicaid recipients with serious mental illness and HIV infection or AIDS. *Psychiatric Services, 54*(9), 1240-1246.

Rutledge, S. E. (2006). Single-session motivational enhancement counseling to support change toward reduction of HIV transmission by HIV positive persons. *Archives of Sexual Behaviour*, January 2, 2007 . Retrieved January 2, 2007, from http://www.springerlink.com/content/x755288x64931285/fulltext.pdf

Sacks, S., Sacks, J., McKendrick, K., Pearson, F., Banks, S., & Harle, M. (2004). Outcomes from a therapeutic community for homeless addicted mothers and their children. *Administration and Policy in Mental Health, 4*(31), 313-338.

Skinner, D. (2005). A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: An outcome study. *Substance Use and Misuse, 40*(4), 483-497.

Stoskopf, C., Kim, Y., & Glover, S. (2001). Dual diagnosis: HIV and mental illness, a population-based study. *Community Mental Health Journal, 37*(6), 469-479.

Street Connections. (n.d.). *Taking Care of Your Veins*. Winnipeg: Street Connections.

Street Connections. (2006). *The Street Sheet* (142). Winnipeg: Street Connections.

Stuart, H., & Arboleda-Flórez, J. (2000). Homeless shelter users in the postdeinstitutionalization era. *Canadian Journal of Psychiatry, 45*(1), 55-62.

Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders.* Retrieved October 30, 2005, from http://alt.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf

Substance Abuse and Mental Health Services Administration. (2006). *National consensus statement on mental health recovery*. U.S.A.: U.S. Department of Mental Health Services. Retrieved April 28, 2007, from http://download.ncadi.samhsa.gov/ken/pdf/SMA05-4129/trifold.pdf

Swartz, M., Swanson, J., Hiday, V., Borum, R., Wagner, H., & Burns, B. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *The American Journal of Psychiatry, 155*(2), 226-231.

Tait, C. (2000). *A study of the service needs of pregnant addicted women in Manitoba.* Retrieved November 21, 2005, from www.gov.mb.ca/health/documents/PWHCE_June2000.pdf

Weiss, S., Kung, H., & Pearson, J. (2003). Emerging issues in gender and ethnic differences in substance abuse and treatment. *Current Women's Health Reports, 3*(3), 245-253.

Willenbring, M. (2005). Integrating care for patients with infectious, psychiatric, and substance use disorders: Concepts and approaches. *AIDS 2005, 19*(Suppl. 3), S227-S237.

Winnipeg Integrated Services Initiative. (2003). *A conceptual framework.* Retrieved October 15, 2006, from http://www.wrha.mb.ca/community/wis/files/ConceptFramework_E.pdf

Winnipeg Region CODI. (2003). *Stakeholder program list.* Retrieved May 31, 2007, from http://www.afm.mb.ca/pdfs/Stakeholders%20Program%20List.pdf

Winnipeg Region CODI. (2004). *CODI update, 3(4).* Retrieved May 31, 2007, from http://www.afm.mb.ca/pdfs/moreaboutWpg.pdf

Winnipeg Regional Health Authority. (n.d.). *Communicable disease control.* Retrieved September 25, 2005, from http://www.wrha.mb.ca/findcare/careincom/public_disease.php

Winslow, C. (2005). *Structure of Dream Catchers program.* Unpublished manuscript.

Women's Health Bureau. (2003). *Exploring concepts of gender and health.* Retrieved November 20, 2005, from http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/exploring_concepts.pdf

Yahne, C., Miller, W. R., Irvin-Vitela, L., & Tonigan, S. (2002). Magdalena pilot project: Motivational outreach to substance abusing women street sex workers. *Journal of Substance Abuse Treatment*, *23*, 49-53.

Yin, R. (2003). *Case study research design and methods.* (3rd ed.). California: Sage Publications.

Ziedonis, D., Smelson, D., Rosenthal, R., Batki, S., Green, A., Henry, R., Montoya, I., Parks, J., & Weiss, R. (2005). Improving the care of individuals with

schizophrenia and substance use disorders: Consensus recommendations. *Journal of Psychiatric Practice, 11*(5), 315-339.

Zilberman, M., Tavares, H., Blume, S., & el-Guebaly, N. (2003). Substance use disorders: Sex differences and psychiatric comorbidities. *Canadian Journal of Psychiatry, 48*(1), 5-13.

Appendix A

Recovery

The 10 Fundamental Components of Recovery include:

• **Self-Direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

• **Individualized and Person-Centered**: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

• **Empowerment**: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

• **Holistic**: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

• **Non-Linear**: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

• **Strengths-Based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles

(e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

• **Peer Support**: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

• **Respect**: Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

• **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Adapted from the National Consensus Statement on Mental Health Recovery. Available at the Substance Abuse and Mental Health Services Administration's National Mental Health Information Center at http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/.

Used with permission from the Substance Abuse and Mental Health Services Administration on April 28, 2007.

(Substance Abuse and Mental Health Services Administration, 2006).

Appendix B

Cut-down, Annoyed, Guilty, Eye-opener-Adjusted to Include Drugs (CAGE-AID) Questionnaire

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

(Brown & Rounds, 1995)

Appendix C

Mental Health Screening Form-III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins - "Have you ever ...."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? YES NO
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES NO
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES NO
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see? YES NO
6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO
   (b) Did you ever attempt to kill yourself? YES NO
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES NO
8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help. YES NO
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? YES NO
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO
11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO
12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For

example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO
14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO
15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES NO
16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES NO

Print client's name: _____

Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments: _____

Total Score: _____ (each yes = 1 point)

www.asapnys.org/Resources/mhscreen.pdf

(Carroll & McGinley, 2000)

Appendix D

Winnipeg Region CODI Stakeholder Program List October, 2003

Winnipeg Stakeholder Program List

Addictions Foundation of Manitoba, Winnipeg Region
Anxiety Disorders Association of Manitoba, Winnipeg
Behavioural Health Foundation
Canadian Mental Health Association, Winnipeg Region
Consumer
Health Canada, First Nations & Inuit Health Branch
Klinic Community Health Centre
Laurel Centre
Main Street Project
Manitoba Adolescent Treatment Centre
Manitoba College of Family Physicians Inc
Manitoba Schizophrenia Society
Mount Carmel Clinic
Native Addiction Council of Manitoba
Salvation Army, Anchorage
Sara Riel Inc.
Serenity House
Tamarack Rehab Inc.
WRHA, Aboriginal Services
WRHA, Community Mental Health Program
WRHA, Grace General Hospital, Mental Health Unit
WRHA, Health Sciences Centre, Mental Health
WRHA, Health Sciences Centre, Spiritual Care
WRHA, Health Sciences Centre, Psychology
WRHA, Health Sciences Centre, Addictions Unit
WRHA, Health Sciences Centre, Mood Disorders Program
WRHA, Schizophrenia Treatment and Education Program
WRHA, Misericordia Health Centre
WRHA, Program for Assertive Community Treatment
WRHA, Psychogeriatric Care Program
WRHA, Seven Oaks General Hospital, Mental Health Unit
WRHA, St. B General Hospital, Mental Health Unit
WRHA, Victoria General Hospital, Mental Health Unit

Stakeholder Agency/Program (outside Winnipeg)

Addictions Foundation of MB (Northern Region)
Addictions Foundation of MB (Western Region)
Brandon Regional Health Authority
Burntwood Regional Health Authority
Serkirk Mental Health Centre

http://www.afm.mb.ca/pdf/StakeholdersProgramList.pdf

Used with permission from Winnipeg Region CODI on May 31, 2007

(Winnipeg Region CODI, 2003)

Appendix E

APPROVAL CERTIFICATE

20 February 2006

TO: **Diane Heywood** (Advisor D. Gregory)
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2006:014**
"Street-involved Women with Co-occurring Disorders: Development of Policy and Practice Recommendations for Street Connections"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement**.** This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.

- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix F

WRHA Review Ethics Board Approval Letter

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

1800 - 155 Carlton St.
Winnipeg, Manitoba
R3C 4Y1 CANADA
TEL: 204/926.7000
FAX: 204/926.7007
www.wrha.mb.ca

155, rue Carlton, suite 1800
Winnipeg, Manitoba
R3C 4Y1 CANADA
TÉL: 204/926.7000
TÉLÉC: 204/926.7007
www.wrha.mb.ca

April 21, 2006

Diane Heywood, RN

Dear Ms. Heywood,

Re: Proposal "Street-involved Women with Co-occurring Mental Illness and Substance Use Disorders: Development of Policy and Practice Recommendations for Street Connections"
WRHA Reference No: 2006-004

Based on the amended changes you submitted April 20, 2006, we are pleased to inform you that your research access request for the above-named study has been approved by the Winnipeg Regional Health Authority (WRHA) Research Review Committee pending confirmation that the following conditions are met or agreed to:

- You, your co-investigators, and your research assistants comply with the relevant privacy legislation as indicated below.
  - ☐ *The Personal Health Information Act*
  - ☒ *The Freedom of Information and Protection of Privacy Act*
  - ☐ *The Personal Health Information Act* and *The Freedom of Information and Protection of Privacy Act*
- You complete and return the attached Confidentiality Agreement(s) to Cathy Pope, WRHA, 1800 – 155 Carlton Street, Winnipeg, MB R3C 4Y1;
- You submit to our attention any significant changes in your proposal prior to implementation or any significant changes during the course of the study;
- You submit a summary of the final results of the study to the WRHA and provide us with a copy of any publications arising from the study;
- It is an expected courtesy that WRHA will be given a minimum of five working days advance notice of publication or presentation of results with policy implications, in order to be prepared for public response;
- You agree to be accountable for appropriate storage and elimination of material.

Thank you for selecting the Winnipeg Regional Health Authority as the site to conduct your research. Please let us know should you encounter any site-related difficulties during the course of your study.

We extend best wishes for successful completion of your study.

Sincerely,

Dr. Mike Moratt
Executive Director, Division of Research & Applied Learning
Chair, Research Review Committee
Winnipeg Regional Health Authority

cc. Dr. Brian Postl
Ms. K. Choptain
Dr. Ken Brown

Encl: FIPPA Agreement

Appendix G

Access Letter for Programs' Team Leaders

May 31, 2006

Practicum project: Street-involved women with co-occurring disorders: Development of policy and practice recommendations for Street Connections

Team Leader
Address

Dear Team Leader:

I am undertaking a practicum project examining the current services available for street-involved women with co-occurring mental illness and substance use disorders. I want to more fully understand the strengths, challenges, limitations and opportunities with services offered to this population.

To this end, I would like to request permission to invite administration and staff currently employed with Street Connections to participate in interviews regarding the services they provide to this population. The attached letter of invitation introduces this project and invites potential participants to contact myself, the principal investigator directly at xxx-xxxx. The interviews will take place in April 2006 at a time and location convenient to each participant.

I am approaching three programs to participate including Street Connections, PACT and Dream Catchers.

I would greatly value your support in this practicum and your advice regarding prospective staff who work with this population in your program.

Participation in the interviews is completely voluntary and staff is at liberty to decide whether or not they will take part in the interviews.

This project has ethical approval from the Education/Nursing Review Ethics Board (ENREB) at the University of Manitoba. All inquiries will be treated confidentially.

The committee chair for my practicum is David Gregory, RN PhD. He may be contacted at xxx-xxxx and/or David_Gregory@umanitoba.ca if you have questions, concerns or comments for him regarding any aspect of this practicum.

Daniela Evenson, Director of Operations Community Health is also a member of my practicum committee. She can be reached at xxx-xxxx or DEvenson@wrha.mb.ca should you have questions for her regarding this practicum.

Respectfully,

Diane Heywood, RN BN
Graduate Student, University of Manitoba

Appendix H

Invitation to Participate

March 2006

Dear Staff:

I am working on a practicum project regarding street-involved women with co-occurring mental illness and substance abuse disorders. I want to more fully understand services provided to this population.

I am requesting your assistance as your knowledge and perspectives will be most valuable. Would you like to take part in an interview with me regarding the challenges, strengths, limitations and opportunities of the services offered by yourself and your program?

The interviews will take place in April 2006 at a time and location of your convenience. The interviews will take approximately one-hour each.

If you are interested in participating in an interview or if you would like more information about the study, please contact myself, Diane Heywood at xxx-xxxx.

I would greatly appreciate hearing from you by XXX date.

The Education/Nursing Review Ethic Board (ENREB) at the University of Manitoba approved this practicum.

Participation in this practicum is completely voluntary and you are under no obligation to take part in the interview

Thank-you

Diane Heywood, RN BN
Graduate Student, University of Manitoba

Appendix I

Interview Guide

1. What are the strengths in the services you offer this aggregate? What works well? Why?

2. What are the challenges with the services you offer this aggregate? What makes working with this population harder? Why?

3. What are the limitations in services you offer? What gets in the way? Why?

4. Where are the opportunities to improve services you offer this aggregate? What could be developed to improve your program's services? What needs to happen for this to occur?

5. What best-practice recommendations do you and your program utilize with this population? Why are certain practices used as opposed to others?

6. From your perspective, how does your program screen for street-involved women with co-occurring disorders? What are the challenges and limitations with respect to screening? What are the strengths? What are the opportunities?

7. What services are utilized to engage and maintain contact with clients from this aggregate? What are the challenges and limitations? What are the strengths and opportunities?

8. What services do you find useful with this aggregate in comparison to males with CODs?

9. What practices work well with different members within this population? Differences may be based on characteristics such as sex trade work, injection drug use, youth, pregnancy, aboriginal ethnicity or other minorities.

10. Which practices do not work as well with different members within this aggregate?

11. What linkages/connections do you and your program have with other agencies (formal and informal)? What linkages are useful? Why?

12. What other linkages are needed? What needs to happen in order to develop this?

Appendix J

Confidentiality Pledge

The study described above and my role as the transcriber in it has been explained to me. I have been compensated for my time and efforts. I have had a chance to ask questions. I will receive a copy of this consent form for my records and reference in order to maintain the confidentiality process. I understand that anything I have heard while working as a transcriber will not be repeated except to the Principal Investigator. I understand that I am not to speak with anyone about the interviews I have been transcribing. Any notes I have made will be turned over to the Principal Investigator(s) or Project Manager at the conclusion of the process.

_____

Transcriber (sign name) (Print name)

Date

Appendix K

Consent

Practicum Project Title: Street-involved women with co-occurring disorders: Development of policy and practice recommendations for Street Connections.

Researcher: Diane Heywood

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

In Winnipeg, the population of street-involved women with co-occurring disorders is open to several health and social problems. At the same time, this group may also have trouble obtaining helpful health and social services. This purpose of this practicum is to examine current Winnipeg-based services available to this population. A comparison will be made to recommended best practices based on the research to develop policy and practice recommendations for Street Connections that are relevant and feasible.

The purpose of this interview is to discuss current services and practices including strengths, challenges, limitations and opportunities that you provide in your work with population. The interview will take approximately one-hour and will be tape recorded and transcribed verbatim.

Your participation will be confidential and your name will not be linked with interview data. Diane Heywood and her practicum committee will have access to the anonymized data. The transcriptionist will sign a pledge of confidentiality. Reports from the interview will offer analysis regarding groups of people, not from one person. No one will be able to identify specific people form these reports.

All data and transcripts will be stored, locked and secured in the principal investigator's office in a geographically separate location from the consent forms for at least five years at which time it will be securely disposed of as confidential waste.

The risks to you or a third party are minimal.

If you would like a one-page summary of the results of this practicum, please fill out your name and address on the attached page then return that page to the researcher. Also the principal investigator (Diane Heywood) will inform you when she will provide a presentation of the results to programs participating in this practicum.

Your signature of this form indicates that you have understood to your satisfaction the information regarding participation in the practicum project and agree to participate as an interviewee. In no way does this waive your legal rights nor release the researchers, sponsors or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering questions

you prefer to omit, without prejudice of consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Principal Investigator: Diane Heywood

Committee Chair: David Gregory

External Member: Daniela Evenson

The research has been approved by the Education/Nursing Review Ethics Board at the University of Manitoba. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122 or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

_____

Participant's Signature Date

_____

Researcher and/or Delegates Signature Date

If you would like a one-page summary of the results of this practicum, please fill out your name and address then return this page to Diane Heywood.

_____

Name

_____

Address Postal Code

_____

E-mail

Appendix L

How to talk to your partner about Safer Sex

Sex has always been an important part of life. Yet, after all this time, people still find sex hard to talk about. It is so important to talk to your partner before engaging in any kind of sexual behavior.

If you really think about it…talking about safer sex with your partner could literally save your life! ! Nowadays, talking about sex is more important than ever because of sexually transmitted infections (STI's) like HIV, chlamydia, gonorrhea, syphilis, herpes etc

This conversation may be a little awkward, but you are taking care of your health! Not only is this a great way to show yourself respect, but your partner will see that you care about your body, and will respect the healthy choices you make.

There are lots of good things that can come out of talking about safer sex. You can save yourself from embarrassing trips to the clinic, avoid painful infections (itching and burning are no fun!), weird smells and even death. Most people will understand that you're only looking out for your health and theirs. And if they don't, please ask yourself if such a person isn't worth it.

Just be firm and prepared, and make sure that you leave yourself an opening to put off sex if your partner is unwilling to meet your requests.

Tips:

- make sure you keep your self respect
- be clear about using protection, honest and open about your desires, likes and dislikes

Remember, worrying about pregnancy or disease is one of the biggest desire killers, so let your partner know that taking precautions will only help you get into it more...which will almost certainly make it better for them too.

Information from Canadian Federation for Sexual Health http://www.cfsh.ca

One day a teacher had a taste test with her students. She picked a little boy to do the first test. She blindfolded him, put a candy kiss in his mouth and asked, "Do you know what it is?"
"No, I don't," said the little boy.
"OK, I'll give you a clue. It's the thing your daddy wants from your Mom before he goes to work."
Suddenly, a little girl yelled, "Spit it out! It's a piece of ass!"

The Street Sheet

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981-0742

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Think about it…

"Anybody who believes that the way to a man's heart is through his stomach flunked geography"
- Robert Byrne

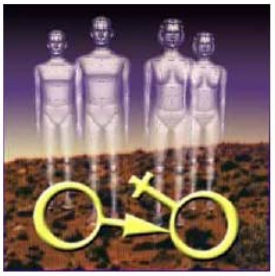
"Flies spread disease - keep yours zipped. "
- Author Unknown

"For the first time in history, sex is more dangerous than the cigarette afterward."
- Jay Leno

"Sex at age ninety is like trying to shoot pool with a rope. "
- George Burns

"Sex appeal is fifty percent what you've got and fifty percent what people think you've got."
- Sophia Loren

"Sex is like snow, you never know how many inches you're going to get or how long it will last"
- Author Unknown



Let's talk about

SEX!

In today's world, Safer sex does not just mean wearing a condom, but also includes knowing what to avoid and make the right decisions.

Bad Dates & Street Hassles

Week 2

On August 23 @ 9:00 pm. 2 men picked up women @ Parr & Manitoba negotiated $$ for a blow with just one guy. They started talking in their language. They wanted her to do both of them for the $$ she said no & tried to get out of the car. She opened the door they grabbed it shut, they stopped @ Arlington & Stella she opened the door again they grabbed her by the shirt, the car dragged her till it ripped. She got away with scrapes to the shoulder
30ish, passenger looked 35ish,
were in a 4 door, clean silver car.

Week 2

Friday in the middle of June, a woman picked up at **Manitoba and Alkins** and was taken to an **industrial park near Shepard**. At first the man was nice, then he started getting rough. During the date he pulled her legs apart and tried to take off his condom. He then tried to take naked pictures of her, telling her "don't move". The woman has heard that this man has assaulted two other women. **He is described as**
nar
burgundy Oldsmobile.

Week 3

On Thursday, August 17 @ about 12:30 a.m. a woman was picked up at Powers and Jarvis. She was taken to a warehouse at **150 Sutherland**. Once inside the warehouse, the man released two rottweilers to attack her. The woman was able to run out of the warehouse and jump into the back of the man's truck, then climbed on the cab. She was there for about 15 minutes until a vehicle drove by and the man in it distracted the dogs.
brown eyes approx

Week 4

On Tuesday August 8th @ about 4 a.m. a woman was picked between **Pritchard & Selkirk** (on Parr's back lane). She was taken outside **Winnipeg on Highway #6.** He had been drinking. She asked him for a ride home and he started asking her how it feels to know that 'she's going to die tonight'. & "tonight you're going to die", "don't even fucking speak", "I'm only giving you one chance to pray to your God, do you know who your God is?". He hit her twice on the head and made her take her clothes off. She was able to jump out and run when the vehicle stopped. **The man was described as being in his mid 30's**
dirty on the inside. There were 2 rows of seats in the back and 1 row in the front.

Week 4

On Friday August 8th @ about 1 a.m. a woman was approached by a man on a bike at the corner of **Sutherland and King.** They walked down **Sutherland (near Schultz).** They negotiated on a blowjob. He gave her the money **first.** As she was doing the blowjob he grabbed her hair and put a knife to her throat. He made her take all of her clothes off. He took off with her clothes and he threw them away. She had to walk naked to find her clothes.
a pot belly, had a moustache and was wearing a gold necklace.

Week 4

On August 2nd, when a woman was approached by a male in a dirty, **green van** near King and Sutherland. The woman stopped to chat with the male but he tried to drag her into the van calling her a

We wanna do you!

Did we get your attention?

We give FREE Hepatitis A & Hepatitis B shots here in the van (called Twinrex).

Who should get it?

- Street involved people
- People with HIV or AIDS
- Men who have sex with men
- People who smoke or inject drugs
- People with chronic diseases (like Hepatitis C, lung disease, cancer)

So, if you have not been immunized, call for a home visit, catch us cruising, or come see the nurse in the Street Connections van at one of our stops.

Nine Circles Community Health Centre Clinic

NCCHC

940-6001 for Clinic Info

Drop-In Clinic for STI, HIV Testing
705 Broadway
Wednesdays 1:00 - 7:00 p.m.

Do you have concerns about HIV OR OTHER SEXSUALY TRANSMITTED INFECTIONS?
945-2437
1-800-782-2437
www.ninecircles.ca

Nine Circles Community Health Centre
Free and Confidential Information & Support
Protect Yourself, Know the Risks

I see a guy sitting outside a place called "Suzy's Legs"

I ask "What are ya doing?"

He responds "Waiting for Suz's legs to open so I can get a drink."

Nurse's Notes

Does penis size really matter?

Every teenaged boy and man at one point in their life has asked themselves this question: "Is my penis big enough?" Society puts a lot of pressure on men to have large penises. In fact, men are bombarded with lotions, potions, and devices to increase penis size. It is no wonder that many boys and men have issues with the size of their penis.

We learn that men must have big penises from:

- Media (television, magazine articles, books, pornography, etc.)
- Locker room talk
- Male competition
- Equating penis size to power, money, and/or success

However, having good sex has nothing to do with the size of the penis. We've all heard, "it's not how big it is, it's what you can do with it that counts!" And, in general, this is very true.

You don't need a big penis because:

- The vagina is a potential space and can accommodate whatever size object is inside it
- The first third of the vagina is most sensitive (has the most nerve endings)
- Oral or anal sex can be painful, especially if the penis is very thick

Even though there is no biological reason proving that "bigger is better," some men and women do prefer a big penis.

Men and women might like larger penises because they:

- Think they look nicer either flaccid (limp) or erect (hard)
- Enjoy the feeling of fullness; either orally, vaginally, or anally

Some men are genuinely concerned with the size of their penis. For them, penis size does matter. They may have been teased in the locker room or a partner may have laughed at them when they undressed. Men who think their penis is small may have difficulty pursuing relationships and/or may encounter erection difficulties during sexual encounters.

Most men who think they have a small limp penis actually have an "average" hard penis. A smaller limp penis grows considerably more when erect than a longer limp penis grows.

Furthermore, penis size varies considerably between men. Accepting the size of your penis and discontinuing comparing your penis to others will help you lead a more fulfilling and enriching sexual life.

Information from Canadian Federation for Sexual Health http://www.cfsh.ca

Van Schedule & Messages

All home visits for syringes & nursing MUST be done before 10:00 pm or you will have to wait till the next day.
The van runs from 6:00 pm till 12:30 am.

6:30 - 6:40 pm	Stopped at Sargent Ave. & McGee
6:45 - 6:50 pm	Cruising Central Park
6:50-7:00 (Mon. & Weds.) pm	Stopped on Princess St. near Higgins Ave.
7:05 - 7:20 pm	Stopped at Main St. & Rupert Ave.
9:30 - 9:45 pm	Stopped at Andrews St. & Selkirk Ave.
10:00 - 10:15 pm	Stopped at Main St. & Sutherland Ave.
10:40-11:00 pm	Cruising Ellice Ave. & Sargent Ave.
11:00 - 11:25 pm	Cruising Osborne Village & Assiniboine Ave.
11:30 pm - 12:30 am	Last cruise North End, Ellice & Sargent Ave

Please note: The van at 705 Broadway will only have safer crack kits available on Thursdays from 11:30 - 12:00 am and 1 - 1:30 pm. During daytime phone 981-0742 to see if staff are available.

There are no scheduled stops in the afternoon, but the van will go out if time permits.

There is a very important message left for you in the van. Please call 981-0742.

The ABC's for Safer Sex.....

Abstinence - the safest way to avoid infections. NO sex!
Birth control pill - helps prevent against pregnancy, but not STI's
Condoms - help prevent pregnancy and STI's, but only work when worn!!!
Dental dam - If you're going to be licking your partner's vulva, clit or ass (eating out), use a dam. They can be bought at pharmacies, or make your own by cutting the end off of a condom, and slicing the condom down the side to form a rectangle!
Education - learn about how to keep yourself safe from HIV and STI's
Female condom - a loose fitting plastic condom that fits in a woman's vagina (pussy) to help prevent against pregnancy and STI's or up a male ass (just remove the inside ring)
G - **gloves** - if you put your finger/fist into someone's anus or vagina (bum or pussy), it is safest if you wear a latex glove and lots of lube
H - **Hepatitis** C - A liver disease caused by a virus. It is spread by blood and other body fluids.
Infections - bacterial (can be cured) and viral (some stay in your body forever - Hep C is sometimes treatable/curable)
Jacking Off - Getting yourself or your partner off with your hand.
Kissing - a wonderful way to demonstrate your affection for your partner; but watch out for open sores which may be syphilis or herpes!
Lubrication - Also referred to as "lube." A water-based mixture used to make masturbation or intercourse more pleasurable by enhancing or providing a slippery feel.
Masturbate - The act of "playing" with your genitals or partner's genitals (cock, balls, pussy, bum), for sexual excitement, usually to orgasm.
Non-lubed condoms - these condoms are meant for only **blowjobs**
Oral sex - blowjobs or rimming (eating out) - always use a condom or dental dam to protect yourself from STI's
Pregnancy - a possible result of not practicing safer sex
Quickies - even when you are having a quickie, make sure you use a condom!
Responsible - You need to be responsible to protect yourself from becoming infected
Syphilis - a sexually transmitted infection that could lead to serious side effects or even death if left untreated
Talk - talk with your partner about what turns both of you on - make your sex life more interesting..... but do so safely!
U- It is all about you, take the measures to protect yourself and your body from STI's such as syphilis and HIV
Voyeurism - a fancy way of saying watching others have sex, or being watched when you are having sex
Warts - genital warts (HPV) are a virus that may lead to warts on your genitals. If left untreated it may lead to cancer
X-rated movies - a lot of people get turned on by watching others having sex in movies
Yellow, red, green - try flavoured condoms to make your sex life more interesting!
Zero-tolerance - insist that you and your partner practice safer sex - if they don't want to use a condom or dam then insist that you will not have sex with him/her.

Victim Services
Domestic Violence Unit

Ladies, have you been assaulted by your partner, and charges were laid?

Formerly known as the "*Women's Advocacy Program*", the *Victim Services Domestic Violence Unit* provides basic legal information on charges, rights and protection to women whose partners have been charged with assault against them.
They also offer short term counselling and referrals.

You can find them at:
1410-405 Broadway Ave.
Phone: 945-6851

Needle Use And Disposal

Please do not to discard needles on the ground or in public places.

Save your needles to exchange for new ones with the Street Connection van.
We would like ALL needle users to properly dispose of their needles and to exchange their needles for new ones.

Sharps disposal containers are available from the van at your request.
Discarding your needles the wrong way may harm you and other people in the community.

A kindergarten class had a homework assignment to find out about something exciting and relate it to the class the next day. When the time came to present what they'd found, the first little boy walked up to the front of the class made a small white dot on the blackboard and sat back down. Puzzled, the teacher asked him just what it was.
"It's a period," said the little boy.
"Well, I can see that," she said, "but what is so exciting about a period?"
"Damned if I know," said the little boy, "but this morning my sister was missing one... now my Dad is furious!!

Used with permission from Street Connections on April 25, 2007.

(Street Connections, 2005)

Appendix M

Taking care of your veins

Taking care of you

Before you use again, here's one idea that can help you take care of your veins. You may have other ways too. Do what you can. And remember that if you can smoke your drugs, this is less risky for spreading infections like HIV and hepatitis.

Where you shoot can be as important as how you shoot. Pay attention to your own safety, comfort and warmth. If you in a place where you feel safe relaxed and unrushed, your veins will be bigger, closer to the surface and easier to hit.

There are also sites to shoot into that lead to less problems – like your arms. If you have to use your legs, know that it is easier to get blood clots from shooting there. Then, know that the veins in your hands, wrists and feet are more fragile and sensitive, so it is easier to miss the shot or cause a lot of pain if you use here. Shooting in your neck or groin goes back to your heart and is riskier. It's easier to overdose or a major infection.

Get a feel for you veins. Feel around for your veins. Tap them. Feel for them when you are not using. It will help you know your sites. Ask the nurse in the van to help get to know where your veins are. (For women, remember that your veins can be harder to hit. This happens for many reasons, size of veins being only one). Getting to know your veins can help you hit them instead of missing. And the more that you miss, the more trouble your veins will give you down the road. Everyone's body is different, get to know your own.

Develop you veins. Exercise your arm (or leg if you must) muscles and your veins will develop too. Repeatedly squeezing a ball of something in you hand will work out your arm muscles. Push-ups, pull-ups, wrist curls work too.

Keep it clean. Keep it separate. The cleaner the area around you when using, the less germs that can get into your veins (including plain old dirt or hepatitis C & other viruses). This means more than just wiping your arm with an alcohol swab. It also means cleaning the table (or whatever) you use to cook your drugs. Plus, wash your hands AND the site you are going to shoot into! Soap and warm water is one of the best cleaners. Scrub for 15 seconds (sing a short song to yourself so you don't stop scrubbing too soon).

If you don't have a sink or water for washing, alcohol wipes are better than nothing. Air dry before shooting, so the shot will sting less.

Then, keep your works separate from others who are using so you cannot pass germs on.

Use sterile needles and only use them once. You've heard it like a broken record that's tried and true – NEVER SHARE. If you reuse your needles, even on yourself, you also take the chance of vein or skin damage. With each injection, the needle gets dirty, dull or barbed. This can cause abscesses or infections. Plus, sharing used needles puts everyone at risk for infections such as HIV, Hepatitis C, Hepatitis B etc, etc, etc.

Crush your drugs. The finer the powder, the easier it dissolves into the water or whatever you use for shooting. This lowers the less chance of injecting small, pieces into you veins. But with most prescription pills, there are additives that won't dissolve, no matter what. These pieces can travel in your veins and clog up in your lungs – called chalk lung. Chalk lung can make it very hard for you to breathe.

Use filters to get extra crap out of your drugs. Get clean filters that are the right size for you. Then, the filter will stay cleaner with less handling or cutting to make it the right size. Filters are available from the van. Other filters can be gotten from q-tips etc, but, you have to cut them off and germs from your hands or scissors can get on the filter, then into your drugs, then into you. Fibers from some cigarette filters can get caught up in your lungs/body and cause an obstruction or infection.

And, just like needles, never draw up from the same filters as anyone else. Sharing filters also increases your chance of other infections – HIV, Hep C and Hep B etc.

Use clean sterile water or liquid. Clean drugs too. The cleaner the liquid and drugs, the less damage they do to your veins and body. If you don't have sterile water, you can boil water for 10 minutes, then cool it down. This kills germs. If you are trying to break down crack for injecting, a cleaner choice that really works is ascorbic acid (vitamin C) powder mixed with clean or sterile water. This is cleaner and easier on your veins than vinegar or lemon juice.

And, just like needles, never draw up water/liquid from the same source as someone else. That is, when 2 or more of you draw up water from the same spoon, vial or whatever you use, you take the chance of sharing other infections too. You know, HIV, Hep C and Hep B etc.

Use rubber ties/tourniquets to pump up your veins. Even if you have big veins, a tie will pump them up before shooting, which is easier on your veins. Use a clean tie without blood or dirt (especially if you share a tie with anyone).

If you inject yourself, make sure you can untie/release it. Make sure you can release it no matter how strong the hit. Or else, if you pass out, your arm could die or get damaged from lack of blood flow while you are out.

After you get a hit, and see blood, release the tie before you inject the rest of the shot. Releasing the tie makes sure there is less pressure on you veins and less leaking out of your veins. This means there will be less chance of infections, abscesses or bruises.

Use something clean to stop the bleeding after you shoot up. A clean finger, cloth or tissue will do the trick. Push on the site firmly so that you bruise less and heal quicker. If you use a dirty finger or used cloth to stop the bleeding, this can pass germs into your vein or under your skin. Now, an alcohol wipe may seem like a good clean idea, but it will have dirt from when you wiped your skin. And, the alcohol will make the bleeding go on longer.

Care for your veins after you shoot. Care for your veins after you shoot. Keep an eye on you're the sites where you shoot. Watch for signs that an infection is starting to develop such as swelling, hardness or pain. Paying attention to the sites you shoot into gives you an edge to knowing when a problem might be starting (Street Connections, n.d.).

Used with permission from Street Connections on April 25, 2007.

(Street Connections, n.d.)

Appendix N

PACT Model Recommended Standards	PACT Model Fidelity Review
A. Staff Composition 1.	**Minimum Team Size** 10 Full time equivalent (FTE)/urban; 5-7 FTE/rural
2.	Clinical staff-client ratio of 1:10 (excluding physician)
3.	Psychiatrist(s) – 16 hours per 50 clients
4.	Program administrative assistant 1 FTE/urban .5 FTE/rural
5.	Full time masters level clinician as team leader
6.	At least 8 (3 FTE/Rural) of nonphysician staff are mental health professionals (MSW,MSN, BSN, OTR, etc.)
7.	At least 1 FTE - Substance Abuse Specialist
8.	At least 3 FTE – RN(urban) 1.5 FTE RN(rural)
9.	At Least 1 FTE - Vocational Specialist
10.	At Least 1 FTE - Peer Specialist
B. Key Staff Roles 1. Team Leader	a. Leads daily organizational team meeting
	b. Leads treatment planning meetings
	c. Available to team members for clinical consultation
	d. Provides 1:1 supervision
	e. Functions as a practicing clinician
2. Psychiatrist	a. Conducts psychiatric and health assessments
	b. Supervises the psychiatric treatment of all clients
	c. Provides psychopharmacologic treatment of all clients
	d. Supervises the medication management system
	e. Provides individual supportive therapy
	f. Provides crisis intervention on-site
	g. Provides family interventions and psychoeducation
	h. Attends daily organizational and treatment planning meetings
	i. Provides clinical supervision
3. Registered Nurses	a. RNs and physician manage medication system
	b. Administers and documents medication treatment
	c. Conduct health assessments
	d. Coordinate services with other health providers

4. Vocational Specialist	a. Lead clinician for vocational assessment and planning
	b. Maintains liaison with vocational rehabilitation and training agencies
	c. Provides full range of vocational services (job development, placement, job support, career counseling)
5. Peer Specialist	a. Peer Counselor position is integrated within the team
	b. Peer Counselor and other team members share roles
6. Substance Abuse Specialist	a. Serves on individual treatment team of clients with Substance Abuse Disorders
	b. Lead clinician for assessing, planning and treating substance use
	c. Provides supportive and Cognitive Behavioral Treatment - Individually and in groups
C. Outreach & Continuity Care 1.	At least 75% of all contacts occur out of office
2.	Difficult to engage clients are retained
3.	Difficult to engage clients seen two times per month or more
4.	Acutely hospitalized clients seen two times per week or more
5.	Long-term hospitalized clients seen each week in hospital
6.	Team plans jointly with inpatient staff
D. Program Size & Intensity 1.	Program size does not exceed 120 clients (80 clients in rural areas)
2.	Staff to client ratio does not exceed 1:10
3.	Clients contacted face-to-face average of three times per week
4.	Unstable clients contacted multiple times daily
E. Admission & Discharge are Criteria Specified 1.	Admission criteria specify target population
2.	At least 80% of clients have 295-296 Axis I Diagnosis
3.	Discharges mutually determined by clients and team
4.	Team assumes long-term treatment orientation
F. Clinical Charts 1.	Charts are uniformly organized
2.	Prescribed chart contents are current and complete
3.	Progress notes follow problem orientated medical records format
G. Office Space 1.	Easily accessible to clients and families
2.	Common workspace, layout promotes communication
3.	In office medication storage area
H. Interagency Relationships 1.	Active collaboration with other human services
2.	Active client-specific liaison with social service agencies, health care

		providers, and other agency assigned caseworkers
I. Hours of Operation	1.	Staff on-duty seven days per week
	2.	Program operates 12 hours on weekdays
	3.	Program operates eight hours on weekends and holidays
	4.	Team member on-call all other hours
J. Team Communication and Planning	1.	Organizational team meeting held daily Monday to Friday
	2.	Meeting completed within 45-60 minutes
	3.	Clients' status reviewed via daily log and staff report
	4.	Team leader facilitates discussion and treatment planning
	5.	Services and contacts scheduled per treatment plans and Triage
	6.	Shift manager determines staff assignments
	7.	Shift manager prepares daily staff assignment schedule
	8.	Shift manager monitors and coordinates service provision
	9.	All staff contacts with clients are logged
K. Assessment and Treatment Planning	1.	Baseline and ongoing assessments are documented
		a. Psychiatric
		b. Vocational
		c. Activities of daily living and housing
		d. Social
		e. Family interaction
		f. Substance use
		g. Health
	2.	Assessment done by qualified staff
	3.	Individual treatment teams of three to five staff per client
	4.	Treatment planning meetings weekly
	5.	Treatment planning meetings led by senior staff
	6.	Clients participate in formulating goals and service plans
	7.	Five-Axis DSM-IV on plans
	8.	Problems, goals, and plans specific and measurable
	9.	Treatment plans transferred to client weekly schedule
	10.	Treatment planning schedule posted two months ahead
	11.	Treatment plan reviewed/modified at key events in treatment course

	12.	Treatment plan reviewed and rewritten at least every six months
L. Services	1.	Case management
		a. Mental health professional case manager assigned for each client
		b. Other individual treatment team staff back up case manager
		c. Case manager provides supportive therapy, family support, education, collaboration and crisis intervention
		d. Case manager plans, coordinates and monitors services
		f. Case manager advocates and provides social network support
		g. All mental health professional staff perform case management
	2.	Crisis assessment and intervention
		a. available 24 hours per day
		b. Team member is available by phone and face-to-face with back up by team leader and psychiatrist
		c. Collaboration with emergency services providers
	3.	Individual supportive therapy
		a. Ongoing assessment of symptoms and treatment response
		b. Illness and medication effects education
		c. Symptom management education
		d. Psychological support, problem solving and assistance with adapting to illness
	4.	Medication management
		a. Psychiatrist actively supervises and collaborates with RNs
		b. Frequent psychiatrist assessment of client response
		c. All team members monitor medication
		d. Medication managed in accordance with policy and procedure manual
	5.	Substance abuse treatment
		a. One or more designated Substance Abuse Specialists
		b. All team members assess and monitor substance use
		c. Interventions follow an established dual diagnosis treatment model
		d. Individual interventions provided
		e. Group intervention provided
	6.	Work related services
		a. Assessment of interests, abilities, and effect of mental illness on employment

	b. All team members provide vocational services, coordinated by team Vocational Specialist(s)
	c. Interventions to reduce symptom and behavioral impediments to employment
	d. Ongoing employment rehabilitation plan developed
	e. On the job collaboration with client and supervisors
	f. Off the job work related supportive services provided
7.	Activities of daily living
	a. Self care skills training
	b. Home making skills training
	c. Financial management skills training
	d. Use of available Transportation skills training
	e. Use of health and social services skills training
8.	Social, interpersonal relationship and leisure time
	a. Communication skills training
	b. Interpersonal relations skill training
	c. Social skills training
	d. Leisure time skills training
	e. Support to clients in participating in social, recreational educational and cultural community activities
	f. Team organizes leisure time activities
9.	Support services
	a. Access To Medical And Dental Services
	b. Locate and maintain safe, clean, affordable housing
	c. 80% of clients live in independent community housing
	d. Financial management support
	e. Access to social services
	f. Transportation and access to transportation
	g. Legal advocacy
10.	Family and other support system interventions
	a. Ongoing communication and collaboration between team and family
	b. Education about clients' illness and family's role in treatment
	c. Interventions to reduce conflict
M. Policy and Procedure	

Manual	1.	Admission and discharge criteria and procedures
	2.	Job Descriptions, performance appraisal, training plan
	3.	Program organization and operation (program hours, on-call, service intensity, staff communication, team approach, and staff supervision
	4.	Assessment and treatment planning
	5.	Medical record management
	6.	Service scope
		a. Case management
		b. Crisis assessment and intervention
		c. Symptom assessment, management and supportive therapy
		d. Medication prescription, administration, monitoring and documentation
		e. Substance abuse services
		f. Work related services
		g. Activities of daily living
		h. Social, interpersonal relationships and leisure time
		i. Support services
		j. Education and support to families and other supports
	7.	Client rights
	8.	Program performance improvement and evaluation

Used with permission from NAMI – National Alliance on Mental Illness on May 2, 2007.

(NAMI - National Alliance on Mental Illness, 2006)

Appendix O

Sage House

Sage House is a Mount Carmel Clinic Community Outreach Program located at 422 Dufferin Avenue. It is a street women's health, outreach and resource service that works towards improving the health of street-involved women, transgenders living as women and those involved or affected by substance abuse. Sage House offers HIV/AIDS prevention, free condoms, pregnancy testing, counseling/support, health education, nursing services available during drop-in hours, onsite nursing care, referrals and advocacy to other services, laundry/bath/kitchen facilities, someone to talk to and volunteer opportunities.

(Mount Carmel Clinic, 2004).

Appendix P

Ever been unable to get telephone messages?

CONNECT 2 offers a safe, confidential contact number. **CONNECT 2** lets you have a phone answering service even if you don't have a telephone. Many agencies, businesses and churches have phones you can use for free. You can also use a friend's or relative's phone to retrieve messages.

Now you can get your own messages! And this voice mailbox is free! **CONNECT 2** can help! For more information on how you can get one of these free voice mailboxes - call New Life Ministries (xxx-xxxx). Through the participating agencies, the CONNECT 2 pilot offers 1,500 free voice mailboxes to people in Winnipeg.

(New Life Ministries, n.d.)

Appendix Q

What is an ACCESS centre?

A site can qualify to use the term "ACCESS" if it meets the following criteria:

- The community's perspective and input is encouraged in addressing main health and social issues in the community area, AND;
- Approaches which help prevent problems and promote citizen and community health and well being are supported, AND;
- Citizens are able to obtain information about the full range of services offered by both partners through in-person contact with a service navigator, which may be supplemented by written and electronic information; AND;
- Trained service navigators provide excellent customer service, be able to appropriately assess citizen's presenting needs, be knowledgeable about the full range of services, and be able to arrange appointments and make referrals to the appropriate program specialist/intake worker/ case worker etc, in any location in the community area or with a centralized service, AND;
- Staff must be active participants in the community area's network of services and interdisciplinary service delivery team(s), AND;
- Hours and locations of service are convenient to the public, AND;
- Services are provided collaboratively with other community organizations such as justice, recreation etc., AND
- On site services must include one or more services from each of the partners (WRHA and FSH) plus primary care services, plus other services that may be available on an itinerant basis or by appointment at that site.

(Winnipeg Integrated Services Initiative, 2003, p. 15).