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21 A comprehensive, community process on ending homelessness: The System of Care Approach

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Many of the authors in this book wrote about interactions with emergency homeless shelters, the foster care system, outreach programs and more; as well as mainstream services such as healthcare, addictions programs and mental health services. As it stands, people access each of these services separately. For those of us who are housed this is usually just a minor inconvenience; the fact that we get a prescription at the doctor's office and often have to fill it somewhere else entirely isn't generally a big deal. In the context of homelessness, however, disjointed services are difficult to get to, organize and arrange. Richard aptly describes the frustration this causes in his story:

> *Help is scattered all over the place, with too many barriers, too many hurdles and too much red tape. Today, again forced to work within the system, I am left frustrated…I would like to see a facility that would have people come in one door and have everything they need under one roof—like one-stop shopping. To the left we have doctors, dentists, psychiatrists and mental health care; on the right we have addiction counsellors, personal care workers for housing, etc. So at the end, when you walk out the last door, you're ready for*

a new start (Henry [Richard], 2015, p. 62).

A solution to this kind of experience is service integration, the coordination and merging of services both within and outside of the homelessness sector. This allows various agencies and programs to function together as one system geared toward ending homelessness (Gaetz, 2014). Without service integration, agencies function independently and fragmentally to the detriment of people trying to use their services. When agencies do not work together, whether they have the same goals or not, they are less likely to achieve effective results (Gaetz, 2014). People experiencing homelessness access both mainstream and housing/homelessness-specific services and a lack of integration often means duplication (organizations offering the same services) and few coordinated solutions.

Necessary Strategies to Facilitate Service Integration: Coordinated Intake and Case Management

There are two important parts of service integration: coordinated intake and case management. Coordinated intake, also known as 'coordinated assessment'—or as 'common assessment' in the United Kingdom—is a standardized approach to assessing a person's current situation, the acuity of their needs, the services they currently receive and those they may require in the future (National Alliance to End Homelessness, 2013). This approach goes beyond simply using the same data-collecting tools and sharing information amongst agencies, and is key to delivering integrated and focused early interventions for individuals and families at risk of homelessness. It considers the background factors that contribute to risk and resilience, changes in acuity and the role that friends, family, caregivers, community and environmental factors play in a person's development and ability to move forward (Gardner, 2010).

Using coordinated intake can reduce duplicate assessments, which means that people accessing services won't have to tell their story multiple times. It is important to remember that these stories can be emotionally difficult to share (traumatic) or stigmatizing (LGBTQ2 status, criminal involvement, mental health problems, etc.). People who are homeless, especially in larger cities, often say that having to retell their story at every new agency can be a very difficult and troubling experience. Stasha writes about the difficulty in constantly sharing in her story, ultimately choosing to focus "on my strengths

and what I learned from my traumatic experiences, rather than describing the trauma itself" (Huntingford, 2015, p. 86). Few people experiencing homelessness have that choice.

Together with coordinated intake, effective case management can help people get timely access to the most appropriate services based on their needs. Originating in the mental health and addictions sector, the strategies and tools of case management can be used more broadly to support anyone who has experienced homelessness in overcoming challenges they may face. It is a comprehensive and strategic form of service provision whereby a caseworker assesses the needs of the client (and potentially their family) and, where appropriate, arranges, coordinates and advocates for access to a range of programs and services designed to meet the individual's needs. The goal of case management is to empower people, draw on their own strengths and capabilities, and promote an improved quality of life by facilitating timely access to necessary supports, thus reducing the risk of homelessness and/or helping them achieve housing stability.

As just mentioned, avoiding the risk of homelessness—and not just addressing homelessness when it's already happened—is a crucial goal of case management. This approach works best within a system of care, where links are made to necessary services and supports based on identified client need, meaning that once a person becomes homeless, or is identified as being at risk, they are not simply sent to emergency services. In case management, intake is done, risks are identified, goals are established, and plans are put in place. Individuals and families therefore become 'clients' not of specific agencies, but of the entire sector (Calgary Homeless Foundation, 2014). Clients are supported from the moment they are identified as (potentially) homeless right through to the solution stage; and sometimes after they have either returned home or moved into a place of their own.

Had risk assessment been used with most of our authors, especially those who experienced recurring homelessness like Derek and his family, many terrible experiences of homelessness could have been avoided. Derek reflected on his mother's fluctuating instability and recalled that he, his sister and his mother would often transition from being housed to "sleeping in transition houses, abandoned houses and even abandoned vehicles" (Book, 2015, p. 15). No one, especially young children, ought to live in these conditions. Case management could have created plans in advance, rather than allowing

Derek and his family to fall through various social safety nets before being provided with appropriate assistance.

Many of the authors also reported transitioning from one program or service to another, and often accessed several services or programs simultaneously. In "Anatomy of a Hero," Joe's journey into homelessness began in foster care. It continued when he was admitted into Lakehead Psychiatric Hospital, and then after his release from the criminal justice system. Additionally, Joe had many interactions with healthcare facilities throughout his life.

While Joe's story speaks to the tendency to access services consecutively, an example of accessing several services simultaneously can be found in "Hail Mary Pass'" (Thistle, 2015, p. 35). Jesse was staying at a shelter, accessing health care services at a hospital and being served by a street outreach program at the same time. He also went on to be admitted into the criminal justice system, and accessed healthcare therein. His experience, and those of many others, could be described as: "a patchwork emergency response that is not effectively coordinated into a system of care designed to end homelessness" (Gaetz, 2014, p. 26).

The lived-experience stories in this book are a testament to the fact that homeless and mainstream services inevitably overlap, which is a foundational rationale for moving toward service integration (Gaetz, 2014). This is perhaps most clearly illustrated in Jesse's story, as his inadequate living environment at a shelter had a profound impact on his ability to recover from a serious leg injury. In Jesse's case, the key mainstream service he had received (healthcare) and the main homelessness service he accessed (the shelter system) functioned independently.

This lack of coordination undeniably had negative repercussions on Jesse's health. After his surgery was categorized as a complete failure by his doctor, Jesse was told that he risked losing his leg, and that his recovery depended on his overall self-care; but Jesse was forced to return to the streets, despite the doctor's awareness of his living situation. "When I told the doctor I was staying at a homeless shelter, his face turned sullen. He knew, like I did, that it was a shithole of a place to recover in" (Thistle, 2015, p. 39). Nevertheless, Jesse was not permitted to stay at the hospital and wound up en route back to the shelter, unaccompanied and without transportation after having a shock-inducing procedure performed on his leg. Unfortunately, his medical

equipment and medication was stolen within a matter of days, and the nurse never showed up to the shelter. The loss of all tools to ensure sufficient recovery left Jesse hopeless, and as a person who struggled with addiction, he (regretfully) turned to substance use, against doctor's orders, as a coping mechanism. This contributed to the development of gangrene and the near amputation of his leg.

If one's medical recovery is directly related to an adequate living environment, as Jesse's story shows us, then why are housing issues considered beyond the scope of hospital mandates? According to Jesse, perhaps "…the people who wrote the rules never figured that homeless people have crippling surgery too and need a safe place to recover, or maybe they did and didn't care" (Thistle, 2015, p. 38). This powerful statement draws attention to the need for a paradigm shift - one that would benefit people experiencing homelessness. Specifically, "…an integrated systems response" is needed, meaning that "programs, services and service delivery systems [should be] organized at every level - from policy, to intake, to service provision, to client flow" (Gaetz, 2014, p. 26).

If the policies of the hospital and of the shelter were in keeping with an integrated systems response, Jesse's situation would have looked quite different. In an organized system of care, intake would have involved coordinated assessment, meaning that both the hospital and the shelter would have used the same tools and framework to assess Jesse's situation. Taken a step further, a centralized intake process would have allowed some of the information collected to be pooled and shared between the organizations, thereby speeding up the administrative process and reducing duplication (Calgary Homeless Foundation, 2014; 2011; National Alliance to End Homelessness, 2013). Measures would likely have been taken to ensure that Jesse had a safe place to recover, such as a ward in the hospital, or the shelter could have accommodated him differently (through making exceptions to rules, or providing a private or smaller room). Efforts would likely have been made to monitor the nursing visits, and staff could have helped Jesse with the storage of his medication and medical equipment. In an integrated system, the hospital and the shelter would have worked together to help Jesse, their mutual client, recover.

Service Integration for Youth

Service integration has also proven useful for working with homeless youth, who are an especially vulnerable population. Much like with adults, effectively working with youth requires agencies addressing homelessness and mainstream institutions—like healthcare, social services and education—to work together (Bond, 2010).

It is important to understand that foster care is related to homelessness. Children of homeless families are more likely to end up in foster care. To this point, consider Derek's story: while his family was housed at times, they experienced recurring homelessness. This instability led to Derek and his sister being removed from their mother and temporarily sent to Merrymount Children's Centre, an orphanage (Book, 2015, p. 14).

Additionally, youth who have been in the foster system are at a higher risk of experiencing homelessness later in life. According to Gaetz (2014), "… in three separate studies, the percentage of homeless youth who reported involvement with foster care or group homes ranged from 41 to 43 percent" (p. 40). Through Joe and Rose's lived-experience stories, the foster care system is shown to be insufficient. They both needed additional care that would have been best provided through an integrated model, which potentially could have prevented their later experiences of homelessness.

One might wonder why this care is lacking, when the very purpose of foster care is to remove children from unsafe environments and provide them with an overall better life. One reason is that children are not always given therapy to help them address the trauma and hardships they've lived through. The experiences leading up to entering the foster care system, being removed from one's family (family dissolution) and not ever having known one's biological family can all be very traumatic (Gaetz, 2014).

Although Rose considers herself fortunate for her positive experiences in foster care, she struggled with being separated from her biological parents and with life in foster care in general. Her foster-mom recounted that she used to "get literally sick" from the strain of living apart from her birth parents; this was only remedied by uniting Rose with her parents for a visit, which broke the rules of the foster care system (Henry [Rose], p. 25). Along

with the stigma a misdiagnosis of 'mental retardation', Rose suffered from a loss of culture because her family of origin was Aboriginal and her foster family was not. To this effect, Rose recalls that:

> *Regardless of all my parents' efforts, I still ended up homeless as a consequence of the Sixties Scoop[1]. Going through the Scoop left me wondering which world or culture I belonged in, white Canadian or First Nations society. I was torn between the two (Henry [Rose], 2015, p. 25).*

Joe's story is also relevant here. He too struggled with the circumstances that had brought him to foster care: essentially, his mother "rejected him, as his father had, leaving him abandoned to the care of the Children's Aid Society" (Thistle, 2015, p. 73). Even after Joe had been given the opportunity to heal from his traumatic childhood in a foster home with a more positive environment and a caring foster-parent, he still sought "the pieces to the puzzle of his past" (Ibid, p. 67). This quest for answers ended with further rejection from his mother after he had left the foster care system, resulting in a mental breakdown, institutionalization in a mental health facility and eventually, homelessness.

In addition to the family of origin issues I have just discussed, Joe's story contains a crucial reminder that that foster care placements can be extremely abusive environments that may lead to further trauma. In addition to his family-of-origin issues, Joe was exposed to a great deal of physical abuse, sexual abuse and exploitative labour in foster care.

Joe and Rose's stories demonstrate that foster care, functioning independently, does little to address various traumas that children in this system may be living with, and, in Joe's case, foster care environments were another source of trauma. For these reasons and more, it is beneficial to move toward a 'system of care' approach where services are provided to children, youth, and their families, based on values and principles that allow for assured access to support for recovery from emotional disturbances. Some North American cities have adopted a system of care approach, and the model has also

1 "The term Sixties Scoop was coined by Patrick Johnston, author of the 1983 report Native Children and the Child Welfare System. It refers to the mass removal of Aboriginal children from their families into the child welfare system, in most cases without the consent of their families or bands." From http://indigenousfoundations.arts.ubc.ca/home/government-policy/sixties-scoop.html

been included in the Calgary Homeless Foundation's Ten Year Plan to End Homelessness (Gaetz, 2014).[2]

Consistent treatment aimed at addressing the emotional stresses surrounding Joe and Rose's experiences in foster care could have helped them work through their issues, and would have made more space for healing and recovery in their lives at earlier ages. Contributing to healthy emotional development of youth in foster care, and high-risk youth in general, can serve as a successful deterrent to homelessness, but it requires service integration. Such integration, specifically geared toward youth, is indeed possible. In the context of Canadian communities, one of the top examples of this type of approach is that of Hamilton, Ontario, where:

> *[…] the range of street youth serving agencies in the city actively collaborate to ensure that the needs of young people who become homeless are met through collective planning, integrated service delivery, and a desire to ensure young people's needs are appropriately met by a seamless and comprehensive range of services (Gaetz, 2014, p. 27).*

Hamilton's Street Youth Planning Collaborative is funded by the local Social Planning and Research Council, and has worked with local agencies to develop and implement an integrated strategy. This has made it possible for various services and programs to adopt the same mandate of supporting 'healthy adolescent transitions to adulthood,' thereby allowing agencies to set competition aside to focus on serving youth and preventing/addressing homelessness.

Conclusions

Service integration calls for agencies to shift away from functioning independently, without reference to one another, toward a more cooperative approach where shared mandates of addressing homelessness are created (Gaetz, 2014). When agencies work on bridging the gaps between the mainstream and homelessness services that so many people experiencing homelessness access simultaneously and consecutively, they can serve their clients more efficiently, and can therefore sometimes help to prevent and

2 For information on the Calgary Homeless Foundation's System of Care approach, go to: http://calgaryhomeless.com/what-we-do/system-planning/

address homelessness. This approach is beneficial for individuals, families, adults and youth; and can be undertaken in a system of care model (Gaetz, 2014; Calgary Homeless Foundation, 2014; Calgary Homeless Foundation, 2011) that includes coordinated intake and case management.

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