

**Strategies for Health Promotion: The Annex Harm Reduction Program**  
**Introduction and Part One**  
**Natalie Comeau (990230576) – February 18, 2005**

**INTRODUCTION**

The Annex Harm Reduction Program (hereafter referred to as the Annex) is both a component of, and a compliment to, Seaton House Men's Hostel. Located in downtown Toronto, Seaton House and the Annex within it serve the most marginalized of homeless men. The Annex is primarily noted for being Canada's first 'wet shelter' or 'alcohol maintenance program.' It also features Canada's first infirmary and palliative care program for the homeless, as well as the first training program for medical students in the area of homeless health.

The goal of this report is to develop an understanding of the Annex as a health promotion strategy, by analyzing it according to basic health promotion principles and the Interactive Domain Model or IDM (Goodstadt & Kahan 2001, 2004). The IDM will be used to structure the report, define health promotion concepts, facilitate the creation of an ideal health promotion response, and recommend a course of action that will bring the current Annex program closer to the ideal. Information about the Annex was made available through interviews and discussions with the program creator and director, Arthur Manuel, as well as a counselor and a client service worker, who each have five years experience at the Annex.

**Issue and Response**

The Annex was created to respond to a homelessness crisis in 1995, in which three homeless men froze to death on the streets of Toronto. The subsequent Coroner's inquest found that a number of homeless men, who used alcohol, would avoid all of Toronto's 140 shelters because each required abstinence (Bernstein 1997; CAMH 2005; Wysong 2002). As well as providing immediate sustenance, including food, safety and a place to sleep, the shelter system is

the first point of access for homeless men to get off the street and into contact with services that offer more permanent alternatives to homelessness, including ongoing medical care, counseling, and housing referrals. Without shelter support, most men are caught in a ‘revolving door’ between emergency rooms, jail, and the street.

The Annex is the response that program director, Arthur Manuel, came up with when given “a green light to do something” about homeless alcoholics. In contrast to other shelters, the Annex does not require abstinence to reside there, and currently serves limited quantities of alcohol to clients who comply with their case plans. This creates an opportunity to break the revolving door cycle and open the first gateway; if men decide to enter and stay at the shelter because they are served alcohol, they are better able to access other services that will help them stay off of the street.

Over the last nine years, the Annex has expanded to be an alternative for those men who are non-functioning because they are marginalized, vulnerable and in need of substantial care. The Annex now houses men who are psychiatric survivors and those with severe addiction, concurrent disorders, severe behavioural problems, and/or a long history of homelessness. The men who constitute this population<sup>1</sup> are also referred to as “chronically hard-to-house,” but this more accurately describes their chronic exclusion from social services. The purpose of the Annex is to provide residential stability for those who cannot be served or sheltered anywhere else and to facilitate life changes. Homelessness among these most marginalized of men continues to be a problem in Toronto, and over the years the Annex has grown exponentially to respond to this issue.

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<sup>1</sup> Throughout the report, the “population” refers to men who are eligible for care at the Annex, which include homeless men who are the most marginalized and non-functioning. Contrary to most health promotion literature that would characterize this group as a “community” and the social environment around them as the “population,” the terms in this report are switched to reflect a lack of cohesion and stable characteristics among this group of men.

## Health and Health Promotion

Health promotion is a “values-based approach to promoting health” (Raphael & Bryant 2002) that takes a critical look at the socio-environmental context in which individuals live. In Canada, the *Ottawa Charter* (1986) is most often used to define health promotion:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

These definitions structure health promotion activities around certain ideal goals, values and assumptions that are rooted in social justice. The *Ottawa Charter* states that shelter is one of the fundamental conditions and resources for health; others include peace, education, food, income and equity. The purpose of health promotion activities is to secure these prerequisites by advocating, enabling and mediating.

It is important to understand that health promotion has a very particular definition of health. In contrast to negative or biomedical definitions, which suggest that health is the absence of disease, the *Ottawa Charter* and other advocates (Epp 1996; Ewles & Simnett 2003; Laverack 2004) suggest positive definitions of health as a state of well-being. Health is physical, mental, emotional, social and spiritual wellness. Health is the ability to function. It is implied that health is a continuum on which the potential for wellness can be achieved and compounded at different levels to create different qualities of life. This is the holistic view of health and healing.

## **Steps to Develop Understanding**

To understand and analyze the Annex as a health promotion strategy, the three components of the IDM model will be assessed. Part one of this report will critically examine the foundations on which the Annex rests. Part two will examine the strategies used in the program, as well as the environmental contexts in which the program operates. These two parts will describe a complete picture of the current program and how it can be characterized as a health promotion strategy. Part three will utilize the IDM to suggest an ideal health promotion response to the issue of homelessness among non-functioning men, identify gaps and limitations in the current response of the Annex, and propose an action plan to bring this response closer to health promotion ideals.

### **PART ONE: THE FOUNDATION**

The goals, values and assumptions held by the Annex staff are vital to the program's function, and are the absolute driving force in its growth. Processes of strategy discernment and day-to-day decision-making are rooted in the foundation, which is composed of three layers: goals and objectives; values and ethical positions; and theories, beliefs and assumptions. Formal and informal sources of evidence also contribute to the foundation. Aside from explicit goals and theories, the other parts of the Annex foundation are implicit in the strategies used and decisions made. The Annex has not constructed specific mission statements, vision statements, objectives or values and these, therefore, are not available in written or oral formats. Based on personal communications with staff, the author has inferred the components of all sections of the foundation and how they relate to health promotion, except the primary goals and identification of theories. The strengths and limitations of this proposed foundation will conclude Part One.

## I. Goals and Objectives

According to Goodstadt & Kahan (2005), the Annex' goals are what they are trying to achieve. Goals are their intended outcomes or impacts. Objectives are the observable or measurable results of specific activities that the Annex undertakes to achieve its goals.

The primary goals of the Annex are identified as:

- To reduce mortality and morbidity among the most marginalized and vulnerable of homeless men
- To provide residential stability

The secondary goals of the Annex are identified as:

- To increase stability, function and health among individuals in this population
- To create a program that removes the barriers, and offers opportunities, to break the revolving door cycle between jail, emergency rooms and the street
- To direct clients onto stable and healthy life paths and to journey with them as far as they desire

The objectives of the Annex are identified as:

- Reduced mortality and morbidity in this population of homeless men
- Provision of shelter for this population
- Increasing numbers of men who come into the program instead of staying on the street
- Increased self care and healthy decision-making among clients
- Improved physical and mental health outcomes for clients
- Increased ability for clients to access social services, such as medical care, stable food sources, identification, substance abuse treatment, housing support, legal and financial counseling, job counseling, social support and counseling
- Positive shifts in physical, environmental and social determinants of health

Annex goals and objectives can be matched to the health promotion goals and objectives suggested by Epp (1996), Goodstadt & Kahan (2001, 2004) and the *Ottawa Charter* (1986). The main goal of health promotion is to increase the health of individuals and communities. Health promotion objectives that are exemplified by the Annex include: enriching individual and community life; creating supportive environments; facilitating the development of personal skills; increasing preventive action; enhancing people's ability to cope; and fostering self care.

Though it appears that the primary goals of the Annex concentrate on a negative definition of health, the Annex meets health promotion's goal and objectives, if the focus is

shifted. The Annex helps men improve their health and quality of life by strengthening their access to resources and their personal capacities. This has the effect of reducing harm (morbidity and mortality) in the short and long-term.

After promoting healthy qualities of life, strengthening personal capacities is the biggest overlap between the Annex and health promotion objectives. The Annex program is designed to facilitate life changes, which are not the same as ‘lifestyle changes.’<sup>2</sup> Life changes refer to changes in environments, relationships and access to resources, as well as the development of decision-making skills, behavioural skills and coping skills that aim to increase functioning. The Annex supports life change through increasing individual control, which is vital to empowerment, another health promotion objective.

Other objectives of health promotion include: building healthy public policy, facilitating social justice and equity, strengthening community action, reorienting health services, contributing to healthy environments, encouraging participation, sharing power and building alliances (CPHA 1996; Goodstadt & Kahan 2001, 2004; *Ottawa Charter* 1986). Some of these latter principles are achieved by the Annex as a consequence of meeting their primary goals and objectives. Others are being increasingly employed by the Annex as strategies to facilitate the program’s growth, though they are not currently seen as primary drivers for the program (see part three for a more detailed exploration of this transition).

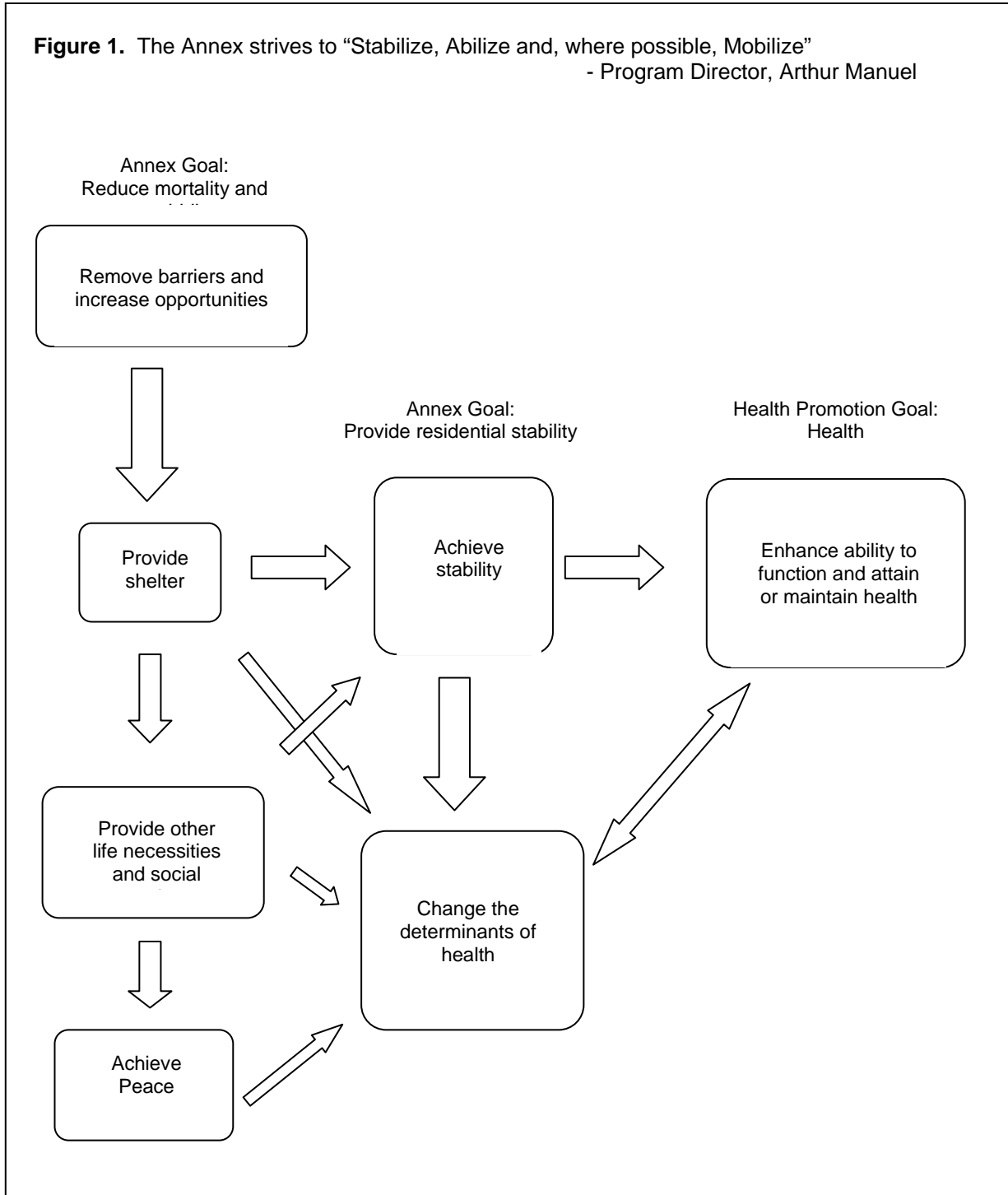
Figure 1 examines how Annex goals and objectives build upon each other sequentially and overlap with health promotion goals and objectives. While the intent is to read down the

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<sup>2</sup> The approach of ‘lifestyle change’ in contemporary and popular health promotion practice most often includes strategies that stress lower-risk choices for those located in middle and upper-class strata, such as healthy eating or anti-smoking campaigns. This approach emphasizes individual responsibility and assumes the freedom, desire and ability to make and implement lower-risk choices. Its goal is to create individual behaviour change by reinforcing dominant power relations and moral judgments that are dependent on receiving, and complying with, information about risk reduction that comes from outside the individual.

'columns,' which map the impact of each primary goal, each component in the figure can also be conceptualized as an aim, a strategy and an outcome, depending on where one begins to read. If all arrows are reversed, the underlying drivers of decision-making, and the outcomes or strategies of the Annex program, are exposed.

**Figure 1.** The Annex strives to “Stabilize, Abilize and, where possible, Mobilize”  
- Program Director, Arthur Manuel



## II. Values and Ethical Positions

Values and ethical positions are one group of drivers that influences decision-making.

Values are the preferences and priorities that are shared within the Annex community (Goodstadt & Kahan 2001, 2005). Ethical principles “provide guidelines for appropriate values-based conduct” (Goodstadt & Kahan 2005).

The values of the Annex are identified as:

- Social justice
- Respect
- Patience
- Compassion
- Tolerance
- Acceptance
- Unconditional support
- Individual choice and responsibility
- Honesty and pragmatism
- Accessibility
- Equity
- Human rights, especially the right to life, health and shelter, among other basic necessities

The ethical positions of the Annex are identified as:

- Dignity: Respect the life, death and choices of each individual by supporting him
- First, Do No Harm: The first principle of the Hippocratic Oath
- Help Others: People have a duty to contribute to each other’s health and sustainment
- Client-centered: Prioritize the client and his needs and experiences
- Firm Compassion: Consistency in respect and the expectations of conduct lead to peace, which is vital to the program’s function and the safety of the clients and staff
- Discernment: Assess each situation individually and choose appropriate actions based on the potential consequences of that action
- Positive reinforcement: Judgment and forced behaviour changes will not lead to positive life change

Annex values and ethical positions can be matched to health promotion principles of social justice, respect, equity and holistic health (CPHA 1996; Goodstadt & Kahan 2004). The Annex aligns itself with health promotion’s support of the power and dignity within each

individual (CPHA 1996), the effects that social and environmental determinants have on health, and the rights of individuals to the basic necessities of life and health (*Ottawa Charter*).

### **III. Theories, Beliefs and Assumptions**

The theories listed below are ways of systematically viewing the problem of homelessness and the Annex solution. These theories are descriptive ways of understanding the history and direction of strategies used at the Annex, rather than being tools that are consciously employed by the staff in daily decision-making. The theories of homelessness and harm reduction are combined with the Annex' values and goals to produce beliefs, all of which are rife with assumptions about the nature of the problem and response.

#### *Theory of Homelessness*

The black hole theory of homelessness is also called the stage theory of homelessness (personal communications with Mr. Manuel, echoed in Austen & Sirko 2003) and explains the nature of the problem (see Figure 2). Homeless people either pass through the stages sequentially or are able to secure housing and leave the street and/or shelter. The first stage is usually precipitated by a crisis, such as a loss of employment or social and community support. While all homeless people experience the first stage, 70% will find homes and leave the street/shelter within a week. The second and third stages are usually experienced by those who have mental illness, addictions, concurrent disorders, behavioural problems or poor physical health. Out of this 30% who will continue to be homeless and will begin cycling through various institutions, 24% will find homes within a year, with the aid of social services. The remaining 6% will experience chronic homelessness and will live in streets/shelters for 1 to 30 years. Annex clients have been homeless for an average of 15 years.

This final stage is that of the “black hole,” when the chronic homeless become “decompensated.” Their new standard is the street/shelter and their capacities and resources decrease in a downward spiral. An enormous amount of energy is directed towards this group, with little impact:

Our emergency response system is not designed to handle these people, who present in emergency rooms with a multitude of physical, mental, emotional, and personal problems including schizophrenia, clinical depression, chronic alcoholism, diabetes, cirrhosis of the liver, level four cancers, no personal identification or money, no family or friends, and with no intention of giving up alcohol. (Austen & Sirko 2003)

This 6% uses 54% of the resources directed toward the homeless. The entire purpose of the Annex continues to be to respond to stage-three, chronic homeless men, and all strategies are designed to support them.

**Figure 2.** Stage Theory of Homelessness

	Stage One	Stage Two	Stage Three
Amount of time as homeless	2 days – 1 week	Up to 1 year	1 year +
% of homeless who experience this stage	100%	30%	6%
Capacities	Need support	Are stunted	Are damaged or non-existent
Amount of support needed for change	Low	High	Extremely high

*Theory of Harm Reduction*

The theory of harm reduction explains how and why the Annex chose to approach chronic homelessness with their specific type of programming, as well as how its efficacy can be evaluated.

Harm reduction is grounded in the empirical knowledge of a continuum [of activity] where harm may occur at any level... The primary focus of harm reduction is on people who are already experiencing some harm ... The most appropriate interventions, whether macro or micro, are those geared to movement from more to less harm. (CAMH 2003)

Harm reduction strategies encourage the achievement of immediate and realizable changes, over hoping for dramatic and idealistic changes in the future. The reduction of harm happens incrementally and constant re-evaluation is useful to ensure efficacy. Harm reduction's tenets include: pragmatism; respect; evidence-based practice; non-judgment; tailored needs and responses; flexibility; improved quality of life; prioritizing individuals' goals; and empowerment (CAMH 2003; Cavalieri 2005; CHRN; HRC 2001). Respect for autonomy and individual decision-making is a core principle that differentiates harm reduction from other ways of trying to reduce harm, including criminal justice sanctions or abstinence-only programs that increase stigma, punishment and long-term harms (CAMH 2003).

It is easy to see that these tenets overlap with the goals, objectives and values of the Annex and of health promotion. The concepts of empowerment and holistic health are central to both health promotion and harm reduction. Instead of stigmatizing past choices, behaviours or circumstances, harm reduction encourages capacity building by focusing on the individual's ability to make healthy decisions in present situations. This overlap in approaches may be the reason Mr. Manuel states, "Harm reduction is what we used to call good social work."

### *Beliefs and Assumptions*

The theories of homelessness and harm reduction, along with the Annex' goals, objectives, values and ethical positions, are dependent on specific beliefs and assumptions for their continuation. Beliefs are propositions that are held as truth (Goodstadt & Kahan 2005). The following beliefs and assumptions guide decision-making in planning Annex strategies.

Beliefs and assumptions about the nature of the problem of homelessness are based on staff experience with clients, as well as evidence from the program and outside sources. These beliefs explain the significance of homelessness and how society works to perpetuate it.

In regard to the nature of homelessness, the Annex believes that:

- homelessness escalates, deteriorates, cycles and confines
- men who have lived on the streets the longest are the most marginalized and non-functioning
- shelter is a fundamental determinant of health and functioning
- current criminal justice, medical and social systems are inadequate and detrimental; they inflict harm on this population by not offering the support required, by being hard to negotiate for someone seeking care, by being compartmentalized and hard to coordinate, and by lacking staff training and program standards of action on homelessness
- for this population, there is no other alternative to the street
- homelessness results from, and exacerbates, a loss of control in one's surroundings and/or behaviour
- clients experience anger and a loss of hope on the street and will resist help for varying periods of time
- social, legal and medical systems are hard to manage, not the men themselves<sup>3</sup>

Other beliefs and assumptions explain how change happens and guide decisions about how the program can be implemented and evaluated.

In regard to how change happens, the Annex believes that:

- there are alternatives to death, loss, illness and depression
- there are alternatives to homelessness
- everyone deserves and has a right to life, health and a home, among other basic necessities
- shelters provide the physical space that is required for accessing other services
- providing shelter removes the largest barrier for accessing these services
- shelters provide stability that allows opportunities for the acceptance of other services
- stability is necessary for healthy decision-making
- providing access to alcohol removes one barrier for entering shelters and facilitates clients staying in the program
- life change is possible, though it may take time
- change can occur within individuals and, therefore, tailored approaches are useful
- small changes add up to create a dramatic life change
- at some level, at some time point in time, the client will have a desire to change and this desire is the biggest facilitator of change, if support programs are readily accessible
- clients will stay in the shelter when they recognize that the benefits of staying outweigh the costs
- controlling choices, environments and behaviours are possible and desirable for healthy functioning

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<sup>3</sup> This is Mr. Manuel's response to the characterization of Annex clients as the "hardest to manage" of all the homeless.

- strategies for giving support should be practice and action-oriented; guidelines for efficacy are developed from experiences of trial and error
- staff can make demands of clients and take action to protect the peace and safety of those in the shelter through the use of minimal rules and social control
- change does not happen in a vacuum: staff, physical space and other environmental influences must be supportive
- evidence of program efficacy is drawn from a variety of sources: personal experiences with clients, staff and the community; subjective and objective changes in the mental and physical health of clients; reduced morbidity and mortality in the larger community; economic savings in social systems
- it is the role of public, and medical, health systems to address the issue of homelessness by reducing harm and promoting health

The Annex espouses the following health promotion beliefs and assumptions:

- health is holistic and exists on a continuum
- social structures influence health
- individuals cannot reach a state of health completely on their own, because of limitations in their resources or capacities
- it is the role of health promotion to work towards a more equitable distribution of resources
- it is possible to facilitate change by mediating, enabling and advocating

Ultimately, the Annex assumes that giving people the help that they need is the purpose of well-executed social work, harm reduction and health promotion. This assumes that an individual or group with more resources can “give help” to those with less resources and is consistent with the initial steps in the health promotion process of enabling, wherein the promoter has more privilege than the client. In health promotion strategies that enable and encourage participation, the promoter seeks to share more and more power with the client as time passes. The health promotion value and objective of power sharing seeks to shift control to the client and this is part of the Annex’ plan to increase functioning and facilitate life change.

#### **IV. Sources and Uses of Evidence**

Evidence is “information that is used in making decisions” (Goodstadt & Kahan 2005) and, therefore, influences the approaches used at the Annex. The program’s creation was spurred by evidence that showed a service gap and demanded that this gap be filled. The 1995

Coroner's inquest found that homeless alcoholic men had no place to get shelter or other social services. There was no existing evidence from which to draw, as it was the first program of its kind in Canada. The program's design was based on harm reduction because its goals matched the outcomes desired. The results (impacts, outcomes, changes) of the strategies are the biggest sources of evidence.

The program's current function is based on experiential evidence. The Annex' continued existence is supported by evidence that there is a need for the program; it is filled to capacity every night, grows in size every year, and houses men for years of their life. Some clients have lived at the Annex since it was created nine years ago. Most clients' only experiences of shelter have been at the Annex, and without other alternatives, most clients have been permanent residents of the Annex for years. While death on the street has decreased, death in the Annex has increased. Though this occurrence is troubling, it is seen as evidence that health was fostered, because death was delayed and because it took place in a supportive and comfortable environment.

Most of the Annex' day-to-day operation is based on 'tiny wins' (small life or behaviour changes) experienced by staff and clients. The staff evaluates progress through the subjective judgment of goal achievement or life change, adherence to the program's flexible code of conduct, and adherence to the individual's case plan. Evidence of life changes includes: change in behaviours and capacities (developing manners, getting a job, reuniting with family, developing friendships, eating well, decreasing drinking); change in access to services (counseling, health cards, ID cards, medical help, job placement, housing placement); improvement in mental and physical health; and reducing the possibility of future harm. Experiential evidence is readily and immediately available, and is thus part of the feedback loop

in which individual strategies are tailored to each client. Tiny wins and large changes also encourage clients and staff to keep working together.

Evidence of the program's efficacy is also available in, and from, outside sources. The theories of homelessness and harm reduction support the Annex' approach by presenting evidence that demonstrates the efficacy of certain types of interventions with homeless men. Two major investigations have documented evidence of the effects of the Annex in the homeless population and the larger community. The first evaluation was performed by the City of Toronto after the first year of operation (Bernstein 1997). It provided evidence of the need for the program and recommended its continuation. A second evaluation has recently been performed by the Annex' medical doctor, Dr. Tomislav Svoboda, for his PhD. It provided evidence of the social, time and economic cost savings that the Annex provided by reducing the use of criminal justice, medical and social services. This theoretical and research-based evidence is used primarily by those who are not located within the program, perhaps because they do not have access to experiential evidence and perhaps because they have different goals than the Annex.

## **V. Strengths and Limitations of the Foundation**

### *Strength: Broad Definitions of Health and Healing*

As mentioned previously, the Annex' original and primary goals emphasize negative definitions of health. Upon examination it becomes clear that Annex objectives, values, assumptions and theories are based on broad, positive definitions of health used by health promotion. The goal to reduce barriers and increase opportunities also reflects the aspects of empowerment and social justice that are central to holistic health. The use of harm reduction has reinforced this breadth and allowed flexibility in creating approaches that treat and prevent disease, and enhance the quality of life of non-functioning homeless men.

*Strength: Flexibility*

Since most of the components of the foundation are implicit, there is no tension between ideals and realities. Practice is always rooted and relevant because the main, and only explicit, decision-making guide indicates that staff just “do what has to be done” to reduce harm and increase functionality in any given situation. Another strength of having few explicit foundations is that approaches can be tailored to meet individual needs. Efficacy is developed through experience and interaction not by following a recipe. Other groups can learn, but not copy, the Annex program, which results in resource and capacity building among staff.

*Strength: Multiple Levels of Impact*

By supporting individual men, who are non-functioning, the Annex is having an impact on this homeless population as a whole and on the larger community in which these men are situated. The pragmatic and tailored approaches that the Annex employs have resulted in changes at various levels of society. At the micro level, individual men are given support to get into, and stay within, the shelter. This results in increased individual capacities. At the meso level, the most marginalized homeless are sheltered and their addictive, mental and behavioural problems are addressed. This results in a more equitable distribution of the basic necessities of life for this population. At the macro level, homelessness, homeless death, crime, poverty and economic and time costs are reduced.

*Limitation: Implicit Foundations*

The implicit nature of the foundations does make it hard to apply the Annex program elsewhere. It also makes it difficult for the Annex to self-evaluate, grow and affect broader social policy in the area of homeless health. A lack of systematically collected and documented evidence also hinders self-evaluation and replication in other communities.

*Limitation: Role of Relationships*

There is a lack of information and indication of the role of relationships in the foundation. It is unclear what the Annex assumes about human nature and the capacities of its clients and staff. It is unclear how clients and staff view and relate to each other. For example, it would be helpful to know how power relations are formed and maintained. It is very hard to infer the impact of these relationships on the operation of the Annex, without observing interactions. However, a superficial understanding of the role of relationships will develop in Part Two's description of strategy implementation.

*Limitation: Experiential Evidence*

The uses of evidence at the Annex are congruent with how health promotion uses evidence. The use of experiential evidence reinforces the definitions of, and contributes to the attainment of, holistic health and healing. Both the Annex and health promotion, as a discipline, are currently faced with increasing demands for formal research and evaluation, and for the creation of evidence-based practice (or documentation-based practice). These demands may limit the future of Annex and health promotion strategies, as they currently operate, by restricting funding and other resource supports.

**Defining Shelter, Providing Hope**

Mr. Manuel's description of the Annex as being the "antithesis of other shelter programs" indicates that the Annex has a unique purpose in Toronto. In contrast to shelters that offer security and custodial care, jails that offer holding cells for punishment, emergency rooms that offer temporary respite, and streets that offer disease and death, the Annex offers a sanctuary, a home, and, most importantly, the only alternative. The Annex seeks to bring men *into* the

program and to rehabilitate them *within* its walls. The Annex will encourage clients to leave only if they have a better place to go, which is rarely a possibility.

The foundations of the Annex make it different than every other shelter in Toronto. Holistic health and healing are possible when health promotion and harm reduction principles are applied in a sanctuary setting. In this shelter the foundation is securely constructed, and the woodwork of its frame is exposed. The Annex operates by keeping this frame, or purpose, in sight at all times. Part Two will examine how environments impact the operation of the Annex and how they interact with the foundations to guide the strategies used.

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**Strategies for Health Promotion: The Annex Harm Reduction Program  
Part Two and Three: Environmental Contexts and Practices  
Natalie Comeau (990230576) – March 30, 2005**

**Changes made to Part One:**

- Annex uses negative definition of health
- Annex goals and objectives that match with HP: increase access by creating supportive environments, develop personal capacities
- do do lifestyle/behaviour change, but also address SDOH (directly and indirectly)

**PART TWO: ENVIRONMENTAL CONTEXTS**

According to Arthur Manuel, “change does not happen in a vacuum.” He stresses that every detail of the Annex’s environment is consciously decided-upon, whether it is planned far in advance or chosen on the spot. Decision-making is dependent on maximizing situations, relationships and resources. This results in a unique approach that must be fostered if the Annex is to continue to reach its goals.

**I. Nature and Origins of the Issue of Marginalized Homeless**

The Annex program was created as the response to the issue of homelessness among vulnerable men in Toronto. The theory of homelessness and the beliefs of the Annex staff present micro theories of why homelessness exists in this population. Losses of employment, family, money, and/or social support create crisis situations in which individuals will find themselves struggling to survive (and function) without a home. The onset of physical and mental health issues may lead to self-medication and concurrent disorders, making it even harder to access supports for these issues and find a home. The Annex believes that the men that they house are chronically marginalized because of their alcohol, behavioural, physical health and mental health dysfunctions. The Annex aims to help these men regain their functioning in as many areas of life as possible.

Macro theories of why homelessness exists seek to explain why social and material losses occur. Mr. Manuel describes how general economic recessions and cuts to social services, including various types of health care and income provision, may precipitate or exacerbate losses.<sup>4</sup> He notes that homelessness is reinforced when medical, criminal justice and social systems are unsupportive, compartmentalized and hard to negotiate. Homelessness is also reinforced through stigma and social sanction in personal relationships, in relationships with one's community, and in relating to institutional systems.

According to the Annex and to health promotion, homelessness is a health-related issue because housing is a prerequisite for, and social determinant of, health and well-being. Homelessness among Annex clients directly influences their health by contributing to their physical and mental diseases and by creating barriers for them to get help related to their diseases. Homelessness also indirectly creates barriers for accessing other prerequisites of health, such as a stable food source.

Vulnerable homeless populations have fragile relationships with shelter systems and often make up a large part of the "absolutely homeless," a group who does not use shelters (Gaetz 2004). Many of the absolutely homeless suffer from mental health and addictions issues, or concurrent disorders, which compromise their ability to overcome the barriers to accessing health care and shelter services. Homeless men who suffer from mental health and addictions

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<sup>4</sup> Mr. Manuel 'credits' Ontario government cuts to welfare and a general devolution of social support systems with contributing to homelessness in general. In a report to the UN on homelessness, Hulchanski (1998) stated that stricter regulations for welfare, disability and unemployment supports (as well as their benefits) were enforced in the early 1990s, which coincided with an end to federal spending on social housing in 1994, and resulted in a decrease in renters' incomes and a general increase in homelessness (see also Gaetz 2004). A lack of national housing program (implying political prioritizing) is cited as one of the biggest obstacles to overcoming homelessness (Crowe 2004, Hulchanski 1998).

issues are more vulnerable to illness and injury, less likely to be allowed entry into shelters, and more likely to be discriminated against by medical, criminal justice, employment, income and housing providers, as well as other homeless people and community members (CAMH 2005; Crowe 2004; Gaetz 2004). Mr. Manuel argues that the deinstitutionalization of those with mental health issues is contributing to the numbers of marginalized homeless.

## **II. Response to the Issue of Marginalized Homeless**

The current response to the continued issue of homelessness is dependent upon the Annex's success in operating as an organization. The Annex organization influences, and is influenced by, external and internal environments.

### A. External Environment: Analysis of Political and Economic Factors

#### *Initial Socio-Political Climate*

It was a 1996 Coroner's Inquest that made the issue of homeless among marginalized men into a crisis in Toronto. The Inquest found that some homeless death was caused by a combination of homelessness and alcohol use (Bernstein 1997; CAMH 2005; Wysong 2002). Alcohol users were barred from, and resisted entering, Toronto's shelters because the programs required abstinence.

It is not clear why the deaths of three homeless men, within one winter, shocked the city (Crowe 2004) and spurred the creation of the Annex. Three does not seem like a large number, so the author wonders what sort of political climate existed to support of a harm reduction response at that time. Housing advocates were seeing increasing homelessness, particularly among people with severe health issues (Crowe 2004). Perhaps their voices were strong and unified. Perhaps economic interests prevailed; the Coroner's Inquest uncovered that many homeless alcohol-users were not using the shelter system, but were using many emergency

medical and criminal justice services. The vulnerable homeless were identified and labeled as the ones who were most troublesome to the city in terms of financial and human resources.

Certainly, the Inquest drew attention to the ongoing problem of homelessness, and some powerful interest group was watching, as money was made available to Seaton House to start the program. It is also unclear why Seaton House was chosen (or offered) though the program is known for housing the “worst” of the homeless (those most disturbed and disturbing).

Unfortunately, the issue of homelessness among marginalized groups is only increasing and calls for harm reduction, supportive housing and other specialized shelter programs for homeless people with mental health and addictions issues are still being made (CAMH 2005; City of Toronto 2003; Crowe 2004).

#### *Current Stakeholder Influences*

Beside staff, clients and housing advocates, the Annex receives support and direction from other stakeholders. The Annex has working relationships with Toronto Public Health (TPH), St. Michael’s Hospital (SMH), the Rotary Club, and of course, Seaton House and its other programs. TPH helps the Annex track homelessness and control infectious disease outbreaks, such as a recent tuberculosis outbreak. SMH and the Rotary Club have helped coordinate financial and human resources to provide more diverse medical care. Seaton House provides parallel services, including programs for those men who are sober (regular shelter beds and services) and for those who need acute behavioural modification (O’Neill Risk Reduction Program). The Annex also tries to keep a positive relationship with the surrounding community by having an open house each year.

The provincial and municipal governments currently fund the Annex, which has an operating budget of approximately \$2 million per year (Elliott 2001; Mr. Manuel). In 2002, the

Rotary Club of Toronto donated \$350,000, which was combined with \$150,000 from the federal government's National Homelessness Initiative, to create the Annex's infirmary (News Release 2002; Rotary Club 2005). Part of the infirmary's operation is dependent upon the participation of medical professionals, including residents and nurses from SMH. Political climates and stakeholder resources are related to each other and influence the operation of the Annex by putting constraints on, and giving opportunities for, the program's ability to provide services.

### B. Internal Environment: Analysis of the Organization

As a program, and mini-organization within Seaton House, the Annex has a powerful internal environment that influences its operation and success. The internal context is made up of socio-structural components that include physical influences (place), social influences (staff), and emotive influences (atmosphere), all of which contribute to the clients' health. It is the combination of space and staff that results in a certain atmosphere at the Annex.

#### *Place: Physical Context*

The Annex is located on the third floor of Seaton House, a huge shelter that is 4 stories high and is the size of a city block. The Annex's main common area has three lounges, a small room with the bar, a smoking room, a balcony, an office for the five counselors, a shift coordinator's office, and the front desk/meeting space. Off this main area are two wings of sleeping spaces with 2-4 beds and lockers in each room. At the end of one wing is the Infirmary, which offers rooms with two beds and fully wheelchair-accessible bathrooms in each one. The nurses' station, doctors' conference room, medical clerk's office and program director's office are located at the end of the infirmary. The Annex provides about 135 beds in total, 32 of which are devoted to the infirmary. Once on the third floor, the program is only accessible through a set of locked doors, though clients are free to come and go at any time. The large amount of space

that is dedicated to the clients, and relatively little amount that is dedicated to administration, is indicative of the program's priorities.

From observations, the author found the Annex clean but sparse. All of the physical features are functional, except for the TVs and games tables in the lounges. While the sleeping spaces are clean and tranquil, the common areas would feel more institutional if there were not so many people interacting in every space. Seaton House was renovated, both structurally and aesthetically, between 1999 and 2001 and the Annex is currently renovating its main area by painting and reorganizing. It will be interesting to see how these renovations influence the feel of the space. The only artwork present was painted by one of the clients to decorate the wall of an additional storage/games room located in the main area, which is currently not in use. There are plans to continue this artwork and make the room into a quiet space for reading or family meetings. One counselor felt that the quiet room would foster mental health by facilitating education, creative pursuits, calm reflection and personal interaction.

The space is functional, which allows physical health care needs to be met. The space lacks aesthetic appeal, which is a lesser priority in terms of program planning, but which could positively influence mental and emotional healing. The lack of aesthetic appeal is particularly troubling when considering that some men spend years of their lives in the Annex, and yet this deficit is balanced by the intense and supportive social context that positively contributes to their health.

#### *Staff: Social Context*

The Annex staff is vibrant. The staff is made up of a large number and variety of people, who contribute a range of expertise while consistently focusing on the same goals and objectives as their co-workers. Current positions at the Annex include:

- **program coordinator** – oversees operation
- **counselors** – case management, counseling and resource support
- **infirmiry coordinator and medical clerk** – takes care of infirmiry files and doctor/resident coordination
- **medical doctor and residents** – provide physical clinical care (acute and chronic)
- **nurse manager** – coordinates nurses
- **annex nurses** – first aid, client monitoring, dispense medications, refer to other services, hygiene care
- **infirmiry nurse** – same as annex nurse but works in infirmiry
- **psychiatrists** – provide mental health care (on demand)
- **hospital liaison** – coordinates medical pathway and gets men into emergency and other hospital services faster by using pathway
- **client services workers (CSWs)** – Help with the everyday care of the clients: take care of their day-to-day physical needs, advocacy, take them to outside appointments, social outings, bartender, informal counselor, first aid, deescalate crisis situations
- **bartender** – doles out alcohol and cigarettes according to schedule
- **shift supervisors** – oversees staff on a shift and is responsible for incidents that happen on shift
- **foot care specialist** – provides foot care (on demand)

On weekdays, all of the staff positions listed above will be represented. For example a weekday shift could include the program supervisor, a shift supervisor, 5 CSWs, 5 counsellors, the nurse manager, 2 nurses, the infirmiry coordinator, the infirmiry nurse, 2 residents, and maybe a psychiatrist. On weekends and weeknights, the CSWs provide most of the care, under the supervision of a shift supervisor. Currently, doctors are only available during weekdays, psychiatrists visit ‘on demand’ a few times a week, as does a foot care specialist, and a nurse is available between 7am and 11pm everyday. When ongoing palliative care is needed, VON and CCAC services<sup>5</sup> are provided in the infirmiry.

Staff are handpicked and trained on site. Upon arrival, all staff must complete training in the following areas: hostel standards; physical intervention; crisis de-escalation; and first aid. Training is updated every year and additional workshops are offered once a month at Metro Hall. All staff are specially chosen and ‘groomed’ by Mr. Manuel and Dr. Svoboda, who have been

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<sup>5</sup> VON stands for the Victorian Order of Nurses, CCAC for Community Care Access Centre, both of which provide home care to people who need medical attention but are located outside of hospitals or nursing homes.

consistent leaders at the Annex. Mr. Manuel describes how Dr. Svoboda refers to the Annex staff as “the navy seals of the shelter world” because of the strenuous and high quality work that they perform. Mr. Manuel states that the Annex has the reputation of having some of the best staff in Canada, and the counselor and CSWs report that they have heard finding employment in another shelter or social service system was easy for those who had previously worked at the Annex.

This social context is indicative of some of the program’s strengths and weaknesses, as well as ways in which the program contributes to the clients’ health. The staff members see their variety of backgrounds as strengths. They appreciated the diverse perspectives and talents that are constantly being offered. This diversity was not always present and has increased as the program has grown from a few CSWs and social workers, who performed all tasks, to a wider range of positions with more specialized duties. According to one counselor, the increased numbers of staff with more specialized duties has decreased burnout, because jobs have become more manageable. Burnout is a major concern and does not allow staff to attend to clients’ needs properly.

It is difficult to ascertain the nature of relationships between staff members. Some superficial observations indicate that there is both a hierarchical power structure and a more evenly distributed level of trust and responsibility amongst all staff. Mr. Manuel has grown into the position of program director and his focused vision of the Annex is apparent in all areas of its operation. His vision guides the Annex because he continually demands respect from, and gives respect to, the staff and the clients. As staff members have become more specialized, each contributes to case management by providing different information and by exerting power in different ways. For example, medical residents have the ability to address and document complex physical traumas, whereas CSWs have the ability to de-escalate crises and foster life

changes and to document these. This means that staff members are only able to contribute to the program's operation in limited ways. Specified abilities and responsibilities may interact with the large size of the staff to result in limited participation in program planning. Nonetheless, staff members do work together and they were observed doing variations of each other's tasks. More importantly, they presented a unified picture of the Annex's expectations to the clients by backing each other up.<sup>6</sup> The combination of hierarchy and high level of individual responsibility and decision-making power allows each client's case to be tailored and implemented in ways that would most effectively contribute to his health.

*Atmosphere: Emotive Context*

CSWs report that the Annex is a loud and busy place, and this is easily confirmed through observation. At any given time of day, between 100 and 150 people, including clients and staff, share the relatively small space. Isolation is non-existent and loneliness is limited. Socializing between the clients, and between clients and staff, is part of operation and CSWs are often the ones to develop the deepest relationships with clients because of their level of involvement in personal care and social situations. As loneliness decreases, and respect and trust grow, feelings of inclusion are possible. Inclusion is extremely important for marginalized people because it serves to decrease stigma, increase mental health, and increase functioning through social interaction and support. The staff reports that clients who move out of the Annex often find it lonely in the community, and they return to it for counseling and medical appointments, for meals, and for social interactions and outings, if not to restore it as their

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<sup>6</sup>During the tour of the Annex, it was observed how counselors and CSWs would communicate non-verbally to relay information to each other about a particular decision or circumstance in which they needed another's help to maintain. In one instance, a client was asking for a water bottle from the front desk when a staff member knocked on the window and shook his head, after which the member at the desk replied, "Sorry, no extra bottles here." This is how cohesion and social control are maintained.

primary residence. The on-site infirmary and palliative care program exemplifies the energy that goes into keeping clients safe, functioning, included and happy for as long as possible.

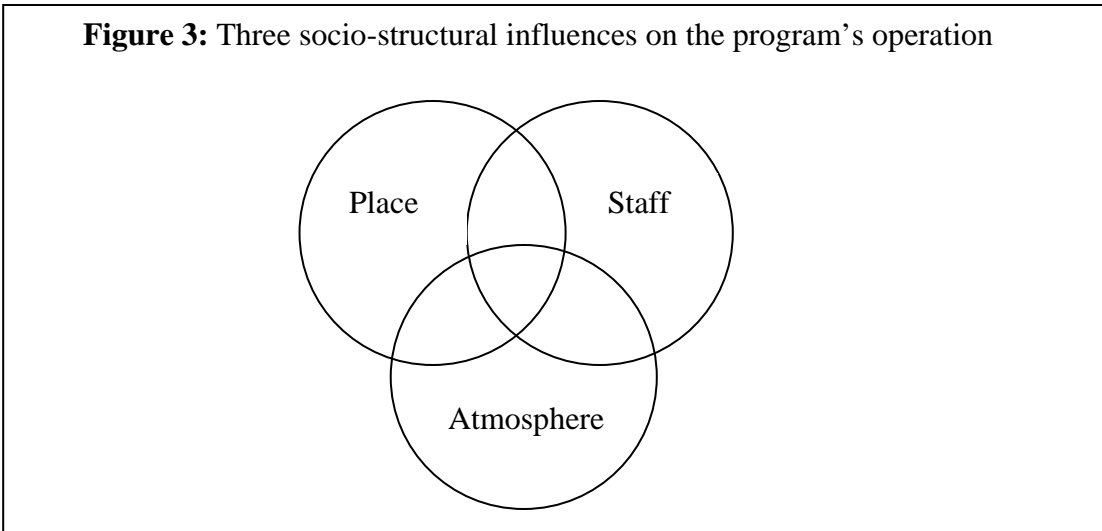
Observation and experience also reveal a remarkable feeling of peace. Despite the hustle-and-bustle, and despite the stereotypes and experiences of non-functioning men as disruptive and destructive,<sup>7</sup> the Annex is not filled with tension. When asked how peace and control are maintained with men who have severe mental, substance use and behavioural issues, Mr. Manuel replies that peace cannot be forced, but unfolds when unconditional support and acceptance create space for trust and respect to grow. Clients experience unconditional support when they are provided shelter and care even when they drink, even when they spit and swear, even when they are least functioning, even when they are dying.

It is this balance between action and tranquility that allows the atmosphere to contribute to the clients' health. Continued and singular leadership by Mr. Manuel means that there is one vision of the Annex and one way of approaching the clients to reach the program's goals. Practicing harm reduction, and prioritizing certain values and ethical positions (see part one), allows a specific atmosphere to exist that makes it possible to attend to the clients and their needs. In health promotion terms, the emotive context contributes to creating a supportive environment for healing to take place.

The relationship between the socio-structural influences can be best illustrated with interlocking forms shown in Figure 3.

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<sup>7</sup> The type of non-functioning men who are welcomed and wanted at the Annex are refused entry at other shelters because of their alcohol use, mental disorders, physical traumas, and behavioural problems, such as lack of sociability, aggressive behaviour and/or alcohol intoxication (Bernstein 1997; CAMH 2005; McNeil 2002; Wysong 2002).



### ***III. Environmental Vision***

The Annex's vision is to create a stable, peaceful sanctuary and to have an outside community that will support the shelter. This vision of the environment can be mapped onto health promotion visions as listed by Goodstadt & Kahan (2004), which include: creating structures and conditions that are health enhancing for everyone; amassing adequate resources and using them efficiently; clearly defining roles, policies and procedures; respecting people and ecosystems; and generating ongoing learning. The Annex also strives for the maintenance and fulfillment of health among the homeless men they serve, and the greater Toronto community, and tries to do this in the most efficient way. Annex policies and procedures are both clear and flexible, which facilitates ongoing evaluation and reflection and is the strength of their harm reduction approach used (see part three for a more detailed discussion). Finally, it appears that the Annex desires to create a world in which respect is more prominent.

The Annex's understanding of the power of environments is also congruent with that of health promotion. Health promotion holds that creating supportive environments is vital to health (WHO 1986), and that healthy environments include control, social and administrative support, a

functional and welcoming physical space, and a dynamic staff (Goodstadt & Kahan 2001).

Health promoters assert that time, money, human resources and evidence of efficacy all pose challenges to a program in its planning and implementation (Goodstadt & Kahan 2001). It is important to recognize the Annex's environmental vision at this point in the report because it is actively employed when making decisions about implementing practices.

### **PART THREE: PRACTICES**

The environments and the foundations influence and support the practices of a program or organization (Goodstadt & Kahan 2001). The Annex helps homeless men regain their health and functioning in as many areas of life as possible, by employing a variety of activities and strategies.

#### **I. Specific Activities Employed**

The Annex employs many activities to provide residential stability, reduce mortality and morbidity, and increase health and capacities to function. The Annex staff described the following activities, and the author inferred their corresponding purposes:

- **Place to sleep and live**
  - Approximately 32 infirmary beds, and 135 beds in total, are available; most beds are assigned to regular clients; if a regular client is absent all night the bed may be given to another client for the night; a locker for personal belongings comes with each bed; clients are allowed to stay indefinitely; meals and snacks are provided
  - Purpose: to decrease numbers of men sleeping on the streets
  
- **Alcohol provision**
  - Beer and wine are served at regular intervals according to the clients' case plans; the bar is open between 8am and 11pm and distributes wine, beer (on request and planning) and cigarettes; non-potable forms of alcohol are replaced
  - Purpose: to remove a large barrier for this population to use shelters (abstinence); to reduce the harms from drinking alcohol

- **Medical care**
  - Seaton House's doctor and residents from SMH attend to acute and chronic physical ailments and monitor clients' health over time; nurses dispense medication, address first aid issues, monitor health, provide consultations and referrals, and encourage practices for good hygiene
  - Purpose: to increase, regain and/or stabilize the clients' physical health
- **Resident Training**
  - Residents are recruited from the Inner City Program at SMH and are trained in the area of homeless health in their practice at the Annex
  - Purpose: to facilitate a greater understanding of the health issues and needs of chronic homeless men
- **Foot care**
  - Foot care specialist visits on an 'as needed' basis, particularly when clients enter the program with the most severe foot injuries
  - Purpose: to provide foot care to clients; to improve physical health
- **Psychiatric care**
  - Two psychiatrists visit the Annex regularly to assess and treat clients
  - Purpose: to provide mental health care, illness diagnosis and treatment
- **Counseling and case management**
  - Five counselors meet with clients regularly and formulate and monitor case plans for each individual; counseling and support are offered to clients; access to social services outside of the Annex is coordinated; reassessment of case plans occur after crises or if clients return after drinking outside of the program
  - Purpose: to provide various levels of support to clients; to allow constant evaluation of case plans and possible improvement in health and stability
- **Infirmery**
  - Space to provide medical care that is well-equipped; separate rooms and beds; accessible bathrooms; special case management; VON and CCAC services for 24 hour care
  - Purpose: provision of longer-term care after crisis or return from hospital
- **Palliative care**
  - 24-hour care for the dying occurs in infirmary; provided on 'as needed' basis
  - Purpose: to allow dying men to remain in their 'home' and with the people they know when they are dying
- **Fusion model: "Homeless Pathway" or "Integration and Triage"**
  - All clients sign release forms upon registering with Annex and this information is kept to increase the speed at which they access hospital services; hospital liaison contacts hospitals when emergency or non-acute care is needed and send existing personal information, medical history and release forms to the hospital

- Purpose: to facilitate quicker registration and treatment of clients who are normally kept waiting the longest in hospitals
- **Behaviour Modification**
  - Individual case management that focuses on increasing positive/healthy behaviours and choices, such as hygiene, and decreasing negative/harmful practices, such as inappropriately expressed aggression (e.g. spitting); education and information provision is mixed with coercion (usually a withholding of alcohol)
  - Purpose: to increase function and maintain a safe and supportive environment
- **Personal care**
  - CSWs provide each client with personal care by helping those who cannot complete tasks themselves, such as hygiene, eating, walking and attending social service or medical appointments outside of the Annex
  - Purpose: to facilitate daily function
- **Recreation**
  - Three lounge rooms have TVs and games tables; supervised group outings to sports games or artistic events occur when tickets are donated; both current and ex-clients are invited on outings
  - Purpose: to provide stimulation and distraction to clients who spend time at the Annex; to facilitate their mental, emotional and social health; to facilitate relationship-building
- **Identification and health card clinics**
  - Identification and health cards are acquired for each client and are kept at the Annex; photocopies are made should clients need them for outside purposes; Annex staff can vouch for a client's identity
  - Purpose: to increase access to social and medical services by removing the barrier of unknown identity
- **Social reunions**
  - Staff encourage and facilitate clients' reunions with family and friends
  - Purpose: to increase mental and emotional health; to increase rehabilitation and the possibility of breaking the cycle of homelessness by strengthening outside social supports
- **Supported abstinence**
  - Valium and other medical assistance are given to those who want to stop or decrease their alcohol intake
  - Purpose: to support abstinence and ensure its success

- **Financial program**
  - Clients may deposit money received from ODSP, Public Works or PNA<sup>8</sup> or amassed elsewhere into the Annex ‘bank;’ clients are charged for wine (about 50 cents a glass) and any beer or cigarettes they wish to purchase; staff help clients create a budget for the month and a corresponding schedule for their drinking, smoking and spending habits; payment for alcohol is withdrawn directly from their ‘account’ and predetermined amounts may be released to clients at regular intervals
  - Purpose: to increase financial stability and personal control and satisfaction by decreasing binge drinking and spending
  
- **Job support**
  - Clients who are able to work are helped to find jobs inside and outside Seaton House;<sup>9</sup> clients can work in Seaton House’s laundry room and/or do housekeeping in the Annex; clients get 40% of their wages immediately to spend or save and the Annex ‘bank’ keeps 60% of wages in savings for when client leaves the program
  - Purpose: to secure safe jobs and greater financial stability; to provide purposeful activity and foster health through skill-building
  
- **Advocacy**
  - Clients who need specific help negotiating medical, legal or other social systems are supported; counselors and CSWs attend outside meetings with clients and help them to complete paperwork, attain documents, manage crises and plan for the future
  - Purpose: to increase independence and access to services
  
- **Housing re-direct program**
  - Helps clients move into permanent housing or long-term care facilities
  - Purpose: to provide residential stability outside of the Annex
  
- **Open house**
  - One day a year when the public and surrounding community is invited to visit the Annex; show the community what kind of work is being done in the Annex and how this affects the community’s health and operation
  - Purpose: to increase outside support for the program

Currently, the Annex is operational 24 hours a day, but once had 12 and 24-hour programs. The Annex started as a 12-hour program that was only open at night; shelter and basic medical care were provided and abstinence was not required. Alcohol substitution and

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<sup>8</sup> ODSP stands for Ontario Disability Support Program; ‘Public Works’ is the current term for welfare; PNA stands for Personal Needs Allowance, which is a small sum of money that the provincial government gives to people who have no other income or assets, but who are living in a place that provides sleeping spaces and food. Current PNA rates are around \$116 a month (Annex staff; Community Living Toronto 2005).

<sup>9</sup> Most clients are non-functioning to the point that they cannot work.

provision then commenced and the program was expanded to include a day program, since it was realized that the men who had no other place to go during the night also had no other place to do during the day because of their particular needs. Today, most men live at the Annex continuously ('permanently') and those who have recently been registered also spend their days in the programs' space.

## **II. General Strategies Employed**

Like many other successful health promotion programs, the Annex is flexible in the ways it employs strategies to address the issue of homelessness. The three general strategies from the *Ottawa Charter* that are focused on in the Annex are advocating, enabling and mediating.

*Advocacy* involves working towards making political, economic, social, environmental, behavioral and biological factors favorable for health (WHO 1986). *Enabling* refers to ensuring that people have equitable opportunities and resources to achieve their fullest potential, and includes fostering supportive environments, access to information, skills building, and decision-making (WHO 1986). *Mediation* involves coordinating action and facilitating communication and work between diverse interest groups (WHO 1986).

The Annex spends most of its energy and activities to enable clients. The program increases access to information and services and helps the men develop personal skills, while creating a supportive environment that makes it possible for these to take place. For example, the activities of behaviour modification, financial program and job support seek to increase capacities for decision-making and control, which would not be possible without residential stability and social support.

Some energy is directed towards advocacy and mediation. The Annex's version of advocacy involves helping people negotiate medical, legal and social systems in person and on

paper. Health promotion's understanding of advocacy is sometimes considered to be broader than this and would include consciously influencing policy by voicing support for people who are not present or who are silenced. The Annex inadvertently engages in advocacy when it undertakes mediation. While mediation is not a planned strategy, it is a skill that Mr. Manuel has had to develop to coordinate care from a variety of medical professionals, social professionals, legislators, funders and staff members. This coordination requires speaking on behalf of the men and recounting their stories and needs to garner support. A focused vision, relatively simple processes, and appealing values may contribute to the program's success in mediation.

The theory and application of harm reduction provides a cohesive strategy that focuses the Annex's advocacy, enabling and mediation work on particular goals and outcomes. In this case, the harm reduction strategy is not limited to substance use, that is alcohol consumption. Alcohol-related harm reduction does occur: non-potable forms of alcohol are replaced with wine; alcohol bought outside of the Annex can be brought in and stored at the bar; and moderate drinking guidelines are enforced through scheduled distribution. The values, ethics, beliefs and approaches of harm reduction can also be seen in non-alcohol related aspects of the Annex's operation. The values and practices of pragmatism, non-judgment, acceptance and unconditional support come from the harm reduction philosophy. The belief that institutional systems exacerbate homelessness and marginalization, by setting up disempowering environments and being hard to negotiate, means that the whole program itself is a harm reduction practice because it reduces harms that these institutions create. For example, men may have been denied income because of their lack of residence, but the Annex seeks to reestablish that resource and reduce the harms that a lack of income inflicts.

### **III. Processes Employed**

Processes for admission include establishing entrance criteria. If potential clients are too high-functioning they are not admitted. The rule-of-thumb states that if they cannot go anywhere else to find shelter that they be accepted into the Annex. This is also the rule for re-accepting previous clients. Staff members report that because part of the Annex's program is to modify problematic behaviour and to house those who are non-functioning, it "takes a lot to turn a man away" or kick him out, because staff expects the worst. 'Discharge' (encouraged leaving) occurs only if the man has a better place to be sheltered, which is often not available.

Mr. Manuel describes other rules-of-thumb that guide how activities are implemented. The first line of the Hippocratic Oath, "First, do no harm" refers to the application of harm reduction theory to the activities that aim to remove barriers to shelter and care. Each case is assessed individually, based on present circumstances and knowledge of the client's tendencies, abilities and limitations. The staff reports that individual case management takes creativity to ascertain the best mix of activities and ways to implement them for each man. Mr. Manuel's rule, "make it simple," does not mean that performing activities or making case decisions is easy; instead, it refers to finding the most efficient way to give clients the appropriate tool, care or access to fill their need. Needs are voiced by the clients and identified by the staff.

Highly trained and experienced staff members, that trust and support each other, help implement activities smoothly and maintain peace. Both social control and a flexible code of conduct are used to keep a safe and calm atmosphere. Behaviour modification and crisis de-escalation occurs through social control, which uses the powers of familiarity (trust), coercion (withholding alcohol) and appeals to reason (information provision). Seaton House's Code of Conduct is quite extensive and strict but the staff assures me that the punishment for

infringements is not nearly as strict in the Annex. Mr. Manuel summarizes the three rules of conduct at the Annex as, (1) no fighting, (2) no stealing, and (3) listen to the first two. However, counselors and CSWs are quick to point out that even these rules are flexible. Clients who exhibit severe behavioural disturbances or violence may be temporarily referred to police or Seaton House's O'Neill Risk Reduction Program, which concentrates on behaviour modification.

In the previous section on staff environment, it was argued that staff members, particularly counselors and CSWs, have the responsibility and ability to respond to the clients' needs. This means that they can make decisions about whether and how to provide program activities, as well as the application of behaviour modification or crisis management interventions. In an attempt to provide more cohesive care, all incidents are documented and the position of the 'author' is noted so that changes in physical or mental health, and in behaviours, needs and decisions can be tracked over time. Major interventions for emergent health/behaviour patterns are decided upon between the counselors, medical professionals and program director. Minor situations and situations that need immediate resolution are handled, and documented by, the counselors and CSWs. Each situation where clients adhere to case plans, modify their behaviour, or make positive/healthy choices are perceived as "tiny wins" by the staff and are used as experiential evidence of activity efficacy.

#### **IV. Analysis of Activities and Strategies**

##### *Variety of Practices*

It is possible to see that the Annex employs a wide variety of activities and strategies to achieve its goals and objectives. The main service provided is that of shelter, which includes a place to sleep, eat and perform personal care. Alcohol provision (substitution and supply) has been constructed as *the* harm reduction practice, and as a specific activity itself. Annex staff

explained to the author that, in practice, alcohol provision is used as a tool to encourage men to enter, and remain in, the shelter. Stable alcohol use is used as a tool to address other harms. The program's other activities may appear to be less important and focused but, when practiced in combination with shelter provision, present a comprehensive strategy to increase equity and access to social services, which were previously non-negotiable for the clients, and which can greatly contribute to their health.

### *Relationships Between Practices*

The aim to “Stabilize, Abilize, and where possible, Mobilize” (Mr. Manuel) describes how the Annex's incorporates activities and strategies to decrease illness and increase health, by changing individual behaviours and circumstances, while simultaneously changing the social determinants of health that influence this marginalized homeless population. As stated in Part One, the Annex is having an impact on multiple locations (macro, meso, micro) and types of people (including staff, clients, community members). Staff members should be recognized for their ability to utilize such simple methods to effectively implement a wide range of services.

Having a variety of practices is possible because activities and strategies build on each other. Some activities are prerequisites for others; for example, achieving residential stability is necessary for behaviour modification. Some activities are possible because other activities are occurring; for example, palliative care, social reunions and job support have been added to the list of activities because they can be provided when a man has a place to sleep and live.

In reaching its goals and objectives, certain activities are employed that have unintended consequences on the surrounding community, and which result in future strategies being easier to implement. Mr. Manuel recounts the following example: the Annex wants to have medical personnel on-site to increase access to them. Approximately 50-60 residents have trained at the

Annex over the last 9 years, and Mr. Manuel is beginning to see the first and second generations of residents, who have graduated to become doctors, returning to train the next generation of residents. While reorienting health care systems is not an explicit goal of the Annex, the training of medical professionals on homelessness issues is expanding, and can be thought of as inadvertently achieving this health promotion goal.

#### *Relationship to Foundations and Environments*

Unintentional outcomes result from a synergy between foundations, environments and practices. Peace, changing health care systems, an atmosphere of inclusion, and shelter as ‘permanent’ sanctuary have emerged because the goals, values, staff, physical environment and activities have been allowed to change to respond to the needs of the clients. The Annex and its staff have been flexible in tailoring their responses not only to individuals, but also to the vulnerable homeless population, by continually developing a greater understanding of their needs. This understanding becomes entrenched as beliefs about the issue and response, leads to an expansion of goals, reinforces the values, and helps shape the social (staff) and physical environments into supportive structures. The infirmary and palliative care program are examples of this understanding and flexibility.

The flexibility of the strategies and processes of implementation reflect the flexibility of the foundations because the (implicit) foundations are created through action. There is congruence between the foundations and practices (see Figure 4 for an example of this) because the entire program is based on a simple process that guides both. When presented with a problem, such as death among vulnerable homeless men or a lack of identification, it appears that the Annex staff asks three questions: What is the need? Why does it exist? What is the most straightforward way to respond to the need and change the conditions that influenced its

existence? These questions are based on pragmatism and compassion, which come from the philosophy of harm reduction, a theory that informs the goals, objectives, values, ethical positions and activities.

**Figure 4:** Mapping specific activities onto primary and secondary goals

(The checks indicate the initial reason(s) that an activity was created, though activities may reach other goals directly or indirectly.)

Activities	Goals				
	Reduce mortality and morbidity	Residential Stability	Increase Stability, Function, & Health	Remove barriers	Directed and stable life paths
<b>Shelter</b>	✓	✓	✓	✓	✓
<b>Alcohol provision</b>	✓		✓	✓	✓
<b>Medical care</b>	✓		✓		✓
<b>Resident Training</b>				✓	
<b>Foot care</b>	✓		✓		✓
<b>Psychiatric care</b>	✓		✓		✓
<b>Counseling</b>	✓		✓		✓
<b>Infirmary</b>	✓		✓	✓	✓
<b>Palliative care</b>	✓		✓	✓	✓
<b>“Homeless Pathway”</b>	✓		✓	✓	
<b>Modify behaviour</b>	✓		✓		✓
<b>Personal care</b>			✓		✓
<b>Recreation</b>			✓		✓
<b>ID health card</b>			✓	✓	
<b>Social reunions</b>			✓		✓
<b>Supported abstinence</b>	✓		✓		✓
<b>Financial program</b>			✓	✓	✓
<b>Job support</b>			✓	✓	✓
<b>Advocacy</b>				✓	✓
<b>Housing re-direct</b>		✓	✓	✓	✓
<b>Open house</b>					

## V. Strengths and Limitations of the Practices

The processes, relationships and variety of practices at the Annex simultaneously present strengths and weaknesses. Mr. Manuel refers to this complexity when he describes the Annex’s existence as both “good,” because of the service it provides to men who could not access it

elsewhere, and “bad,” because it is still needed and because it grows in size each year to respond to the need.

### *Strengths*

The wide variety of, and cohesive relationship between, the activities are strengths of the program. Flexibility in activity implementation and case management is also strength, as is the simple (as in straightforward) process for problem identification and decision-making. The efficacy of strategies is also strength. Emphasis on ‘tiny wins’ and individual case management means that some immediately- noticeable outcomes can motivate clients and staff to keep exerting effort. Most clients use almost all of the activities offered by the Annex,<sup>10</sup> as they have grown out of client demands and needs.

It is apparent that some of the Annex’s goals are being reached through its practices. From the point of view of the staff, the provision of medical care on-site means that continuous, better quality care is available, particularly for those with chronic issues. Staff members have seen clients access institutions and supports that would be completely inaccessible outside of the Annex, such as legal management and debt consolidation. The staff values being able to demonstrate compassion, through the palliative care program, for example, and foster community-building amongst those men who reside in the program ‘permanently.’ The program has become a ‘permanent’ home/sanctuary for some clients, which is an unintended strength as those who would not experience this anywhere else can do so at the Annex. The program’s goals and objectives are achieved through individual behaviour change and addressing the social determinants of health, and set an example for other health promotion initiatives.

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<sup>10</sup> The activities least used are abstinence support, job support and the housing re-direct program, which require that clients are somewhat functioning. Fortunately, to offer and implement these activities does not take many resources, even if they are not used regularly.

### *Weaknesses*

The Annex does not have activities with which to perform research or evaluation, nor does it have activities to strengthen the health or functioning of the internal organizational environment. Processes surrounding evaluation and staff interaction were the hardest to ascertain. These two areas are important for replication (modeling), and the fact that their practices are informal or implicit may explain why it is hard for other organizations to secure training or even understand the scope of the resources needed for a program like the Annex to be copied in another urban centre.<sup>11</sup> In addition, having a straightforward process for problem identification and decision-making does not mean that it will be easy to articulate or implement a response.

To be functional and to provide activities that are beneficial, the Annex must limit its program to its resources. The Annex does not have the capacity to address other forms of drug addiction, which is particularly problematic for those with concurrent disorders. The Annex does not have the resources to do advocacy outside of its mediation role, though change in the larger community is happening indirectly. Unfortunately, the Annex will not ever be able to provide all the activities necessary to reverse morbidity and increase health and well-being within their client population, but the program provides as many services as possible with the resources available.

Even with a balance between limited activity provision and a variety of staff positions/tasks, staff members report being concerned about burnout. Considering the long shift

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<sup>11</sup> While Annex staff members speak positively about being a model for other programs, there is only one other similar program in Canada: the Managed Alcohol Program at the Shepherds of Good Hope in Ottawa, Ontario. In response to a request from Halifax to open a similar program, McNeil (2002) reports that Mr. Manuel preferred to engage in workshops as a method of training, rather than communicating written policies, because he believed that harm reduction was best achieved in a series of actions offered in a comprehensive program. It is unclear if this training occurred.

hours (12 hours), type of population (non-functional), responsibility for decision-making (around crisis and case management) and long list of activities to accomplish, this concern may seem very real to staff. A flexible, and ever-growing list of activities could feel burdensome or crippling.

### **Demonstrated Competency**

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*Competency* refers to a readiness or ability to act and respond, as well as a state of being well-equipped or fit to do so (WRUD 2004). The Annex responded, and continues to respond to, a need for shelter and sanctuary among a vulnerable homeless population. Political and economic support continues to be available for the program, which is reaching its goals and objectives through a variety of activities and strategies. The Annex's readiness is rooted in material, social and emotional maturity that emphasizes a rational, yet radical, vision of the world it seeks to create. In Part Four, an ideal health promotion response to the issues of homelessness will be described and matched to the current Annex program to identify potential gaps and opportunities for change. Based on the foundations, environmental influences and current practice capacities, recommendations for the future will be made.

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**Strategies for Health Promotion: The Annex Harm Reduction Program**  
**Part Four and Five: Recommendations and Conclusion**  
**Natalie Comeau (990230576) – April 15, 2005**

**PART FOUR: GAP ANALYSIS AND RECOMMENDATIONS**

To further develop an understanding of the Annex as a health promotion strategy, its current characteristics and programming will be compared to those of an ideal health promotion response. A gap analysis will identify the areas of inconsistency, which will shape the recommendations made. These recommendations are proposed to bring the current Annex response closer to the health promotion ideal.

*I. Ideal Health Promotion Response to Issue of Marginalized Homeless*

**Ideal Health Promotion Response**

Health promotion theorists and practitioners have proposed principles and criteria that map what an ideal health promotion response, to any health or health-related issue, would look like. The following ideal response is synthesized from a variety of key sources (CPHA 1996; Eakin et. al. 1996; Epp 1996; Goodstadt & Kahan 2001, 2004; Hyndman 1998; Laverack 2004; MacDonald 1998; Naidoo & Wills 1998; WHO 1986).

The issue of concern should be related to health. Ideally, the issue should be a priority for action, and have the potential to be changed or influenced. The response should not only target the issue of concern, thereby influencing health and its many determinants, but also be tailored to the population of concern and adapted to their needs, capacities and surroundings.

Health promotion responses try to achieve certain things. The ideal health promotion goal is to increase the health, or enhance the well-being and quality of life, of individuals and communities. The objectives of an ideal health promotion response would include one or more of the following: creating supportive environments; facilitating the development of personal

skills and capacities; increasing preventive action; enhancing people's ability to cope; fostering self care; building healthy public policy; facilitating social justice and equity; strengthening community action; reorienting health services; building alliances; and encouraging participation and sharing power (empowering).

Values influence how objectives and strategies are decided upon. Ethical positions guide conduct into congruence with values. Ideal health promotion values include: social justice; respect; equity; holism; ecology; power sharing; enriched individual and community life; anti-oppression; anti-authoritarianism; and community participation, ownership and leadership. Ideal health promotion ethical positions direct decisions and actions to: benefit without increasing harm; put principles above self-interest; foresee consequences; make the strategies for decision-making, program planning and conflict resolution explicit; deal with competing ethical considerations; and express the value-laden nature of health promotion.

Ideally, health promotion practitioners initiating work on a project believe that health is holistic and is influenced by many social, structural and environmental determinants, that individuals have power and dignity, that individuals have rights to the basic necessities of life and health, that a critical mass is needed for social change, that intersectoral effort and communal support are needed for change, that permanent and drastic change is possible, and that individuals cannot always change their own health and health-related situations by themselves.

Ideal health promotion responses should be explicit about their use of theory, which can range from complex sets of interrelated concepts to sets of informal beliefs and assumptions about health and human nature. Theories contribute to an understanding of the nature of the issue or of appropriate responses. Major areas of health promotion theory include how health influences other areas of life, how people create change, how organizations function, the

relationship between individual, community and health sectors, and how specific activities, such as advocacy, contribute to health. Most practitioners agree that all assumptions and theories should be explicitly voiced to minimize conflict and confusion about what goals are trying to be achieved and what strategies are best to achieve them. Explicitly stating theories also means that they can be integrated into each stage of practice.

There are specific ways that an ideal health promotion response engages with evidence. Evidence should come from a variety of internal and external sources, including all stakeholders, and describe not only the outcomes of past and current practice, but also the efficacy of the processes used to implement strategies. Evidence should be trustworthy, appropriate to the specific issue and setting, and derived from both quantitative and qualitative methods, though evidence can range from informal feedback from participants and staff to formal reports from outside sources. Evidence should be used in every stage of practice (planning, implementation, evaluation, redesigning) and contribute to knowledge and organizational development.

There are specific ways that health promotion conceives of, and engages with, environments. Ideal health promotion responses address specific concerns that are voiced by communities, who lend resources. There is an acknowledgment that external environments influence both the issue and response. Health promotion also acknowledges the importance of a supportive internal environment, which manifests as staff control, social support, pleasant and functional physical surroundings, and positive relationships with coworkers. Ideal environmental visions include: structures, systems and conditions that are health-enhancing for all; resources that are adequately and appropriately used; clear roles, responsibilities, policies, processes, and procedures; respect for individuals, groups and ecosystems; and opportunities for ongoing evaluation, reflection, and learning.

There are a variety of health promotion strategies from which one can choose. Recall that according to the *Ottawa Charter* (WHO 1986), the three main categories, under which all strategies fall, are advocating, enabling and mediating. It is possible to add critical thought and reflexivity to these major groups because they are required to identify issues of concern and plan appropriate actions. Ideal health promotion strategies, activities and processes of implementation, should: address the health and environmental issues; be used with, and in support of, other strategies; create change at micro, meso and macro levels; be modified as needed; enhance health; be flexible; empower; build capacity; strengthen relationships; respect differences; contribute to healthy environments; be efficient and efficacious; and make good use of available resources. There should also be strategies that contribute to research and evaluation of the issue and response. Research and evaluation should be conducted at all and stages of implementation.

All strategies have equal merit, but the utility of each one is dependent upon its match to the issue of concern and to the specific health promotion goals, objectives, values, theories and evidence that are espoused. This is one area where good decision-making skills are needed. Ideal health promotion responses balance the constraints of time and money, with the demand for evidence, and the need and desire to create change.

### **Ideal Health Promotion Response to Issue of Marginalized Homeless**

The issue revolves around a population of men who have severe trouble functioning due to alcohol use, mental illness, and concurrent and behavioural disorders. These men have difficulty using other shelters in Toronto and they need a lot of care and assistance to stay alive and to function. Not only are their most immediate disorders directly health-related, their

dysfunction in other areas of life exacerbates their mental and physical illnesses and indirectly influences these by hindering how the men obtain the prerequisites needed for health.

It is important to identify the origin and scope of the goal to understand the scope and focus of an actual or ideal response's objectives, strategies, and uses of theory and evidence. The original call for a response to this issue envisioned a program that would resolve the entire problem, as opposed to one part of it. The following ideal is based on the overall goal of decreasing death among homeless alcohol users and of resolving as much of the issue of homelessness among the most vulnerable men, in the city of Toronto, as possible. This broad scope is indicative of a broad environmental vision in which health is enhanced for all and all have equitable access to the services and resources they need.

Ideally, a health promotion response either originates from those experiencing the issue or from an outside source that has a valid interpretation of their experiences and/or health status. This means that the 1995 call for a solution should have come from the marginalized men or from someone who intimately knew their needs. Implementing a response strategy also requires a supportive or receptive socio-political environment, which was available in 1995.

To decrease morbidity and mortality, an ideal health promotion response would aim to increase the men's health, which includes enhancing their well-being in all areas of their life that are suffering, and trying to raise their overall quality of life. To resolve the entire problem of homelessness among the marginalized, the response must aim to achieve all of the following objectives: creating supportive environments; facilitating the development of personal skills and capacities; building healthy public policy; strengthening community development; reorienting health services; building alliances; and empowering.

Creating a supportive environment would mean changing the surrounding communities' reactions to the men, which would include increasing the health and function of surrounding neighbourhoods and institutional systems, as well as organizing political, social and physical supports for them. Part of creating a supportive environment means attending to the natural and physical environments in which the men live. This includes examining the physical landscape of the neighbourhoods where they live, and developing an understanding of the men's daily activities and how these are mediated by access and in-accesses, as well as how the men meet their physical needs for shelter, nutritional sustenance and alcohol.

Another part of supportive environments occurs within the response. The response itself must be a supportive environment for the men, in which they can develop personal skills and capacities to cope with their illnesses, access resources, and work towards well-being in all areas of life. Support would foster empowerment, allowing the men to increase control over their health and exercise power in other areas of their life.

Creating supportive environments is linked with strengthening community development. The health of communities is linked to the health of individuals and community action can, therefore, be directed towards either. Community action requires human and material resources, as well as an ongoing dedication to sharing information and encouraging public participation. Changing the communities' reactions to these vulnerable men would mean that the existing community responses become more helpful to the men, use fewer resources, and add to community health.

Creating supportive environments and strengthening community development are also linked with building healthy public policy. Policy influences, and sometimes dictates, why physical environments are shaped in particular ways and/or how community action can proceed.

Responding to the needs of the most vulnerable men requires not only an understanding of current public policies and how these impact the men's lives, but also a vision of what kinds of policies would benefit them directly and allow supportive action.

Reorienting health services is linked with community development. An evaluation of health care systems, particularly those that respond to people with mental health and addictions issues, would be useful to discover why they are not able to deter disease and death among these vulnerable men. Plans to reorient these systems and to coordinate them with the health promotion response, would directly enhance the men's physical and mental health. In this way, building alliances between multiple institutions, and between institutions, governments and the shelter system, is necessary to create a supportive environment for action.

The ideal response would exhibit, and be explicit about, all of the values and beliefs listed above. Out of respect for each man's humanity, the response would seek social justice. By using critical, holistic and ecological lenses through which to look at the men's situations, an analysis of the social determinants and oppressive conditions that influence their health would emerge. Social justice would manifest as increased equity in access to medical, social and shelter services, and in a more equitable distribution of housing, income, addiction services and mental health services. The ideal response would empower the men to negotiate medical and legal systems better, to be critical of their situations, and to lead and participate in actions that would address their needs. The enrichment of these men's lives would occur with greater equity and empowerment.

The ethical position of "benefiting without increasing harm" is key to understanding a health promotion approach that is rooted in social justice. Recognizing the humanity and rights of a behaviourally-disturbed, alcoholic, who has been homeless for 10 years, is fundamental to a

health promotion response that seeks to improve the quality of life of these men. This is in direct contrast to approaches that would “write them off” by supporting existing patterns of service provision that enable their death. The other ideal ethical positions should also be followed.

The ideal response would use theory to explain one or more of the following areas: why homelessness exists (issue); how substance use, mental illness and homelessness interact (issue); why non-functioning men do not use other shelters (service provision and use); ways to break the cycle of homelessness, decrease death and increase health (how to create change); and/or the capacities and limitations specific to these men (addiction, mental illness and human nature). Understanding the nature of the problem and solution would influence how objectives are put into practice in the activities.

Ideally, the response would be based on previous evidence indicating the efficacy of either the response, as a whole, or of its constituent parts. Evidence would come from the men, the immediate neighbourhood, criminal justice systems, health care systems, addiction and mental health services, existing shelters, and the men’s families and friends. Evidence would include a mix of informal and formal qualitative and quantitative data. Evidence would show that the response decreases death and disease among this population, increases well-being in a variety of areas, increases access to services, makes their addiction, mental health and behavioural disorders more manageable, is supported by healthy public policy, is situated in supportive environments, allows the men to take active leadership and other participatory roles, and increases the function (efficacy and financial growth) of the institutions that have traditionally given these men support.

A variety of strategies and activities would be needed in an ideal health promotion response to the issue. Critical thinking and reflexivity would be needed at all stages of strategy

development and implementation. Activities that advocate, enable and mediate would be needed to resolve the whole issue. Some activities would enable the men to function by increasing their personal capacities and by providing supportive environments. Other activities would advocate for better service provision, funding and policy, in the city of Toronto. Finally, some activities would mediate between institutions to coordinate policy and care among them and to coordinate their actions with those of the response. Ideally, the response would include activities that develop research on the issue and evaluation of the response, as well as strategies to support the internal environment and organizational function.

To resolve the whole issue, the response must impact micro, meso and macro levels. An ideal health promotion response would first attend to the men as individuals and as a vulnerable population. As their functioning and well-being increased, so would that of the surrounding communities, including the immediate neighbourhood, the local criminal justice system, the local health care systems (and emergency rooms, especially), and local businesses. Quite a comprehensive program would be needed to increase the health and well-being of all of these people.

## *II. Gap Analysis*

The ideal health promotion response to the issue of marginalized homeless will now be compared to the current Annex response. Areas of consistency and inconsistency will be noted for the purpose of making recommendations.

### **Issue**

The identification of the problem of homeless alcoholic death in Toronto, and the call for a response to this issue, came from institutions. It was the Coroner's Inquest that named and brought forward the issue, and it is assumed that government institutions, community

organizations, and the local criminal justice and health care systems also supported the prioritization of this issue. They certainly support the Annex response now, by donating financial and human resources and by collaborating to operate new systems of service delivery.

The call for a response did not come from the most marginalized of homeless men, however, the specific Annex response was fashioned by those who had worked closely with this population. The Annex's clients do influence the response as their needs are identified and 'demand' attention. New activities are added each year to address these needs.

### **Goal**

The Annex's goal has shifted over time from trying to reduce morbidity and mortality on the street, to increasing the overall health of its clients. Making the leap to holistic health has happened inadvertently at the Annex, rather than consciously. Providing sanctuary insinuates that quality of life is important for these men and the Annex's strategies have grown in scope to reflect this goal. Because the Annex has certain priorities for helping the men, the provision of basic necessities, such as shelter, looks just as much like risk/harm reduction (and disease avoidance) as it looks like health promotion.

### **Objectives**

The Annex seeks to create supportive environments for health and for health promoting activities within their walls, within other institutions and organizations, and within the surrounding communities. The Annex also seeks to facilitate the development of personal skills, which enhances people's ability to cope and fosters self-care. By removing the barriers to accessing shelter and other services, the Annex creates a supportive environment that not only satisfies the men's basic needs, but also offers them choices and supports them in making healthier choices. Finally, the Annex seeks to increase preventive action, particularly at the

secondary and tertiary levels<sup>12</sup> and this is congruent with harm reduction practice. Health promotion tends to look ‘upstream’ for the origins of harm and, therefore, focuses more heavily on primary prevention.

Health promotion objectives, that seek to build healthy public policy, facilitate social justice and equity, strengthen community action, build alliances, and reorient health services, are indirectly achieved by the Annex as a consequence of meeting the objectives just listed. The Annex is contemplating actively employing these objectives to facilitate the program’s growth. The Annex also recognizes that explicitly stating the contribution that they are currently making to these areas might serve to garner general support for the program.

One other set of objectives is not sought by the Annex: enriching life and empowerment. Enriching the lives of individuals and community members means recognizing and encouraging “authenticity, creativity, critical reflection, joy, meaningfulness, [and] social connectedness” (Goodstadt & Kahan 2004). For Annex clients to have these experiences requires empowerment. It requires that they actively take control of their lives, as opposed to being subject to forces exerted by other people and environments, that they actively make decisions, that they participate in the operation of their home (the Annex) and that they share power with those around them.

### **Value, Beliefs and Ethical Positions**

The Annex exemplifies the health promotion values of social justice, respect, equity, holism, and anti-oppression. The health promotion ethical position of “benefiting without increasing harm” can be easily matched to the Annex’s espousal of the first statement in the

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<sup>12</sup> Primary prevention stops harm from occurring (Mausner & Kramer 1985). For example, preventing homelessness, especially chronic homelessness, stops its attendant harms from happening. Secondary and tertiary prevention decrease the impact of harm and rehabilitate after harm, respectively (Mausner & Kramer 1985). For example, providing potable alcohol decreases the impact of drinking and providing medical care seeks to restore health after the body and mind have been damaged.

Hippocratic Oath: “First, do no harm.” In stating this position, the Annex emphasizes how many of Toronto’s institutions and services recreate oppression and illness among marginalized homeless men. The Annex does express its value-laden nature, its deep respect for its clients, and its critical stance on their oppression. The program does reflect on both the short and long-term consequences of its activities and believes that these activities will affect its clients’ health more positively than other city programs.

Congruent with health promotion, the Annex believes in the power and dignity within each individual, the effects that social and environmental determinants have on health, the rights of individuals to the basic necessities of life and health, and the possibility that change can happen. The Annex also believes that, on the street, their clients are limited in their capacities to change their situations, make better decisions and improve their health, and, therefore, that the program can aid these processes.

Ecology, enriched individual and community life, power sharing, and community participation, ownership and leadership are not values that are explicitly stated or implied at the Annex. The lack of ecological and empowering values may be indicative of the belief that a given set of resources and capacities can only result in a limited set of outcomes. It is almost certain that, if asked, the staff members would voice their support of the ‘goodness’ of these latter values, though there are no objectives, beliefs or strategies that correspond to them. Furthermore, the Annex does not have an ethical stance on having explicit operational processes, including decision-making strategies, program planning and conflict resolution.

### **Theories**

Annex uses the theories of homelessness and harm reduction. While harm reduction is not usually considered to be a major health promotion theory, (DiClemente et.al. 2002; Glanz et.

al.2002), the Annex uses it as such. Harm reduction is also an approach that guides practice and influences the type of health promotion that the Annex undertakes. Sometimes the goals, values and strategies of health promotion and harm reduction are similar and sometimes they are dissimilar (see Appendix A for a comparison chart of the approaches). Harm reduction theory explains how certain activities can contribute to a client's health.

### **Evidence**

The Annex uses very little evidence apart from the 'tiny wins' that are experienced by staff and clients, and the ongoing use of the program. The program is not based on previous evidence of similar strategies because it did not exist. There is supporting evidence about the efficacy of harm reduction that comes from outside reports on other drugs. Evidence of the program's success exists, but it has generally not been operationalized, measured or reported in either internal or external evaluations, with the exception of Dr. Svoboda's work on the social and economic benefits to criminal justice, medical and governmental systems. The quality of life of the clients has not been researched.

### **Environments**

The Annex's approach to the environment is congruent with the way that health promotion engages with it. The program continually responds to the environment and uses the resources offered by community members to provide services. The Annex focuses on this area by seeking to change the physical location and social environments in which their clients live, thereby increasing their health. The creation of a supportive environment is limited by the extent to which the Annex directly organizes activities for strengthening community development, building healthy public policy and reorienting health services.

There is very little information about the vision of the organizational environment or the rules that govern roles, responsibilities, policies, processes and procedures. The organizational environment does seem to be functional and cohesive, so perhaps the rules were just not explicitly stated to the author. The Annex has not prioritized or completed an analysis of the physical spaces that exist on the streets or within the program walls.

### **Strategies and Activities**

From a health promotion point of view, the Annex can be applauded for using a wide variety of activities that seek to provide the prerequisites for health, enhance individual capacities, address the social determinants of health that affect their clients' lives, and (indirectly) contribute to community development. The program focuses most of its energy on enabling and mediating. There is little advocacy work being done. The Annex's activities demonstrate efficiency and efficacy, enhance health, strengthen relationships, make good use of available resources, are flexible, and have impacts on micro, meso and macro levels.

The Annex does not have activities that contribute to research or evaluation, or to supporting organizational function. While a solid critique of Toronto communities is needed to create this innovative program, there is little internal reflexivity about how the program might contribute to, or enable, the problems it works to rectify. It is not obvious if any of the activities empower or respect differences.

### **III. Ideal Changes**

The following list summarizes the gaps identified above and turns them into positive statements of activity that the Annex could undertake to conform to the ideal health promotion response to the issue of marginalized homeless:

- Homeless clients should be asked about what kind of services they want and if they want the Annex's programs to continue.

- Holistic health, including well-being and quality of life, should be emphasized as a goal and a value, from which the objective and activity of enriching the clients' lives can follow.
- Greater effort should be focused on primary prevention; this may require activities that build healthy public policy and make the broader community into a supportive environment.
- There should be an overt acknowledgment of why building healthy public policy, facilitating social justice and equity, strengthening community action, building alliances, and reorienting health services are important steps in responding to the issue, and how the Annex is currently addressing these areas (inadvertently).
- The Annex should engage in more direct activities that build healthy public policy and reorient health services for their clients and for similarly oppressed groups of people in Toronto.
- The empowerment of clients should be taken seriously, made an objective, a value and incorporated into activities and program planning.
- A critical analysis of physical environments and the ecological impact of the issue and response should be commenced.
- The Annex should have a clear organizational framework that details operational processes, goals and plans for evaluation.
- Harm reduction and health promotion theories/approaches should be explicitly integrated. Areas of similarity should be identified, and plans to manage differences between them should be made. Links between similar values, such as social justice, equity and compassion, could help in formulating goals, objectives and activities.
- A theory, and related set of beliefs, about the connection between mental illness, addiction, and homelessness should be used. Similarly, an understanding about the clients' capacities, and the best ways to create behaviour change among them, should be formalized.
- Research and evaluation on the evidence of success of Annex outcomes and processes should be started. Evidence of all kinds and from all areas of the Annex's operation should be gathered. Evidence about the health of men and their quality of life in the Annex (as compared to the street) should be prioritized. Evidence should be used to garner socio-political support and funding.<sup>13</sup>
- The response should be tailored to its client base and show more sensitivity towards the diversity of its clients.

#### **IV. Mitigating Constraints and Opportunities**

##### *Organizational Characteristics*

According Weick & Quinn (1999), the Annex would fit into the *continuous change* organizational model, because the program is always changing and expanding, and because its principles emphasize responding to each situation individually. The Annex's current plans for change include creating a 24-hour nursing position, to provide more continuous care and to cut

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<sup>13</sup> Socio-political support may be considered more valuable at the Annex. Mr. Manuel points out that effective and efficient money management is more useful than "throwing money at the problem."

down on their use of VON and CCAC services when 24-hour palliative care is needed, and providing free dental care. The program's development has been organic; its activities have emerged over time and built on each other. Knowing the Annex's style of organizational change is important for making recommendations. For organizations that are continuously changing, "change is a redirection of what is already underway" (Weick and Quinn 1999:4). The gap analysis has frozen the program and identified the unintended consequences and directions of its activities. The recommendations will send the Annex in a new direction.

#### *Concerns from Annex Staff*

The recommendations will also take into consideration the concerns that were consistently voiced by staff members. The death of clients happens frequently and is very troubling for the staff, who spend enormous amounts of time with them and who develop relationships with them over the years. The staff understands that these events are probably deterred because of the Annex's care and agree that death in the Annex is preferable to one on the street because of the palliative care and social support provided in the program. It seems that the Annex started as a quick solution to get men off the streets, and that the program was not prepared for its long-term components.<sup>14</sup> The Annex has grown each year since it began and is aware of the ongoing need for its services; it needs a long-term organizational plan. As well, it was not expected that the program would turn into a 'permanent' home for the men, wherein they would spend years of their life; the Annex needs to examine its long-term health goals for the men and how harm reduction's short-term emphasis might hinder this, while still providing care for their clients' immediate and severe problems.

The Annex will have to be innovative to keep up with the demand for its services, without growing in a way that disrupts the supportive internal environment. As mental health

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<sup>14</sup> This is best illustrated in the shift from a 12-hour program, to 12 and 24-hour programs, to a 24-hour care model.

facilities are currently closing in Ontario, how many more men will knock on the Annex's door? The author fears that fast growth will accelerate the program's institutional atmosphere, as the staff grows and the social atmosphere becomes as mechanistic as the current physical space. An explicit long-term vision is needed not only to facilitate service implementation but also to reinforce the Annex's strong values.

It is stressful to work at the Annex, as lots of effort goes into keeping the clients alive and stable, but there are no guarantees about when, or if, a breakthrough in functioning will occur. The staff reports that community members and politicians lack an understanding about harm reduction and about the realities of life on the street. Burnout among staff is a constant threat, but was considered to be a greater problem in the early years of operation when the staff was not as large or diverse as it is today. Now, the staff's diversity is considered to be a strength.

#### *V. Recommendations*

The following recommendations describe what kinds of activities and processes the Annex should undertake and why they are important. They have been selected over other ideal changes, and modified according to the mitigating factors of concerns and organizational characteristics. The objectives of these activities and processes are:

- To shift to a more positive definition of health,
- To use empowerment as a way to increase health,
- To be sensitive to issues specific to the population, such as experiences of diversity,
- To look long-term, and
- To engage in research and evaluation to further the program and other similar programs.

It is important to note that the recommendations are linked to each other and, if performed in conjunction, would boost the Annex beyond reducing harm and towards promoting health.

### **Recommendation #1: Activities for Quality of Life**

The Annex should direct some energy towards enhancing the quality of life of their clients, especially because most of the men spend years, and often the last years, of their life in the program. Better qualities of life could be achieved through increasing the aesthetic appeal of the spaces and providing varied recreational activities. This is particularly important for those who have mental health and behavioural difficulties.

First, the Annex should complete the renovations of its art/quiet room. Every other space in the Annex is functional and lacks aesthetic appeal. This space should be cleaned, comfortable furniture provided, and the art on the wall completed. This space would provide an alternative to the bustling noise of the other common areas, and would allow quiet and creative activities, such as reading, artwork, or visiting with family, to take place. Second, the Annex should provide alternative forms of recreation to watching television and going on the occasional outing. Perhaps an art therapy program, or similar activity, could be provided for recreational and therapeutic purposes.

### **Recommendation #2: Empowerment**

Empowerment is central to health promotion and involves learning a variety of skills to gain greater control over one's health and over the factors that impact one's health. While decision-making is an important part of empowerment, clients at the Annex are limited to making decisions about their individual behaviours, as the staff determines program developments and the range of healthy service choices. Furthermore, clients are not encouraged to learn other skills that would allow them to express creativity, leadership or even domestic independence.

Giving greater flexibility in decision-making is limited by the clients' behavioural difficulties, however, some options could be provided to men who are more stable in their behaviour. These men could be asked for their suggestions about activity programming. Other clients could learn manual, creative, leadership or domestic skills through employment or recreational activities.

### **Recommendation #3: Sensitivity Training**

The author assumes that the clients have a variety of age, cultural, ethno-racial, sexual, religious and educational experiences, because they are a large group who come from a diverse urban community. Diversity is not explicitly addressed at the Annex, but the program should be attentive to the ways that these experiences might influence service provision within it. Since most of the Annex's activities involve providing the basic necessities of life, it is unlikely that the majority of its services would change if critically examined from a lens of diversity, but as quality of life is prioritized and recreational activities are introduced, it may become more important to recognize the various experiences of the clients.

Sensitivity training would raise awareness among staff members about diversity issues. The counselors, with their social work backgrounds, are probably already aware of these issues and work them into the clients' case plans. Sensitivity training is usually inadequate to completely change attitudes or cover all the details of such a broad range of issues, but it could remind those who are already cognizant of them to continue making them a priority in their interactions with the clients and with other staff members.

### **Recommendation 4: Vision**

*The Annex should formulate a vision of the future. The origins of the program, coupled with harm reduction philosophy, reinforce short-term timelines and visions. As the*

*Annex moves into its tenth year, it needs to make decisions about the goal and scope of the program and how it should function as an organization to meet those goals. Certainly, the lack of concrete organizational foundations and processes hinder implementing Annex-like programs in other places and may allow the cohesiveness of the program to erode as it grows. The Annex should begin to explicitly state the elements of its vision, while being mindful of the need to incorporate both focused goals and flexible processes.*

#### **Recommendation #5: Long-Term Care Facility**

*The biggest service that would contribute to the clients' quality of life, and create opportunities for more empowerment to occur, would be a long-term care facility. A facility of this type is needed because healing does happen, and because the Annex's clients are significantly prolonging their lives by using the program's services. It is possible for the men to permanently leave the streets if they are supported, however, the Annex staff explains that complete re-integration into 'normal' society is not possible for them because of their marginalized experiences. Staff members recount stories of clients who returned to the Annex after being placed in supportive housing or long-term care facilities that not only required abstinence, but were also filled with men who did not have addictions experience. For these clients, the Annex was their home and it was where their support networks were located.*

*A long-term care facility could be modeled after the Netherlands' Seniorenpannd, a retirement home for drug addicts that opened in November 2004 (Honore 2004). Addicts in Holland are living longer because of access to medical services, and yet they find it hard to stop using drugs and integrate with the surrounding community; "Getting old doesn't mean your addiction just goes away," says one resident (Honore 2004). The facility seeks to provide stability and quality of life; "The main aim of Seniorenpannd is to help drug users live out their*

*final years in comfort and dignity” (Honore 2004). Cleaning, cooking, medical, and social work services are provided. The residents are allowed to obtain drugs on the street and use them in their rooms.*

### **Recommendation #6: Evidence**

Finally, the Annex may need to engage in more research and evaluation. The call for evidence-based practice is guiding current academic and governmental endeavours and the Annex may be increasingly pressured to measure and document its success. Nonetheless, the program has grown each year without much formal evidence (of which the author is aware).

Evidence of efficacy is particularly important if it seeks to contribute to other populations, both inside and outside Toronto. Implementing Annex-like programs in other cities requires the knowledge, skills and experiences of the Annex staff to be transmitted. While formal documentation would surely facilitate this, the rate of change and the difficulty of putting the program’s straightforward, yet complex, principles into practice means alternative forms of information transmission, such as workshops, could be more appealing. Research on similar populations, such as female and underage homeless, could be coupled with an evaluation of Annex practices, to result in a comprehensive plan for these other groups in Toronto. Lastly, evaluation could demonstrate if, and how, the program is using its resources in the most efficient way possible.

### *VI. Action Plan*

This action plan will suggest how the process of making change should begin. The types of resources and participants needed to implement each recommendation are outlined, as are the challenges that the Annex will face in making a decision about each one. Activities that are

appealing will need complete feasibility assessments. Once an activity is approved, the indicators of success can be identified.

### **Activities for Quality of Life**

Finishing the quiet room should be made the first priority. The room needs to be emptied and storage space for its contents will have to be found elsewhere. Comforting furniture, including multiple sofas, tables and lamps could be bought or collected through a single donation. Long-term donations could include books or magazines. An art therapy, or similar, program could be started once a week. It would require personnel, perhaps a volunteer, and art supplies. The activity leader would solicit for art supplies to be used in the art therapy program and to finish decorating the quiet room.

It must be particularly challenging for the Annex to decide what is a necessity and what is an amenity for their clients. Originally, providing basic necessities and medical care was a large contribution to this population as it radically decreased morbidity and mortality. Now, it is understood that death and disease also decrease as health (and quality of life) increases. It will be challenging to convince outside community members of this, however, there is some social and financial support for quality of life activities, as demonstrated by the donations that support the palliative care program. Evidence of the impact of mental health promotion could be used in support of these activities.

### **Empowerment**

Activities for empowerment will have to be brainstormed and carefully chosen based on the clients' needs and capacities. It will be very challenging to increase their control while maintaining a safe and functional program. Formal avenues for client feedback could easily be incorporated into the program; a comments box that is continuously available or that circulates

on a regular basis would allow the clients to voice their opinions while still keeping the ultimate decision-making power with the staff. Similar feedback strategies could be used with staff and community members. Empowerment from skill building will result from the activities that increase quality of life. Fostering empowerment does not necessarily require many resources; it can be accomplished by tweaking existing or future activities.

### **Sensitivity Training**

Sensitivity training could occur in the form of a half-day workshop that is provided as part of the mandatory initial training and yearly updates of the staff. A workshop leader who is recruited from outside of the Annex would be ideal to facilitate discussion about these delicate topics. The cost of providing the workshop could be minimized by engaging a smaller organization, such as the University of Toronto's OPIRG.<sup>15</sup> Larger organizations, such as the Centre for Addiction and Mental Health, may also offer similar workshops at higher costs. Staff resistance will also be challenging. Staff members may resist this training because they either have a deep understanding of the issues or because they are not ready to change their attitudes. Finally, if an important concern is identified and linked with a particular activity, there are no mechanisms for deciding if, and how, change can be made.

### **Vision**

Drawing up explicit visions will require time, good communication skills, and plenty of social support among all those involved. The biggest challenges will be including staff and clients, and voicing the willingness for them to be involved. Some research and evaluation should be conducted before the process starts so that decisions can be informed by individual experiences and by evidence of activity efficacy. Energy will be needed to come to consensus

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<sup>15</sup> OPIRG stands for Ontario Public Interest Research Group. Every major university has a branch of this volunteer-run organization, which frequently conducts workshops on social justice issues. (See [www.opirguoft.org](http://www.opirguoft.org) for more information.)

about goals, roles, timelines, priorities, and desired outcomes. It will be challenging to make decisions about who can participate and how their feedback will be incorporated, without having first chosen a decision-making strategy.

### **Long-Term Care Facility**

Running a long-term care facility would take an enormous amount of planning and resources. The initial steps should involve an evaluation of 'normal' facilities, hospices for other marginalized populations, and Holland's Seniorenparade. This would start the process of making a decision about this recommendation's feasibility. Time and human resources will be needed to gather extensive information about operating costs, possible funders, the characteristics of the physical space needed, and organizational structure. This recommendation is the most challenging because it demands the greatest amount of resources and requires that attention is given to organizational vision and function.

### **Evidence**

Operationalizing and measuring evidence takes time, money and human resources, as does report writing. External reviewers could perform evaluations for a variety of costs. Ideally, the reviewer should have a variety of research skills that include blending qualitative and quantitative methods and operationalizing health and its determinants. In the same way that it should develop a concrete vision, the Annex should decide on its stance as model for other programs. If the decision is that it could be a model for other programs and that its staff will participate in training and communication, a strategy should be planned that includes the type and amount of information to be shared, the method of communication, and the time and resource boundaries of the Annex.

*Bridging the gap between harm reduction and health promotion*

The theory and approach of harm reduction that is currently used at the Annex is a step towards health promotion. The recommendations made attempt to catapult the Annex into a broader understanding of health that is still congruent with harm reduction's values of respect and compassion. The recommendations push the Annex to be more critical of its processes and outcomes. These activities and processes were selected to be the most health-enhancing (as opposed to health-maintaining) for the least amount of resources. Caring for 130 men for a year with approximately 2 million dollars and a staff that works tirelessly during 12-hour days, implies that there are not a lot of free resources for extra activities.

**PART FIVE: CONCLUSION**

I was already convinced of the Annex's importance, and of its harm reduction approach, before walking through its doors. Because of my academic training and personal interests I came to it from a different place than most people. I was more interested in how harm reduction played out in processes and philosophies of approaching the men, rather than the efficacy of a specific harm reduction activity. My analytic bias, therefore, is not to convince the reader why giving alcohol to homeless alcoholics is a good idea, but to describe how experiencing material, physical, mental and social stability is vital. This project has turned into my own advocacy campaign, wherein I have tried to convince my family, friends and classmates about the subtly radical work that the Annex is doing.

The Annex is impressive because it balances many of the current tensions in health promotion practice. Tension is found in the debates between: individual behaviour change and a more upstream focus on the social determinants of health; the collective good and the individual good; theory and practice; and harm reduction and health promotion. These tensions dissipate

within this comprehensive strategy. This is possible because there is a strong moral drive that exists among the Annex staff members, which allows an unexpected level of patience and trust to dominate the program's atmosphere and operation. The morality espoused is reinforced in the simplicity of the Annex's principles and is consistent with that of health promotion and harm reduction.

The Annex seeks to improve the health of vulnerable homeless men in Toronto by providing a wide variety of activities, including shelter, health services and social support. Their continual growth and extended use by clients indicates their success as a response. The Annex is not the perfect health promotion solution to the issue of marginalized homeless, and there is room for improvement, however, the work that is done with the resources it has is remarkable. It has taken nine years for the Annex to grow from a 'band-aid solution' wherein homeless alcoholics were sheltered, to an organization that is slowly challenging dominant stereotypes of homeless, addicted, mentally impaired and behaviourally challenged men.

**Appendix A: Comparing Aspects of Health Promotion and Harm Reduction Approaches\***

<i>Health Promotion</i>	<b>Approach</b>	<i>Harm Reduction</i>
Health and Well-being	Goals	Decreased harm
Improved quality of life		Improved quality of life
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Build healthy public policy	Objectives	<b><i>Change public policy</i></b>
Create supportive environments		Enhance individual decision-making
Strengthen community action		Enhance community welfare
Develop personal skills and capacities		Create alternatives to punishment and stigma
Reorient health services		Decrease death and disease
Organizational development		Prevent most destructive harm
Enrich individual and community life		
Increasing preventive action		
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Holism	Values and Beliefs	Pragmatism
Ecology		Respect
Equity		Human rights
Social justice		Non-judgment
Anti-oppression		Non-coercion
Anti-authoritarian		Flexibility
Community ownership and leadership		Autonomy
Value-laden		Value-neutral
		Humanism
	Dignity	
<hr/>		
Enable, Advocate, Mediate	Operating Mechanisms and Strategies	Tailored interventions
Empowerment		Voluntary participation
Balance autonomy and community accountability		Balance autonomy and community accountability
Reflexivity		Negotiation
Diffused control		Centralized control
Participant-driven		Client-centered
Future-oriented		Present-oriented
Coalition, collaboration, cooperation		Risk Assessment
Resists institutionalization?		Seeks institutionalization?
Challenges dominant political and social structures		Challenges dominant political and social structures
Focus on SDOH and EDOH		Focus on harm/problems of use, not use itself

Experience-based (Qualitative evidence)	Reasoning	Research-based (Quantitative evidence)
Changing social positioning and environments changes capacities		Changing access changes choices and behaviours
“Health is essential for life”		“First, do no harm”
Look beyond mortality and morbidity (and reduced death and disease as goal)		Look beyond drug use (and cessation as goal)

\* This chart was taken from Comeau (2005).

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