Holistic and Intersectional Harm Reduction Services
For People with Developmental Disabilities

THE SHIFT

The opportunity to create this document, to offer this information, is not without sacrifice. We, the creators, would like to take this moment to honour those whose lives taught us, whose struggles showed us the true value of human rights, whose deaths were not in vain because the lessons they taught will be remembered forever as part of **THE SHIFT**.

We will not forget them, and as you move forward, we ask that you remember them also.

THE SHIFT

Holistic and Intersectional Harm Reduction Services For People with Developmental Disabilities

This is an opportunity for you to save a life.

That sounds dramatic, like an attempt to sell you something, but it isn't.

This is ***THE SHIFT***. With a mindset shift — just a tiny shift in your viewpoint — you can save a life.

It's the defining characteristic of harm reduction … saving lives. But it requires ***THE SHIFT*** from a mindset of: This or that; yes or no; worthy or unworthy — ready or not.

It is a chance to save the lives of those clinging to the edges of our world — those who do not fit the mold of the "perfect victim," the "perfect patient" or even someone to invest time and resources in when there are so many desperate for help. Tiny, actionable changes — a shift in your mindset — and you moving forward with an eye to harm reduction (rather than perfection) and you can save a life. More than that, you can give someone their dignity back.

We may not get to choose the path our lives take, but to do so with dignity is a basic human right.

Harm reduction is not about happy endings. Once you experience ***THE SHIFT*** in your mindset, you'll see it too. There is no perfect solution, but there is one that ensures that everyone's needs are met, even if they are not quite what you expected.

WILLIAM'S STORY

William wasn't just born with an intellectual disability, but he was raised by a mother who also has one. Then, on top of his disability, he faced racism as an Indigenous man, as well as suffered a deeply traumatic incident. He began self-medicating at an early age, and the trauma of that worsened his disability and worsened his abuse of alcohol.

He was 45 years old when he first began working with an direct support worker, who focused on harm reduction — ensuring that William stayed alive while they worked to find a way out of the cycle of hopelessness that he found himself in. No organizations before this had focused on William as a "whole person" — they saw only specific and individual issues, too many to overcome — and thought by offering or engaging in services would be a "duplication" of services offered by another organization. In reality, William did not "fit" within the mandate of any one organization.

Two simple things changed William's life forever.

You see, before he met his direct support worker, William was making a bad impression on our community. He was drinking in public and engaging in the behaviours that come with that. He was also panhandling to afford the alcohol, and doing so while intoxicated. He was an unwelcome presence, to say the least.

So, William's direct support worker and the police came to an agreement: William could panhandle between 1 and 3 p.m., each day, if he is sober. The police would keep an eye on William, to ensure he was adhering to the agreement, as would the direct support worker.

It was the trust and unconditional acceptance William built with his direct support worker that allowed the second element to work. A key component of harm reduction is that people feel supported unconditionally, without judgement or pressure to change.

The second element the direct support worker put in place — supportive housing. A small, manageable apartment for William to call his own. The direct support worker helped William learn to run a home, and to keep himself reasonably healthy.

The ending to this story is not that William stopped drinking. William would never be ready to stop drinking. Alcohol has been his constant companion since the age of nine, it would take as long to undo the trauma as it did to inflict it. Every program that could help him sensed this, and rather than consider a different approach, they simply turned their backs.

But when William had a home, he had a safe place to drink, safe from others and from the weather. In turn, making his community more tolerant of his panhandling because he was no longer disruptive. He made more money than ever before, and no longer needed to consider theft.

Sadly, William lost his life. The battles he faced were too many and his body could not stand up to the illnesses he developed from being on the street for too long. Rather than dying unknown, or dying in a ditch, or in a jail cell, William died with dignity.

William passed away in his own bed, in his own home. There were 60 people, family, friends and community members who attended his funeral.

This is harm reduction. And that is how little it takes to change someone's life — to give them back their dignity.

What you are about to read may not be easy for you. It won't just be a range of emotions that the true stories you will read in ***THE SHIFT*** will elicit, but the feelings of discomfort and defensiveness that often come when we challenge preconceived notions; the ideas and biases that we have all built, regardless of origin. Whether ignorance, inability or intention, these biases must be challenged in order to experience ***THE SHIFT***.

THE SHIFT is a resource to be used for harm reduction within the developmental services sector. It is built around the person-centred, "Nothing about Us, Without Us," philosophy and is focused on non judgemental and inclusive care that is culturally sensitive, evidence-based, accessible and more than anything, individual-led and based on incremental gains. Wars are won one battle at a time.

THE SHIFT is about disrupting the cycle of hopelessness within our vulnerable populations, and the cycle of helplessness felt by everyone who has tried to negotiate a system that is built around siloed services trying to treat intersecting issues. Those who genuinely want to help, to heal their community, only to find the obstacles before them are based around the idea that each person is their issues, rather than the complex and nuanced human beings we are. That begins with THE SHIFT and the biases surrounding our view of the people with developmental disabilities.

NOTE: While based in truth, the stories contained within this document are composites of issues facing many with developmental disabilities in Ontario, and do not reflect any one individual.

THE SHIFT

A NARROW FOCUS

CHALLENGING PRE-CONCEIVED NOTIONS OF THE DEVELOPMENTALLY DISABLED

Throughout the years and across the globe, there are myths, untruths and stigmas surrounding people with disabilities — specifically people with intellectual disabilities. According to Laurie Block, of the Disability History Museum,[1] these stereotypes are usually based on ideas such as:

1. People with disabilities are different from fully-human people; they are partial or limited people, in an “other” and lesser category. As easily identifiable “others,” they become metaphors for the experience of alienation.

2. The successful “handicapped” person is superhuman, triumphing over adversity in a way that serves as an example to others; the impairment gives disabled persons a chance to exhibit virtues they didn’t know they had, and teach the rest of us patience and courage.

3. The burden of disability is unending; life with a disabled person is a life of constant sorrow, and the able-bodied stand under a continual obligation to help them. People with disabilities and their families — the “noble sacrificers” — are the most perfect objects of charity; their function is to inspire benevolence in others, to awaken feelings of kindness and generosity.

4. A disability is a sickness, something to be fixed, an abnormality to be corrected or cured. Tragic disabilities are those with no possibility of cure, or where attempts at cure fail.

5. People with disabilities are a menace to others, to themselves, to society. This is especially true of people with mental disability. People with disabilities are consumed by an incessant, inevitable rage and anger at their loss and at those who are not disabled. Those with mental disabilities lack the moral sense that would restrain them from hurting others or themselves.

6. People with disabilities, especially cognitive impairments, are holy innocents endowed with special grace, with the function of inspiring others to value life. The person with a disability will be compensated for his/her lack by greater abilities and strengths in other areas — abilities that are sometimes beyond the ordinary.

Partial, limited, other, lesser, abnormal, menace. Or on the other side, benevolence, noble sacrificers, teaching patience and courage.

There is no middle. There is no view of the person with the disability, simply the veil that is placed on them by society, the one that marks them as someone who is a burden to others, or must burden themselves by raising others above them.

There certainly is no view that contains words like "complete." Complex, nuanced, a patchwork of experiences, teachings, cultures, and even pop culture, the way most able-bodied people see themselves.

There certainly isn't room for the questions of the higher self — one's place in the world — or even the desires they have for life. They are lesser, and therefore, their needs and desires are lesser. Other than care, the same care you would offer a child, there should be no issue.

THE FOREVER CHILD

People with a developmental disability, particularly those who have an intellectual disability, are often seen as childlike. Whether they are excluded from their peers or integrated into friendships, there is still the belief that those with an intellectual disability are not able to fully understand the world around them, and therefore, do not need to be prepared for it the way an non-disabled child would.

Not only are they not prepared, but they are not exposed to the risk-taking opportunities that their peers are given. They are not invited to participate, nor given the opportunity to make mistakes or they are shielded from the consequences.

Able-bodied children are also informed about drug use, whether it is simply the parental acknowledgment of its existence, or an encounter with drugs. And it's those experiences that often begin on the lower end of the intoxication scale, with substances that have less risk of harm, and addiction.

These youth are also given the opportunity to understand, and engage, in sex and sexuality, as well as communicate their understanding of their own gender identity.

GENDER AND SEXUALITY

The path to understanding one's sexual or gender identity can be difficult to travel for any person. This journey is made even more difficult when the person is exploring their true selves and is without the information to understand their feelings. In essence, how can a person identify as being gay, understand what that means, when they have never heard the concept before; when they believe they are the only one?

This is the case for many people with developmental disabilities.

Not only are they not included in deep discussions of sexuality — not even the biology of it, let alone the nuances and intricacies of interpersonal sexual relationships — and not given the opportunity to explore what that means for them.

This is also true of gender identity.

Western binary concepts of gender identity are built around the exterior and interior reproductive parts, female and male. Intersex is a general term used for situations in which a person is born with reproductive, or sexual anatomy, which doesn't immediately fit the description of the biological "female" or "male."

While it is incredibly difficult to pinpoint the actual number of intersex children born — due to the case-by-case nature of these judgments — the Intersex Society of North America base its statistics on the number of times a specialist in sexual differentiation is called in to make a pronouncement: About 1 in 1,500 to 1 in 2,000 births. However, due to subtle forms of sex anatomy variations, some of which won't show up until later in life, that number is higher.

Even from a biological standpoint, a binary view of gender may not be evidence-based.

The view from a person with a developmental disability; someone who has never had the access to an understanding of the complexities of gender; may have even greater issues with their identity.

Sadly, when a person isn't given the power to understand their true selves, their mental health suffers. Statistics[2] show that LGBTQ people face:

- Higher rates of depression, anxiety, obsessive-compulsive and phobic disorders, suicidality, self-harm, and substance use.
- Double the risk for post-traumatic stress disorder (PTSD) than heterosexual people.
- LGBTQ youth face approximately 14 times the risk of suicide and substance abuse than heterosexual peers
- Of trans respondents in an Ontario-based survey, 77% had seriously considered suicide and 45% had attempted suicide.

Without room to be seen as a fully human adult, with desires and a need to understand their true selves, people with developmental disabilities — particularly intellectual disabilities — will pursue other means, such as look to others for information; others who may not have their best interests at heart.

Risk-taking behaviours can lead to unintentional pregnancies, sexually transmitted infections (STI), even HIV/AIDS and hepatitis C. It can also lead to transmission of infections to others.

Additionally, the potential to alleviate physical desires, or please new friends, is not the only draw to this. The potential income opportunities that come from exploiting oneself is often the only choice for women in vulnerable populations, but may also be the preferred choice. The opportunity to please others, themselves, and make money leads to one of the great crises in Ontario at the moment: Human trafficking.

The words human trafficking often call to mind the idea of smuggling people across a border, but it is in fact, at its core, exploitation. It can also include labour exploitation or "forced work," but for women, it is the sexual exploitation aspects of human trafficking that is the issue.

The victims of police-reported human trafficking, 97% were women and girls. Almost half (45%) were between the ages of 18 and 24. Nearly three in 10 victims were under the age of 18 (28%), while the remainder were 25 years of age or older.[3]

The sexual exploitation of children, adults, of children exploited into their adulthood, do not know any other life except their sexuality being used as a tool for profit by another.

Victims are most commonly exploited by family members, by those who come to a community promising a new life to those without hope, or those who meet with vulnerable people living in urban centres but are in precarious situations. One out of every three cases, it is a former or current partner of the victim.

Statistics Canada shows that between 2009 and 2018, police services in Canada reported 1,708 incidents of human trafficking; an average annual rate of 0.5 incidents per 100,000 population. In Ontario, there were 0.9 incidents per 100,000 population. These numbers are likely higher, as they are dependent on police-reporting, which is not often the case with survivors.

This is much worse for Indigenous women and girls, who are disproportionately affected by many of the harms of a vulnerable population. It has been established by the Inquiry on the Murdered and Missing Indigenous Girls and Women that Indigenous women are 16 times more likely to be murdered than non-indigenous women. It can easily be extrapolated that Indigenous women and girls are more susceptible to human trafficking.

The inability to differentiate good friendships and good relationships from bad — simply attention and money, or nothing at all — some people with developmental disabilities will fall victim to the effects of human trafficking.

TRAUMA

Researchers are only beginning to understand the types of trauma that can affect someone, how deep those effects go, and how much the trauma can shape a person. That is true for those who did not actually receive the trauma.

The Trauma Informed Practice Guide, created by the BC Provincial Mental Health and Substance Use Council,[4] lists the following types of trauma as considerations for individual health:

- **Single incident trauma:** An unexpected and overwhelming event (accident, natural disaster, single episode of assault, sudden loss, witnessing violence);
- **Complex trauma:** Ongoing abuse, domestic violence, war, ongoing betrayal;
- **Developmental trauma:** Results from early exposure to ongoing or repetitive trauma incidents (as infants, children, youth) involving neglect, abandonment, abuse (emotional or physical). Often occurs within a child's care-giving system and disrupts healthy attachment and development;
- **Historical trauma:** The cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma (genocide, residential schools, slavery);
- **Intergenerational trauma:** An aspect of historical trauma that describes the psychological or emotional effects that can be experienced by people who live with trauma survivors.

Intergenerational trauma is also common to another group that suffered immensely — Holocaust survivors.

Clinical psychologist Dr. Yael Danieli developed the Danieli Inventory for Multigenerational Legacies of Trauma, and it was her research that first offered startling findings in the grandchildren of Holocaust survivors.

It is easy to understand the direct hurt of that trauma — the fear, oppression, domination and abuse — that is forced upon a group of people. But then the group trauma begins to move through future generations. Stories, warnings, even silence can impose fear on those who never experienced the initial traumatic actions. There is research that clearly shows that intergenerational trauma affects the DNA of grandchildren from those who have endured group trauma, and they didn't even hear the stories firsthand. In many cases, it is causing them to have a higher risk of developing Post Traumatic Stress Disorder (PSTD).[5]

Historic and intergenerational trauma can be found anywhere there was colonization. From the peoples of Africa, who were enslaved, to the Indigenous people in Canada. This historical trauma response is found around the world.

Trauma also has an unfortunate place in the world of the developmentally disabled.

In addition to any other trauma they face in the world, they face the traumas of a life of being "other" — feeling isolation, fear, and having difficulty navigating the world. There is often abandonment, whether that is actual or in the form of neglect. There is a sense that they are a burden, an inconvenience, which can weigh heavily on a person's sense of self. Beyond that, without the feeling of contribution at home and in society, a feeling of worthlessness creeps in and this in turn can lead to pursuing risk-taking behaviours, which will only add to the existing trauma.

OBSTACLES TO OVERCOME

In addition to these complex issues, causing some individuals to have certain aspects of themselves to go without consideration, people with developmental disabilities — specifically intellectual disabilities — have difficulty navigating social systems without support. It isn't just about finding resources that meet their needs, it also requires attention to an individual's ability to communicate effectively, advocate for themselves, and understand what might be expected of them. It isn't always a possibility for an individual to adhere to rigid schedules, or written-only aspects of registration. Even the act of entering a clinical setting can re-traumatize someone with a history of negative experiences with "helping" professionals. Ensuring that people with developmental disabilities have the resources in place, as well as the ability to fully participate, should be part of any care model.

SAFE, SUPPORTIVE AND AFFORDABLE HOUSING

The centre of any harm reduction planning is safe housing, and in the case of those with developmental disabilities, safe and supportive housing. The major obstacles in this are not only low housing supplies and rising rental rates in the community, but also landlords weary to renting to complex tenants.

Supportive housing is specialized to each individual, but is often centred around learning to run a house, and receiving continued aid in learning how to manage the requirements needed. Safety in a home allows each individual the privacy they deserve, protection from the elements, and the chance to maintain their health. It also means that a home is a place to hide. It provides refuge from those who wish the individual harm, or those who have undue and inappropriate influence on them. It is a place of protection.

Affordability in relation to housing could be defined two ways:

1. A rental amount that is "affordable," based on the amount of income one has; or
2. Having an income that makes a rental amount "affordable."

As part of Reaching Home: Canada's Homelessness Strategy, the federal government advises a Housing First[6] approach to solving the homelessness crisis faced by many communities.

PRINCIPLES OF HOUSING FIRST

- **Rapid housing with supports:** This involves directly helping individuals locate and secure permanent housing as rapidly as possible and assisting them with moving in or rehousing if needed. Housing readiness is not a requirement.
- **Offering individuals' choice in housing:** Individuals must be given choice in terms of housing options, as well as the services they wish to access.
- **Separating housing provision from other services:** Acceptance of any services, including treatment, or sobriety, is not a requirement for accessing or maintaining housing, but individuals must be willing to accept regular visits, often weekly. There is also a commitment to rehousing individuals as needed.
- **Providing tenancy rights and responsibilities:** Individuals are required to contribute a portion of their income towards rent. The preference is for individuals to contribute 30% of their income, while the rest would be provided via rent subsidies. A landlord-tenant relationship must

be established. Individuals housed have rights consistent with applicable landlord and tenant acts and regulations. Developing strong relationships with landlords in both the private and public sector is key to the Housing First approach.

- **Integrating housing into the community:** In order to respond to individual choice, minimize stigma and encourage individual social integration, more attention should be given to scattered-site housing in the public or private rental markets. Other housing options, such as social housing and supportive housing in congregate setting, could be offered where such housing stock exists and may be chosen by some individuals.
- **Strength-based and promoting self-sufficiency:** The goal is to ensure individuals are ready and able to access regular supports within a reasonable timeframe, allowing for a successful exit from the Housing First program. The focus is on strengthening and building on the skills and abilities of the individual, based on self-determined goals, which could include employment, education, social integration, improvements to health or other goals that will help to stabilize the individual's situation and lead to self-sufficiency.

As well, the limitations are flexible to the situation, as per the strategy: "As of April 1, 2019, all mandatory Housing First investment targets that were under the previous federal homelessness program have been removed. This gives communities more flexibility in how they use the Housing First approach for populations beyond those experiencing chronic homelessness and to use other innovative approaches to address local needs."

If this type of housing is not currently available, there needs to be an increase in the supply, one that meets the demand. While this investment is large, the cost to the current system is larger.

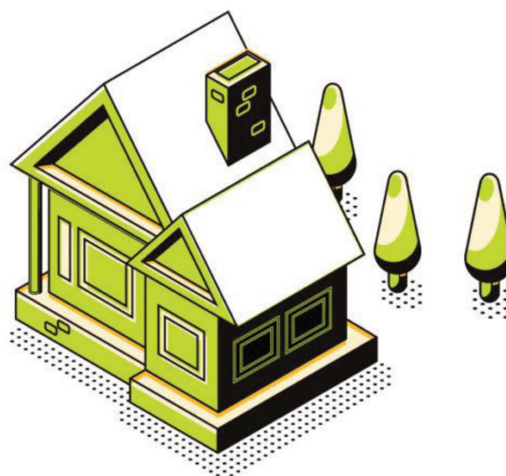
For instance, in 2017, the Auditor General of Ontario released a report on the cost of housing alternatives.[7] While this list is somewhat out of date, and without consideration of the pandemic, the numbers are startling:

- Average cost of providing social housing to one household: $613 per month
- To stay in a shelter bed: $2,100 per month
- To stay in a long-term-care bed: $3,960 per month
- To stay in a correctional facility: $4,300 per month
- To stay in a hospital bed: $13,500 per month.

According to a report from the Canadian Mental Health Association, homelessness has significant costs for cities and taxpayers[8]:

- The State of Homelessness reports that the annual cost of homelessness to the Canadian economy is $7.05 billion.

Every
$10 invested
in housing-first services results in
$22 savings
in costs of other services.



Housing First makes a difference.

Association canadienne pour la santé mentale Ontario

CHALLENGES TO AFFORDABILITY

In addition to challenges finding a room or apartment, there is also the ability to pay for it. Those with developmental disabilities are more likely to receive their income from social services and are therefore subject to the rigid and unchanged rules and amounts available.

OW & ODSP RATES AND THE ONTARIO CHILD BENEFIT								
FAMILY TYPE	**PREVIOUS**				**NEW AS OF JULY 2020**			
OW	BASIC NEEDS	MAX SHELTER	MAX OCB	**TOTAL**	BASIC NEEDS	MAX SHELTER	MAX OCB	**TOTAL**
Single	$343	$390	$0	$733	$343	$390	$0	$733
Single parent - 1 child	$360	$642	$119.50	$1,121.50	$360	$642	$121.75	$1,123.75
Single parent - 2 children	$360	$697	$239	$1,296	$360	$697	$243.50	$1,300.50
Couple	$494	$642	$0	$1,136	$494	$642	$0	$1,136
Couple - 1 child	$494	$697	$119.50	$1,310.50	$494	$697	$121.75	$1,312.75
Couple - 2 children	$494	$756	$239	$1,489	$494	$756	$243.50	$1,493.50
ODSP								
Single	$672	$497	$0	$1,169	$672	$497	$0	$1,169
Single parent - 1 child	$815	$781	$119.50	$1,715.50	$815	$781	$121.75	$1,717.75
Single parent - 2 children	$815	$846	$239	$1,900	$815	$846	$243.50	$1,904.50
Couple	$969	$781	$0	$1,750	$969	$781	$0	$1,750
Couple - 1 child	$969	$846	$119.50	$1,934.50	$969	$846	$121.75	$1,936.75
Couple - 2 children	$969	$918	$239	$2,126	$969	$918	$243.50	$2,130.50

SOURCE: INCOME SECURITY ADVOCACY CENTRE[9]

If you are a single person, your monthly Ontario Works benefit is $343 for basic needs, $390 for shelter costs, for a grand total of $733 per month. On Ontario Disability Support Program (ODSP), your benefit is $672 for basic needs, and $497 for shelter, a monthly total of $1,169.

NEW BARRIERS — COVID-19

This crisis, of course, has been worsened exponentially by the COVID-19 pandemic. Services for developmentally disabled individuals are best offered in person, where they are most comfortable. That approach is currently limited due to safety precautions. Additionally, registrations and forms — as well as information — are located online to facilitate the closing of government offices. However, the only access some people have to the Internet is the library, which has also been closed at various times during the pandemic. It is difficult for many people with developmental disabilities to navigate without support.

THE SHIFT BEGINS

If there was once a narrow lens — one of profession, or personal experience — now is the time to take ***THE SHIFT*** to an expanded view.

THE SHIFT begins with four words: Humility, Awareness, Sensitivity and Safety.

Shift to ➜ Humility: "We have knowledge, but we are also without knowledge."

Humble yourself before lived experience and understand that, to put it plainly, "you don't know what you don't know." Education, experience and expertise will never replace the acknowledgment that you will always be learning. You will always need to ask questions and truly listen to the answers. Acknowledge and honour the differences rather than respond with assumptions. Move forward with humility.

Shift to ➜ Awareness: "Identify and challenge your beliefs and assumptions."

Be open to challenging your fundamental beliefs, to radically altering your worldview by listening to new voices. Learn about the cultures, issues, and obstacles facing all the parts of your community. Learn the specific obstacles, then approach possible solutions with humility. Recognize differences between your worldview and others. Acknowledge your own cultural practices behaviours, and the impact they may have on others. Do what is necessary to ensure that you understand the individual's diverse needs.

Shift to ➜ Sensitivity: "Actionable changes to harmful assumptions and beliefs."

Put these learnings into place for both you and the individual. Adapt how you approach and provide service. Sensitivity goes beyond recognizing differences, it is appreciation for and comfort with differences. Practise empathy, flexibility, willingness to learn from the individual. Identify similarities, differences, as well as the individual's goals, capacities and priorities.

Shift to ➜ Safety: "Moving forward with humility, awareness and sensitivity."

As you create a place of safety for the individual, strengthening, encouraging and empowering them within the self-determined action plans, it will be with humility, awareness, and sensitivity towards the person in front of you, as well as their unique needs. Incorporating the necessary accommodations for the individual to feel safe. Safety is individual-determined and requires an ongoing commitment on behalf of the service provider.

As you proceed through ***THE SHIFT***, you'll find that your worldview will be consistently challenged, and that you will also be constantly learning. Each person is different and contains a multitude of intersecting issues, which brought them into a vulnerable population and seeking outreach help. It is important that once you have had ***THE SHIFT***, you continue to examine your practice.

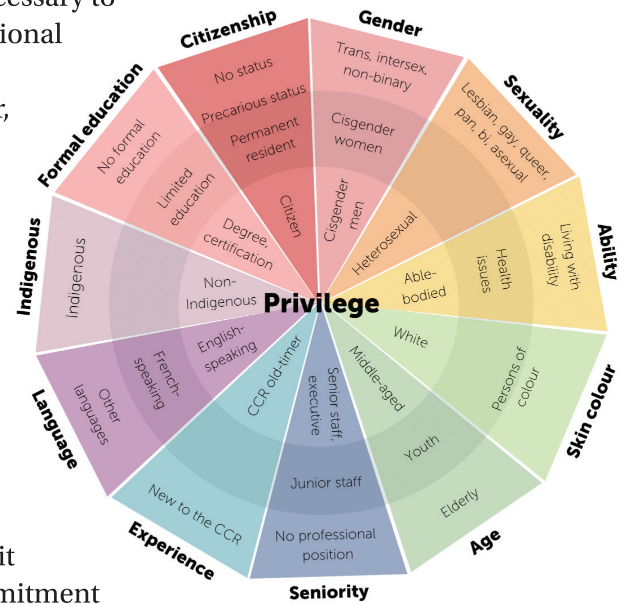
By viewing your interactions with your community through a new lens, as well as taking the opportunity to practise critical reflection, you ensure that you are a place of safety, and of solutions.

CRITICAL REFLECTION

Every mindset is influenced by several things, and it is necessary to examine these influences. The lens of profession — professional ethics, one's own values and life experiences — as well as understanding how these experiences influence each other, will offer the solutions necessary for current crises.

There is also the component of critical reflection, which relates to power and the imbalance that can come when one, who does not have a developmental disability, is given influence over their choices. While many do not feel powerful in their everyday life, this diagram, called "The Power Wheel,"[10] may offer some additional information.

When critical reflection is used to open the mindset to new experiences and understandings, there is the ability to understand a worldview different than your own. It is a commitment to self-evaluation, and critiquing each individual interaction to ensure that you have approached it with humility, awareness, sensitivity and safety. It is a commitment to acknowledging and addressing power imbalances and developing a mutually beneficial relationship.



SOURCE: Canadian Council for Refugees

SELF REFLECTION

- **DID I** encourage and open and inclusive environment? Did I ensure that concepts of race, age, gender, gender identity, sexuality, disability, spirituality, culture and beliefs have been considered as part of the individual's specific needs?

- **WHAT WAS** good about my interaction, and what could I improve on? Are there alternatives I could choose for next time, and have I made myself aware of them?

- **AM I** seeing hidden assumptions not just in myself, but in others, as well as the individuals? What are the hidden rules in my culture that are not clear to others? What hidden rules and social cues might I be missing from the cultures of others?

- **AM I** focusing on the most pressing or central issue as it is to them, or myself? What do they feel is the problem that needs a solution? Am I seeing this from their point of view, or my own?

- **DID I** express bias in my communication? Have I represented other viewpoints as having integrity and worth?

- **DID I** expand on my idea or express it another way? Did I give an example or visual aid? Could I elaborate on what I have said? Could I be more specific or provide additional details?

- **HAVE I** considered an alternate worldview? How might someone else interpret a situation I experienced?

- **DID I** begin and end with the same message? Do my conclusions match the evidence I have presented?

To correct these issues, changes to the social systems are needed, but that kind of change is a long-term investment. It takes time — a popular comparison is "getting a cruise ship to turn left." You'll complete the turn, but it will take time.

In the meantime, the only possible solution is to reduce the harm that is facing these people this very moment, while the ship corrects its course.

This is the principle of harm reduction, as it relates to those with a developmental disability: Strategies to meet immediate safety needs until supports are ready, or until the individual is ready. It is based on a non-judgemental and individual-led approach, focused on inclusivity and incremental gains.

Currently, adults with developmental disabilities require services based on their actual needs, and those are far more unique than ever before. Not only are harm reduction models necessary, but providing access to culturally sensitive addiction and mental health intervention, as well as support for justice-involved individuals. There are even more specific needs, such as assistance with medication, health management — especially with individuals who do not stay in one place for long — as well as establishing healthy routines.

THE SHIFT is focused on engaging with people who have developmental disabilities in a way that meets the individual on their terms, a place in the community where the individual feels safe. It is aimed at helping those individuals, particularly with intellectual disabilities, to feel safe, independent and empowered. To help everyone become a citizen of the community in a way that balances the needs of both sides, positively, and significantly reduces the reliance on costly crisis/emergency services.

PRINCIPLES OF HARM REDUCTION

Harm reduction places the focus on programs, policies, and practices that aim to reduce the negative consequences associated with behaviours that are typically considered high risk. It also includes the need to ensure that service is not restricted, based on a mandated change in behaviour.

While there are many practical approaches to harm reduction, the principles and theory behind the practice are important to understand, as many in-the-moment experiences and interactions will require creative solutions, rather than those that can be followed step-by-step.

The Canadian Mental Health Organization describes the "key principles of harm reduction"[11] as:

- **Pragmatism:** Some level of drug use in society is to be expected. Containment and amelioration of the drug-related harms may be a more pragmatic and feasible option, at least in the short term, than efforts to eliminate drug use entirely.
- **Humane values:** No moralistic judgment is made about an individual's decision to use substances, regardless of level of use or mode of intake. This does not imply approval of drug use, rather, it acknowledges respect for the dignity and rights of the individual.
- **Focus on harms:** The extent of a person's drug use is of secondary importance to the risk of harms resulting from use. The first priority is to reduce the risk of negative consequences of drug use to the individual and others. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence. In some cases, reduction of level of use may be one of the most effective forms of harm reduction. In others, alteration to the mode of use may be more practical and effective.

• **Balancing costs and benefits:** Some pragmatic process of assessing the relative importance of drug-related problems, their associated harms, and costs/benefits of intervention is carried out in order to focus resources on priority issues. This analysis extends beyond the immediate interests of users to include broader community and societal concerns. This rational approach allows the impacts of harm reduction to be measured and compared with other interventions, or no intervention at all. In practice, such evaluations are complicated by the number of variables to be examined in both, short and long term.
• **Priority of immediate goals:** The most immediate needs are given priority. Achieving the most pressing and realistic goals is usually viewed as first steps towards risk-free drug use or discontinued use. Harm reduction is based on incremental gains, which can be achieved over time.

The goal of harm reduction is to help people with developmental disabilities build the skills necessary to achieve various degrees of independence, in a way that fosters their self-reliance and self-sufficiency, while also realistically preventing any further harm.

Harm reduction is the choice of those who wish to save lives. And it is life or death.

The following are true stories, and they are happening in your community right now.

TARA'S STORY

Tara is a middle-aged woman who has an intellectual disability, as well as a seizure disorder. Seizures not only cause brain damage and are degenerative, recovering from them is difficult and painful.

This is the root of Tara's pain. From a young age, every night when Tara closed her eyes to go to sleep, she would have a seizure. Her limbs would either thrash or hold rigid, her bite gnawed into her tongue, and the lack of oxygen, caused brain damage. Not to mention the fear of the seizure, Tara had to deal with the fear of the pain — every time she tried to sleep.

She had extensive medical interventions, but with no relief. So, she stayed awake however she could. On and off the streets since she was a teen, Tara started medicating with drugs.

She stays up as long as she can, getting as high as she can, for several days so she won't have a seizure. She's been doing this for five years now.

It never works.

She collapses and ends up in the hospital. She doesn't get placed into a program for addictions, because she has a developmental disability. Unfortunately, the developmental sector is not designed with the tools to treat her addictions. She doesn't get into a program suited to her because she isn't suited to it. She misses meetings scheduled during the morning hours, and gets her file closed. She is a victim of siloed agencies that can't treat her intersecting issues, limited by misconception mandates and funding requirements.

More than anything, how can she be asked to change under the current conditions? Giving up the drugs means the pain of seizures.

CHANTAL'S STORY

Chantal is an Indigenous woman in her 20s, who has never really had a home. She has family and does have a relationship with them, but they live far away and experience substance abuse and mental health issues of their own. She didn't live with them long; she became a crown ward at a young age, lived and ran from multiple group homes until she ended up on the street.

This woman, with no one to guide her life, also has an intellectual disability and is diagnosed with a mental health disorder. The trauma she suffers is both directly experienced and the burden of intergenerational trauma.

She finds solace in drugs and alcohol to medicate her pain. She aligned herself with the only people who accepted her, they brought her into their group and convinced her they were her friends, only so they could take advantage of her.

They take advantage of her body — they traffic her — but she thinks it's okay. That's because trauma, disability, and the lack of good relationships in her life have left her craving even a hint of normalcy, of love.

Sadly, the past approach of the developmental sector to "protect and restrict," preventing her from using substances or engaging in drug culture, caused resistance in her, and she instead made greater efforts to assert her autonomy and independence.

And now, she lives on the street.

Chantal was found brutalized, assaulted, and left vulnerable. She has been found this way on more than one occasion. She has no memory of the events that caused the injuries. Considering the additional presence of suicidal ideations and attempts, she likely will not be found alive next time.

But help for Chantal requires her to be ready for change — to want to change. But why would she when these people are her friends? Perhaps the only ones she's ever known?

READINESS FOR CHANGE

It is the idea of readiness for change, or even willingness for change that is a large part of the understanding of harm reduction. The behaviour does not need to be stopped or judged, only shaped into a pattern that ends the cycle of harm and the strain on social resources.

Tara and Chantal's stories, and even William's story from section one, are all displays of their resourcefulness and adaptations to the pain they face. Changing, even lessening the pain, could be out of reach, but reducing the harm an individual causes themselves — while acknowledging their pain and the steps they take to ease — is the key to a successful harm reduction policy.

There is another element to help change resistance, that is the sense of family on the street, which may never have been experienced by the individual before.

While Joel is now a registered nurse and direct support worker, he has experience living without a home and used drugs to treat the symptoms of his undiagnosed ADHD.

Below, he notes in this firsthand account his experiences, both as a person with lived experience and as someone who has a current outreach relationship with the vulnerable populations.

JOEL'S STORY

Trauma certainly delays development, impairs social function, internalizes and locks away the self behind safeguards and physiological response to a world that's been proven to be unsafe. It leaves many gaps that dependence on others assists greatly with:

- Lack of experience knowing what it's like to be loved, cared for. Many have had this reality since birth.
- Lack of experience knowing they can trust others, again often born into circumstances that were untrustworthy from the start.
- Lack of experience of healthy, adult relationships — often socialized by peers in lack of adult presence and involvement.
- Lack of orientation to the world — many simply haven't been taught some of the basics of our world, surviving on panhandling, sex-trade, petty theft of basic needs, etc., since they were young. To many, the idea of resume building and having this "normal life" they see out there

is inconceivable. Many never really had a parent that orientated them to how this works, even from a basic human interaction stand-point.

These are all things that are present out there, and that's without the addition of any pre-existing challenges. In this sense, people with developmental disabilities feel a strong sense of belonging on the street. People have the humility to recognize from their own experience that no one is perfect, that this person is not any less than I am, and to recognize the person for their strengths instead of their weaknesses. In the street world, there is a far different focus that's not as disabling as our world of privilege.

Most I've known with these forms of limitations have rarely been connected to services, and have been cared for, and supported, by their street family and friends to their dying days. Sometimes, this is in direct rejection of the systems they felt viewed them as "broken and need fixing," as one put it. With stigma layers upon stigma, the individual also gains the identity of a "street person," and/or a "drug user." This is in addition to coping with often being the runt of the pack on the street, being labelled "challenged," without a second glance when it serves as a display of power to a group. They may have to depend on others for food, acquiring and injecting their drugs, finding a place to sleep, filling out forms, remembering appointments, along with all the terms and conditions this may come with. Some people need to make sure the extra work makes their own struggle for survival easier, and there's limited avenues to this on the street.

The challenges faced by someone with developmental challenges in poverty, and substance use, come from a place of power and safety, and not so much their individual capacity. This is what some find solace in and attractive about the street, the recognition of their capacity and personhood in a world where it can be very hard to find. Good people, often acting to the best of their ability, face some of the greatest hardships in our society. It's what life on the margins is like, when you feel left out of everywhere, there's always someone else out there in the empty space with you. My uncle had Down syndrome, and though he stayed away from substances, he ended up in many of those low-threshold places, which had people who were using drugs. This was his experience, as well of mixed sanctuary of acceptance, along with the accompanying bullying that came from places where people with the most intense struggles gather.

In this sense, intervention often looks like those same things: True trust and acceptance, true appreciation for them, true acceptance of their capacity, re-enforcement of just how capable they are, true education on what mutually healthy relationships are, and education to increase their independence. For many out there, the condition itself is not nearly as disabling as the ingrained, embedded belief that they're incapable of caring for or protecting themselves. When someone is this far to the margins, the smallest lessons can be some of the most transformational, life-changing accomplishments. So often, it's the simple, little things.

Treatment plans that focus on regimented ideals, and a saviour mentality, cannot hope to cure the issues that plague our communities. Without a harm reduction model as a central focus — a need for practical decision, which will allow the individual to determine a plan that not only works for them but reduces their impact on social systems and their community. These situations seem overwhelming, as though there is no way to solve them. But there is … it is the model of harm reduction. Focusing on winning battles rather than the wars, and allowing ***THE SHIFT*** to show you how to see through a common lens.

THE SHIFT

THE COMMON LENS

You should be commended for getting this far.

THE SHIFT is a movement. It means you will change the way you look at the world. Since you have gotten this far, that means you have read the stories and the difficulties that are faced by members of your community. That means you have decided to shift your mindset, to help us win the battles. You are exactly the person we have been looking for.

You can be a hero in someone's life — give them peace, dignity and hope — and you won't have to give much of yourself. You can be a part of a community collective, one that is focused on a coordinated, collaborative approach to harm reduction. Once you have gone through ***THE SHIFT***, you will see the world with new eyes. Yes, you will see the hurt and the pain that surrounds some individuals, but you will also see a way through it.

THE SHIFT will have you see the world through the common lens. No longer restricted by the views of your profession, of your personal experiences, or even the biases you may not know you had. You will have removed the obstacles to see the person as they truly are. Though there will be some hard problems and issues, do not let that old lens keep you from seeing the joy of the individual in front of you. Laugh at their jokes, listen to their stories, see them as they are and do so without judgement.

More than anything, ***THE SHIFT*** is about seeing a situation and a person through a common lens and fully understanding not only what they need to survive and thrive, but also, what they don't need.

What they don't need is judgment; authority-imposed restrictions from a power they do not feel is considerate of their life and value. A person with developmental disabilities does not need to lose their own power — the power to make decisions, to choose how they will engage with risk, and to determine the course of their own life.

Neurotypical people often assume that those with a developmental disability need protection. And, while that is true, they don't need the paternalistic restriction that the system currently provides.

Developmentally disabled adults do not need these restrictions when they are centred around taking away their power to make choices for themselves. It also makes the incorrect, and somewhat dangerous, assumption that people who are developmentally disabled will simply "do as they are told."

Again, that is the influence of society's view — a person with a developmental disability is "The Forever Child."

THE SHIFT is about empowering people like William, Tara and Chantal. Allowing them to live in a way that brings them the closest thing to peace they know, while limiting the harm that can come to them, by creating a safer and more welcoming community.

This isn't about condoning behaviours; it's about not judging them in the first place. There will be times when you must make a choice on what would be best for an individual, even though that decision goes against your values, or morals. This is the importance of undertaking ***THE SHIFT***. If there is something within this toolkit that has stirred something in you, revealed a piece of information you hadn't considered, or a reality that took you completely by surprise, then perhaps the values you currently hold are not based in fact as you once thought.

THE SHIFT is not just about completing a session or understanding a problem. It is the need to move into every interaction with another individual with an understanding of the common lens — the one that does not spring from personal values, biases or agendas, simply your belief in the need to save a life.

At its core, ***THE SHIFT*** is giving you a common lens to see the world as it is — messy, complex and intersectional. Once you have done this, you will see the way you can help.

The beauty of the common lens is that once you look through it, you'll see the light that appears on the other side.

The light in a story like William's. A story where you can give a man the dignity and respect of a home, of personal privacy, and the ability to create a life for himself that is so enriching to others, they attend his funeral as mourners.

Integral to his story was the ability of the outreach and support people he encountered, to see the complexities of who he was, and specifically, what he needed, and how that could work within the community.

Central to it, however, is safe and supportive housing. This is the way to end the cycle of hopelessness felt by the vulnerable populations of your community. The sense of helplessness felt by frontline workers, emergency personnel, and truly, anyone who wants to help the members of their community.

HOUSING AS A HUMAN RIGHT

The common lens, what THE SHIFT should allow you to view the world through, reveals that a safe, supportive and secure housing situation is not only the keystone in the foundation of harm reduction, but a human right under Canadian law.

When Canada ratified the United Nations International Covenant on Economic, Social and Cultural Rights[12] the federal government voted to not only "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," but to also "recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent."

As part of a document called, Right at home: Report on the consultation on human rights and rental housing in Ontario,[13] The Ontario Human Rights Commission detailed their findings regarding the need for housing:

"Adequate housing is essential to one's sense of dignity, safety, inclusion and ability to contribute to the fabric of our neighbourhoods and societies. As the Commission heard in this consultation, without appropriate housing, it is often not possible to get and keep employment, to recover from mental illness or other disabilities, to integrate into the community, to escape physical or emotional violence or to keep custody of children."

The Ontario Human Rights Commission is also quite clear that even beyond the concepts of housing availability and affordability, is the discrimination that often inhibits an individual's ability to secure housing. When factors, such as gender, family status, race, ancestry, as well as social or economic status, can prevent someone from obtaining an apartment or room, the disadvantage only increases when that person also has a developmental disability. When many of these factors intersect, the risk for discrimination is even greater.[14]

It can be understandable, of course, that many landlords would move towards a protectionist attitude when choosing tenants for their buildings — their investments. In addition to the need for continued lobbying to government agencies to make the negotiations between tenants and landlords easier on both sides, it is important to understand the regulations under the Ontario Human Rights Code, and specifically the duty to accommodate:[15]

> "Under the Code, housing providers have a duty to accommodate the Code-related needs of tenants, to make sure that the housing they supply is designed to include people identified by Code grounds, and to take steps to remove any barriers that may exist, unless to do so would cause undue hardship."

Those needs are not just accommodations for physical disabilities, but for tenants who may have intellectual disabilities, are aged or have changing family situations, and even religious requirements. A landlord is also required under the code "to take steps to help a tenant who may be unwell or who is disruptive towards others, either because of a disability or due to that person being the target of discrimination themselves."

According to the human rights code, housing providers can also apply a Housing First approach and take steps to prevent and address human rights in rental housing by developing:

- Anti-discrimination and anti-harassment policies
- Plans for reviewing and removing barriers
- Procedures for responding to accommodation requests
- Procedures for resolving disputes quickly and effectively
- Education and training programs.

The best approach is to follow some key human rights principles:

- Design inclusively, and create no new barriers
- Identify and remove existing barriers
- Maximize integration
- Assess and accommodate individual needs short of undue hardship by exploring ideal, interim and next-best solutions using a cooperative process that maximizes respect, dignity and confidentiality.

In addition to following best practices, and mandatory legal approaches, a commitment to adequate housing — and in this case, housing that is supportive, safe and affordable — is not only the way to lead with your emotions, but also with logic.

HOUSING FIRST

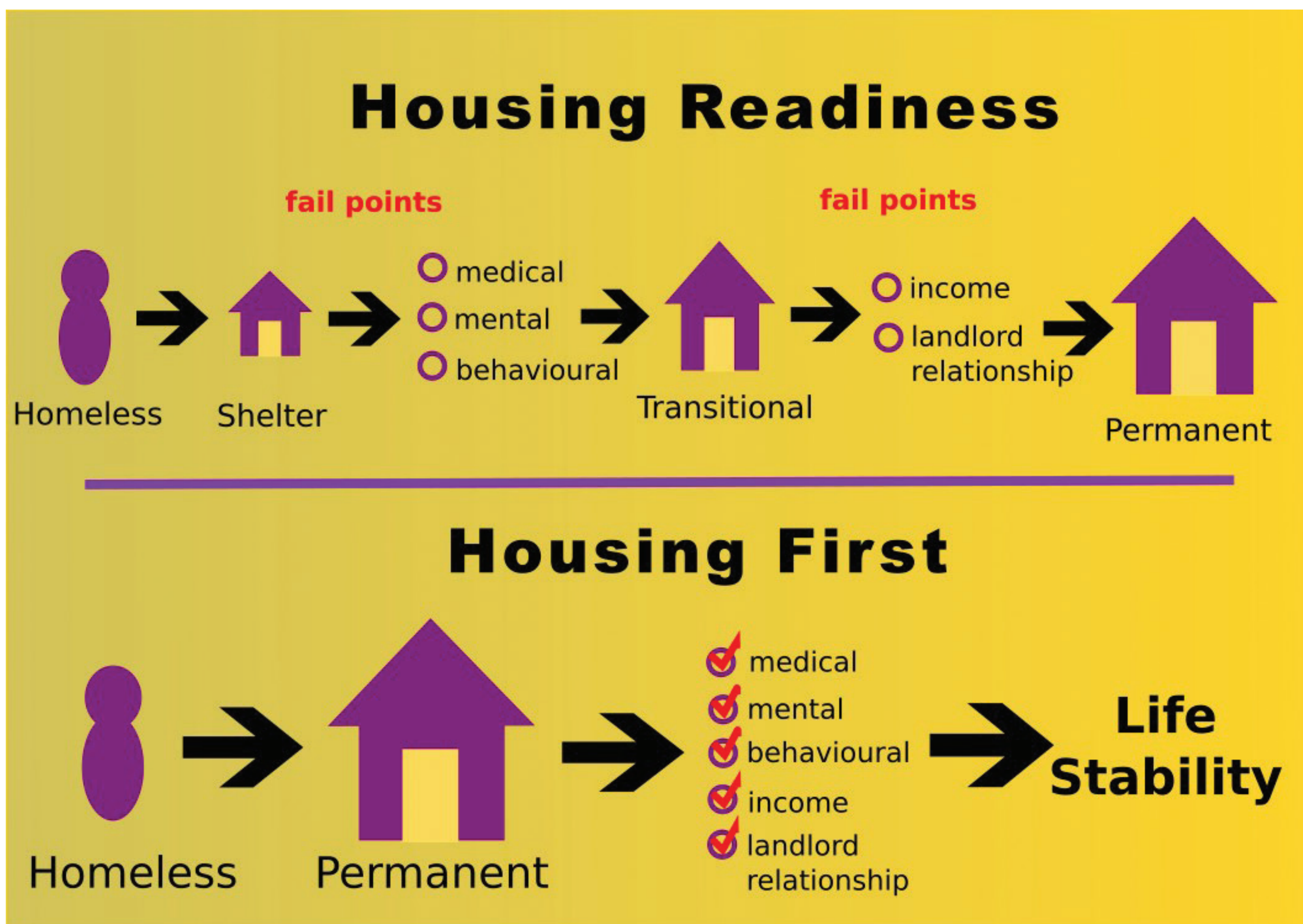
According to the Canadian Observatory on Homelessness, the largest national research institute devoted to homelessness in Canada:[16]

“Housing First is an approach to ending homelessness that centres on moving people experiencing homelessness into independent and permanent housing as a first step. It provides people with immediate access to permanent housing with no housing “readiness” or compliance requirements, is recovery-oriented and centres on consumer choice, self-determination and community integration.”

Housing First (HF) can be utilized and understood in three different ways:

1. As a foundational philosophy embedded within a systems approach;
2. As a specific program provided by an agency or government body; and
3. As a team designed to meet the needs of specific target populations.

If it is based in the correct principals, it can be remarkably effective. Housing readiness, or the belief that an individual or household must address other issues that may have led to their homelessness prior to entering housing, is not one of those tenets. Readiness, as shown in the diagram below, can immediately present “fail points” for the individual.



SOURCE: 100khomesbtv.weebly.com/housing-first.html

Additionally, the factors that cause housing instability often worsen under a "housing readiness," or "treatment first" model.

TREATMENT FIRST VS HOUSING FIRST		
FACTOR OF HOUSING INSTABILITY	**TREATMENT FIRST APPROACH**	**HOUSING FIRST APPROACH**
Homelessness	Individuals must be "housing ready" prior to being given access to housing. **Problem:** Adequate housing is a human right.	As human beings, individuals have the right to adequate housing.
Mental illness	Established psychiatric treatment (e.g. med compliance) is required before housing. **Problem:** Healing/stability cannot occur without housing.	Housing is a precondition for effective psychiatric treatment. An outpatient service team must be available to the individual once they are housed.
Substance use	Sobriety is required before stable housing can be expected of individuals. **Problem:** Recovery is often conditional upon the stability that housing provides.	Housing is a precondition to recovery; focus on harm reduction, not abstinence.
Social deviance	Rehabilitation is required before access to housing is made available. **Problem:** Housing instability promotes recidivism.	Housing is a precondition of proper rehabilitation and community integration.
Unemployment	Stable employment is required for housing. **Problem:** Stable employment is impossible without housing.	Housing is a precondition for stable, long-term employment.
Disability	Support network is established prior to housing. **Problem:** The efficacy of outreach and community support depends on housing stability.	Adequate housing is a precondition for the establishment of an effective support network; support network is established alongside housing.

A Housing First approach is built on:

Immediate access:

- Adequate housing is a human right and not a feature of life that has to be earned through treatment compliance.
- Access to adequate housing is a precondition for recovery.
- HF programs instantiate this principle by moving clients into housing, regardless of any "readiness criteria" as quickly as possible.

Consumer choice:

- Individual should be as in charge of their home, and their own life, as much as possible.
- Individual should have some choice when it comes to the location and nature of their home.
- Similarly, individual should be able to choose the nature and extent of the recovery support they receive.

Recovery orientation:

- HF programs ensure that individuals have access to the kinds of services that they require, in order to live a healthy life.
- Focus on harm reduction: Accepts that the use of illicit drugs is a reality, choosing to minimize risk instead of condemning or ignoring use.

Social inclusion:

- HF strategies will support individuals to become better integrated in their communities. Recognizing that isolation can destabilize housing, the HF model understands the social complexities associated with a healthy life.
- Three central strategies adopted to promote inclusion include: (a) the establishment of scattered site housing; (b) the separation of support from housing; and (c) access to opportunities to participate in community activities.

Research from the Mental Health Commission of Canada [17] shows that HF not only rapidly ends homelessness, but does so cost-effectively.

The research study, At Home/Chez Soi, was the world's largest trial of HF, and followed 2,000 participants for two years in five Canadian cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. The study grouped the individuals by their approach: Housing First (HF), and Treatment as Usual (TAU).

As well, the HF groups were arranged according to their needs, as part of a support-based team approach to HF:

Assertive Community Treatment (ACT) teams:

- Designed to provide comprehensive community-based supports for individuals with challenging mental health and addictions issues and may support individuals in accessing psychiatric treatment and rehabilitation. These teams may consist of physicians and other healthcare providers, social workers and peer support workers.

Intensive Case Management (ICM) teams:

•Designed to support individuals with less acute mental health and addictions issues through an individualized case management approach. The goal of case management is to help individuals maintain their housing and to achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations.

Teams focused on:

- Life skills for maintaining housing, establishing and maintaining relationships and engaging in meaningful activities
- Income support
- Vocational assistance, such as enrolling in school, finding employment, or volunteering
- Managing addictions
- Community engagement

Results were clear:

- Across all cities, HF participants obtained housing and retained their housing at a much higher rate than the treatment as usual (TAU) group. In the last six months of the study, 62% of HF participants were housed all the time, 22% some of the time, and 16% none of the time; whereas 31% of TAU participants were housed all of the time, 23% some of the time, and 46% none of the time.
- Among the participants who were housed, housing quality was usually better and more consistent in HF residences than TAU residences. HF is a sound investment.
- On average, the HF intervention cost $22,257 per person per year for ACT — supports those with high needs participants; and $14,177 per person per year for ICM participants with moderate support needs.
- Over the two-year period, after participants entered the study, every $10 invested in HF services resulted in an average savings of $9.60 for high needs/ACT participants, and $3.42 for moderate needs/ICM participants.
- Significant cost savings were realized for the 10% of participants who had the highest costs at study entry. For this group, the intervention cost was $19,582 per person per year on average.
- Over the two-year period following study entry, every $10 invested in HF services resulted in an average savings of $21.72.

It should be strongly noted, however, that these specific ACT/ICM supports are not available to most people with developmental disabilities, specifically intellectual disabilities. This is one of the great factors in these individuals "slipping through the cracks" of the system or becoming a "hot potato" that is bumped from service to service without results.

In practice, these HF solutions can be applied to a wide range of situations. And, because of ***THE SHIFT***, you can now see through the importance of stable and supportive housing for someone hoping to be a better community member.

LANDLORD'S TESTIMONY

"I first became aware of the work of Community Living over 25 years ago when I rented an apartment to an individual who received their support. Early in my relationship with Community Living, I was able to see firsthand the amount of support they provide individuals and the efforts the staff go through to work to resolve any issue to the satisfaction of all involved. The professional staff totally sold me on their commitment and dedication to improving the lives of developmentally disabled individuals and made me feel like I want to be a part of this team.

From the perspective of someone who has rented many units to Community Living, you will not find a better tenant, complete with professional support staff to assist the individuals and work with the landlord to resolve issues."

— Stephen Hernen

Property owner in Huntsville, Ontario and longtime Community Living supporter

The common lens could be used to form a coalition of stakeholders, representatives, service providers and other partners to oversee a community Housing First Program, either with the concept forming the underpinning of planning, the approach to all systems within a community organization, or as a team program focused on outreach and support.

The program could include existing and upcoming affordable housing, marked specifically for the purposes of HF initiatives, or finding programs that offer financial subsidies and support to landlords who participate in HF. Teams can connect individuals with the necessary health services, as well as employment or subsidy opportunities, and overseeing the continued housing stabilization of individuals who are at risk of chronic homelessness and eviction.

The common lens shows you the whole person; it also shows you that every person needs a home. Every person has a right to a home, and when they are given one that is secure, safe, affordable to them, it gives them as much autonomy and independence as they can manage. Solutions to seemingly impossible problems will reveal themselves.

As you create a place of safety for the individual, strengthening, encouraging and empowering them within the self-determined action plans, it will be with humility, awareness and sensitivity towards the person in front of you, as well as their unique needs. Incorporating the necessary accommodations for the individual to feel safe. Safety is individual-determined and requires an ongoing commitment on behalf of the service provider.

End the cycle of hopelessness in your community. End the cycle of helplessness among the first responders, emergency and direct support workers struggling to keep people alive.

Take THE SHIFT on shift. Ensure that you move forward with humility, awareness, sensitivity and safety, and you and your community will have the benefit of leaders — like yourself — forward thinkers based in harm reduction who see clearly through the Common Lens.

THE SHIFT

BEGINS

If there was once a narrow lens — one of profession, or personal experience — now is the time to take ***THE SHIFT*** to an expanded view.

THE SHIFT begins with four words: Humility, Awareness, Sensitivity and Safety.

Shift to ➜ Humility: "We have knowledge, but we are also without knowledge."

Humble yourself before lived experience and understand that, to put it plainly, "you don't know what you don't know." Education, experience and expertise will never replace the acknowledgment that you will always be learning. You will always need to ask questions and truly listen to the answers. Acknowledge and honour the differences rather than respond with assumptions. Move forward with humility.

Shift to ➜ Awareness: "Identify and challenge your beliefs and assumptions."

Be open to challenging your fundamental beliefs, to radically altering your worldview by listening to new voices. Learn about the cultures, issues, and obstacles facing all the parts of your community. Learn the specific obstacles, then approach possible solutions with humility. Recognize differences between your worldview and others. Acknowledge your own cultural practices behaviours, and the impact they may have on others. Do what is necessary to ensure that you understand the individual's diverse needs.

Shift to ➜ Sensitivity: "Actionable changes to harmful assumptions and beliefs."

Put these learnings into place for both you and the individual. Adapt how you approach and provide service. Sensitivity goes beyond recognizing differences, it is appreciation for and comfort with differences. Practise empathy, flexibility, willingness to learn from the individual. Identify similarities, differences, as well as the individual's goals, capacities and priorities.

Shift to ➜ Safety: "Moving forward with humility, awareness and sensitivity."

As you create a place of safety for the individual, strengthening, encouraging and empowering them within the self-determined action plans, it will be with humility, awareness, and sensitivity towards the person in front of you, as well as their unique needs. Incorporating the necessary accommodations for the individual to feel safe. Safety is individual-determined and requires an ongoing commitment on behalf of the service provider.

As you proceed through ***THE SHIFT***, you'll find that your worldview will be consistently challenged, and that you will also be constantly learning. Each person is different and contains a multitude if intersecting issues, which brought them into a vulnerable population and seeking outreach help. It is important that once you have had ***THE SHIFT***, you continue to examine your practice.

By viewing your interactions with your community through a new lens, as well as taking the opportunity to practise critical reflection, you ensure that you are a place of safety, and of solutions.

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NOTE: While based in truth, the stories contained within this document are composites of issues facing many with developmental disabilities in Ontario, and do not reflect any one individual.

FURTHER RESOURCES

HOMELESSNESS:

Canada's Homelessness Strategy
https://www.placetocallhome.ca/what-is-the-strategy?utm_source=sudbury.com&utm_campaign=sudbury.com&utm_medium=referral

Auditor General Report on Homelessness:
https://www.auditor.on.ca/en/content/annualreports/arreports/en17/v1_314en17.pdf

HOUSING FIRST STRATEGY:

https://housingfirsttoolkit.ca/

https://www.homelesshub.ca//sites/default/files/HousingFirstInCanada.pdf

Real Xchange CL Essex County,
A Hub for Resources, Knowledge Exchange, Collaboration and Learning in the DS Sector
https://realxchange.communitylivingessex.org/

CULTURALLY SENSITIVE HARM REDUCTION:

https://caan.ca/wp-content/uploads/2012/05/WalkWithMe_en.pdf

HARM REDUCTION:

https://www.catie.ca/

http://www.ohrn.org/webinars/

https://towardtheheart.com/

http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction

HARM REDUCTION – FRONTLINE:

A Manual for Frontline Staff Involved with Harm Reduction Strategies and Services January 2011
http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/CompleteHRTRAININGMANUALJanuary282011.pdf

Ontario Harm Reduction Network HRN: Sector specific webinars to help educate workers in harm reduction practices
http://www.ohrn.org/webinars/

Upside Down and Inside Out
Upside%20Down%20and%20Inside%20Out%20-%20Supporting%20a%20person%20in%20crisis_Supporting%20the%20people%20who%20care

PARTNER INFORMATION

COMMUNITY LIVING

Address: 741 Wallace Road, North Bay, P1A OE6
Contact: Jill Faber
Phone: 705-471-9021
Email: jfaber@communitylivingnorthbay.org
Notes: ______________________________

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HANDS – THE FAMILY HELP NETWORK

Address: 391 Oak Street East, North Bay, P1B 1A3
Contact: Tina Thomason
Phone: 705-476-2293, ext. 1215
Email: TThomason@handstfhn.ca
Notes: ______________________________

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CHRISTIAN HORIZONS

Address: 957 Lakeshore Drive, North Bay, P1A 2H1
Contact: Ingrid Dykstra, Mike Thompson
Phone: 705-476-6318
Email: idykstra@christian-horizons.org, mthompson@christian-horizons.org
Notes: ______________________________

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NIPISSING MENTAL HEALTH HOUSING & SUPPORT SERVICES

Address: 222 Main St E, North Bay, P1B 1B1
Contact: Mary Davis (Carla-communications)
Phone: 705-476-4088
Email:
Notes: ______________________________

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AIDS COMMITTEE OF NORTH BAY AND AREA

Address: 269 Main Street West, Suite 201, North Bay, P1B 2T8
Contact: Stacey Mayhall
Phone: 705-497-3560
Email: acnbaed@gmail.com
Notes: ______________________________

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COMMUNITY COUNSELLING CENTRE OF NIPISSING

Address: 361 McIntyre Street East, North Bay, P1B 1C9
Contact: Alan McQuarrie
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Email:
Notes: ______________________________

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VICTIMS SERVICES OF NIPISSING DISTRICT

Address: 135 Princess Street West, North Bay, P1B 8K6
Contact: Kat Jodouin
Phone: 705-472-2649
Email: ed@vianet.ca
Notes: ______________________________

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NORTH BAY REGIONAL HEALTH CENTRE

Address: 50 College Drive, North Bay, P1B 5A4
Contact: Dr. Ken Boss, Dual Diagnosis Psychiatrist (North Bay/New Liskeard), Marc Picard EMS Manager, Central Ambulance Communications Centre
Phone: 705-474-8600
Email: Ken.Boss@nbrhc.on.ca, Marc.Picard@ontario.ca
Notes: ______________________________

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ONTARIO PROVINCIAL POLICE – NORTH BAY

Address: 867 Gormanville Rd, North Bay, P1B 8G3
Contact: Darcy Wall
Phone: 705-477-2449, 705-752-0537
Email:
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COMMUNITY LIVING - HUNTSVILLE

Address: 99 West Road, Huntsville, P1H 1M1
Contact: Suzanne Willett
Phone: 705-789-4543, extension 204
Email: Suzanne.willett@clhuntsville.ca
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NORTH MUSKOKA NURSE PRACTITIONER-LED CLINIC

Address: 5 Centre St N, Huntsville, P1H 2C1
Contact: Julie McBrien (Inpatient Social Worker), Dr. Gullar (Psychiatrist)
Phone: 705-224-6752, (Dr. Gullar, 705-325-2201 ext. 6415)
Email: jlmcbrien@osmh.on.ca
Notes: ______________________________

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CANADIAN MENTAL HEALTH ASSOCIATION – MUSKOKA/PARRY SOUND

Address: 173 Manitoba Street, Suite 202, Bracebridge, P1L 1S3
Contact: Dana Sproule, Dual Diagnosis Program
Phone: 705-645-2262
Email: dsproule@cmhamps.ca
Notes: ______________________________

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PARTNER INFORMATION

MUSKOKA PARAMEDIC SERVICE – HUNTSVILLE STATION NO. 5

Address: 15 Ott Drive, Huntsville
Contact: Jason Moore
Phone:
Email: Jamoore@muskoka.ambulance.ca
Notes: ______________________________

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ONTARIO PROVINCIAL POLICE - HUNTSVILLE

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Contact: Josh Fleming, Kate McKay, Dana Morris
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Email: Josh.Fleming@opp.ca, Dana.Morris@opp.ca, Kate.McKay@opp.ca,
Notes: ______________________________

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COMMUNITY LIVING TEMISKAMING SOUTH

Address: 513 Amwell Street, Haileybury, P0J 1K0
Contact: Tony Rachwalski
Phone: 705-630-7022
Email: trachwalski@clts.ca
Notes: ______________________________

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TEMISKAMING HOSPITAL

Address: 421 Shepherdson Road, New Liskeard, P0J IP0
Contact:
Phone: 705-647-8121
Email:
Notes: ______________________________

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MINO M'SHKIKI INDIGENOUS HEALTH TEAM

Address: 421 Shepherdson Road, New Liskeard, P0J IP0
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Phone: 705-647-7855
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CANADIAN MENTAL HEALTH ASSOCIATION COCHRANE/TEMISKAMING

Address: 330 Second Avenue, No. 201, Timmins, P4N 8A4
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Phone: 705-267-8100
Email: mharkin@cmhact.ca
Notes: ______________________________

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PAVILLION FAMILY RESOURCE CENTRE

Address: 345 Cecil Street, Haileybury, P0J 1K0
Contact: Melanie Ducharme
Phone: 705-672-2128
Email: Melanie.ducharme@pavwc.com
Notes: ______________________________

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COCHRANE TEMISKAMING NATIVE HOUSING INC.

Address: 112 7th Avenue, Cochrane, P0L 1C0
Contact: Blandine Courville
Phone: 705-272-5718 ext. 5
Email: ctnh@puc.net
Notes: ______________________________

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COCHRANE/TEMISKAMING RESOURCE CENTRE

Address: 8 Whitewood Avenue East, New Liskeard, P0J 1P0
Contact: Joel McCartney
Phone: 705-647-5101
Email: jmccartney@ctrc.on.ca
Notes: ______________________________

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ONTARIO PROVINCIAL POLICE — TEMISKAMING

Address: 300 Armstrong St N, New Liskeard, P0J 1P0
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Email: Rob.Maki@opp.ca
Notes: ______________________________

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ONTARIO PROVINCIAL POLICE — KIRKLAND LAKE

Address: 26 Duncan Ave N, Kirkland Lake, P2H 3H7
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FOUNDING PARTNERS

THE SHIFT is the result of a collaborative and passionate working group who came together as caring members of the community to create this model of learning. We thank you for your attention and we honour those who taught us the need for **THE SHIFT**, by challenging our preconceptions and changing our worldview.

CONTACT INFORMATION

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HANDS – THE FAMILY HELP NETWORK

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Special thanks to Rooke Pitura, Kenora Association for Community Living

THE SHIFT

IT BEGINS WITH FOUR WORDS:
HUMILITY, AWARENESS, SENSITIVITY AND SAFETY

Shift to ➜ Humility: "We have knowledge, but we are also without knowledge."

Humble yourself before lived experience and understand that, to put it plainly, "you don't know what you don't know." Education, experience and expertise will never replace the acknowledgment that you will always be learning. You will always need to ask questions and truly listen to the answers. Acknowledge and honour the differences rather than respond with assumptions. Move forward with humility.

Shift to ➜ Awareness: "Identify and challenge your beliefs and assumptions."

Be open to challenging your fundamental beliefs, to radically altering your worldview by listening to new voices. Learn about the cultures, issues, and obstacles facing all the parts of your community. Learn the specific obstacles, then approach possible solutions with humility. Recognize differences between your worldview and others. Acknowledge your own cultural practices behaviours, and the impact they may have on others. Do what is necessary to ensure that you understand the individual's diverse needs.

Shift to ➜ Sensitivity: "Actionable changes to harmful assumptions and beliefs."

Put these learnings into place for both you and the individual. Adapt how you approach and provide service. Sensitivity goes beyond recognizing differences, it is appreciation for and comfort with differences. Practise empathy, flexibility, willingness to learn from the individual. Identify similarities, differences, as well as the individual's goals, capacities and priorities.

Shift to ➜ Safety: "Moving forward with humility, awareness and sensitivity."

As you create a place of safety for the individual, strengthening, encouraging and empowering them within the self-determined action plans, it will be with humility, awareness, and sensitivity towards the person in front of you, as well as their unique needs. Incorporating the necessary accommodations for the individual to feel safe. Safety is individual-determined and requires an ongoing commitment on behalf of the service provider.