

SECTION 1

Philosophy and Approach

This Section outlines the conceptual frameworks and philosophical premises that structure the work that drop-ins do. This Section can be useful as an educational aid; as a resource when applying for grants; as a way to broaden your understanding of the diversity of the Toronto Drop-In Network (and what unifies it); or as an advocacy tool (whether for use in participant action groups, in challenging a proposed law, or when fighting community attempts to close your drop-in).

This Section is divided into two main areas:

- **1A DEFINING OUR WORK**
 - Who We Are
 - What We Do
 - Who We Serve
 - Attachment
 - Appendix 1A.1: Sample Mission Statements

- **1B CONCEPTUAL TOOLS**
 - Social Inclusion and Social Justice
 - Health Promotion and the Determinants of Health
 - Harm Reduction
 - Community Development

SUBSECTION 1A

Defining Our Work

Who We Are

There has been substantial debate about the precise definition of a “drop-in.” Drop-ins vary in their mandates, the services they offer, the environments they cultivate, their governance structures, the populations they serve, and the types of staff or volunteers they recruit. Each drop-in has its own philosophical approach, mission statement, and mandate that guide it in its daily operations and its development of policies (see **Appendix 1A.1**).

Models and terminology. Drop-ins operate according to a variety of models – and there are probably as many models as there are drop-ins.¹ The models discussed below exist only in theory – in practice, most drop-ins combine elements from various sources:

- **Faith-based model:** Drop-ins are an extension of a particular church, ministry, or spiritual community, and drop-in users are often referred to as “guests.” The focus is on providing meals and other basic needs, and providing a space for socially marginalized people to build community and be respected. Anyone may be a guest – all are welcomed and accepted.
- **Clubhouse model:** Drop-in users are “members” and join the club to access the drop-in. Membership is usually restricted by age, gender, or some other characteristic of identity or life experience. The clubhouse model is intended to foster a sense of belonging to, and ownership of, the drop-in. Programming focuses on basic needs (showers, laundry, meals) and on recreational activities (card games, movies, sports, social events).
- **Health-focused model:** This model sees the accepting, communal space as the entry point for people to receive health services that they otherwise have difficulty accessing. Many, though not necessarily all, staff have medical training and work intensively with “clients” or “service users” to treat their illnesses, help them overcome addictions, and assist them in accomplishing their goals for positive change. What makes it a “drop-in” rather than a “walk-in” clinic is its focus on the socially marginalized population as its clientele and its efforts to meet needs that go beyond a purely medical or physical health model. For example, the building may have shower and laundry facilities, or open its doors during extreme weather alerts, or organize advocacy groups.

¹ This Toolkit tries to avoid focusing its discussions on any one particular model described above. Instead, it takes good practices from each of these models to recommend to drop-ins. The term used throughout this manual for drop-in users is “participants.” This term was chosen to be the most neutral, as it does not belong to any one particular model. It also suggests autonomous and active drop-in users who elect to participate in the life of the drop-in, whether they choose to access the space, meals, services, activities, or any other aspect of the drop-in.

- **Community development model:** The focus in this model is less on professional intervention and more on peer support and capacity building. Here the welcoming, informal space of the drop-in is intended to foster the development of supportive relationships. Staff work to empower drop-in users to become advocates on their own behalf (e.g. with landlords) and on behalf of their community (e.g. with local politicians).

Common characteristics. Since drop-ins have such different organizational cultures – and even different language is used to discuss the people they serve – it is no easy task to settle on one definition that includes them all. Some have tried to define drop-ins as providers of basic needs; this accurately describes one aspect of the service that all drop-ins provide. However, defining what constitutes a basic need, or which basic needs must be met in a drop-in, becomes problematic. Different drop-ins focus on different basic needs – some offer showers, while others don't have the space or facilities for that; some have day beds, while others don't permit sleeping in the drop-in space; some operate food banks, while others focus on providing hot meals.

There are some common characteristics, however, that describe this diverse group of services:

- **Responsiveness and flexibility.** Drop-ins start in response to a need in a particular community, and they change their services and practices as the needs of the population change. What makes the drop-in model so unique and so valuable is its flexibility. It exists as an open-ended operation where, rather than establishing one practice and continuing it, drop-in staff are continually adjusting and improving their services, programs, and policies.
- **Respect for autonomy.** Different drop-ins may focus on different basic needs, but they all emphasize the fundamental importance of treating socially marginalized people with the same respect granted to everyone else. This approach involves respecting an individual's personal autonomy – their ability to make their own decisions about how they want to live their life, the services they want to access, the changes they want to make, and the rate at which they want to make those changes. This does not mean drop-in workers refrain from discussing potential interventions (e.g. detox) with a participant, but it means they do not impose those interventions, or make them a requirement of accessing the drop-in.
- **Holistic approach.** Drop-ins take a holistic approach to working with people, recognizing that any one particular need – e.g. for housing – is always bound up with many other needs – e.g. the need of formerly homeless people to feel safe and “at home” in a new apartment; the need

for interventions into hoarding behaviours, so that people’s possessions do not end up crowding them out of their homes; the need for community, so that a person now living alone can balance their familiar life and friends on the street with their new living situation; the need for food and nutritious meals; the need for meaningful activities over the course of a day; the need for an advocate who can intervene on a person’s behalf with a landlord; and so forth.

These three attributes – **flexible responsiveness, respect for autonomy, and holism** – locate drop-ins within the landscape of social services. Drop-ins are generalists in a landscape of ever more specialized institutions. Their approach involves a certain amount of “**intentional informality**” that is simply not possible for many other types of organizations. But this informality should not be mistaken for a laissez-faire attitude; it is “intentional” in that it seeks to create a particular kind of environment where participants can establish a level of comfort and trust before sharing sensitive information, access services in their own time, and develop supportive relationships with their peers.

It is this relaxed environment and respect for autonomy that participants emphasize when they define what a drop-in is. A drop-in is “a place where you can sleep or have a coffee and interact with other people, and where nobody lectures you or belittles you”. It is also “a place to get information, self-help, a shower, housing, legal aid, and employment skills” and “deal with self esteem and address health issues.” A drop-in is “a calm area,” “a safe house,” “a refuge,” and “a port in the storm.”

Most other institutions, by the specialized nature of their work, take a more clinical approach to working with participants. They are guided by institutional or government mandates that define the goals for participants, the steps that must be taken to meet those goals, and the conditions of life required to remain eligible for the services and resources provided. This organizational structure is designed to efficiently handle large numbers of people, and can be very effective. These two approaches to service provision are not exclusive, but complementary: the drop-in approach is not “better,” but it does respond to needs that cannot be met by the other approach; it is not “worse,” but it should not be replaced by a more formalized model.

What We Do

All drop-ins provide an informal social setting, respond to some basic needs, and offer some sort of programming. The roles of drop-in programs can generally be organized into four clusters, described in the following way by researchers at the University of Sheffield:²

- 1. Providing for basic needs:** Basic needs can include food, clothing, showers, laundry, and a safe place that is warm in the winter and cool in the summer. Some

² This section has been adapted from Maureen Crane, Ruby Fu, Phil Foley, and Anthony M. Warnes, *The Role of Homeless Sector Day Centres in Supporting Housed Vulnerable People*, Sheffield (UK): University of Sheffield, 2005, pages 33-36.

provide meals because participants may lack the money, facilities, or skills to prepare food, or they live alone and are not motivated to cook. Drop-ins provide an environment that is safe, with staff that are responsive to personal health and well-being.

- 2. Providing opportunities for social contact:** All drop-ins have some kind of common room where meals or snacks can be eaten and participants can socialize. Many participants may not feel welcome or comfortable in “traditional” community centres and find drop-ins more accessible. Many participants have weak informal social networks and little or no contact with relatives, and drop-ins can provide a relaxed social setting in which people can make new friends. Many housed participants are formerly homeless and are currently only precariously housed. For them, having access to a supportive community may help them stabilize and stay housed.
- 3. Providing support for well-being:** In providing support for participants’ well-being, drop-ins fill a gap in the provision of community support services for vulnerable people, though this role is not adequately recognized and is often constrained by insufficient resources and staff.

Drop-ins provide support for participants’ well-being in different ways, corresponding to their organizational mandate, staffing capacity, and financial resources. Some drop-ins provide help with housing, debt problems, rent arrears, physical and mental health concerns, social assistance issues, and substance use problems. Some offer individualized case work and some offer more informal emotional support to people who find it hard to cope with everyday stresses and adverse events.

- 4. Providing the opportunity for change:** Many drop-in programs help people build skills, motivation, confidence and self-esteem so that they can rebuild their lives and sustain housing (if they have it). Life skills training, meaningful activities, education, and work training programs are offered. For those who are homeless, it is difficult to remain employed. They become trapped in a cycle of “no home, therefore no job, therefore no home.” When eventually they are housed, they have often been unemployed for several years.

The work projects developed by some drop-in programs are beneficial for people who are not ready to return to conventional employment. Many drop-ins offer life skills training classes and community kitchen programs. Some people have always lived with others until they became homeless and have never been responsible for daily living tasks such as cooking and budgeting. While in hostels or on the streets many people do not have the opportunity to practice these skills, so difficulties may only become apparent when a person is housed and has to manage alone.

It is important to recognize that the roles on this list are not exclusive and the lines are often blurred. For example, providing a meal is both a response to basic needs and an opportunity for social contact and community-building. Running a recreational activity like arranging flowers is an opportunity for socializing that can also be an intervention for positive change, helping newly (and precariously) housed people connect with their new home. Responding to people's health problems (whether mental or physical) can be categorized as providing for basic needs, providing support for well-being, and providing an opportunity for change.

Who We Serve

Just as it is difficult to identify the limits and boundaries of what defines a drop-in, it is difficult to pin down a definition of drop-in participants. Drop-ins do not work with only one sector of the population, or with a group of people that is easily categorized. For example, drop-ins are often thought of as serving the “homeless” population, but this is problematic for three reasons:

1. **Population.** Drop-ins serve socially marginalized people who are housed as well as those who are living on the streets.
2. **Definition.** The term “homeless” itself is often misunderstood as referring exclusively to people who are living on the streets or in squats, ravines, or parks. The 2001 *Toronto Report Card on Homelessness* defined the term as a condition of people who
 - Live outside,
 - Stay in emergency shelters,
 - Spend most of their income on rent, or
 - Live in overcrowded, substandard conditions.³

Research has also been done on “hidden homelessness,” where people have no home of their own, but sleep at a friend's or relative's place.

3. **Cycles.** Many people go through cycles of homelessness. A drop-in participant who is currently staying in a hostel may get a space in a subsidized apartment tomorrow. A participant who is living in a rooming house today may be out on the street tomorrow. Sometimes the difference between homeless and housed, or between precariously housed and stably housed, can depend on the intervention of the drop-in.

The term “homeless” is also misleading as a description of drop-ins' populations, because it implies that there is only one problem – the lack of housing – and thus only one solution – housing. Of course, helping people find homes is something that many drop-ins do, or invite external housing workers in to do, but since lack of housing is not the only concern participants have, it is not the exclusive focus of drop-ins' services.

³ City of Toronto, *The Toronto Report Card on Homelessness*, 2001, page 2. Available at: www.toronto.ca/homelessness/homelessnessreport2001.pdf.

Multiple needs. Drop-ins work with people with “multiple needs;” this is defined by Homeless Link as people who are experiencing challenges in a number of areas of their lives, such that if they were to overcome one of these issues, the others would still inhibit their acceptance by the wider social world, their ability to remain stably housed, or their ability to hold down a job. These individuals may be homeless or housed, and they typically are not in contact or not communicating well with the social service agencies that could help them. Someone with multiple needs is grappling with two or more of the following issues:

- Mental health problems
- Physical health problems
- Misuse of alcohol, drugs, or other substances
- Learning difficulties
- Behaviour control difficulties
- Vulnerabilities because of their age.⁴

Social and geographical communities. Drop-ins also tend to come into being in response to the needs of a particular community. Communities may be geographical or social, and these two often partially overlap. For example, one community centre with several drop-in programs operates in the heart of Toronto’s queer community. This organization serves both a local neighbourhood that includes both LGBTQ⁵ and non-LGBTQ people, and the LGBTQ community that stretches beyond its catchment area. Most drop-ins report a core of participants who come from within their geographical community, and a number of other participants who travel there for the social community of a specific population (e.g. First Nations, seniors, youth, women, men, etc.), environment (e.g. quiet, spiritual, etc.), or needs (e.g. mental health, addictions, etc.) that the drop-in focuses on.

All of this means that it is hard to pin down which population it is, exactly, that drop-ins serve. Drop-ins are diverse and serve a variety of populations. But this diversity is in part due to one practice that all drop-ins have in common: drop-ins are open and welcoming places to all those who need their services, whoever those people may be or wherever they may come from.

ATTACHMENT:

- **Appendix 1A.1 – Sample Mission Statements**

⁴ Homeless Link, “7: Working with people with multiple needs,” *Day centres handbook: A good practice guide*, London (UK), 2004, pages 7.4-7.5.

⁵ “LGBTQ” stands for Lesbian, Gay, Bisexual, Transgendered/Transsexual, and Queer.

Appendix 1A.1 Sample Mission Statements

Source: Reproduced from documents collected from TDIN drop-ins during the Good Practices Toolkit consultations, May-September 2006.

MISSION STATEMENTS

#1: Faith-Based Model

We seek to nurture community with the neighbour, especially the homeless, alienated, economically poor and women at risk. We welcome everyone without distinction and offer opportunities for participants, volunteers, and staff to be nourished in body, mind and spirit.

#2: Clubhouse Model

To supply and render services of a charitable nature to poor and needy persons and, for such purposes, to provide, maintain, operate, and conduct a centre for social activities, recreation, and other privileges for elderly, homeless, unemployed men.

To endeavour to interest the public in the social problem presented by elderly, homeless, unemployed men, and to further the alleviation of this problem.

To establish training and education centres and to train poor and needy persons in gainful trades, professions and occupations, with a view of enabling such persons to become self-supporting.

To cooperate with other organizations, whether incorporated or not, which have objectives similar in whole or in part to the objectives of the Corporation.

#3: Health-Focused Model

We believe that the most effective way to improve health is to have programs designed and run by the community affected; therefore, we are working towards community participation and decision making in all aspects of the centre's activities.

We believe that health care services should be accessible to all members of our community. We are committed to providing, and ensuring access to, responsive, culturally sensitive services to meet the needs of our diverse community. We recognize that the community and its needs are constantly changing and we are committed to regular evaluation of all programs.

We recognize that social, economic and political issues, such as poverty, inadequate housing, unequal access to services, etc. affect health. We are committed to working with community residents and agencies to advocate for better policies and service delivery on related issues.

We believe that comprehensive health care should include maintaining good health as well as treating illness; therefore, our services will include treatment, support, prevention, education and advocacy on physical and mental health issues.

#4: Community Development Model

[Drop-In Name] is a women's organization that offers practical and emotional support to women through programs, which enable them to take greater control over their lives.

[Drop-In Name] works to change social conditions, which endanger women's lives. The following are [Drop-In Name]'s overarching goals:

- **Program:** To offer socially isolated, low income and homeless women assistance, support and encouragement through social and recreational programs.
- **Advocacy:** To support or promote, in collaboration with other organizations, the health, education and social welfare of any woman or group of women and to encourage the development of services or programs that foster self-reliance
- **Administration:** To manage programs, services, and advocacy efforts; to ensure the use of human resources reflects [Drop-In Name]'s overall commitment to the value of women's roles as human service providers and volunteers; to ensure the agency's financial autonomy is maintained by utilizing diverse private and public funding sources.

SUBSECTION 1B

Conceptual Tools

In addition to the policies and practical advice offered throughout this Toolkit, theoretical frameworks and concepts are also important tools that help drop-ins build the foundation for their work and articulate the rationale behind their approach to funders and other outside bodies that may want to understand their work.

The following terms and conceptual frameworks provide a basis for understanding and reflecting on and developing good practices:

- **Social Inclusion and Social Justice**
- **Health Promotion and the Determinants of Health**
- **Harm Reduction**
- **Community Development**

Social Inclusion and Social Justice

“Social inclusion” is the approach taken by drop-in workers to help people become full participants in their community in economic, social, psychological, and political terms. The concept encourages reflection on the multiple barriers to social equality and generates expectations for change at various levels of society – from widespread attitudes to governmental policies to service delivery practices.

“**Social exclusion**” is a concept that was developed as an alternative term for “poverty.” “Poverty” focuses too exclusively on finances and ignores the social marginalization experienced by people with minimal resources. Also, as a personal descriptor, “poor” can obscure systemic and structural oppression and can place the emphasis instead on individual abilities.⁶

“**Social justice**” is a term linked to social inclusion; its goal is also “the full and equal participation of all groups in a society that is mutually shaped to meet their needs.”⁷ It envisions a world in which the current unequal divisions of labour, responsibility, and privilege are reorganized more equitably and the principles of fairness are applied in even measure to all individuals, regardless of class, status, ethnicity, gender, sexuality, age, or any other discriminatory factor.

⁶ Toronto Enterprise Fund, “Section 1: Background,” *The Business of Inclusion: Building Livelihoods for Homeless and Low-Income People*, prepared by Eko Nomos Program Development Consultants, October 2003. Available at: <http://action.web.ca/home/uwgt/attach/TEF%20-%20section%201%20final1.pdf>.

⁷ Maurianne Adams, Lee Anne Bell, and Pat Griffin, *Teaching for Diversity and Social Justice: A Sourcebook*, New York: Routledge, 1997.

Drop-ins often see their primary task as creating an environment where relationships between people are organized according to the principles of fairness, rationality, consideration, and kindness. They work to foster an environment of social justice within the drop-in, and to work with participants to advocate for a more socially just community outside of the drop-in.

Health Promotion and the Determinants of Health

Drop-ins conceive of health, like poverty, in broader terms than a simple attribute of a person. The Ottawa Charter for Health Promotion states that “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.”⁸

Determinants of health. A number of factors work together to affect people’s health, including:

- **The social and economic environment** – for example, income, education, social status, access to health care, support networks, employment and working conditions, etc;
- **The physical environment** – for example, rural, urban, industrial, tropical, etc.; or in a place with water filtration systems, in a war zone, in overcrowded housing, etc.; and
- **A person’s individual characteristics and behaviours** – for example, genetics, gender, culture, age, hygiene practices, smoking habits, exercise, nutritional intake, etc.⁹

Health promotion. The determinants of health described above do not exist in isolation from one another, but rather work together in a complex system. Health promotion takes this system into account as it enables people to increase control over and to improve their health through:¹⁰

- **Building healthy public policy**, through legislation, fiscal measures, taxation, and organizational change that will foster greater equity and cleaner, safer environments;

⁸ Ottawa Charter for Health Promotion, adopted at the First International Conference on Health Promotion, Ottawa, November 21, 1986. Available at: www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.

⁹ Canadian Health Network, “What Makes People Healthy?” n.d. Available at: www.canadian-health-network.ca. Last modified February 2005.

¹⁰ Ottawa Charter, 1986.

- **Creating supportive environments**, where people take care of each other, our communities, and our natural environment;
- **Strengthening community actions**, through facilitating full and continuous access to information, learning opportunities, and funding support for public participation in and direction of health matters;
- **Developing personal skills**, through health and life skills education; and
- **Reorienting health services**, beyond clinical and curative services to a mandate that includes broader social, cultural, political, economic and physical environmental components.

The health promotion approach focuses on strengthening the skills and capabilities of individuals, groups, and communities to enable them to take action and gain some measure of control over the determinants of health. As the Health Promotion Agency for Northern Ireland notes, “health promotion is not something that is done on or to people; it is done by, with and for people.”¹¹

Harm Reduction

Harm reduction is a broad-based approach that takes into account the effects of potentially harmful behaviour on all aspects of a person’s life as well as the impact on the wider community. For example, laws that prohibit smoking in enclosed spaces or near public buildings were instituted both to discourage individuals from smoking (or decrease the number of cigarettes they consume in a day) and to protect the community as a whole from the damaging effects of second-hand smoke.¹² Other measures taken in response to unhealthy or unsafe behaviours include graduated licencing programs for young drivers; distribution of free condoms at health clinics to reduce the spread of sexually-transmitted infections; physicians prescribing methadone to help heroin addicts overcome their dependency; homeless shelters dispensing controlled quantities of alcohol to people who are addicted to alcohol and would otherwise be on the street creating a disturbance or freezing to death in the winter; and so forth.¹³

Acknowledging that not all people who engage in unhealthy or unsafe activities are at a point where they will accept interventions aimed at stopping their behaviour, the harm reduction approach works to minimize the damaging effects that these behaviours can have.

¹¹ Health Promotion Agency for Northern Ireland, “What Is Health Promotion?” n.d. Available at: www.healthpromotionagency.org.uk/Healthpromotion/Health/section2.htm.

¹² Ontario Ministry of Health Promotion, “Frequently Asked Questions about Ontario’s Smoke-Free Strategy,” n.d. Available at: www.mhp.gov.on.ca/english/health/smoke_free/default.asp. Last updated September 15, 2006.

¹³ Adapted from Paul Garfinkel, “Reducing harm in our society,” *Toronto Star*, Thursday, September 7, 2006, page A22.

At many TDIN drop-ins, **harm reduction strategies** include putting out baskets of condoms (and distributing them specifically to sex trade workers), handing out crack kits (to reduce the use and sharing of unsanitary equipment), installing safe needle disposal containers, making sure water and food are always available, and providing people who are under the influence with a safe space where others cannot take advantage of them (especially when they are incapacitated by drugs or alcohol). These strategies are accompanied by education regarding available alternatives, treatment options, and social service agencies, which participants may choose to access in their own time.

The harm reduction approach taken at many drop-ins recognizes that people have many needs related to their personal health and safety that may not get addressed if being sober is a condition of service. These drop-ins welcome drug and alcohol users the way they would any other person, and begin a **non-judgmental dialogue** with them around their use. Talking openly about the issue allows them to make participants aware of the dangers of substance use and how they can be prevented. Workers can ask participants how they are doing and discuss strategies for safe use. This approach allows staff to meet participants “where they are at” in terms of their substance use, and to let them know that they can access the help they need if they choose to quit, without imposing this as a requirement for accessing the drop-in.

Community Development

Community development works through concrete and effective community action that builds the community’s strength, sustainability and capacity to set priorities and make decisions on issues that affect its health and well-being. Participants need to be involved in program design, planning and implementation if the activities and solutions the drop-in is developing are to be rooted in an understanding of the community’s perception and experiences of its needs and issues.

Taking a community development approach to service planning encourages service providers and participants to take responsibility for strengthening the fabric of their own community, by asking themselves what kind of place their community is and how services may be used to positively influence the quality of life there.

The community development approach builds on the following principles and beliefs:¹⁴

- Social exclusion occurs when people lack access to education, employment, decent housing, health care, and other conditions necessary for full participation in society.
- We need to build coalitions and partnerships with others whose work deals with the factors that contribute to social exclusion. The health of

¹⁴ This list has been adapted from the Association of Ontario Health Centres (AOHC), “Principles and Beliefs,” *Building Healthy Organizations*, August 2002.

our community develops through such partnerships.

- Programs need to operate on community development principles, such as collective decision-making and action, leadership development and peer support techniques where people learn and teach from their own experiences.
- Management and staff must share information and knowledge with the community to help them make informed decisions.
- Our organization has a responsibility for providing resources and information to our community, and helping it to meet its health goals.
- We need to be aware of the issues that affect our communities. We need to join with others and speak out on these issues in an effective way.

It is a good practice to develop a statement of beliefs and principles, and involve participants in its development.