2002 CALGARY HOMELESSNESS STUDY

Final Report
October 2002
Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Universal Declaration of Human Rights article 25, par. 1.

Even the most sophisticated studies cannot determine the morally “right” way to spend public money.

Barbara Dickey, Harvard University, 2000
Acknowledgements

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- Calgary Urban Projects (CUPS)
- Calgary Drop In Centre
- Murdoch Manor
- The shelters for women fleeing violence
- The Golden Age Club
- The Kerby Centre
- The Mustard Seed (Calgary) Street Ministry
- The Salvation Army
- Urban Society for Aboriginal Youth (USAY)

We were greatly encouraged by the number of homeless and relatively homeless people who took the time to talk to us about their experiences and to indicate the areas where service providers can work to help people avoid homelessness or get out of it sooner.

We would also like to thank the Calgary Homeless Foundation (CHF), the funder of this project, the CHF Research Steering Committee and the Community Action Committee for their support and assistance in managing a very complex process.
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Executive Summary

Background

The 2002 Calgary Homeless Foundation study was carried out between April and September 2002. The study, which built upon the 1997 research, had three goals:

1. To update our information about the characteristics of homeless people in Calgary using the survey instrument from the 1997 study, with appropriate changes to update the instrument;
2. To map the current homelessness system, identify how individuals and families move through the system, and identify gaps in the system; and
3. To develop a profile of the population at risk of becoming homeless by identifying the factors that may precipitate homelessness for individuals and families.

A research team from the University of Calgary was selected to develop and implement an appropriate protocol to gather information from both Absolutely Homeless (AH) and Relatively Homeless (RH) individuals in Calgary, and to complete the data analysis and report writing. The core research team worked collaboratively with community stakeholders in all phases of the research, to structure a randomized and stratified survey sample, design and gather quantitative information, and complete clinical interviews to gather qualitative information. The research data were used to develop a model of the process of homelessness in Calgary and to make recommendations about how to prevent homelessness and/or shorten its duration.

The level of collaboration and the solution-focused approach of the Calgary community was remarkable throughout this project. The research team had a very short timeframe (4 months) to carry out an extraordinarily complex task, and the project could easily have stalled without the heartfelt cooperation of the community. Funders, sector chairs, front line agency staff and homeless/relatively homeless people actively volunteered to participate in focus groups, workshops and individual interviews. They wholeheartedly took on the task of advising the research team on a myriad of issues, from debating the merits of stratified sampling and the various definitions of homelessness to providing advice on the best locations and times to locate the relatively homeless, and identifying appropriate individuals to take on the role of surveyors. In a very real sense, this report is a continuation of Calgary’s commitment to a collaborative approach to understanding and addressing homelessness in our city.

Key Findings

Comparing 1997 and 2002 CHF Study Results
Throughout the key findings and results sections, the 2002 study has been compared to the results of the 1997 study whenever possible. However, it is important to acknowledge that the definition of homelessness used in 2002 was different than that used in 1997. The process of selecting the 2002 definition is described in detail elsewhere. The 2002 study used the World Health Organization definition of Absolute and Relative homelessness as follows:

Absolute homelessness or shelterless refers to individuals living in the street with no physical shelter of their own, including those who spend their nights in emergency shelters. Relative homelessness refers to people living in spaces that do not meet the basic health and safety standards including:

1. Protection from the elements;
2. Access to safe water and sanitation;
3. Security of tenure and personal safety;
4. Affordability;
5. Access to employment, education and health care;
6. Provision of minimum space to avoid overcrowding.

It should be kept in mind that the 1997 study focused exclusively on individuals who would be classified as AH in the 2002 study. Therefore, comparisons between the 2002 RH group and the 1997 study are not appropriate. Comparisons between the 2002 AH group and the 1997 group are possible in most instances. However, a few caveats should be kept in mind when making these comparisons. First, it is important to be aware that the AH population in 1997 and 2002 are not necessarily the same people. The 2002 study is not a continuation of the 1997 study from a longitudinal perspective. Second, the studies had much in common that was intentional (such as some of the questions asked and the study timeframe) as well as unintentional (economic and environmental factors) which serve to strengthen the comparisons. Third, and perhaps most importantly, the methodology varied between the two studies. The 1997 survey worked with a small number of agencies and faced barriers to data collection due to confidentiality issues. Survey respondents were referred to the 1997 research team by agency staff, and no qualitative interviews were conducted. The 2002 study did not use individually identifiable information and therefore had much wider access to homeless people. Respondents were randomly sampled from a wide variety of facilities and street locations throughout Calgary. Individuals who had been homeless in Calgary more than once were also invited to participate in a clinical interview. The 1997 study used an excellent process and reported essential information about homelessness in Calgary at a time when little empirical research was available. However, the methodology employed in 2002 likely means that the results offer a more realistic picture of the homeless population as it currently exists in Calgary.

It should also be noted that the 2002 process used a stratified sample. In other words, the number of people to be surveyed in each sector (such as the number of youth, or the number of seniors) was decided upon in advance. This approach was taken for several reasons. First, there are no definitive sources to provide accurate demographic profiles on homeless individuals in Calgary or any other jurisdiction. Second, the literature indicates that the demographic profile of homeless populations varies from jurisdiction to jurisdiction. Third, the research team and the research steering committee considered the Calgary stakeholders (service agencies and funders) to be the best source of knowledge regarding the population they serve. Consequently, the number of people surveyed and their demographic profile was developed through an extensive, collaborative effort involving many of the community stakeholders in focus groups and an all-day workshop. The method worked well to meet the goals of the study, which were, in part, to ensure that voices of the homeless were heard from all of the sectors. However, it does mean that the study cannot speak to the demographic profile of the Calgary population, since those criteria were established in advance. For instance, the community decided that 21% of the people surveyed should be “youth”. The study therefore cannot conclude that youth make up 21% of the Calgary homeless population, since this proportion was set as part of the study methodology.

The Absolutely Homeless Sample (N=238)
Evidence from the 2002 study, suggests that there are several differences between the homeless population accessed for the 1997 study and that accessed in 2002. Among the absolutely homeless, males were older, and females younger than those in the 1997 sample. Both the AH and RH groups have less education than the 1997 cohort did, and they are less likely to have marital partners. When the 2002 data for the absolutely homeless are compared directly against the 1997 results, (i.e. calculating percentages based on the total number of responses) lack of work is less likely to be identified as the primary reason respondents give for
being homeless. Instead, health problems top the list for both males and females who are AH, followed by the cost of rent and family problems. However, when asked about the immediate cause of their homelessness, all groups stated that having insufficient funds for rent was key. AH males indicated that the immediate causes of their homelessness were lack of work/lost job and insufficient funds for rent. AH females indicated domestic difficulties and insufficient funds for rent. Youth have additional reasons for being homeless that are not shared by the older AH cohort.

The data also show that both the frequency and duration of homelessness have increased since 1997. The number of people who have experienced homelessness more than once has increased by 6%. In 1997, only 15% of respondents had been homeless for more than 1 year, and only 5% had been homeless for more than 5 years. The latter group was considered to be chronically homeless by the 1997 team. In 2002, 26% of male AH respondents indicated that it had been more than a year since they last had a home, and 10% indicated that it had been more than 5 years. 23% of female AH respondents indicated that they had been homeless for more than one year but less than 5 years, and 6% had not had a home for more than 5 years. In order to more accurately compare the 2002 and the 1997 results, the 2002 male and female groups must be combined as they were in 1997. The result is a 9% increase in the number of people who have been homeless for more than one year but less than 5, and a 3% increase in the number of people who have been homeless for more than 5 years.

In the 2002 study, AH individuals were more likely to have been born in Calgary, with an increase of 6% in this group over 1997. Virtually all other AH individuals in the 2002 study who were not born in Calgary were either from other parts of Alberta or had arrived in Calgary from other Canadian provinces. Only 2 individuals out of 309 were from outside Canada, a drop of 7% from 1997. 62% of respondents reported that they had been in Calgary for more than one year. Age was a significant factor in duration of stay in Calgary, with younger people accounting for a disproportionately larger number of those who have been in the city a shorter period of time, and seniors accounting for a disproportionately larger number of those who have been in the city for 15 years or more.

When AH males migrate to Calgary, they usually do so for economic reasons, including hoping to find work, but they are also likely to be seeking a better life than the one they left behind. AH women are equally likely to arrive for economic and family reasons, although they, too, are seeking a better life. What they find, however, are high rents - the primary reasons provided by AH respondents for not having a permanent home were factors associated with high rents (i.e. being unable to afford the damage deposits or the rents, or not having sufficient funds to take the steps necessary to obtain and keep a job). Damage deposits/start up costs were reported as a barrier to moving out of homelessness 10% more often than in 1997. Rental rates were reported 7% more often as the primary barriers to having a permanent home than they were in 1997. This result is despite the fact that 5% more AH individuals are working in some capacity than were working in 1997. On average, employed AH people earn $1,377.27 per month for full time work, $786.79 per month for part time and $395.62 for occasional or casual work. Individuals who are not employed, including those who do not work because they are disabled, report average monthly incomes of $648.88. The majority of individuals who were not currently employed indicated that they would like to find work (76% of AH, 66% of RH). The primary barriers to employment for the AH group were health problems, not having a fixed address to put on application forms, and not having access to a telephone.

There are some positive differences between the experiences of the 1997 and 2002 cohorts. For instance, the number of people who report that they have gone without food for more than 1 day has dropped by 10% since 1997. Similarly, there has been an 9% drop in the number of people who report that they have slept outside at least once during their current episode of homelessness. However, a number of survival strategies that were not included in the 1997 study were important factors for both the absolutely and the relatively homeless, including
dealing drugs or doing drug related favors, and using food banks. The number of people who reported that they did not have an Alberta Healthcare Card has dropped by 5% since 1997, although cost continues to be an important barrier to having a health card and accessing health services.

Approximately half of the AH group were experiencing mild to severe mental health problems, moderate general health, and moderate levels of disability as measured by the Wisconsin Quality of Life and WHODAS II. 48% of the AH group reported having periods of anxiety or depression at least some of the time during the past month. 31% of the AH group had felt suicidal during the past month. A significant number of AH individuals (N=60, 26%) did not know where to go for mental health care. Problems accessing health care when it was needed jumped from 20% in 1997 to 30% in 2002; an increase of 10%. Again, lack of money is one of the primary reasons for not accessing health care. Respondents indicated that the barriers to accessing health care included being unable to afford the transportation to get to care, the cost of medications, or costs of some other aspect of care. The majority of AH people have current untreated dental problems, and almost half of the AH sample have a current substance abuse problem.

The Relatively Homeless Sample (N=71)

RH individuals are considerably older than their AH counterparts (an average of 41 vs. 36 years of age respectively). The reasons they gave for their current situation were somewhat different from those of the AH group, in that the RH male respondents indicate lack of supported housing as the primary cause, closely followed by high rents. RH females indicated that high rents are the principal problem. When asked what the immediate cause of their homelessness was, RH males indicated that lack of social service benefits and insufficient funds for rent were key, as did the female RH group.

Evidence from the RH group shows that they have experienced housing problems just as often as their AH counterparts have (5.5 times for AH, 5.7 times for RH). The RH group has considerably longer tenure in Calgary than the AH group, with 74.7% having been in the city for more than one year. Male and female RH individuals migrate to Calgary for different reasons. While both are drawn primarily due to family and friends who have moved here, or who were already living in the city, males are also drawn for economic reasons, which females did not mention. Both groups are seeking a better life. Like their AH counterparts, what they find when they arrive are unexpectedly high rents. The primary reasons provided by RH respondents for not having a permanent home were factors associated with high rents (i.e. being unable to afford the damage deposits or rents, or not having sufficient funds to take the steps necessary to obtain and keep a job).

Fewer RH people work when compared with their AH counterparts, although this is likely due to the fact that many of the RH group were youth, seniors and women fleeing violence (most often with children). Each of these groups faces additional barriers to employment, even without housing difficulties to contend with. The RH group also earns less than the AH group, reporting $1,150.00 per month for full time work, $790.00 for part time and $355.56 for occasional or casual work. Although 66% of RH respondents indicated they would like to find employment, they reported barriers due to their older age and lack of education.

The majority of RH respondents are experiencing negative mental health overall, moderately good general health, and a lower level of disability (i.e. they are less disabled than the AH group). The majority, (N=56, 79%) of RH individuals reported that they had some periods of anxiety and/or depression over the past month. A significant minority, 26.7% had felt suicidal in the past month. A significant number (N=22, 31%) of the RH group did not know where to go for mental health care services.
Although RH respondents do not report problems accessing health care as frequently as the AH group does, they still reported a 25% rate of access issues. This rate is a 5% increase over the rate reported in the 1997 report for AH persons. Dental problems are a concern for 45% of the RH group, and 31% have a current substance abuse problem. These rates are both lower than those for the AH group.

It is possible that the changes noted above are due to the differences in the sampling methodology used by the two studies. The 1997 study, working with a smaller number of agencies, studied primarily the Singles sector population. The 2002 study worked with a larger variety of agencies in order to survey all of the eight sectors. 36% (110) of the 2002 surveys were administered on the street, in locations such as bottle depots, Olympic plaza, and areas known to be frequented by sex trade workers. These differences make it likely that the 2002 survey provides a more accurate picture of the experience of AH and RH persons across the sectors. The research team feels confident in stating that, with the exception of the reduction in the percentage of AH people who go for long periods of time without food, or who are forced to sleep outside, the situation for both AH and RH people in Calgary has grown more grave since 1997. More of the AH group work, but they are less likely to be able to afford damage deposits, rent, health and dental care. While it is clear that AH and RH people in Calgary can survive, in that they can find overnight accommodation and food, it is also clear that an organized system to move AH and RH people out of poverty and homelessness in a sustainable way has yet to be developed. There are certainly examples of agencies working together to identify and house specific families and individuals, but these partnerships are not able to keep up with the numbers of homeless persons in any sector.

**Recommendations to Reduce Homelessness**

**Local Initiatives:**

1. **Offer a “One-Stop” Approach to Accessing Services:**
   Although individual services are often excellent, there is no systematic process in place to offer a “one-stop” approach to accessing them. AH and RH individuals must focus much of their attention on daily survival needs. The evidence shows that they also have significant barriers to accessing services for mental and physical health conditions, and insufficient funds for public transportation to get to service locations. Furthermore, a large proportion of the AH and RH population has low resilience characteristics associated with developmental trauma, loss of developmental assets, mental health problems and addictions. Most services for the homeless cannot realistically be based on an office-practice model that requires them to find their way through the system and its many barriers unaided.

2. **Develop Community Outreach Teams for connecting homeless persons to services:**
   The goal of these teams should be to coordinate currently available services and advocate for RH and AH individuals to obtain equitable access to appropriate programs. This mandate includes actively working in an ombudsperson role where necessary when homeless people experience difficulties with services (for example, if they have been barred for life, or have an interpersonal problem with a specific staff person). By actively assisting AH and RH people to engage available services, these teams will be well placed to help people permanently out of poverty and homelessness.

The teams should be community based, inter-disciplinary and inter-agency, and modeled on an assertive outreach approach. The teams should be prepared to take responsibility for pulling elements of the system together to support their clients, and be willing to work primarily in the community, rather than in office-based practice. It would be logical to provide space in the same area as the “one-stop” services recommended above.
These teams should address many of the barriers that AH and RH people experience, including: problems obtaining Alberta Healthcare Cards or SFI; replacing lost identification; accessing healthcare; finding housing that will accept SFI; and mediating landlord and roommate disputes. For these teams to be successful, they must be staffed with people knowledgeable about what services are available in the community and from government sources, and strongly linked to relevant agencies such as the Calgary Housing Company, police services and mental health services. Resources currently exist in Calgary to help train such teams. It is possible that existing agencies could initially collaborate to form demonstration teams, using existing staff positions where possible and requesting funding for additional staff as necessary.

3. **Establish Administrative/legal advocacy groups to serve AH and RH people.**
   a) 19% of AH individuals do not have an Alberta Healthcare card because they do not know how to obtain one. Substantial numbers of people have lost their identification and are unable to replace it. Individuals often speak of problems with landlords and roommates that are legal in nature (i.e. being locked out of an apartment that they paid for in full or in part, by a roommate or landlord; having items stolen by roommates or landlords; being evicted for no apparent reason, with no notice and so on). Individuals also often speak of legal issues with employers, such as not getting paid, not having their WCB claim processed, or being removed from long term insurance disability benefits without justification.
   b) This group could potentially work with the CHF, appropriate community partners and the legal community to find creative ways to address the issue of garnisheed wages as an employment disincentive. For example, perhaps funds could be established to allow a phased in approach to paying childcare or other related supports so that, as stable earnings go up, garnishees phase in. In any event, wages should not be garnisheed until the individual in question is earning above the poverty line.

   Often nothing is done about these issues because the respondents either do not know how to solve the problem or are unable to attend to it because survival issues take priority. However, the problems continue to face them as they attempt to make better lives for themselves. A centrally located legal advocacy office is needed to assist with these problems (perhaps with the “one-stop” service recommended above).

4. **Increase the transparency and accountability of the Calgary Housing Company (CHC).**
   The Calgary Housing Company has the very difficult task of allocating a limited supply of social housing in a context where demand far exceeds supply. The waiting list is long, and tenant length of stay extends as the shortage of other affordable housing options worsens. As of September 30, 2002, the CHC’s current waiting list stood at 2000. However, this already difficult situation is also exacerbated by that fact that CHC’s current processes and practices mystify and frustrate many of the homeless individuals the research team interviewed. Stories abound of lost files, individuals who are told they are getting housing, only to be told that they aren’t and vice versa, waiting lists that are years long while apartments and townhouses sit empty. In the absence of information to refute these views, some individuals do not apply. They assume that the stories are true, and that there is therefore no point in applying. This belief may account, in part, for the very low level of access by the AH sample to units managed by the Calgary Housing Company. It is therefore recommended that the Calgary Housing Company arrange for an external evaluation of its processes, information flow, and outcomes, with particular emphasis on outcomes for the persons served. It is further recommended that the evaluation findings be used to improve services and outcomes and to inform a campaign that would begin to rebuild a positive relationship with the community.
It should be pointed out that the recommendation for an external evaluation is not a reflection on the ability of Calgary Housing Company staff to improve their own programs. Rather, it is an acknowledgement that Program Evaluation is a specialized discipline that most organizations do not need on a full time basis. Consequently, most evaluators are external to the organization. The goals of an evaluation may be formative (to assist a program as it develops) or summative (to make a statement of value on the objective outcomes achieved by the program) or both. It would also be particularly useful for Calgary Housing Company to undertake an external evaluation at this point in time because such a venture would provide objective evidence of the effectiveness of the organization in achieving its goals. In addition, it can provide evidence of the areas that need to be improved (such as, for instance, the need to increase housing stock in order to meet its goals) to assist the organization as it continues to improve its services. Finally, an external evaluation process adds credibility that helps to ensure the results will be well received by the various stakeholder groups such as the persons served, funders and other community service providers.

5. **Provide monthly transit passes to AH and RH people.**
   At a minimum, passes should be provided to people who are actively seeking employment. However, this might be further expanded to all AH and RH individuals so they can access other services such as health care.
   a) People need dependable access to transportation if they are to find and maintain jobs and housing and access health care and other necessary services.
   b) Currently, people may obtain a single bus ticket if they know where to find them and arrive early enough to obtain the few that are available. If the tickets run out that day, the person may be unable to get to work and, in any event, will almost certainly be late if they do manage to obtain other transportation. Attempting to work in such uncertainty exacerbates the problem if an individual is already hard to employ.
   c) Individuals attempting to use the public transit system but unable to pay for a ticket may be fined significant amounts which they have no way to pay other than serving days in jail.
   d) It is important to the dignity of homeless individuals that they not be easily identified. Consequently, monthly bus passes should not be different from those used by other transit system rider groups such as students. In this way, the passes will be distinguishable by the transit authority but not by others (such as potential employers).
   e) Passes should be provided at the discretion of the front line service agencies, who know their clientele better than any other organization(s) in the city can.

6. **Increase short and long-term transitional housing for all sectors.**
   a) Overnight shelters fill an immediate need and are an essential part of Calgary’s response to homelessness. However, they are not intended to provide the stable housing and support services that are necessary to assist individuals who want to find and keep work. Such persons need a permanent address to put on application forms, to receive and make telephone calls, and to use as a base to find and keep employment. Steps have been made in the shelters towards these goals - for example, the access to computers and telephones etc. at the Centre of Hope was frequently mentioned as an invaluable resource. However, these resources are insufficient to maintain stable access to work.
   b) Supported housing for persons with mental illnesses and/or addictions is a high priority need. In the absence of support, these individuals are unlikely to succeed in remaining housed, and will continue to suffer increasing medical and dental problems. Transitional beds in supported living environments are especially necessary for individuals leaving psychiatric facilities. Without these facilities, too
often mentally ill individuals who have been stabilized in hospital are returned to street living conditions, where they deteriorate rapidly.

7. **Clarify and ease the way in to the mental health system.**
   Despite the fact that many of the AH and RH respondents indicated that they had mental health problems, including about 30% who had suicidal ideation, more than 25% do not know how or where to access mental health care. This issue can be addressed at the local level but also provincially.

8. **Focus on the Prevention of Homelessness:**
   The CHF, community agencies, and funders should develop an approach to funding prevention efforts directed at assisting at-risk individuals, including children, and families to avoid homelessness. A state of the science review on homelessness prevention should be completed to confirm the findings of this report and identify best practices in this area. The results of the current study, and those included in the literature review, suggest that there are clear risk factors that can be identified in early childhood. Systematic primary and secondary prevention programs are likely to provide better outcomes in the long term than crisis oriented interventions can, and should be supported as a long-term strategy aimed at reducing the reproduction of homelessness.

9. **Conduct a “State of the Science” Review on homelessness.**
   CHF and the Calgary community have developed a ‘sector based’ approach to serving the homeless population. Although an in-depth examination of the literature on each of the sector areas is beyond the scope of the current report, sectors are encouraged to undertake such a review for their specific areas. This recommendation is based on the assertion by Begin et al (1999) that the underlying problems and potential solutions for homelessness may vary considerably based on characteristics such as gender, age and ethnicity.

10. **Carry out additional analysis on the dataset collected in the 2002 study.**
    Suggested additional analysis include, but are not limited to the following:
    a) Examine the data by sector groups on each of the major sections of this report. Carry out statistical analysis, including effect size, between each sector group and the larger group. This analysis will help to better distinguish the characteristics and needs of each group, including points of intersections between groups. Furthermore, it will avoid washing out important characteristics of sub-groups which otherwise go unacknowledged due to larger group trends (i.e. the women fleeing violence group mentioned that they need daycare, but the stratified sample was arranged such that there were insufficient numbers of individuals who fit the WOMEN FLEEING VIOLENCE classification to make this a key recommendation for the overall AH or RH groups).
    b) Examine the raw data to understand the supports that are used to care for individuals who would otherwise be cared for by the AH or RH (question E7b).
    c) Examine the qualitative responses to question EMS9 (“Can you tell me what things you have tried to get off the street, i.e. to find or keep a home”)
    d) Examine the qualitative responses to question EMSS3 (Youth Only) (“What does your perfect place look and feel like”)

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Systemic Changes:

11. Address systemic issues which sustain homelessness:
   In order to be successful, the system must address ways to:
   a) obtain a living wage for employees and for those who are unable to work;
   b) remove barriers to re-entering education;
   c) greatly increase the supply of supported, transitional housing for all sectors; and
   d) provide advocacy services for individuals in the AH and RH populations.

12. Lobby to raise the minimum wage in Alberta:
   The collective efforts of the Calgary Homeless Foundation and its agency, funders and political partners should be vigorously dedicated to raising the minimum wage in Alberta in order to assist people out of poverty. Those who work for minimum wage and have no other source of financial support (e.g., family contributions) cannot hope to remain stably housed, or, if they are already homeless, earn sufficient money to establish savings that would allow them to move back into the housing market. In effect, the combination of low SFI rates, regulations that exclude the homeless from access to SFI, and a low minimum wage rate, both precipitates homelessness and acts as a powerful barrier to movement out of homelessness.

13. Lobby to change the welfare system in Alberta:
   The collective efforts of the Calgary Homeless Foundation and its agency, funders and political partners should be vigorously dedicated to changing SFI policy in order to assist people out of poverty. The current level and administration of SFI, for example, perpetuates poverty in at least three ways:
   a) Alberta’s Supports for Independence allowance (SFI) cannot be obtained by individuals who do not have a permanent address. Although some transitional housing facilities have occasionally been declared “permanent” addresses for some individuals, these exceptions are not consistent. The barrier to be overcome here is the one that prevents a homeless person from obtaining temporary SFI as a step toward finding housing.
   b) At its current level, SFI is inadequate to meet the basic essentials of life. The Calgary rental housing market provides few options for the homeless. Given the actual cost of rents in Calgary, it is virtually impossible for an individual or family on SFI to afford housing, let alone have sufficient money remaining to pay for other monthly living costs. AISH recipients are somewhat better able to afford housing, but are nevertheless kept in poverty due to low AISH payment levels.
   c) Without a stable home address, it is very difficult for individuals to seek or maintain employment.

   Research on poverty in Canada supports the necessary increases in SFI rates. For example, “a single parent with two children ages 3 and 7 receives $11,852 a year. The same parent earning Alberta’s minimum wage for a 37-hour week would make $15,220 (including GST rebate and government benefits). Both of these incomes are well below any of the urban Low Income Cutoff rates (LICOs) for a three-person household. The lowest LICo for a household of three is $20,790 - the rate for an urban center with a population of 30,000 or under”,(1), p.vi Although Alberta’s SFI rates are supplemented by the provision of health benefits, they remain inadequate to provide the necessities of life.

14. Request a Government Review of Provincial Housing Authorities:
   There is a strong need for a review of the mandates, policies and procedures of the Provincial Housing Authorities. This review should consider whether the current mandates, policies and procedures of the Authorities consider and respond to the issues of housing our homeless. This information resulting from such a review is also essential to allow
community funders and front-line agencies to understand what housing is actually available, how it is allocated, and who is and is not eligible to benefit from it. The accurate communication of this information to the community, including the homeless population, would be of considerable assistance in addressing disparate, contradictory, and mistaken beliefs about the mandates, policies and procedures of the Housing Authorities. It is also needed to support a more positive, collaborative climate between the Authorities and the community agencies and individuals that interact with them.

These are daunting goals that will not be accomplished in the short term. They require long term vision, service innovation, and community coordination. However, the progress to date in Calgary, particularly in the community’s efforts to enact a shared plan for addressing homelessness, makes it likely that the Calgary collaboration will find ways to succeed in this very difficult task.
Introduction and Purpose
The 2002 Calgary Homeless Foundation (CHF) study was designed to build upon and expand the findings of the 1997 CHF study. Consequently, whenever possible, the results of the 1997 study have been incorporated into the current report for comparison purposes. For example, this report follows the sequencing of the 1997 report whenever possible, and comparisons with the 1997 findings on absolute homelessness have been used extensively.

The 2002 study was conducted exactly five years after the 1997 study, during the same May to September timeframe. Many economic and environmental factors were similar between the two time periods. Calgary’s economy is still strong, and is projected to lead the country for the next three years. “In 2001, the economy grew by an estimated 4.5% (real gross domestic product), the highest growth among provinces”.(2), (p.2) The Conference Board of Canada expects that Alberta’s provincial economic growth rate will be 2.3% in 2002(3). The net migration increase in 2002 is anticipated to be 20,962(4) as individuals continue to be drawn from all over Canada in search of work. In 2001, employment in Alberta grew by 2.8%, or 43,900 new jobs. Alberta’s unemployment rate averaged 4.6% during the same time period.(2) Calgary’s vacancy rate remains very low at 1.2%, and average apartment rental rates have continued to climb faster than the national average. Between October 2000 and October 2001, the increase in cost for a 2 bedroom apartment was 5.8%. Average rent increases were the second highest nationally, behind Edmonton where rents increased by 9%(3). The average renter in Calgary can expect to pay $450 - $470 for a bachelor apartment, $602 - $738 for a 1 bedroom and $658 - $846 for a 2 bedroom unit, depending upon location in the city. (3)

The 1997 study timeframe was impacted by the preparation work for the International Police and Fire games, which drove even low rental hotel accommodation to premium prices. The 2002 study had a similar influence in the G8 summit, which took place in late June. The similarities in the contexts of the two studies increases the validity of comparisons made between their results for the absolutely homeless group.

There were, however, also some significant differences between the two projects. First, and perhaps most important among these differences, was the impact of the 1997 study in supporting the development of a new organizational body, the Calgary Homeless Foundation (CHF), for agencies and funders involved in homelessness. The CHF provided a conduit through which the agencies involved in the various sectors could be accessed to participate in the 2002 study. This sponsorhip ensured maximum involvement of stakeholders in the 2002 study, and provided invaluable opportunities for inclusiveness and collaboration. Second, the 1997 study observed that “obtaining additional funders for shelter beds was the most important and critical issue that needed to be addressed”,(5)(p.2) Their observation was heeded. Consequently, the city has experienced significant growth in the number of available shelter accommodation beds since 1997, primarily through the construction of the Drop In Centre and the Centre of Hope. Because of these developments, concerns about providing short term/emergency shelter accommodation for individuals were not paramount in 2002, although housing shortfalls remain an important issue for many sectors.

One additional environmental change that occurred between the 1997 and 2002 studies centers around the issue of confidentiality and the related issue of access to homeless population information. The 2002 study did not encounter the concerns regarding confidentiality that impacted the ability of the 1997 to collect information on homeless individuals from multiple sectors and locations. In contrast, the 2002 team was able to use a randomized, stratified survey sample at a wide variety of agencies and street locations. A subset of individuals who were identified by the survey as having been homeless in the city more than once also participated in a follow-up clinical interview. As a result of this process, the 2002 report represents all sectors of homeless individuals. Participant confidentiality was protected by assigning a unique identification number that allowed surveyors to connect survey information
to clinical interview information. Respondents were never asked for identifying information such as names.

The goals of the 2002 study were different than those in 1997. Specifically, the 2002 research project was intended to focus on three goals:

1. To update our information about the characteristics of homeless people in Calgary, using the survey instrument from the 1997 study (with appropriate changes to update the instrument);
2. To map the current homelessness system, identify how individuals and families move through the system, and identify gaps in the current system; and
3. To develop a profile of the population at risk of becoming homeless by identifying the factors that may precipitate homelessness for individuals and families.

In conclusion, the 1997 and 2002 studies operated in similar economic situations but with significant methodological differences that should be kept in mind when comparing results.

Study Organization
In the fourth quarter of 2001, the Calgary Homeless Foundation Research Steering Committee (CHFRSC) announced a call for research proposals to carry out the 2002 study. The CHFRSC was composed of three members of the Calgary Homeless Foundation, three Sector Chairs, and one member each from the Calgary Health Region, the City of Calgary, and Human Resources Development Canada. The research contract was awarded to the Centre for Community Services, a non-profit consulting organization located at the University of Calgary in the Division of Applied Psychology. The CHFRSC continued to guide and advise the study team throughout the process of data collection and reporting.

Organization of this Report
In order to facilitate comparisons between the 2002 and the 1997 results, this report has been organized as much as possible using the 1997 report as a template.

1. **Study context and background** provides the reader with critical information required to interpret the findings of this report. Information in this section includes the literature review update for new work on homelessness since 1997, and descriptions of the process used to develop appropriate definitions of homelessness and hidden homelessness, the sampling methodology, development of the research instruments, selection and training of surveyors, conducting the survey, developing the clinical interview, selecting the clinical interviewers and conducting the clinical interviews.

2. **The results section** has been kept in the same order as the 1997 report as much as possible in order to facilitate comparisons where these are appropriate. The quantitative results appear first and speak to the data gathered by the survey work. This section includes socio-demographic information on the respondents, information on their current situation, reasons for being homeless, reasons for coming to Calgary, immediate and long term housing needs, reasons for not having a permanent home, employment situation, sources of income for unemployed respondents, barriers to employment, survival skills, health status, service and shelter utilization. The results of the qualitative analysis, follow the quantitative results.

3. **The discussion section** brings together the learnings from the updated literature review, quantitative analysis of the survey data, and the model and case study materials developed from the clinical interviews. This section specifically addresses each of the three study goals and includes the presentation and discussion of a possible process model for understanding homelessness in Calgary.
4. **The recommendations** section identifies the key steps required to improve outcomes for people who are homeless in Calgary and identifies key areas where additional research is required.

It is important to note that the results of the study are not listed in order of importance. When comparisons with 1997 data are possible, results are listed in the same order as they were found in that report. When 1997 data comparisons are not possible, results are usually listed in their order of appearance in the 2002 surveys. Results for the absolute homeless and relatively homeless participants in the 2002 study are presented together to facilitate comparisons between the two groups, since their results are often quite different. Aggregating the results across the two groups of homeless respondents would have glossed over these important differences.

It should also be noted that the 1997 study included a section that described the agencies involved in that study. Given the sheer number of agencies and funders involved in the 2002 study, this exercise has not been repeated in the 2002 study, although a list of involved agencies by sector served is included as Appendix A. Several organizations, such as the City of Calgary and the Street Survival Guide, spend considerable time and effort to collect information on various agencies and there was little benefit to be gained by repeating their efforts here.
Study Context and Background

Past Research & Literature Review:
The state of the literature on homelessness has improved considerably since the 1997 report. A number of good quality empirical studies have resulted in a few review articles, including the excellent work of Barbara Dickey(6). The literature has expanded so significantly that it is beyond the scope of the current project to review it exhaustively. The 2002 research team has, however, updated the 1997 literature review and added a few additional areas it considered particularly relevant.

Articles for review were pulled in a systematic fashion. In addition to working with a number of gray-literature reports provided by the Calgary sector chairs, the 2002 research team searched the peer-reviewed literature including the PsycINFO, Embase, CINAHL, Medline, PubMed, and Web of Science databases. Relevant gray literature sites were also searched, including websites for Statistics Canada, CMHC, the National Resource Center on Homelessness and Mental Illness, the Government of Alberta, the Library of Parliament Parliamentary Research Branch, and the Public Justice Resource Centre among others. Search parameters were restricted to English language from 1997 onward. The Key search term was “homeless*”. However, specific searches were also carried out for “homeless*” combined with each of “resilience,” “attachment,” “children” and “Canada”. In addition, searches were carried out on each of the databases for particular authors know to publish in this area. Additional articles were also obtained if the first round of articles referred to a particularly relevant publication. The literature on resilience and attachment theory were primarily reviewed to assist in building the Model of Homelessness Causation and are not included in the review that follows.

Articles were reviewed and classified into empirical and non-empirical categories. The methodology of each paper was then categorized as qualitative or quantitative and rated according to a number of dimensions. Empirical articles were reviewed in terms of the comprehensiveness of their literature review, the research questions and design, population and sampling, data collection and capture and analysis/reporting of results. Non-empirical articles were reviewed based on the scope of the article, writing style and logic, credentials of the author, journal, date range and relevance of ideas to homelessness.

Definition of Homelessness
The debate regarding the definition of homelessness continues to hamper research in this area. Essentially, the definitions range from very restrictive (i.e. confined to only those individuals who use emergency shelters or sleep outside) to very inclusive (such as the definition developed in the “View from the Sidewalk” research recently completed in British Columbia(7). The definition used has a serious impact on the number of people who are considered to be homeless. A broad definition will include greater numbers of people and will present the situation as being more serious than a restrictive definition will. The perceived seriousness of the problem in turn tends to drive resources devoted to its resolution. Consequently, the debate around definitions tends to become quite political. There is little disagreement regarding the extreme end of homelessness (using emergency shelters or on the street), however, as one moves further away from the extreme, debate increases. As Casavant(8) states, every definition is valid to some degree. However many researchers are moving towards using the U.N. definition of homelessness(9, 10) for a number of reasons, including the advantage of being able to compare data across studies. Although it is possible to debate the virtues of each definition, the 2002 CHF research team believed that such an undertaking would be fruitless, particularly since the City of Calgary has documented some of the most widely used definitions and the information is freely available(11). Instead, the team actively engaged the Calgary community in selecting among the most widely used definitions in order to
best meet the needs of the community. The process used to determine the definitions of homelessness and relative homelessness used in this study is described in the Study Context and Background section of the report.

**Determining the Size of the Homeless Population**

Since the 1980s, the phenomenon of homelessness has grown and the composition of the homeless population has become increasingly varied.\(^{(8)}\) “In North America, for example, the homeless population includes a large and growing number of women, youth, families, mentally disturbed people, new immigrants, and members of various ethnic communities; in Canada, it includes many Aboriginal people”\(^{(8)}\) (p.4).

The actual size of the homeless population is intimately tied to the definition of homelessness employed in each study. For example, “two U.S. researchers have given estimates for the United States as a whole: these vary between 250,000 and 3,000,000”\(^{(8)}\) (p. 11). The best and most recent count in the U.S. is from the Urban Institute, which estimated the number of homeless people from interviews conducted in a representative sample of urban and rural areas in 1996. Their estimate of between 2.3 and 3.5 million people was based on individuals who were using some type of homeless service (not necessarily shelters)\(^{(12)}\). The first Canadian attempt to estimate the number of homeless people was carried out by the Canadian Council on Social Development (CCSD) in 1987. Unfortunately, the results were questionable due to a low response rate from agencies, failure to include people who were not staying in shelters on a particular evening (January 22, 1987), and reliance on service providers as the only source of information. The study estimated that between 130,000 and 250,000 people were homeless in Canada. Statistics Canada used a similar methodology during the 1991 Census (a one day survey of 90 soup kitchens in 16 Canadian cities) that also met a lukewarm reception due to methodological concerns. Other studies have estimated the homeless population in Canadian jurisdictions such as Ottawa, Toronto and Vancouver\(^{(13-16)}\). Still others have attempted to enumerate specific groups, such as homeless youth or the homeless mentally ill. The estimates generated through these studies vary widely. Consequently, Canada currently has no official data on homelessness prevalence, despite repeated calls within the country and from the United Nations for such data.\(^{(8)}\)

Homeless population estimates have been attempted in Alberta using a number of methods, including the City of Calgary biennial Homeless Count. The May 15, 2002 count found that there had been a 34% increase in homeless persons between 2000 (N=1,296) and 2002 (1,737). The Horizon Housing society has estimated the number of homeless people in Calgary at between 5,000 and 7,000\(^{(8)}\) and the 1997 Calgary Homeless Study indicated that almost 3,000 people did not have access to stable housing at that time. However, the resulting estimates vary widely depending upon the differing methodology of each project (e.g. time period covered, locations).

It is clear that there is no definitive methodology for assessing the number of homeless persons in Canada or in specific jurisdictions. The Canada Mortgage and Housing Corporation (CMHC) has attempted to address this critical issue by making homelessness a research priority. As of 2000, CHMC was developing a computerized research tool to standardize collection and management of shelter admission data. The software is intended for use by homeless agencies to collect relevant information that will to improve our understanding of the homeless population. The project, officially named the Homeless Individuals and Families Information System (HIFIS) was launched on March 22, 2000.\(^{(17)}\)

**Characteristics of the Homeless Population**

The 1997 CHF report indicated that the age of homeless people was dropping, that the number of women was increasing, and that aboriginal people were, in some cases, more than 50% of the homeless population. Research completed since 1997 further defines the homeless population using overlapping groups based on a number of demographic characteristics.
including age, gender, ethnicity and health status. Although the specific makeup of homeless populations vary from jurisdiction to jurisdiction(9), it is clear that “the homeless now include women, children, teenaged youths, the mentally ill, newly arrived immigrants, refugees, women victims of spousal violence, persons recently released from prison, and casual workers”.(8) (p. 16).

The increased understanding of the characteristics of the homeless population has implications for solutions to the problem, since “each of the homeless subgroups appear to have significant differences that ought to influence how we deal with homelessness. Moreover, the solutions with the greatest promise for eliminating the problem, could be very different, depending on whether they are directed to women, young people, native people or refugees.”(8) (p. 16). It is increasingly important that the different sub-groups of homeless be better understood. Although an exhaustive investigation into each of the possible groups (such as women, youth or Aboriginal people) is beyond the scope of this review, a few examples may be of value to demonstrate the importance of avoiding a homogenous approach to solving homelessness.

Aboriginal People:
The 1996 Census indicates that 3% of the total population (approximately 800,000 people) identify themselves as Aboriginal peoples. That number includes North American Indian, Metis and Inuit, Registered Indians and/or First Nation Indian Band members). Sixty-six percent (66%) identify as North American Indian, 26% at Metis and 5% as Inuit. The Aboriginal population is concentrated mainly in western Canada with 12% of the total population of Manitoba, 11% of Saskatchewan, 5% of Alberta and 4% of the B.C. consisting of Aboriginal people(18). However, Aboriginal people represent a disproportionately large percentage of the homeless population in a number of jurisdictions. In 1996, “Individuals of Aboriginal origin accounted for 35% of the homeless population in Edmonton, 18% in Calgary, 11% in Vancouver, and 5% in Toronto, but only 3.5%, 1.9%, 1.7% and 0.4% of the general population of these cities respectively.”(9) (p. 230)

The Aboriginal population in general has unique characteristics, which must be taken into account when addressing homelessness. For example, the Aboriginal population is relatively rural. In 1996, more than half of Aboriginal people lived in an area classified as rural.(18) This pattern is in sharp contrast to the non-Aboriginal population, 75% of whom live in urban areas. The Aboriginal population is also significantly younger than the non-Aboriginal population. The average age of Canadian Aboriginal people during the 1996 Census was 25.5 years, compared to the average of 35.4 years for the non-Aboriginal population.(18) Most Aboriginal people live with immediate family, but the family arrangements are different from those of non-Aboriginal people. For example, Aboriginal people are less likely to be living with a spouse, and more likely to be in common-law relationships or to be single parents. Barriers to obtaining an advanced level of education are also more prevalent for Aboriginal people, which may contribute to their higher rate of unemployment. In 1996, 24% of the Aboriginal labor force was unemployed.(18)

The statistics regarding Aboriginal people in Canada are sufficient to justify developing customized approaches to working with this population to prevent homelessness. The homelessness literature is relatively mute on the barriers that the Aboriginal population faces when attempting to access employment or education opportunities. Boydell, Goering & Morell-Bellai(19) recommend that future research and planning focus on the strengths of homeless people, including Aboriginal people, when considering sustainable solutions to prevent homelessness. Solutions must address the underlying problems and be acceptable to Aboriginal people in order to work. The same could be said for virtually any of the subgroups of homeless that have become targets of research interest.
**Families:**

“Families occupy 42% of shelter beds in Toronto(13) and about 35% of the shelter beds in Ottawa(16)” The number of homeless families in Calgary is increasing; a trend that has been noted in other jurisdictions.(20) Women head 90% of homeless families. In Alberta in 1996 there were 40,870 two-parent families and 30,720 lone-parent families living in poverty (below the LICO cutoff for their area). In Calgary there were 83,550 two-parent families with children under the age of 18 in 1996, 13,160 (16%) of whom were living in poverty.(1) In 1996 the average family income in Alberta was $58,320. The average income for a poor family was $14,540(1). This data stands in curious juxtaposition to the recently released Government of Alberta report indicating that, in 1997, 92% of Albertans lived above a preliminary version of the Market Basket Measure (MBM)(2), p. 52. It is apparent that the debate about differing concepts of poverty and the way poverty is measured is likely to continue, even with the publication of the first Statistics Canada data using MBM in the fall of 2002(21).

**Mentally Ill:**

There is considerable debate about the prevalence of mental illness among the homeless population. There is still a common misconception that homelessness resulted from de-institutionalization and, therefore, that the majority of homeless people must have mental illnesses. However, it is very difficult to engage homeless people sufficiently to objectively evaluate their mental health status, or to make contact with the more severely mentally ill who avoid interpersonal contact almost entirely. Therefore, reports in the literature on mental illness prevalence rates among this population tend to vary widely. One large source of variance in estimates is whether substance abuse is classified as a physical or mental health problem. For example, one study states that “the prevalence of mental disorders among homeless individuals varies from 80-95% in the U.S.A., Australia, Canada, Norway, and Germany to 25-33% in Ireland and Spain. The most prominent mental disorders among the homeless, which vary from country to country, are depression, affective disorders, substance abuse psychotic disorders, schizophrenia, and personality disorders.”(22) However, in another report, Martens reports that the prevalence rate of mental disorders among homeless persons in the Western countries varies from 25% to 94.5%(22) Still another review reports that 25% of the homeless population in the U.S. have a serious mental illness.(12)

The methodology employed to enumerate mental illness problems among the homeless population plays a significant role in the confidence with which conclusions about prevalence can be drawn. Identification of a randomized sample of homeless persons which then uses experienced clinicians and psychometrically sound instruments in an in-depth interview/assessment format is perhaps most reliable. However, this method is expensive to carry out and has additional challenges, such as the strong likelihood that mentally ill homeless individuals will avoid or refuse to be interviewed. These problems remain challenges for researchers. However, if the most conservative approach is adopted by taking the lowest reported incidence levels across studies, it is likely that one can confidently say that at least 25% of homeless individuals have a serious mental illness.

For more information on mental illness and homelessness, please see the Homelessness, Mental Disorder & De-institutionalization section below.

**Seniors:**

“Compared with their younger homeless counterparts, older homeless persons [a]re more likely to be white and male, to report lower incomes and poorer health, and to meet the DSM-III-R criteria for lifetime alcohol-use disorder”(22). Persons aged 50 years or older comprise 13% of the male and 3% of the female homeless population according to some studies(22, 23). There is a tendency in the literature to consider anyone over the age of 50 to be a “senior” in terms of the homeless population, perhaps due to the findings that homeless people in their forties and fifties often develop health disabilities that are more commonly seen only in people who are decades older.(24) Again, this speaks to the need to approach the prevention of
homelessness with this group in a unique way, since they are likely to require significant medical intervention in addition to any other approaches considered.

Singles:

Hwang states that “Single men constitute the largest segment of homeless people in most Canadian cities: about 70% of the homeless population in Vancouver, Edmonton and Calgary, and about 50% in Ottawa.” (9) (p.230) Single men are relatively young, with the majority between 25 and 44 years old. (9) Hwang’s assertion is consistent with the findings in the City of Calgary 2002 Homeless Count where the single largest group (44%, N=764) were males aged 25 to 44 years. (20) Research findings tend to imply that the “singles” group should be separated into different components according to age and gender at a minimum. For example, some studies have shown that older singles are less likely to have drug addiction problems but more likely to abuse alcohol, and that older women are more likely to suffer from mental illnesses than older men.

Substance Abuse:

The issue of substance abuse in the homeless population is significant, as is the consideration of dual diagnosis of mental illness and addiction. A recent review of programs for persons who are homeless and mentally ill estimated that 25% of the homeless population in the U.S. have a serious mental illness and 50% have a history of substance abuse. (12) Individuals with dual diagnosis are particularly challenging to work with, and empirical evidence shows that intervention efforts with them are likely to fail if substance abuse issues are not addressed as part of the mental health treatment process. For more information, please see the Mental Disorders and Substance Abuse Among the Homeless section below.

Women:

According to the CCSD study, women account for 30% of the homeless population. The percentage of homeless women in Calgary has varied considerably in the previous homelessness counts. The City of Calgary Homeless Count found that women made up 24% of the population in 1996, 14% in 1998, 20% in 2000 and 16.5% in 2002. (20) Women account for about 25% of homeless people in Vancouver, Edmonton and Toronto, but as few as 10% of the population in Ottawa. (9) “After a divorce, a woman’s income tends to decrease, while that of a man tends to increase.” (8) (p.17). Household income for women after divorce drops by more than 40%, and the poverty rate for women increases by almost threefold. [cited in (8)]. The increasing rates of family breakdown and domestic violence may be one of the primary forces that drive women into homelessness.

Poverty and homelessness go hand in hand, so it is important to realize that poverty rates for women in Alberta in 1996 were 20% compared to 17% for men. The very highest rates are among women aged 15 to 24 years and 75 years and older. After the age of 75, the poverty rate for women in Alberta is 17% higher than it is for men. (1)

Youth:

Street children tend to leave home at about age 15 and often come from families where they have experienced physical or sexual abuse. (9, 25, 26). A 1992 Ottawa study showed that 75% of street children had left home because of sexual assaults or physical and/or psychological/emotional abuse. (27) Furthermore, out-of-home placement such as foster care placement (28-30) or group home placement (30) tends to put young people at risk of becoming homeless. Bassuk et al found that 58% of homeless adolescents had experienced some kind of out-of-home placement (28), running away (20%) (30), or early departure from home (31, 32). These findings again point to the necessity of different prevention and solution approaches for different demographic groups. For instance, counseling may be a critical part of interventions for youth. Also, youth may be particularly challenging to work with since they tend not to use shelters. (9, 33) It is also important to note that aboriginal people are over-represented in the homeless youth population (10) as well as in the adult population.
The above information does not do justice to the complex issues that face the various homeless demographic sub-groups. However, it provides some indication of why it is important to develop targeted interventions that speak specifically to the critical issues facing various groups: an overall intervention which assumes a homogenous population is unlikely to be successful. However, that does not imply that the various sub-groups do not also have characteristics in common. For example, poor health seems to be a hallmark of homelessness.

In a community based longitudinal study of 363 homeless individuals, Gelberg, Anderson & Leake(34) found that homeless adults had “high rates of functional vision impairment (37%), skin/leg/foot problems (36%) and TB skin test positivity (31%)” compared to the general population, (p.1273). The study concluded that homeless people are willing to obtain care if they believe it is important, and tend to access services more when there is a community clinic or private physician as a regular source of care. Studies investigating health and homelessness have been further reviewed below.

Determinants of Homelessness
It is generally believed that the increased incidence of homelessness results from broad societal factors such as the de-institutionalization of the mentally ill, increases in substance abuse issues and so forth. Martens reviewed five decades of research investigating the physical and mental health status of homeless persons(22). As part of the review, Martens developed a succinct synopsis of the risk factors for homelessness as identified by the research literature. He concluded that homelessness is the result of often complex combinations of mental, physical, social and economic problems. Marten’s synopsis is quoted here in its entirety, along with the supporting articles cited and additional articles derived from the 2002 CHF review. Many of the following determinants have been incorporated into the Model of Homelessness developed through the current 2002 CHF study.

- Less feeling of love in the childhood family(31), adverse childhood experiences(31, 35, 36), and childhood unhappiness(37). These are powerful risk factors for adult homelessness,(10, 38) Sleegers et al(39) found that all but one of the homeless research samples reported having experienced one or more adverse life events (56% reported more than four adverse life events);

- Social poverty, which can be observed in many homeless persons, although it may appear differently to different subgroups. It often derives from long exposure to demoralizing relationships and unequal opportunities(40, 41);

- Poverty(10, 41, 42). As a result of limited commitment of resources to safety net services in market-oriented industrial nations, some individuals fall into extreme poverty and homelessness. A lack of appropriate employment possibilities and public support of the poor, and reduced availability of low-cost housing are the primary reasons for the increase in homelessness since the late 70s(43-45). In the United States 43.4 million people lacked health insurance, and nearly one-third of persons living in poverty had no health insurance of any kind(45, 46);

- Poor physical health. This was a major factor in becoming homeless in half of the research population, whereas another 15% stated that it was the “single most important” factor (45, 47);

- Mental disorders, prior presence of psychiatric disorder(35), or recent hospitalization for a mental health problem(28). One-third of the homeless adults in the U.S., Great Britain, Australia, and Canada had a prior history of psychiatric hospitalization(48). Recent substance abuse, depression (49),
schizophrenia(50), and other mental disorders or mental health problems (32, 51), and a number of stressful life events (37) were common;

- Low level of support from friends (49);
- Physical and sexual abuse in youth before leaving home (31, 32, 52-56);
- Residential instability (42, 57);
- Parental divorce (10, 38), antisocial behavior (31, 58), and substance abuse (28, 31, 37, 55, 58);
- A history of drug and alcohol abuse (32, 41);
- Delinquent behavior, expelled from school, placed in reform school (32);
- Foster care placement (15%) (28-30) or group home placement (10%) (30). Fifty-eight percent of the homeless adolescents had experienced some kind of out-of-home placement (28), running away (20%) (30), or early departure from home (31, 32);
- Low education levels (35);
- Minority status (31, 32);
- Less parental education, less-skilled parental jobs (31);
- Less likelihood of the father being home (31);
- High birth order in large family (31);
- Less identification with religious group (31);
- Family conflict (55, 59), family problems (42, 57), or interpersonal conflict (28).
- Lack of employment (41);
- Low welfare wages (41);
- Lack of affordable housing (10, 41)

Quigley & Raphael (60) take a different perspective from Martens. After a systematic analysis of all the survey data available in the U.S. on the incidence of homelessness, they concluded that “rather straightforward conditions in U.S. housing markets - not complex social pathologies, drug usage, or deficiencies in mental health treatments - are largely responsible for variations in rates of homelessness” (p. 4). They state that “holding other things constant, a 10% increase in rents is associated with a 6.5% increase in the incidence of homelessness” (p. 12). Also, “a 10% increase in vacancy rates is associated with a 6% reduction in the rates of homelessness” (p. 13). O’Flaherty adds support to the argument that high rents are associated with homelessness (61). However, such assertions are impossible to test empirically and should be considered cautiously.
Quigley & Raphael also reported that areas with milder winters experienced significantly higher levels of homelessness, and that there was little evidence that the local unemployment rate impacted homelessness.

The determinants of homelessness are complex and the prevention and/or reduction of homelessness will required careful planning and collaboration between service providers, funders, and government to address them effectively. This fact should not discourage service providers from taking positive steps while continuing to lobby funders and government groups to take action. For example, Calgary is well positioned to collaborate on creative solutions that would address a wide number of the determinants of homelessness found in the literature.

**Homelessness, Mental Disorder & De-institutionalization**

Quigley & Raphael (60) found that the decline in mental hospital in-patient populations has been concurrent with increases in prison and jail populations. They also found that the incidence of mental illness among prison and jail inmates is considerably higher than in the non-institutional population, suggesting that “the de-institutionalized mentally ill have been re-institutionalized in prisons and jails” (p.5). Their statistical analysis found that, depending on the time period and model, “a one-person decrease in the hospitalization rate is predicted to increase the prison incarceration rate between .17 and .73 persons” (p. 6). Dickey asserts that “no authors who have delved deeply and broadly into the problem point to de-institutionalization as a root cause of homelessness”(12) (p. 242), 43, 44, 61-65.

These findings do not imply that mental illness has no impact on homeless status. As stated previously, the most conservative estimates indicate that 25% of the homeless population have a mental illness. Furthermore, mental illness is likely to play a significant role in the possible viable solutions for this subgroup. For example, Sullivan et al (62) conducted a longitudinal community-based survey of 1533 homeless individuals in Los Angeles in order to determine the impact of mental illness on quality of life. They found that there were significant differences in both the subjective and objective quality of life between homeless individuals with mental illness and those without. Importantly, the differences between the two groups were attributable to modifiable factors such as income and symptoms rather than by non-modifiable demographic characteristics. Furthermore, therapeutic alliance has been empirically shown to positively influence seriously mentally ill homelessness individuals. A strong relationship between a therapist or significant other and the mentally ill homeless person is predictive of a reduction in homeless status and an increase in general life satisfaction.

**Mental Disorders and Substance Abuse Among the Homeless**

“Homeless mentally ill persons have a distressingly high prevalence of co-occurring substance use disorders.”(12) Bebout (63) conducted interviews with 158 homeless mentally ill participants at baseline, and at 6, 12 and 18 months to assess housing status, residential history, substance abuse and progress towards recovery. They found that “housing stability is strongly mediated by substance abuse” in that higher levels of drug use are associated with decreased housing stability. However, the study also found that formerly homeless persons with dual diagnoses can gradually achieve stable housing if they are provided with integrated, dual diagnosis treatment (62). This finding is supported by the work of Conrad et al who found that, over a five year period, homeless addicted veterans in an experimental group receiving case-managed residential care showed significant improvement over the control group on measures of medical problems, alcohol use, employment and housing stability.(63) Drake and colleagues have also done work in this area, which adds the caveat that integrated treatment for individuals with dual diagnosis (mental illness and substance abuse) does work, but may take 3 - 4 years to achieve success.(64)

**Criminalization and Victimization Among the Homelessness**

Since the 1980s, homelessness has been “increasingly linked to numerous concerns in the areas of criminality, public health and the economy”(8) (p. 5). By criminalizing certain living
conditions, such as sleeping in parks or panhandling, we foster the marginalization of people who live in extreme poverty. This is particularly true when laws address the actions of individuals but not their underlying causes. Perhaps the most provocative work in the area of criminalization and victimization among the homeless is the work of Quigley & Raphael(60) mentioned above.

**Economic Considerations**

As cited above, Quigley & Raphael(60) assert that homelessness is primarily an economic issue based on the availability of housing, in that higher rents and/or lower levels of available rental accommodation leads to increased homelessness. It is clear that poverty is intimately associated with homelessness. Consequently, it is important to note that the Federal/Provincial/Territorial Working Group on Social Development Research’s new Market Basket Measure (MBM) has been adopted and that Statistics Canada is due to begin reporting data using this measure in the fall of 2002. The MBM is based on the concept of necessaries which was “defined by Adam Smith as whatever the custom of the country renders it indecent for creditable people, even of the lowest order, to be without” (65). For example, the Gallup polling company has conducted public opinion polls to determine what custom would define as a poverty line. People were asked “What is the minimum weekly amount of income required for a family of four, consisting of two adults and two children.” When the responses were translated into annual income needs, they came quite close to the Statistics Canada Low Income Cutoff (LICO). The introduction of the MBM will likely influence reporting of poverty quite significantly as can be seen from the examples provided in the tables below.

It is clear that the move to the MBM will increase the debate around the fundamental issue of who is considered to be poor. The debate, in turn, is likely to impact funding levels for government assistance and programs such as SFI and AISH. Therefore, service providers should continue to pay close attention to this process as it unfolds, and seek to influence it where possible in favor of removing current economic barriers to moving out of homelessness and reducing the likelihood of children being raised in poverty.

**Table 1: Comparison of the LICO Levels vs. MBM Thresholds on the Reporting of Poverty (21)**

<table>
<thead>
<tr>
<th>Low Income Cutoff Levels and Market Basket Thresholds (1996)</th>
<th>Population Over 500,000</th>
<th>Population 100,000 to 499,999</th>
<th>Population 30,000 to 99,999</th>
<th>Population Under 30,000</th>
<th>Rural Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LICO Level</strong></td>
<td>$32,238</td>
<td>$27,651</td>
<td>$27,459</td>
<td>$25,551</td>
<td>$22,279</td>
</tr>
<tr>
<td><strong>MBM Level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newfoundland</td>
<td>na</td>
<td>$21,234</td>
<td>na</td>
<td>$19,986</td>
<td>$18,714</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>na</td>
<td>na</td>
<td>$21,310</td>
<td>$20,074</td>
<td>$20,074</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>na</td>
<td>$21,291</td>
<td>$19,899</td>
<td>$21,447</td>
<td>$19,635</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>na</td>
<td>$19,230</td>
<td>$20,742</td>
<td>$18,474</td>
<td>$17,982</td>
</tr>
<tr>
<td>Quebec</td>
<td>$19,953</td>
<td>$19,077</td>
<td>$18,825</td>
<td>$18,657</td>
<td>$17,889</td>
</tr>
<tr>
<td>Ontario</td>
<td>$25,194</td>
<td>$23,202</td>
<td>$22,722</td>
<td>$22,362</td>
<td>$20,370</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$21,746</td>
<td>na</td>
<td>$21,086</td>
<td>$19,970</td>
<td>$19,730</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>$20,582</td>
<td>$19,190</td>
<td>$20,162</td>
<td>$19,226</td>
<td>$19,226</td>
</tr>
<tr>
<td>Alberta</td>
<td>$19,930</td>
<td>na</td>
<td>$19,486</td>
<td>$19,750</td>
<td>$17,626</td>
</tr>
<tr>
<td>British Columbia</td>
<td>$25,196</td>
<td>$24,128</td>
<td>$22,712</td>
<td>$22,136</td>
<td>$20,516</td>
</tr>
</tbody>
</table>

Note: na indicates that there are no communities of this size in the province. Source: Federal-Provincial Working Group on Social Development Research and Information. Construction of a Preliminary Market Basket Measure of Poverty, 1998, p.25

From the above it can be seen that there is a considerable difference between the current LICO rates for a city of Calgary’s size and the proposed MBM Thresholds ($32,238 vs. $19,930).
This will have a substantial impact on the perception of poverty in the province. For example, it may appear that the number of children living in poverty will also suddenly decrease as illustrated in the following example.

**Table 2: Estimated % of Children in Low Income Families (LICO vs. MBM)(21)**

<table>
<thead>
<tr>
<th>Estimated % of Children in Low Income Families, 1996</th>
<th>LICO</th>
<th>MBM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>22%</td>
<td>11%</td>
</tr>
<tr>
<td>Canada</td>
<td>21%</td>
<td>16%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Quebec</td>
<td>23%</td>
<td>13%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>23%</td>
<td>16%</td>
</tr>
<tr>
<td>Ontario</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>British Columbia</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>26%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: Federal-Provincial Working Group on Social Development Research and Information. *Construction of a Preliminary Market Basket Measure of Poverty, 1998*, p.27

**Homelessness and Health**

“Homeless people have a greatly increased risk of death(66). Compared with the general youth population of Quebec, mortality rates among street youth in Montreal are 9 times higher for males and 31 times higher for females.”(9) However, Canada’s mortality rates are lower than those of the U.S. due to a number of factors including “lower rates of homicide, HIV infection and, possibly, Canada’s system of universal health insurance.”(9) (p. 230) Despite Canada’s universal health care system, many people cannot access health care because their identification has been lost or stolen(67). Furthermore, those who do access care often do not follow through on treatment because they cannot afford to do so.(68) Homeless people are at risk for higher incidence of a wide variety of health problems including HIV infection, tuberculosis and hepatitis B.(22, 69) Homeless people in their forties and fifties often develop health disabilities that are more commonly seen only in people who are decades older.(24) Seizures, chronic obstructive pulmonary disease, arthritis and other musculo-skeletal disorders are common among the homeless(70) as are respiratory tract infections(22), poor dental health(71, 72), and skin and foot problems.(73-76) In general, homeless people are more likely to have chronic medical conditions and to encounter barriers to health care than the general population.(77) For an excellent review of the health care problems of homeless individuals in Canada, see Hwang (2001)(9). Hwang concludes that the current Canadian health care system may not adequately meet the needs of homeless people, despite their high burden of illness. He calls for further research into how to best deliver health care services to the homeless and into more research on how to prevent homelessness.(9)

**Research Problems and Methodological Flaws**

Measurement issues and debates over definitions continue to stall progress in homelessness research. However, some progress has been made towards a unified definition of homelessness, in that more researchers are using the U.N. definition. The quantity and quality of empirical evidence has increased rapidly over the past five years due, in part to the increased funding available to carry out such work, as well as the interest raised through public awareness campaigns. However, enumeration of the homeless continues to be an area of considerable debate that is not likely to subside soon.

The gains in empirical research are sufficient to warrant a “state of the science” review in this area of homelessness causes and prevention/intervention. It is important to recognize that a
“state of the science” review is not merely a literature review. It is a systematic and exhaustive review of the empirical and gray literature that necessarily includes an evaluation of the quality of evidence available for both qualitative and quantitative investigations and across disciplines. It should clearly identify the areas where evidence is solid and those areas where more research is required. Further, it should specify what form the additional research should take. In other words, it establishes a research agenda that can then be used to coordinate research efforts on a local, national or international level. In the case of homelessness, such a review should specifically speak to the subgroups that emerge as consistently distinct (i.e. youth or Aboriginal or mentally ill homeless people) as well as the shared characteristics of homeless people in general. It should do so in terms of the interventions that are known to work with each subgroup and those that do not. Whenever possible, best practices and benchmarks should be established as part of a state of the science review. The review should focus on extracting the best available empirical and non-empirical information for service providers, funders and policy makers. Results should be reviewed by an international panel of experts for input regarding thoroughness, and then be distributed widely through a number of venues. Needless to say, such an undertaking is significant, and requires considerable research expertise as well as the willingness and ability to work with stakeholders who are not researchers but who require evidence to effectively work in the area of homelessness. Although a state of the science review is not be to undertaken lightly, benefits to be gained are significant.

Recommendations for practice and policy from the Literature:
1. The literature suggests that prevention of homelessness is “cheaper than curing it after it happens.”(12)
2. For those situations where homelessness is not prevented, early intervention is called for.(41)
3. Programs designed to prevent homelessness, regardless of their form, will fail unless they are “coupled with transitional assistance in the form of information on low-cost housing and referrals; help with security deposits and rent guarantees; case management; and support services for up to 12 months”.(12)
4. Case management services should be designed in a manner that allows a strong therapeutic alliance to be established between the service provider and client.(6)
5. Kuno recommends that strategies to prevent homelessness among the mentally ill should include catching people at the time of discharge from hospitals and acute care facilities.(78)
6. Research shows that housing solutions should be geared towards giving homeless persons as much independence as possible.(79) In other words, homeless people have a strong preference for normalized, independent housing in the community.(10)
7. “The first few months of community living have been proven crucial for adjustment. It is likely that a broad range of services are needed to ensure that those who exit from homelessness do not return.”(79), p. 397
8. Martens(22) includes an extensive list of prevention and intervention programs which have been suggested in the literature.
9. Review and adapt the physician payment system to ensure physicians are paid for work they do with homeless persons, even when the patient does not have a health care card or other identification.(67)
10. Boydell, Goering & Morell-Bellai recommend that professionals focus on the strengths of homeless people, stating that “the sense of hope and positive outlook regarding the future, expressed by many of the homeless individuals in this study, suggest that early intervention to capture and use this motivation to escape homelessness would be useful.”(19), p. 36.
11. Lack of attachment can have serious consequences for young people, resulting in delinquent behavior, running away and eventually street life. Empirical research suggests that contacts with significant others such as family members, acquaintances and social workers can offset the negative influence of poor relationships with parents and lack of
good friends. Generally speaking, research indicates that being connected to even one person that the homeless person believes cares about them can make a substantial difference in their lives.

12. Expanding emergency services will not make the problem of homelessness go away. The solution lies in providing opportunities for retraining, employment, and safe, affordable, drug-free housing before the individual loses hope.(10, 41)

13. A centralized service could assist people to act to prevent homelessness or to quickly resolve their homeless situation.(41, 80)

14. Homeless people must play an integral role in developing any new intervention approaches.(80)

Selecting a Definition of Homelessness for the 2002 CHF Study

The definition of homelessness continues to be debated. In 1997, Arboledo-Florez & Holley stated that experts agree about extreme examples of homelessness. People who consistently sleep on the streets or in parks or who use shelters are obviously homeless. The controversy arises as one moves away from this extreme situation. For instance, is a woman who leaves an abusive relationship in order to protect herself and her children homeless? How should one classify a 17 year old who refuses to return home for unknown reasons? Should levels of homelessness be identified? If so, what are the implications of taking such a stance? Is there a continuum of more or less ‘deserving’ homeless individuals? These are pressing issues that have not been resolved by researchers, government or the agencies that serve the homeless population.

The 2002 research team wanted the definition used in the study to reflect the values and beliefs of the larger Calgary community. Therefore, a broad range of stakeholders were invited to bring forward their preferred definitions of homelessness. Definitions from the literature were added to this collection. The four definitions that seemed most promising were then discussed and ranked by small, mixed groups of service delivery personnel, funders, sector chairs and other stakeholders who attended a workshop at the Calgary Homeless Foundation on May 3, 2002. A list of participants and the proposed definitions of homelessness that were considered at the workshop is included as Appendix C. Of the workshop participants, 78.6% ranked the United Nations definitions as their first or second preference for use in the survey. The next highest ranked definition, at 46.4%, was that developed by the “View from the Sidewalk” research from British Columbia (2001). Consequently, the UN definition, which clearly differentiates between the absolutely and the relatively homeless, was used in this study. The definitions reads as follows:

Absolute homelessness or shelterless refers to individuals living in the street with no physical shelter of their own, including those who spend their nights in emergency shelters. Relative homelessness refers to people living in spaces that do not meet the basic health and safety standards including:

a. Protection from the elements;
b. Access to safe water and sanitation;
c. Security of tenure and personal safety;
d. Affordability;
e. Access to employment, education and health care;
f. Provision of minimum space to avoid overcrowding.
These definitions were then used to develop a screening instrument, incorporating the Mini Mental State Exam, to consistently determine whether respondents were absolutely or relatively homeless (AH or RH), and whether they showed symptoms of mental illness or substance abuse disorder (see Appendix D). The use of the UN definitions has considerable benefit, since they are increasingly the definition of choice in other research studies. Consequently, agencies and funders involved in Calgary will be able to legitimately compare results from the 2002 study to an increasingly broad range of studies from other locations.

Size and Stratification of the Homeless Population for the 2002 CHF Study

Size estimates of the homeless population depend on the definition used. At the time the research was proposed, estimates of the homeless population in Calgary ranged from a low of 1,200 (2000 City of Calgary homeless person count) to 7,500 individuals and 8,000 families who use an emergency shelter or an overnight residence at least once during the year (CHF estimate). The research team assumed that the actual population number lay somewhere between these two estimates. Therefore, it was determined that 275 individual surveys would be required to keep sampling error in the +/- 5% range at the 95% confidence interval.

The research team then turned to the community partners from each sector to estimate the number of individuals to be surveyed for each demographic group in the Absolutely Homeless (AH) category. The literature consistently states that the demographic makeup of the homeless population varies significantly from city to city. Therefore, the evidence supported asking experienced individuals from each sector to estimate an appropriately stratified sample for Calgary’s population. The results of the consensus building process used to generate the estimates can be seen in Table 1. Population estimates were then used to calculate the total number of individuals from each demographic group to be surveyed. Potential respondents were chosen at random by surveyors throughout the city. Agency staff did not refer potential respondents to surveyors, with the exception of a small number of individuals who were mentally ill and were referred for clinical interviews (N=6). The research staff assumed that seriously mentally ill homeless individuals would be less likely than other potential participants to agree to interactions with surveyors who approached them directly. In order to avoid undersampling the mentally ill group, agencies were asked to refer this small number of obviously mentally ill clients to ensure that they would not be completely absent from the sample.

The sample stratification process was only possible for the AH group, since estimates of its population size and demographics could be obtained from knowledgeable community members and verified against baselines in other jurisdictions. Comparable information was not available for the Relatively Homeless (RH) population, who do not use shelters and are often referred to as the “hidden” homeless or “couch surfers”. Consequently, the research team, in collaboration with community partners, decided that the most reasonable course of action for sampling the RH population was to simply ensure that each demographic group included at least 5 RH individuals. The sampling methodology for this group was not ideal by scientific standards. However, the intention was not to obtain a representative sample but to begin the process of understanding this group.

By way of comparison, the 1997 study intentionally sampled a representative cross-section of Calgary shelter users. They worked with seven agencies (Awo-Taan Native Women’s Shelter, Calgary Drop-In Centre, Connection Housing, Mustard Seed Ministry, Salvation Army, Victory Outreach Centre and YWCA of Calgary) to collect retrospective data on shelter users. As previously mentioned, changes in the organization of agencies that work with homeless people in Calgary resulted in the 2002 study having access to and involvement of most of the more than 100 agencies that serve the AH and RH groups. Therefore, a wider range of agencies than was possible in 1997 were included as survey sites in the current study. Retrospective data were not collected. Also, surveyors spent time on the street, at bottle depots, in hotels frequented by those on social assistance or sporadically employed, in abandoned buildings, and so on. Of the 309 survey interviews completed, 110 (35.6%) took place outside of any facility.
Developing the Survey
The 2002 survey was developed through a thorough and painstaking process designed to garner useful information for all sectors while not overburdening respondents. The steps involved in the process included:

1. Using the 1997 survey as the starting place;
2. Adding questions to specifically address the goals of the 2002 study;
3. Adding questions raised by an electronic survey of front line service agencies;
4. Adding questions raised by each of the sector chairs;
5. Adding questions raised by the CHF Research Steering Committee;
6. Presenting the modified survey to 8 focus groups on April 24 and 26. The focus groups were comprised of front-line service providers, sector chairs, funders and representatives from the Calgary Homeless Foundation. Recommendations from the focus groups were reviewed by the research team and incorporated into the survey wherever possible. Carte blanche was given to the focus groups to make recommendations on everything from survey content and wording to sample stratification and suggested survey locations. The research team was particularly interested in identifying any issues that had been missed in the survey and needed to be included. This information was used to modify the survey for the next step;
7. Presenting the modified survey to an all day workshop on May 3. The workshop participants included the same individuals who attended the focus groups as well as some additional participants. The workshop was broken into teams, each of which focused on several of the question domains (i.e. Survival Skills). The teams reviewed the language of each question, possible answers, question order and so forth. Again, the research team reviewed the recommendations from the workshop and further refined the survey;
8. Presenting the modified survey to two focus groups of homeless individuals to review its content and the intended surveying process. These focus groups were specifically asked to advise the research team about whether the language or intended process was clear, whether it might be offensive to respondents, and whether the questions would capture issues of particular importance to homeless people. One focus group (adult) was held at Calgary Urban Projects Society (CUPS) and the other (youth) at Avenue 15. Care was taken to ensure that the focus groups included males and females as well as aboriginal people. The adult group also included both individuals who were members of a homeless family and seniors.
9. The final AH survey was then used to develop the RH survey; and,
10. the entire package (intended sampling methodology, screening instrument, AH and RH surveys, clinical interview process) was presented to the Project Advisory Committee for approval. Approval was granted, and the study was ready to begin the data collection phase.

Selection and Training of Surveyors

Selection of surveyors:
Based on recommendations made by sector chairs and individuals experienced in working with the AH and RH population in Calgary, the research team engaged surveyors who represented specific homeless sectors as much as possible. The aim was to have surveyors who had
experienced AH or RH themselves, and who were still connected to the homeless population in some way. Interviewers were assigned to particular demographic groups in the stratified sample, based on their own demographic characteristics. For example, three of the surveyors were young aboriginal people: they were assigned to interview young aboriginal AH and RH people and to actively seek them out in a wide variety of locations throughout Calgary. Consequently, the sector chairs and other stakeholders were asked for recommendations of people they believed would carefully follow the survey protocol and could effectively engage the AH and RH populations. Thus, a group of surveyors was assembled that allowed the research team the freedom to match interviewer demographic characteristics to respondents to a high degree. Approximately half of the survey team were currently working with AH and/or RH populations, usually as front line service delivery staff.

The survey team was debriefed when the majority of surveying was completed. They indicated that the arrangement of matching their demographic characteristics to those of the AH and RH populations they were charged with interviewing had worked well both in locating individuals who might have been hard to find (such as the RH male youth) and in gaining their trust once located. The team felt they were able to elicit honest answers from the individuals they interviewed and had confidence in the material they had collected. They recommended that a similar interviewing process be used in other research projects to ensure that the population interviewed represented the homeless population, and that answers to the survey questions were not deliberately falsified to take advantage of naïve interviewers.

Surveyor Training:
Training the surveyors was an important component of the process, essential to ensuring the reliability of the information obtained. The training took place over two consecutive evenings (July 3 and 4) at the Calgary Drop-In Center boardroom. All surveyors attended both evening sessions. Members of the research team explained that each surveyor would be expected to pilot the surveys during the day following the first training session and prior to returning the next evening for the second training session. Each surveyor was given a copy of the survey document the day before the first training session and asked to review all questions. A total of 15 surveyors (10 adult, 5 youth) were present for training on the first night, as well as 3 research staff.

The first training session lasted three hours and covered the rationale for the study, an overview of survey methodology, description and discussion of significant sample characteristics, and a thorough review of the screening and survey documents. Some time was spent reviewing the population definitions and the distinctions between AH and RH samples. Surveyors were given a breakdown of sample characteristics, including the percentages and number of people required to fill the stratified sample categories. Considerable emphasis was placed on explaining the process of survey implementation. This component included the importance of asking questions in a consistent way, completing each survey in the same order and generally respecting survey protocol. Time was also spent reviewing surveyor safety issues and identifying factors related to mental health and addiction issues.

Each surveyor was then asked to administer the survey to two members of the target population to which they were assigned. Surveyors were given the option of requesting direct supervision for this piloting portion of the training. Most of the survey team had previous experience with research protocols, and only one surveyor requested this support. The second evening included a thorough discussion of the various issues that arose during the pilot, including survey length, how to organize the outreach interviews, and so on. A basic quota of 20 surveys was then given to each surveyor, and they were made aware that the numbers required would change over time, as the stratified sample began to be filled. Consequently, it was very important to keep in touch with the research team as surveys were completed. Surveyors were then given a sufficient number of survey instruments, payment vouchers and
clinical interview appointment cards, along with a clipboard, identification tag, and laminated answer cards for the WHODAS II and Wisconsin Quality of Life subscales which were embedded in the survey. Surveying began immediately after the training period was completed.

**Conducting the Survey**

The service agencies were consistently helpful and proactive throughout the survey period. Their assistance went beyond simply allowing surveyors to work on their premises. Agencies were willing and able to work with the dynamic nature of the surveying, knowing the challenges that the research team was faced with in obtaining a representative stratified sample. There was no way to predict how quickly each demographic category in the sample would fill up, and this required a daily review of which groups needed to be focused on more intensively. Throughout the study, the research team sought the assistance of the agencies to ensure that the required sample was being obtained. Without the cooperation of the agencies, it is unlikely that an appropriately stratified sample would have been obtained.

Individuals who fit the stratified sample profile that each surveyor was working on were approached by the surveyors and asked if they would like to participate. Respondents were paid $10 for completing the survey. Those who indicated during the survey that they had been homeless in Calgary more than once were offered an appointment card that would provide an additional $15 for completing a clinical interview with one of the members of the clinical team. In order to ensure the safety of the surveyors, who would otherwise be carrying significant amounts of cash, respondents were provided with cash vouchers at the end of the survey, which they could then hand in for payment at CUPS. CUPS provided significant administrative assistance in tracking and handling money for respondents, and in making space available for the clinical interviews. More than 90% of respondents who were given a cash voucher came to CUPS to redeem it.

Surveying and clinical interviews began immediately after the surveyor training on July 4th and continued into mid August.

**Developing the Clinical Interview**

One of the goals of the 2002 study was to map the current homelessness system, identify how individuals and families move through the system, and identify gaps in the current system. The semi-structured survey process alone would not provide sufficient information to thoroughly answer these questions. Therefore, the research team developed a clinical interview for individuals who self-identified during the survey as having been homeless in Calgary more than once.

The research team adopted the qualitative case study methodology developed by Deborah Kraus and Judy Graves (2001) in Vancouver. Kraus & Graves originally undertook the work as a component of regional research on the incidence and nature of homelessness in the Greater Vancouver region, and carried out their research during 2001-2002. The findings of that research are reported in volumes of the Research Project on Homelessness in Greater Vancouver, April, 2002. The qualitative interview format was designed to:

- obtain qualitative information about the homeless population, including women and men, families with children, seniors, aboriginal people, people with mental and physical health issues, and people who are chronically and episodically homeless;
- put a face on homelessness;
- inform the development of appropriate policy and program responses and target scarce resources as effectively as possible;
- document the life experiences of people who become homeless and the situations/processes that led them to become homeless;
- document the kinds of services, programs or other assistance that have been found helpful
Research Report to the Calgary Homeless Foundation, October 2002

for people to exit homelessness, and identify what services are missing, and what are the barriers to accessing services;

• identify prevention strategies; and

• support a communications strategy.

These were also the aims of the qualitative data collection process planned for the 2002 Calgary study. The steps Kraus & Graves used to develop the methodology were thorough and appropriate to research methodology standards. These included:

1. A review of approaches used in Canada and the United States to gather first person qualitative information from homeless and formerly homeless people;

2. Key informant interviews;

3. Development of a draft methodology to conduct personal interviews with people who are homeless and formerly homeless;

4. Two focus group meetings with people who were currently and formerly homeless to obtain their input on the draft methodology and interview guide;

5. Pilot interviews with four (4) individuals who were homeless and with three (3) people who had experienced homelessness in the recent past; and

6. Review of the methodology by a professional qualitative research consultant.

The research team spoke with Deborah Kraus and asked further questions about how well the interview instrument had worked in meeting the Vancouver team’s goals. After several conversations of this nature, the research team asked for and was granted permission to adapt the Kraus & Graves protocol for use in the 2002 study, modifying it where necessary.

The research team then made several modifications to the interview protocol. The two most important of these were the deletion of any items that were redundant with the survey questions, and the inclusion of family of origin and current family questions. Since it was assumed that most clinical interview participants would have completed a survey prior to the interview, the removal of redundant questions was important to avoid burdening the respondents and giving them the impression that they were being asked questions for a second time in order to trap them in some way. Questions about family of origin and current family were added to more thoroughly address the issues of how people become homeless, and to provide material that could be used to illustrate, or “put a face on” the quantitative findings.

Selecting the Clinical Interviewers
The clinical interviewers were all members of the core research team. These included three clinical psychologists, a Ph.D. candidate in psychology, and an R.N. with considerable research experience. Consequently, all clinical interviewers had experience conducting face-to-face interviews on sensitive issues in potentially volatile situations. The team discussed how to handle any emergent issues that arose from the interviews and also met part way through the clinical interview process to discuss the results and process. As the interviewers had extensive experience with the intentions of the 2002 study and its protocols, formal training was not required for conducting the clinical interviews.

Conducting the Clinical Interviews
A total of 61 clinical interviews were carried out. As previously mentioned, most clinical interviews were conducted at CUPS, for two reasons. First, potential participants were in
attendance at CUPS in order to collect their survey money. Locating the clinical interviewers at CUPS provided ease of access for respondents. Second, CUPS provided the research team with administrative support to book appointments, as well as private and appropriate space in a safe environment where interviews could be carried out. It was hoped that a safe and private space in an environment that many respondents were familiar with would set them at ease. This proved to be the case: clinical interviewers reported that respondents were eager to talk, with very few refusing to answer questions. Respondents were generally pleased to discuss their experiences and very interested in what would be done with the results of this study. They often emphasized their altruistic intentions for participating in the research process, especially their hope that they could assist positive change and help others avoid their situation.
Results

Quantitative Analysis

Proposed and Actual Sample

A survey of 238 AH and 71 RH respondents was carried out during the months of July and August. Virtually all individuals who were approached by surveyors agreed to complete the survey, with the exception of some individuals who were believed to be seniors. This latter group proved to be more reticent to talk to surveyors.

Table 3: Proposed vs. Actual Stratified Sample

<table>
<thead>
<tr>
<th>Demographic Group</th>
<th>Population Random Sample Proposed by Focus groups(^1) (N=275)</th>
<th>AH (N=235)</th>
<th>Actual (N=238)</th>
<th>RH (N=40)</th>
<th>Actual (N=71)</th>
<th>TOTAL SAMPLE (N= 309)</th>
<th>% of Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Men</td>
<td>71.0%</td>
<td>167</td>
<td>183</td>
<td>28</td>
<td>41</td>
<td>224</td>
<td>72.5%</td>
</tr>
<tr>
<td>• Women</td>
<td>29.0%</td>
<td>68</td>
<td>55</td>
<td>12</td>
<td>30</td>
<td>85</td>
<td>27.5%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Youth</td>
<td>21.0%</td>
<td>50</td>
<td>57</td>
<td>13</td>
<td>18</td>
<td>75</td>
<td>24.3%</td>
</tr>
<tr>
<td>• Seniors (55+)</td>
<td>18.0%</td>
<td>42</td>
<td>31</td>
<td>9</td>
<td>28</td>
<td>59</td>
<td>19.1%</td>
</tr>
<tr>
<td>Family Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family</td>
<td>14.5%</td>
<td>34</td>
<td>28</td>
<td>14</td>
<td>17</td>
<td>45</td>
<td>14.6%</td>
</tr>
<tr>
<td>• Single</td>
<td>85.5%</td>
<td>201</td>
<td>210</td>
<td>26</td>
<td>54</td>
<td>264</td>
<td>85.4%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aboriginal</td>
<td>29.0%</td>
<td>68</td>
<td>85</td>
<td>12</td>
<td>24</td>
<td>109</td>
<td>35.3%</td>
</tr>
<tr>
<td>• Non-aboriginal</td>
<td>71.0%</td>
<td>167</td>
<td>153</td>
<td>28</td>
<td>47</td>
<td>200</td>
<td>64.7%</td>
</tr>
<tr>
<td>Mentally Ill</td>
<td>N/A</td>
<td>N/A</td>
<td>66</td>
<td>na</td>
<td>14</td>
<td>80</td>
<td>25.9%</td>
</tr>
<tr>
<td>Addictions</td>
<td>N/A</td>
<td>N/A</td>
<td>173</td>
<td>na</td>
<td>39</td>
<td>212</td>
<td>68.6%</td>
</tr>
<tr>
<td>Women Fleeing</td>
<td>N/A</td>
<td>N/A</td>
<td>16</td>
<td>na</td>
<td>15</td>
<td>31</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

A comparison of basic demographics between the 1997 report and the 2002 findings in Table 4 illustrates the results of the different sampling methods. As can be seen from the Table, the 2002 survey included substantially more women, seniors and aboriginal persons than the 1997 study did. In addition, the various stakeholders agreed that allowing mental health and addictions issues to emerge out of the random sample would be the most appropriate method of determining prevalence of these issues in the homeless population. As can be seen from Table 3 above, 25.9% of those surveyed had a mental health problem and 68.6% had a history of substance abuse, as captured by the surveyor using the Mini Mental State exam and triangulated with respondent answers. Current literature indicates that approximately 25% of homeless individuals have a serious mental illness and about 50% have a history of substance abuse.

\(^1\) Please note that these categories are not mutually exclusive. For example, it is possible for a single person to be in the “youth”, “male” and “mental health” categories.
abuse (Dickey, B, 2000; Koegel, Burnam & Baumohl, 1996; Susser, Struening & Conover, 1989). Consequently, it appears that the Calgary population may have parallel levels of mental health issues, but substantially higher levels of substance abuse history than has been found by other studies. 46.1% of the AH sample and 31.0% of the RH sample indicated that they currently have a substance abuse problem, and 74.7% of AH and 64.8% of RH respondents reported a history of drug or alcohol abuse. 70% of the RH and 65% of the AH group indicated that alcohol or drugs had played a role in their housing problems.

It is important to note here that, of the 61 respondents who attended a clinical interview, 70% were found to have a mental illness. Fifty-five of these participants were identified by surveyors as having been homeless in Calgary on more than one occasion, while six were selected on the basis of having a mental illness. The higher prevalence of mental illness found in the clinical interview sample may be more accurate than the survey rate, given that the interview-based judgments of presence of a mental illness were made by mental health clinicians. It is also possible that homeless people who have experienced more than one episode of homelessness in Calgary are more likely to have a mental illness than those who have had only one homelessness episode.

Table 4: 1997 vs. 2002 Sample Basic Demographics

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>1997 Survey Sample (N = 250)</th>
<th>2002 Stratified Survey Sample* (N = 309)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Male</td>
<td>82%</td>
<td>72.5%</td>
</tr>
<tr>
<td>o Female</td>
<td>18%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 24 years or less</td>
<td>25%</td>
<td>24.3%</td>
</tr>
<tr>
<td>o 25 - 54</td>
<td>71%</td>
<td>56.7%</td>
</tr>
<tr>
<td>o 55+</td>
<td>4%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Caucasian</td>
<td>72%</td>
<td>58.0%</td>
</tr>
<tr>
<td>o Aboriginal</td>
<td>22%</td>
<td>35.3%</td>
</tr>
<tr>
<td>o Other</td>
<td>6%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

*Note that the differences are the result of a change in methodology, not a change in the demographics of the homeless population.

Representation:

Since the stratified sample was established based on the consensus opinion of stakeholders who have considerable experience working with the Calgary homeless population, it is unlikely that any groups are under-represented in the sample. These proportions are also supported by the more recent literature. For example, Hwang (2001) indicated that “single men constitute the largest segment of homeless people in most Canadian cities: about 70% of the homeless population in Vancouver, Edmonton and Calgary (p. 230).” This finding is in keeping with the sample size proposed and obtained for single males in the 2002 study.

Hwang further states that Aboriginal people are over-represented in Canada’s homeless population by a factor of about 10. Some interesting discrepancies have arisen in counting aboriginal homeless people in Calgary. For example, the November 1999 Edmonton Homeless Count Committee report indicated that Aboriginal people made up 35% of their homeless population. The current study had no difficulty in obtaining and, in fact, exceeding the
number of Aboriginal people required for the stratified sample, despite the fact that the City of Calgary Count of Homeless persons found only 18% of the population to be Aboriginal in 1998 and 15% in 2002. The 2002 City of Calgary Count of Homeless Persons had a much higher incidence of “visible minorities” participation than the 2002 CHF study does. It is possible that Homeless Count participants were reluctant to categorize a person as Aboriginal with insufficient information and, instead, classified them as “visible minority”. Based on a debriefing of the 2002 CHF surveyors, the research team believes that Aboriginal people are perhaps slightly over-represented in the current study, but not sufficiently to constitute a problem for the results. Eight of the fifteen original surveyors were Aboriginal people who have considerable experience with the homeless population in Calgary. Their familiarity with the population was a significant benefit to the project, but may also have biased the sample slightly towards inclusion of more Aboriginal people. This theory was investigated further. As can be seen from the following table, Aboriginal surveyors did over-sample Aboriginal respondents (65 interviewed as opposed to an expected 51). However, Non-Aboriginal surveyors under-sampled Aboriginal respondents by an identical number (14 instead of 28). The same holds true for non-Aboriginal respondents (non-Aboriginals surveyors over-sampled this group and Aboriginal surveyors under-sampled). This is exactly what was to be expected given the sampling methodology agreed upon by the community stakeholders (in that surveyors should, as much as possible, be similar in key demographic features as the people they were charged with surveying).

Table 5: Aboriginal Respondents x Aboriginal Surveyors

<table>
<thead>
<tr>
<th>PERSON * Demographic - Aboriginal Crosstabulation</th>
<th>Non-Aboriginal Respondent</th>
<th>Aboriginal Respondent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Aboriginal Interviewer</td>
<td>64</td>
<td>14</td>
<td>78</td>
</tr>
<tr>
<td>Count</td>
<td>50.4</td>
<td>27.6</td>
<td>78.0</td>
</tr>
<tr>
<td>Aboriginal Interviewer</td>
<td>80</td>
<td>65</td>
<td>145</td>
</tr>
<tr>
<td>Count</td>
<td>93.6</td>
<td>51.4</td>
<td>145.0</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>79</td>
<td>223</td>
</tr>
<tr>
<td>Expected Count</td>
<td>144.0</td>
<td>79.0</td>
<td>223.0</td>
</tr>
</tbody>
</table>

The 1997 study indicated that Aboriginal people often prefer to sleep outside of the shelters in summer months, and that two agencies having high Aboriginal populations among their clientele were not included in the survey at that time. In contrast, although the 2002 CHF survey was also conducted in the summer months, it intentionally expanded the survey area beyond the shelters in order to include people who choose to sleep outside in the summer. The deliberate sampling of a wide number of street locations, including agencies that serve significant Aboriginal populations, probably also accounts for some of the discrepancy between the number of Aboriginal participants in the 1997 and 2002 studies.

The 1997 study was unable to sample from three significant groups of homeless individuals: women fleeing violence, youth, and families. The first two groups were excluded from that study due to confidentiality concerns. The 1997 study collected retrospective, individually identifiable information, which is strictly prohibited with these groups. The 1997 study did not specifically attempt to survey families, and the facilities included in that study did not serve the homeless family population. The 2002 study had an advantage in that it sought only participation from currently AH or RH people (as opposed to using retrospective data) and respondents were guaranteed anonymity. Therefore, each of these three groups could, and did, participate. Their inclusion in the study adds considerable depth of information on the Calgary homeless population in general, as well as on the specific characteristics of the people
who comprise each of these sectors. As can be seen from Table 3 above, 10% of the overall sample were women fleeing violence, 24.3% were youth and 14.6% were families.

Socio Demographic Characteristics
As can be seen from Table 6, below, there are substantial differences between the 1997 and 2002 homeless populations in terms of demographic characteristics.

Table 6: Socio Demographic Characteristics of the 1997 and 2002 studies

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>1997 Study</th>
<th>2002 Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>RH</td>
</tr>
<tr>
<td></td>
<td>Men % of 205 (Total)</td>
<td>Women % of 45 (Total)</td>
</tr>
<tr>
<td>Average Age</td>
<td>1 missing</td>
<td>10 missing</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. 15-24 Yrs</td>
<td>23.5 (48)</td>
<td>28.9 (13)</td>
</tr>
<tr>
<td>ii. 25-34 Yrs</td>
<td>24.5 (50)</td>
<td>17.8 (8)</td>
</tr>
<tr>
<td>iii. 35-44 Yrs</td>
<td>31.9 (65)</td>
<td>22.2 (10)</td>
</tr>
<tr>
<td>iv. 45-54 Yrs</td>
<td>16.7 (34)</td>
<td>22.2 (10)</td>
</tr>
<tr>
<td>v. 55+</td>
<td>03.4 (7)</td>
<td>08.9 (4)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>2 missing</td>
<td>6 missing</td>
</tr>
<tr>
<td>Never Married</td>
<td>55.7 (113)</td>
<td>42.2 (19)</td>
</tr>
<tr>
<td>Married/Claw</td>
<td>12.3 (23)</td>
<td>06.7 (3)</td>
</tr>
<tr>
<td>Widow/Sept/Divorced</td>
<td>32.0 (65)</td>
<td>51.1 (23)</td>
</tr>
<tr>
<td>Ethnic Origin</td>
<td>4 missing</td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>11.6 (23)</td>
<td>24.4 (11)</td>
</tr>
<tr>
<td>Other Visible Minority</td>
<td>05.6 (11)</td>
<td>04.4 (2)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>82.8 (164)</td>
<td>71.1 (32)</td>
</tr>
<tr>
<td>Highest Education</td>
<td>2 missing</td>
<td>1 missing</td>
</tr>
<tr>
<td>Elementary/JH</td>
<td>33.5 (68)</td>
<td>31.8 (14)</td>
</tr>
<tr>
<td>High School</td>
<td>43.3 (88)</td>
<td>54.5 (24)</td>
</tr>
<tr>
<td>Trade/College/Uni</td>
<td>23.2 (47)</td>
<td>13.5 (6)</td>
</tr>
</tbody>
</table>

AH, Males
The average age of this group is 1.5 years older than it was in the 1997 study. This change is likely due to the increased size of the seniors sector, as dictated by the stratified sample. The number of homeless men who have never married is larger, and there has been a corresponding decrease in the number of people who are divorced/separated or widowed. The percentage of aboriginal males included in the 2002 study is significantly larger than it was in the 1997 study.

The 1997 study theorized that education might be a protective factor against prolonged homelessness. Therefore, an important finding is that the level of education in the 2002 sample is lower than that found in 1997. In the 1997 study 76.8% of the males had high school completion or less and 23.2% reported some post secondary education. The 2002 study shows that 99.4% of the AH males surveyed have high school completion or less. Only a single individual had participated in education beyond the high school level.
AH, Females
The average age of this group is 2 years lower than in the 1997 study cohort. This is an important observation, since more seniors were included in the 2002 study (8 vs. 4). The 45-54 age group is considerably reduced in the 2002 study compared with 1997. The age distribution among AH women in the 2002 study is bimodal, with 83.6% under the age of 45 and 14.5% over the age of 55.

The education level of the 2002 AH female sample is lower than the mean level of education found in the 1997 study cohort. Despite the larger sample of females surveyed in 2002, none had completed education beyond the high school level. This is a significant difference from the 1997 study, where 13.5% (N=6) had gone beyond high school. This group also has a larger proportion who have a grade 9 education or less (39.6% of AH women, cf. 23.3% of AH men).

There were also significantly more aboriginal women included in the 2002 survey (N = 27) than in 1997 (N=11). It is also interesting to note that none of the AH women indicated that they were currently married. This was a somewhat surprising finding. However, as can be seen from the table below, the primary reason for this was that the respondents were cohabitating (common-law) as opposed to being formally married

Table 7: AH Female Marital Status

<table>
<thead>
<tr>
<th>Section F, Question 2</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>14</td>
<td>25.5</td>
<td>25.9</td>
<td>25.9</td>
</tr>
<tr>
<td>Cohabiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(common law)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>9.1</td>
<td>9.3</td>
<td>35.2</td>
</tr>
<tr>
<td>Never married/single</td>
<td>17</td>
<td>30.9</td>
<td>31.5</td>
<td>66.7</td>
</tr>
<tr>
<td>Separated</td>
<td>10</td>
<td>18.2</td>
<td>18.5</td>
<td>85.2</td>
</tr>
<tr>
<td>Single parent</td>
<td>5</td>
<td>9.1</td>
<td>9.3</td>
<td>94.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>5.5</td>
<td>5.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>98.2</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>1</td>
<td>1.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RH, Males
The primary socio-demographic difference between AH males and their RH counterparts appears to be age. The RH males are an average of 5.9 years older. This difference is due in part to the increased number of seniors included in the 2002 study. It is, however, interesting to note that despite the randomized methodology used for sampling, none of the RH males were between the ages of 45 and 54.

RH, Females
RH females differ from their AH counterparts in a number of ways. As with the male RH group, they are older by 4.8 years on average. They are more likely to be widowed, separated or divorced than the AH women (56.7% vs 42.7%) and fewer of the RH women were aboriginal.

As previously mentioned, the 1997 report found that higher education appeared to be protective against multiple episodes of homelessness. To test this hypothesis, the 2002 data were used to compare education with number of episodes of homelessness. It was found that higher education level did not protect this sample of participants from increased episodes of homelessness, \( \chi^2 (2, N=203) = 1.96, p>.05 \). This finding is likely due to the fact that the 2002 sample had only 1 person who had more than a high school level of education, compared to the
53 found in the 1997 sample. The RH women also showed the same pattern that was found in the AH group, with the female sample having a greater proportion who had grade nine or less (37.9% of RH women cf. 24.2% of RH men).

These findings support the 1997 assertion concerning education and homelessness, in that it appears that those with higher education are no longer in the homeless population as sampled in 2002. However, it is important to note that “higher education” in this context does not mean completion of high school. Rather, it refers to those individuals who have some level of education in trade/community or university level institutions. Below this level, the evidence indicates that education does not protect individuals from increased episodes of homelessness. This is an important issue to consider regarding gaps in the current system. If education beyond high school protects individuals from experiencing homelessness, education becomes a critical building block in an effective system to prevent homelessness or speed the exit of individuals from homelessness.

All respondents were asked questions which further explored their “family” status. They were asked “Is there anyone you take care of such as children, family or friends?” and whether they would take care of any other people if they were not homeless. When respondents answered affirmatively, they were asked additional questions regarding who they cared for or where these dependents were now. 25% \( (N=59) \) of AH and 34% \( (N=24) \) of RH indicated there was someone they currently cared for. In both cases the person(s) cared for most often were children, \( N=27 \) (47%) for AH and \( N=15 \) (63%) for RH. In total, there were 42 children being cared for by AH and 39 children being cared for by the RH group. However, a considerable number of both groups indicated that they also took care of non-relatives. 29% \( (N=17) \) of AH and 33% \( (N=8) \) of the RH indicated they took care of a non-relative/friend. In addition, 29% \( (N=17) \) of AH and 8% \( (N=2) \) of RH were taking care of a partner.

52% \( (N=121) \) of AH and 33% \( (N=21) \) of RH responded that there were other people they would take care of if they had stable housing. AH individuals indicated that the majority of people they would care for were children \( (N=51, 43\%) \) and non-relative/friends \( (N=43, 36\%) \) followed at a distance by partners \( (N=15, 13\%) \), parents \( (N=11, 9\%) \), siblings \( (N=11, 9\%) \) and other relatives \( (N=10, 8\%) \). RH individuals indicated that the majority of people they would care for were non-relatives/friends \( (N=9, 43\%) \). This is perhaps explained by the fact that many of the people in the RH group had their children with them. When asked about the number of children they would be caring for if their housing circumstances were different, the AH group indicated that there were 87 children in total and the RH group indicated 7 children in total that they would be caring for if their housing circumstances were different. It may be possible to further analyze the raw survey data to better understand where these dependents are, since the AH or RH respondents are unable to care for them.

Other socio-demographic characteristics of interest which were included in the 2002 study but not in 1997 are included in Table 8. In addition to the above, respondents who were aboriginal or youth were asked additional questions in order to better understand their socio-demographic profiles.

**Aboriginal Respondents**

Aboriginal respondents were asked to identify their status. Of the 92 AH respondents who answered, 54% \( (N=50) \) were First Nations, 21% \( (N=19) \) were Metis, 21% \( (N=19) \) were non-status, 2% \( (N=2) \) were Inuit and 2% \( (N=2) \) were covered under Bill C-31. Of the 23 RH respondents who answered, 70% \( (N=16) \) were First Nations, 22% \( (N=5) \) were Metis, and 9% \( (N=2) \) were non-status. Individuals from both groups were also asked to identify the name of the Nation/Settlement/Northern Community and the area of Canada they were from. The data show that no pattern emerged from the responses to this question, except that the majority of respondents were from the western provinces. 76% \( (N=48) \) of AH respondents and 95% \( (N=18) \)
Aboriginal respondents were further asked about the circumstances surrounding their departure and ongoing involvement with the reserve. Only 9% (N=2) of AH and 13% (N=1) of RH respondents who answered the question indicated that they return to the reserve less than once per year. However, this should be interpreted cautiously due to the low response rate to this particular question. When asked why they had left the reserve the last time, AH and RH respondents had similar responses. 39% (N=25) of AH and 36% (N=5) of RH indicated that family problems were the primary reason they left, followed by lack of housing (26%, N=17 for AH and 39%, N=4 for RH) and lack of employment (22%, N=14 for AH and 29%, N=4 for RH). The majority of respondents indicated that their band did not provide housing (83%, N=64 for AH and 82%, N=18 for RH).

The majority of AH Aboriginal respondents indicated that they would not return to the reserve if given the choice (63%, N=43). This was not the case for RH respondents, 60% (N=12) of whom wanted to return. Both groups were offered the opportunity to explain what it would take to make it possible to return. Responses were reflective of the reasons that people left the reserve the last time; available employment (48%, N=12 for AH, 17%, N=2 for RH), available housing (40%, N=10 for AH, 50%, N=6 for RH) and good housing (36%, N=9, 17%, N = 2 for RH) were the most frequently offered responses.

**Youth Respondents**

Respondents aged 24 or younger were asked about their current child welfare status. The majority of respondents who chose to answer did not currently have child welfare status (98%, N=39 for AH, 67%, N=6 for RH). 10 of the AH (25%) and 2 of the RH youth (33%) indicated they had child welfare status in the past but it had been terminated. 46% (N=19) of AH and 54% (N=7) RH youth indicated that they had applied for SFI but been declined. Although respondents were asked why they were turned down, no pattern emerged from the responses, the majority of which fell into the “other” category (68%, N=13 for AH and 43%, N=3 for RH).

**Current Situation**

Respondents identified the factors listed in Table 9, below as the causes of their homelessness. The 2002 response categories were not identical to the ones used in 1997, however some comparisons can be made. For example, 17% of the 1997 respondents indicated that lack of work was their primary reason for being homeless, compared to only 5.7% of the 2002 sample. 17% of the 1997 sample indicated that they had traveled to Calgary to find work and/or a
better life. The 2002 study did not have a parallel category. However, analysis of the “other” category of responses post data collection created a similar category. The newly created category (i.e. it will not be found on the survey) was summarize as “Sudden Moves” because, although respondents indicated that they were looking for a better life, they usually made the move in an unplanned fashion, without first securing employment or a place to live. It is worth noting that a significant difference exists between AH and RH populations on this point. While none of the RH had responses in this category, 21.2% of AH males and 4.3% of AH females had made sudden and unplanned moves immediately before becoming homeless.

**Table 9: Reasons for Homelessness**

<table>
<thead>
<tr>
<th>Reason Given for Homelessness</th>
<th>AH Male (Total N=183)</th>
<th>AH Female (Total N=55)</th>
<th>RH Male (Total N=41)</th>
<th>RH Female (Total N=30)</th>
<th>Total (N=680)</th>
<th>% of Total (N=680)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Health Problems</td>
<td>57.4 (54)</td>
<td>21.2 (20)</td>
<td>14.9 (14)</td>
<td>06.4 (6)</td>
<td>94</td>
<td>13.8</td>
</tr>
<tr>
<td>2 Rent was too high</td>
<td>38.3 (36)</td>
<td>14.9 (14)</td>
<td>21.3 (20)</td>
<td>19.1 (18)</td>
<td>88</td>
<td>12.9</td>
</tr>
<tr>
<td>3 Family problems (includes abuse)</td>
<td>36.1 (34)</td>
<td>20.2 (19)</td>
<td>14.9 (14)</td>
<td>06.4 (6)</td>
<td>73</td>
<td>10.7</td>
</tr>
<tr>
<td>4 Lack of Supported Housing (type unknown)</td>
<td>21.2 (20)</td>
<td>08.4 (8)</td>
<td>22.3 (21)</td>
<td>06.4 (6)</td>
<td>55</td>
<td>8.1</td>
</tr>
<tr>
<td>5 Landlord problems/eviction</td>
<td>28.7 (27)</td>
<td>10.6 (10)</td>
<td>07.4 (7)</td>
<td>05.3 (5)</td>
<td>49</td>
<td>7.2</td>
</tr>
<tr>
<td>6 Lost Job</td>
<td>34.0 (32)</td>
<td>07.4 (7)</td>
<td>05.3 (5)</td>
<td>02.1 (2)</td>
<td>46</td>
<td>6.8</td>
</tr>
<tr>
<td>7 Could not find employment</td>
<td>33.0 (31)</td>
<td>01.1 (1)</td>
<td>06.4 (6)</td>
<td>01.1 (1)</td>
<td>39</td>
<td>5.7</td>
</tr>
<tr>
<td>8 Fleeing Violence</td>
<td>09.6 (9)</td>
<td>17.2 (16)</td>
<td>02.1 (2)</td>
<td>11.7 (11)</td>
<td>38</td>
<td>5.6</td>
</tr>
<tr>
<td>9 Could not access housing/services for alcohol/drug related problems</td>
<td>19.1 (18)</td>
<td>06.4 (6)</td>
<td>09.6 (9)</td>
<td>02.1 (2)</td>
<td>35</td>
<td>5.1</td>
</tr>
<tr>
<td>10 Did not have family to provide support</td>
<td>14.9 (14)</td>
<td>08.4 (8)</td>
<td>08.4 (8)</td>
<td>03.2 (3)</td>
<td>33</td>
<td>4.9</td>
</tr>
<tr>
<td>11 Wage was too low to afford shelter and basic needs</td>
<td>18.1 (17)</td>
<td>03.2 (3)</td>
<td>06.4 (6)</td>
<td>05.3 (5)</td>
<td>31</td>
<td>4.6</td>
</tr>
<tr>
<td>12 Roommate/Non-Family relationship problems</td>
<td>19.1 (18)</td>
<td>06.4 (6)</td>
<td>01.1 (1)</td>
<td>00.0 (0)</td>
<td>25</td>
<td>3.7</td>
</tr>
<tr>
<td>13 Sudden, unplanned moves to Calgary</td>
<td>21.2 (20)</td>
<td>04.3 (4)</td>
<td>00.0 (0)</td>
<td>00.0 (0)</td>
<td>24</td>
<td>3.5</td>
</tr>
<tr>
<td>16 Other</td>
<td>18.1 (17)</td>
<td>09.6 (9)</td>
<td>14.9 (14)</td>
<td>10.6 (10)</td>
<td>50</td>
<td>7.4</td>
</tr>
<tr>
<td>Totals</td>
<td>347</td>
<td>131</td>
<td>127</td>
<td>75</td>
<td>680</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The 1997 report found that 15% of respondents were homeless due to domestic problems, including issues with roommates. The 2002 study found very similar results, with 14.4% of respondents reporting this factor as a contributing reason to their homelessness. The 1997 study also found that 15% of respondents could not afford to pay their rent. This cause was mentioned more frequently in the 2002 study. The 2002 study examined this issue from two perspectives: (a) rent being too high and, (b) wages being too low to afford both shelter and basic needs. When taken together, they accounted for 17.5% of the reasons that respondents provided for why they were currently homeless. The 1997 study reported that 15% of the respondents had physical problems that contributed to their homelessness. This is roughly parallel to the 13.8% of 2002 respondents who indicated that “health problems” accounted for at least one reason why they were experiencing housing difficulties. It should be noted that
significant differences regarding health exist between the homeless groups. For example, 57.4% of AH males indicated that health was a problem, compared to 6.4% of RH females.

“I’ve been overworked my whole life and now I’m in poor physical shape. I began taking care of my family when I was 8. I was paying rent to my family by age 10 and I was on the streets when I was 12. I’ve been on the streets off and on for 20 years and am just trying to stay ahead of the game.” (Tim)

“The cost. The rents are outrageous. Just for an apartment it’s $600 a month. I want to get my name in at Calhomes, but the waiting list is so long (2 years). I don’t know if I’m coming or going. If I go tomorrow, I have to fill out a form and put the DIC as an address. If I find a place during the wait, I have to go and fill out another form. I just say the hell with it and the process. Why bother?” (Frank)

“Finding affordable housing has been difficult. Once a landlord finds out that I’m homeless and have two kids, they don’t want to rent to me. I don’t use drugs or drink: that’s a stereotype of homeless people.” (Joan)

“My female roommate had failed to pay her rent, and the male roommate was really unreliable in paying the bills. It felt like I was taking on all the responsibility, that I was taking on all the pressure. The stress was too much for me and I felt I needed to take a break – getaway. I quickly decided to pack up and leave for Calgary.” (Wren)

“Lack of affordable housing. To get a one bedroom apartment you’re looking at $600 - $700, not including phone and set-up; it’s likely going to cost you $1,700 to move in. How do you save that with $50/day? It’s a catch-22; the working man is the guy who gets stiffed - crack heads get everything they need while the working guy gets stiffed.” (Bob)

Although it is important to keep in mind that the results of the 1997 and 2002 studies are not always directly comparable, they can often be approximately compared, as has been done in Table 10 to review Reasons for Homelessness. The 1997 study reported this information as a percentage of multiple responses, rather than based on the number of respondents. Table 10 has been calculated in a similar manner for the 2002 study results in order to facilitate direct comparisons.

Although Table 10 was included for comparison purposes against the 1997 results, it can be somewhat misleading. 2002 respondents could provide as many answers as applied to explain the complexity of the causes of their housing difficulties. The average number of factors identified as reasons for being homeless per respondent in the 2002 study was 2.2, compared to 1.46 reasons per respondent in the 1997 study. This could lead to some reasons for being homeless appearing to have increased or reduced. It may be more valuable to review the results in terms of the number of respondents who mentioned each of the reasons. These results are presented in Table 11 below.

From Table 11, it can be seen that lack of work or job loss affects male homelessness more than female homelessness and, conversely, that running from an abusive relationship affects women much more strongly than men. As previously mentioned, traveling to Calgary to find work and a better life, often in an unplanned manner, does not appear to be an issue at all with the RH group, but is important for AH men and women. “Lack of Social Benefits” figures
largely in the explanation given by the RH and fairly strongly for the AH groups. It is important to note that this “Lack of Social Service Benefits” was not solely attributable to issues such as

Table 10: Reasons for Homelessness (% of Total Responses)

<table>
<thead>
<tr>
<th>Reason Given for Homelessness</th>
<th>1997 Study</th>
<th>2002 Study</th>
<th>1997 Study</th>
<th>2002 Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>AH</td>
<td>RH</td>
<td>RH</td>
</tr>
<tr>
<td></td>
<td>Men &amp; Women % of 365 Responses (Total)</td>
<td>Men % of 131 (Total)</td>
<td>Women % of 131 (Total)</td>
<td>Men % of 127 (Total)</td>
</tr>
<tr>
<td>Lack of Work/Lost Job</td>
<td>17%</td>
<td>05.8 (20)</td>
<td>15.0 (52)</td>
<td>01.6 (9)</td>
</tr>
<tr>
<td>Traveled to Calgary to find work/better life</td>
<td>17%</td>
<td>18.2 (63)</td>
<td>19.1 (25)</td>
<td>08.0 (6)</td>
</tr>
<tr>
<td>Domestic Difficulties (incl. Roommate problems)</td>
<td>15%</td>
<td>18.2 (63)</td>
<td>18.3 (24)</td>
<td>21.3 (27)</td>
</tr>
<tr>
<td>NSF for Rent/Evicted</td>
<td>15%</td>
<td>18.2 (63)</td>
<td>18.3 (24)</td>
<td>21.3 (27)</td>
</tr>
<tr>
<td>Poor Physical Health (incl. Addictions)</td>
<td>15%</td>
<td>15.6 (54)</td>
<td>15.3 (20)</td>
<td>11.0 (14)</td>
</tr>
<tr>
<td>Running from abusive relationship</td>
<td>7%</td>
<td>02.6 (9)</td>
<td>12.2 (16)</td>
<td>01.6 (2)</td>
</tr>
<tr>
<td>Lack of Social Service Benefits</td>
<td>4%</td>
<td>11.8 (41)</td>
<td>13.7 (18)</td>
<td>29.9 (38)</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
<td>12.8</td>
<td>12.2</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

being unable to obtain SFI. Rather, it was often an indication of being unable to find supported housing for a number of issues including alcohol/drug, disability and mental health needs. While this is an important issue for all respondents, it is clearly a critical issue for RH males. Being evicted for not having sufficient funds to pay the rent was a prime contributing factor across samples and genders, and the rates for this problem have increased considerably since 1997 (Table 11).

“I was laid off from my job in February and applied successfully for EI. No one had told me that my EI benefits would be deducted, dollar for dollar, from my AISH. I received the first EI cheque in April and spent it all. When I received my AISH cheque in May I wasn’t able to make rent and was asked to leave in June.” (Daryl)

“At least 50% of people don’t like living with roommates because they’re unpredictable. I had one roommate who was a crack addict. I come home and the T.V. and stereo are gone. I’d like to find a decent job that pays decent so that I could do without roommates. Too many bad roommates. Drugs.” (Ed)

2 The 2002 study included Lack of Supported Housing, including lack of housing to support alcohol/drug, disability and mental health needs in this category.
Table 11: Reasons for Homelessness (% of Respondents)

<table>
<thead>
<tr>
<th>Reason Given for Homelessness</th>
<th>2002 Results</th>
<th>2002 Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men % of 183 (Total)</td>
<td>Women % of 55 (Total)</td>
</tr>
<tr>
<td>Lack of Work</td>
<td>34.4 (63)</td>
<td>14.5 (8)</td>
</tr>
<tr>
<td>Traveled to Calgary to find work/better life</td>
<td>10.9 (20)</td>
<td>07.3 (4)</td>
</tr>
<tr>
<td>Domestic Difficulties (incl. Roommate problems)</td>
<td>28.4 (52)</td>
<td>45.5 (25)</td>
</tr>
<tr>
<td>NSF for Rent/Evicted</td>
<td>34.4 (63)</td>
<td>43.7 (25)</td>
</tr>
<tr>
<td>Poor Physical Health (incl. Addictions)</td>
<td>29.5 (54)</td>
<td>36.6 (20)</td>
</tr>
<tr>
<td>Running from abusive relationship</td>
<td>04.9 (9)</td>
<td>29.1 (16)</td>
</tr>
<tr>
<td>Lack of Social Service Benefits³</td>
<td>22.4 (41)</td>
<td>32.7 (18)</td>
</tr>
</tbody>
</table>

In keeping with the 1997 process, the 2002 study attempted to determine how many respondents had been homeless in the past. In 1997, half of the 250 respondents were entirely new to homelessness. In 2002, respondents were also asked if they had been homeless before. Of the AH sample, 64.3% of male and 48.1% of female respondents indicated that this was not their first experience with homelessness. Of the RH sample, 65.9% of males and 63.3% of females indicated that this was not their first experience with housing problems. These data suggest that the number of AH people who are experiencing repeated cycles of homelessness has increased from 50.0% in 1997 to 56.2% in 2002. The RH group had an even higher incidence of repeated housing difficulties, with 64.6% of the RH group indicating that they had experienced housing difficulties on more than one occasion.

To obtain further details regarding the potentially cyclical nature of homelessness in Calgary, respondents were asked about the number of times they had been homeless, and how many of those times had been in Calgary. This question was changed slightly for the RH group, to enquire about the number of times they had experienced housing problems. AH male respondents who answered the question (N=90) had been homeless an average of 5.4 times before, (standard deviation = 5.0). Of these events, 3.76 homelessness episodes had been in Calgary. AH females (N=17) had been homeless an average of 5.53 times before (S.D. = 4.8) with 4.5 of these in Calgary. RH Males (N=27) had experienced housing problems an average of 9.4 times (S.D. 12.5), of which 7.0 had been in Calgary. RH females (N=19) had experienced housing problems an average of 5.1 times before (S.D. = 5.5) with 4.3 of those times in Calgary. The RH males group warranted further investigation due to the unusually high number of occurrences of housing problems and the correspondingly high standard deviation. Three individuals who were outliers in this group reported 50, 44 and 25 previous times of housing problems. The next highest number of times reported was 10. It is likely that these respondents may have interpreted the question as asking how many nights they had experienced housing problems rather than the separate number of occurrences, although there are other plausible explanations. In any event, the data were suspect, and the outliers were removed from the analysis. Re-analysis showed the average number of times that housing problems had been experienced by the RH male group was 6.2 (S.D. = 5.8), with 4.2 of these being in Calgary.

³ The 2002 study included Lack of Supported Housing, including lack of housing to support alcohol/drug, disability and mental health needs in this category.
Stakeholders had expressed an interest in determining whether the reasons youth gave for homelessness varied considerably from the older groups. To answer this question thoroughly requires re-analysis of the 2002 study data to compare the youth group against the older RH and AH sample responses. However, some reasons for being homeless did apply exclusively to the youth group. These reasons are presented in Table 12 below.

**Table 12: Reasons for Homelessness (Youth Only)**

<table>
<thead>
<tr>
<th>Reason Given for Homelessness</th>
<th>2002 Study Results</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH Male (Total)</td>
<td>RH Female (Total)</td>
</tr>
<tr>
<td>1. Professionals did not understand what their needs were</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2. Professionals were unable to help them.</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3. Could not access housing because under 18</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Could not access SFI because under 18 and not married</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Could not access financial assistance because under 16</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>6. Child Welfare Status terminated</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7. Had to wait too long for services</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>8. Only needed financial assistance, not other child welfare services</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Could not access services because truant from school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>15</td>
<td>7</td>
</tr>
</tbody>
</table>

When the AH and RH youth samples are collapsed (not necessarily a wise idea since AH and RH groups appear to be quite distinct, though helpful in this context), it can be seen that the youth group do not believe that professionals understand them or can help them. From a more instrumental perspective, many of the youth group described barriers to services because of their age. For instance, several indicated they could not access housing or SFI because they were too young. Approximately 10% had had their Child Welfare Status terminated. Given that the definition of “youth” for the study was up to and including age 24, it is likely that their status was terminated due to the individuals turning 18, but this possibility also warrants further investigation. The policy regarding termination of child welfare support at age 18 has implications for other variables that may impact on a person’s ability to avoid homelessness or quickly rebound from it. For example, it appears to mean that, once support is withdrawn, the individual will usually not be able to continue their education. Interviews with both the current and past sector chairs for agencies who work with youth indicated that, although it sometimes happens that children who have been part of the Child Welfare system are supported through a year or two of university or college, it is a rare exception to the more general pattern that sees children supported until they finish high school and/or reach age 18. As was demonstrated above, education to this level does not seem to be a protective factor against homelessness.
A high school diploma used to be sufficient to open a substantial number of occupational doors. However, it is now suitable only for entry to a shrinking number of jobs that generally pay minimum or low wages. As the business environment continues to change, it is no longer sufficient for people to obtain college or university degrees, or even a professional degree, and then plan to go out to work and never return to education. The half-life of education and professional qualifications is shrinking at an alarming rate, and individuals are increasingly urged to become “lifelong learners” in order to remain employable (Allred, Snow & Miles, 1996; Arthur & Rousseau, 1996; Brousseau, Driver, Eneroth & Larsson, 1996; London, 1992). The path to education for AH and RH individuals is blocked on a number of fronts. For example, if an individual is on SFI and qualifies for a student loan, the amount of the loan will be deducted, dollar for dollar, from the SFI amount, despite the fact that the loan is not income. Furthermore, there is virtually no transitional housing in Calgary that is sufficiently long term to support individuals who are homeless but motivated to upgrade their education to move beyond minimum wage jobs and out of poverty.

Duration of Current Homeless Episode
Respondents were asked about the length of time they had been homeless during their current episode (“When was the last time you had a home?”). This question was only asked of the AH group. Of the males who answered (N=163), 64.4% indicated that they had a home less than 1 year ago, 25.8% indicated that it had been more than 1 year but less than 5 years, and 9.8% indicated uninterrupted homelessness of more than 5 years. Of the females who answered (N=48), 70.8% had a home less than one year ago, 22.9% more than one year but less than 5 years ago, and 6.3% indicated that their last home had been more than 5 years ago. This finding is quite different from the 1997 report, where only 15% of the combined male and female population had been homeless for more than one year. In comparison, the 2002 study found that 32.4% of respondents who answered the question (N=211) had been homeless for more than 1 year. Furthermore, those who have been continuously homeless for more than 5 years made up 5% of the sample in 1997 and 8.05% in 2002. Both the number of individuals experiencing consecutive periods of homelessness and the number of people experiencing prolonged homelessness in Calgary is much larger than the 1997 study suggested.

The 1997 report found that duration of homelessness was not impacted by age or ethnicity. This was also true in the 2002 sample, although age, with a $\chi^2 (8, N=202) = 15.37$, approached significance ($p<.052$).

Length of Time in Calgary
Solutions to the problem of homelessness may differ depending, in part, upon whether its causes are indigenous to the city or result from an influx of individuals displaced from other locations. Individuals were asked “How long have you lived in Calgary?” If they had not lived in Calgary all of their lives they were also asked “Where did you live before coming to Calgary?” Analysis of the 2002 data (see Tables 13 and 14) shows that, of those AH individuals who answered the first question (N=237), 27% had been in Calgary for at least 15 years, as had 41% of the RH. When asked where they lived before coming to Calgary, the AH who responded (N=196) indicated that 32% (N=62) originated from other locations in Alberta as did 30% (N=16) of the RH. All other RH individuals had migrated from another Canadian province except one person who was from out-of-country. This finding differs from the 1997 report findings, where 21% of the sample “originated” from Calgary. However, it is important to acknowledge that a direct comparison may not be appropriate, since there is insufficient information in the 1997 report to ensure that classifications made in 1997 are the same as those in 2002. For example, individuals who had been in Calgary for virtually all of their lives (i.e. 43 of 47 years) were still classified in the “15+ years” category. This may or may not have been the case in the 1997 study.
Table 13: AH Length of Time in Calgary

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 years</td>
<td>172</td>
<td>72.3</td>
<td>72.6</td>
<td>72.6</td>
</tr>
<tr>
<td>More than 15 years</td>
<td>28</td>
<td>11.8</td>
<td>11.8</td>
<td>84.4</td>
</tr>
<tr>
<td>(not born here)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in Calgary</td>
<td>37</td>
<td>15.5</td>
<td>15.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>237</td>
<td>99.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>238</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 14: RH Length of Time in Calgary

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Calgary &lt;15 years</td>
<td>42</td>
<td>59.2</td>
<td>59.2</td>
<td>59.2</td>
</tr>
<tr>
<td>In Calgary 15+ years</td>
<td>12</td>
<td>16.9</td>
<td>16.9</td>
<td>76.1</td>
</tr>
<tr>
<td>(Not Born Here)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in Calgary</td>
<td>17</td>
<td>23.9</td>
<td>23.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Further exploration of the province of origin (defined similarly to the 1997 report as the immediately preceding location) of those who had moved to Calgary revealed that the most frequently identified province of origin was again British Columbia. In 1997 it was reported that 31% of respondents were from British Columbia. In 2002 this figure dropped to 21.8% for the AH and 19.7% for the RH samples. Ontario still figures prominently for both the AH (14.3%) and the RH (15.5%) groups, although both of these proportions are lower than the 17% reported in 1997. Only two people in the entire sample of 309 indicated that they had moved to Calgary from outside of Canada. This rate is considerably different from the 7% found in 1997.

Given the migration of people to Calgary, it may be important to know how long they have been in the city and what their reasons were for coming to Calgary. Regarding the AH group who answered the question (N=237), 24 (10.1%) had been in Calgary for less than 1 month and a further 28.3% had been in Calgary for more than one month but less than or equal to 1 year. Of these, a significantly higher number were from the younger rather than the older age groups. Of the AH aged 15 - 24, more than half (55.8%, N=29) had been in Calgary less than 1 year. The next highest group was the 25-34 year olds, of whom 47.9% (N=23) had been in Calgary for less than one year. It is important to note that the seniors group respondents had spent significantly more time in Calgary than all other groups. Of the seniors, only 6.7% (N=2) had been in Calgary for less than 1 year. The seniors represented a disproportionately large percentage of those who had been in Calgary more than 15 years, including all of their lives. Overall, age was a significant factor in length of time in Calgary with χ² (20, N=227) = 59.4, p<.001. No other factor, including gender, ethnic status or education, had a significant effect on length of time in Calgary for the AH sample.

Of the RH group respondents who answered the question (N=71), only 4 (5.6%) had been in Calgary for less than 1 month, with an additional 14 (19.7%) having been in Calgary for more
than one month but less than or equal to one year. Age was not a significant influence on length of time in Calgary for RH respondents, nor was gender, education or ethnicity.

**Reasons for Coming to Calgary**

“*I heard the economy was better in Alberta. I wanted to come here to get a better job and a press ticket. I had a job lined up in Red Deer but it fell through. I went to Edmonton to look for another one and started sleeping in shelters.*” (Jeff)

Respondents in both the AH and RH groups were asked what had brought them to Calgary. An individual could give more than one response to this question. Reasons could be categorized as presented in Table 15.

As can be seen from the Table 15 below, virtually no respondents came to Calgary as part of a seasonal migration pattern. The primary driver for AH males coming to Calgary is economic (68.4%), followed at a distance by looking for a better life (17.7%). It is interesting to note that the AH male group is the only one to mentioned that they traveled to Calgary to access shelter locations to any extent (7.0%). AH women also traveled to Calgary for economic reasons (36.6%) but were just as likely to have come to the city because they had social connections via relatives, friends or family either already living here or moving to the city (36.6%). Further, they were more likely than their male counterparts to be seeking a better life (29.3% vs. 17.7%).

**Table 15: Reasons for Coming to Calgary**

<table>
<thead>
<tr>
<th>Reasons for Coming to Calgary</th>
<th>2002 Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
</tr>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>1. Seasonal pattern (i.e. respondent always comes here part of the year)</td>
<td>01.6 (3)</td>
</tr>
<tr>
<td>2. Better access to services (health or social, incl. school)</td>
<td>07.1 (13)</td>
</tr>
<tr>
<td>3. Economic reasons (incl. work)</td>
<td>68.4 (108)</td>
</tr>
<tr>
<td>4. More or better shelter accommodations</td>
<td>07.0 (11)</td>
</tr>
<tr>
<td>5. Relatives, friends or family lived here or moved here</td>
<td>10.8 (17)</td>
</tr>
<tr>
<td>6. Looking for a better life (incl. fleeing difficult situations)</td>
<td>17.7 (28)</td>
</tr>
<tr>
<td>7. Transience (i.e. traveling through Calgary and stopped)</td>
<td>05.0 (8)</td>
</tr>
</tbody>
</table>

The pattern of the RH group is quite different. Only 28.6% of males moved to Calgary for economic reasons and none of the female group cited this reason. The most frequently mentioned reason for moving to Calgary for both males and females in the RH groups was that they had social connections here (39.3% and 39.1% respectively). Looking for a better life was also a significant reason for moving to Calgary for RH males and females (25.0% and 26.1% respectively).

The 2002 study further investigated the circumstances surrounding homelessness for individuals who had moved to the city. As show in the Tables 13 and 14 above, 37 (16%) of the AH and 17
(24%) of RH respondents were born in Calgary. The rest were asked “Did you have a home before you came to Calgary?”. Of the 157 (76%) AH who answered the question, 76% (N=119) indicated that they had a home prior to their move to Calgary, as did 69% (N=29) of RH. The results were further examined to determine if those individuals who did not have homes prior to moving to Calgary were significantly different from those who did. The two groups were compared on age, gender, mental health and addictions status, education, marital status, history of incarceration, history of involvement in the Children’s Aid/Child Welfare, adoption and attendance of themselves or their parents in a residential school. Of these, gender and history of adoption among the AH were significantly different between the two groups (those who had homes vs. those who did not prior to moving to Calgary). It is also interesting to note that parental history of attendance at a residential school was a significant predictor of homelessness prior to moving to Calgary for both the AH and RH with $\chi^2 (1, N= 125) = 4.627, p < .05$) and $\chi^2 (1, N= 33) = 6.607, p < .01$ respectively (see Table 16). The latter finding warranted further investigation to determine the profile of participants whose parents attended residential school.

Table 16: AH Parent Attendance at Res. School x Homelessness status prior to Calgary

<table>
<thead>
<tr>
<th>QA3: Did you have a home before you came to Calgary?</th>
<th>QF7: Did either of your parents attend a residential school?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Count</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Yes</td>
<td>71</td>
<td>21</td>
</tr>
</tbody>
</table>

This issue was further explored and it was found that parental attendance at a residential school, while not exclusively an Aboriginal issue, was more prevalent among the Aboriginal sub-group of the sample. This finding was statistically significant, $\chi^2 (2, N= 209) = 39.41, p < .01$).

Table 17: AH Gender x Home Status Prior to Moving to Calgary

<table>
<thead>
<tr>
<th>Gender</th>
<th>Did you have a home prior to moving to Calgary?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>99</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>119</td>
</tr>
</tbody>
</table>

4 The response rate across the survey was generally quite high. This question was an exception to that general rule. One possible explanation was that people who had been in Calgary for the majority of their lives may not have known the answer to the question because it was too long ago, or they were children. Another explanation is that individuals who had been in Calgary for a long time may have felt that the question did not apply to them.
As can be seen from Table 17, among the AH group, women were less likely and men more likely than expected to have had a home prior to moving to Calgary. The difference between genders is significant, \( \chi^2(1, N=157) = 5.26, p < .05 \). Similarly, Table 18 shows that AH individuals who had been adopted were less likely to have had a home prior to moving to Calgary than those who had never been adopted. The difference between adoptees/non-adoptees was significant, \( \chi^2(1, N=155) = 6.533, p < .05 \). A similar investigation was not possible with the RH population due to the small number (N=3, 4%) of individuals in the RH sample who had been adopted. The 2002 study found that only 4% of the RH sample had been adopted compared to 14% (N=34) of the AH sample. While this may be attributed to the sampling methodology used in the study, it warrants further investigation in future research work.

**Table 18: Adoption Status x Home Status Prior to Moving to Calgary**

<table>
<thead>
<tr>
<th>QF10: &quot;Were you ever adopted?&quot;</th>
<th>QA3: &quot;Did you have a home prior to moving to Calgary?&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected Count</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>29.7</td>
</tr>
<tr>
<td>Yes</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Expected Count</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>38</td>
</tr>
<tr>
<td>Expected Count</td>
<td>38.0</td>
</tr>
</tbody>
</table>

The issue of adoption warrants further investigation for a number of other reasons. As indicated above, significantly more adoptees were homeless prior to moving to Calgary. Also, adoptees are likely over-represented in the AH population (14.2%) vs. the Canadian population as a whole. The research team attempted to obtain adoption information for the Canadian population in order to speak to the significance of this finding. The information was not available at the time this report was released.

Some further exploration of this finding was undertaken and the data indicate that the issue of adoption is more prevalent among the Aboriginal sub-group of the sample. This result was statistically significant, \( \chi^2(2, N=229) = 12.65, p < .01 \).

All individuals were asked "Did you have your own place to stay when you came to Calgary?" Of the 201 (84.1%) AH who answered the question, 126 (63%) indicated that they did not, compared to the 31% (N=13) RH. When asked where they stayed upon arriving in Calgary, AH respondents provided a wide variety of answers that could be roughly classified into 4 categories. Most stayed in emergency shelter accommodation (47%, N=62). The second most frequently mentioned response was sleeping rough outdoors, in flop-houses or abandoned buildings at (23%, N=30) followed by dependent shelter such as staying with friends or family (16%, N=21) and independent shelter such as hotels or apartments at 11% (N=14).

**Youth** were asked a number of additional questions regarding how they came to be homeless/relatively homeless. 33% of AH (N=12) and 39% of RH (N=5) youth indicated that they wanted to return home but could not do so. Most cases were centred around resolving family disputes and/or having insufficient money to either return home or stay there.

**Housing Barriers**

The 2002 study asked a number of questions to explore housing barriers. Respondents were asked what type of housing they needed immediately, as well as what they would prefer in the long term. The AH
Research Report to the Calgary Homeless Foundation, October 2002

group were also asked to identify the main reasons that they did not currently have permanent housing. Wherever possible, results have been compared to the 1997 findings.

**Immediate Housing Needs**

There are some noteworthy differences and similarities between the findings of the 1997 and 2002 studies with regard to immediate housing needs (see Table 19). Starting with the similarities, it is clear that independent living in a place of one’s own continues to be the dream and ambition of AH and RH individuals alike. There were increases reported in this category across groups, but particularly in the RH group. It is also clear that living in an institution or in semi-independent accommodation such as a group home or living with relatives are options that are no more appealing in 2002 than they were in 1997. The preference for the possibility of sharing accommodations has increased a bit as a potential option since 1997, but is considerably more popular with males from both the AH and RH groups than with women.

Turning now to differences, perhaps the most striking is the drop in the number of people who aspire to live in their own accommodation without a rent subsidy. In 1997, this preference was reported by 45% of the sample. In 2002 it has dropped to 19.5% for AH and 6.1% for RH. Also, the RH group is considerably more content to stay in their current accommodations or living arrangements than are the AH. This makes sense, since many of the RH were staying in transitional housing or staying with friends. Also, it is apparent from the number of immediate housing needs that fell into the “other” category, despite a long list of potential housing options, that the most common categories do not necessarily fit either the AH or the RH populations. Consequently, the identification of solutions for immediate housing needs will need to involve consultation with the intended populations to ensure that any proposed solutions will meet actual need.

**Table 19: Immediate Housing Needs**

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>1997 Study</th>
<th>2002 Study</th>
<th>1997 vs. 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>AH</td>
<td>RH</td>
</tr>
<tr>
<td>% of 245 (Total)</td>
<td>Men</td>
<td>Women %</td>
<td>Men %</td>
</tr>
<tr>
<td>% of 183</td>
<td>% of 55</td>
<td>% of 41</td>
<td>% of 30</td>
</tr>
<tr>
<td></td>
<td>AH</td>
<td>RH</td>
<td></td>
</tr>
<tr>
<td>1. Current situation is best</td>
<td>01.6</td>
<td>07.2 (13)</td>
<td>09.1 (5)</td>
</tr>
<tr>
<td>2. Don’t know</td>
<td>03.9 (7)</td>
<td>05.5 (3)</td>
<td>04.9 (2)</td>
</tr>
<tr>
<td>3. Independent living in own home with a rent subsidy</td>
<td>40.0</td>
<td>42.8 (77)</td>
<td>41.8 (23)</td>
</tr>
<tr>
<td>4. Independent living in own home without a rent subsidy</td>
<td>45.0</td>
<td>19.1 (35)</td>
<td>20.0 (11)</td>
</tr>
<tr>
<td>5. Living in an institution</td>
<td>01.0</td>
<td>01.1 (2)</td>
<td>05.5 (3)</td>
</tr>
<tr>
<td>6. Semi-Independent accommodation (i.e. supported or group housing)</td>
<td>01.0</td>
<td>02.7 (5)</td>
<td>03.6 (2)</td>
</tr>
<tr>
<td>7. Living with immediate family</td>
<td>02.0</td>
<td>00.5 (1)</td>
<td>01.8 (1)</td>
</tr>
<tr>
<td>8. Living with other relatives</td>
<td>N/A</td>
<td>00.5 (1)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>9. Room and Board or Hostel</td>
<td>08.0</td>
<td>14.2 (26)</td>
<td>10.9 (6)</td>
</tr>
<tr>
<td>10. Shared accommodations (friends or roommates)</td>
<td>10.0</td>
<td>14.8 (27)</td>
<td>09.1 (5)</td>
</tr>
<tr>
<td>11. Support for finding a job while looking for housing</td>
<td>N/A</td>
<td>06.6 (12)</td>
<td>03.6 (2)</td>
</tr>
<tr>
<td>12. Support for single fathers</td>
<td>N/A</td>
<td>01.1 (2)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>13. Other</td>
<td>21.3 (39)</td>
<td>25.5 (14)</td>
<td>07.3 (3)</td>
</tr>
</tbody>
</table>

57
"All I want is a room with a bed and a window. I’m tired of sleeping on plastic mats...all I need is a room. It doesn’t matter where. I will just try to step up from there. It doesn’t have to be anything else...just a room would be okay...just a bed and a pillow.” (Austen)

Long-Term Housing Preferences

Long-term housing preferences, which are displayed in Table 20, continue to demonstrate that independent living is greatly preferred over other options. However, the AH and RH groups do vary. For example, both male and female members of the RH group are more content to stay in their current circumstances in the short term than their AH counterparts are. Many of the RH were staying in transitional housing at the time they were interviewed (such as the shelters for Women Fleeing Violence), which may account for this result. RH respondents were more willing to live without a rent subsidy in the long term than in the short term. Interestingly, the number of respondents who indicated that “other” options were preferable dropped off remarkably when discussing long term preferences.

Table 20: Long Term Housing Preferences

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>1997 Study</th>
<th>2002 Study</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>AH</td>
<td>RH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Men and</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td></td>
<td>Women %</td>
<td>% of 183</td>
<td>% of 55</td>
<td>% of 41</td>
</tr>
<tr>
<td></td>
<td>of 245</td>
<td>(Total)</td>
<td>(Total)</td>
<td>(Total)</td>
</tr>
<tr>
<td>1. Current situation is best</td>
<td>N/A</td>
<td>02.8 (5)</td>
<td>01.9 (1)</td>
<td>19.5 (8)</td>
</tr>
<tr>
<td>2. Don’t know</td>
<td>N/A</td>
<td>01.7 (3)</td>
<td>01.9 (1)</td>
<td>02.4 (1)</td>
</tr>
<tr>
<td>3. Independent living in own home with a rent subsidy</td>
<td>N/A</td>
<td>30.9 (55)</td>
<td>46.3 (25)</td>
<td>36.6 (15)</td>
</tr>
<tr>
<td>4. Independent living in own home without a rent subsidy</td>
<td>N/A</td>
<td>59.6 (106)</td>
<td>42.6 (24)</td>
<td>41.5 (17)</td>
</tr>
<tr>
<td>5. Living in an institution</td>
<td>N/A</td>
<td>00.0 (0)</td>
<td>05.6 (3)</td>
<td>02.4 (1)</td>
</tr>
<tr>
<td>6. Semi-independent accommodation (i.e. supported or group housing)</td>
<td>N/A</td>
<td>01.7 (3)</td>
<td>00.0 (0)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>7. Living with immediate family</td>
<td>N/A</td>
<td>02.8 (5)</td>
<td>05.6 (3)</td>
<td>07.3 (3)</td>
</tr>
<tr>
<td>8. Living with other relatives</td>
<td>N/A</td>
<td>00.0 (0)</td>
<td>00.0 (0)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>9. Room and Board or Hostel</td>
<td>N/A</td>
<td>04.5 (8)</td>
<td>05.6 (3)</td>
<td>04.9 (2)</td>
</tr>
<tr>
<td>10. Shared accommodations (friends or roommates)</td>
<td>N/A</td>
<td>10.1 (18)</td>
<td>05.6 (3)</td>
<td>14.6 (6)</td>
</tr>
<tr>
<td>11. Support for finding a job while looking for housing</td>
<td>N/A</td>
<td>04.5 (8)</td>
<td>01.9 (1)</td>
<td>07.3 (3)</td>
</tr>
<tr>
<td>12. Other</td>
<td>N/A</td>
<td>04.5 (8)</td>
<td>01.9 (1)</td>
<td>(0)</td>
</tr>
</tbody>
</table>
Reasons for Not Having a Permanent Home

Respondents from the AH group were further asked why they did not have permanent housing at the time of the interview. This question was excluded for the RH group, since some of them were in transitional housing or other circumstances that they may have perceived as relatively permanent, despite not having security of tenure. In parallel with the procedure used in the 1997 study, respondents were invited to provide as many reasons as applied to explain their current situation. However, the surveying procedure was different from the 1997 study, in that respondents were not presented with an array of possible barriers to choose from. Instead, the interviewer classified the respondents’ remarks into categories as they were provided (Table 21).

Table 21: Reasons for Not Having a Permanent Home

<table>
<thead>
<tr>
<th>Reason</th>
<th>1997 Study</th>
<th>2002 Study</th>
<th>1997 vs. 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Can't afford the damage deposit (i.e. initial set-up costs)</td>
<td>52.0%</td>
<td>59.8%</td>
<td>7.8%</td>
</tr>
<tr>
<td>2. Can't afford the rents</td>
<td>55.0%</td>
<td>57.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>3. Don't know how to go about finding housing</td>
<td>05.0%</td>
<td>02.2%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>4. Haven't been able to find or keep a good job</td>
<td>34.0%</td>
<td>28.5%</td>
<td>-5.5%</td>
</tr>
<tr>
<td>5. Health Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Physical</td>
<td>16.0%</td>
<td>41.9%</td>
<td>25.9%</td>
</tr>
<tr>
<td>b. Mental/emotional</td>
<td>17.5%</td>
<td>31.3%</td>
<td>13.8%</td>
</tr>
<tr>
<td>c. Substance Abuse</td>
<td>22.6%</td>
<td>45.3%</td>
<td>22.7%</td>
</tr>
<tr>
<td>6. Lack of suitable housing (incl. Waiting lists for housing)</td>
<td>19.0%</td>
<td>29.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>7. No money/resources to find a job (i.e. bus passes)</td>
<td>19.0%</td>
<td>31.8%</td>
<td>12.8%</td>
</tr>
<tr>
<td>8. Prefer living on the streets</td>
<td>N/A</td>
<td>04.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>9. Lack of social/personal support</td>
<td>N/A</td>
<td>14.5%</td>
<td>10.0%</td>
</tr>
<tr>
<td>10. Logistical problems (i.e. no telephone)</td>
<td>N/A</td>
<td>02.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>11. Transience (i.e. traveling through or just moved to Calgary)</td>
<td>N/A</td>
<td>04.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>12. Other</td>
<td>N/A</td>
<td>00.5%</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>

As can be seen from Table 21, financial issues are the most important reasons for not having a home. Initial setup costs, such as damage deposits and rental rates continue to be the most significant barrier to obtaining permanent housing. When the male and female rates for 2002 are averaged, there is a 10.3% increase in the number of AH individuals who consider initial setup-up costs to be a barrier to housing, compared to 1997. This was also the case for rental rates as a factor, which shows a 7.1% increase. Other barriers that have increased compared to the 1997 cohort are: lack of suitable housing, which has increased by 15%; and lack of money and/or resources to find work, at 13.6%. While it may appear that health problems have

---

5 The 1997 study did not include substance abuse issues in this category, which may account for the difference in findings between 1997 and 2002.
experienced an increase in importance as a barrier when comparing the 1997 and 2002 samples, the comparison between 1997 and 2002 results in this case may be misleading, since the 1997 calculations did not include substance abuse issues.

Finding and/or keeping a good job has reduced in importance as a barrier by 9.6% compared to the 1997 cohort, perhaps because a greater percentage of the AH population is working than was the case in 1997.

**Employment Situation**

The 1997 report found that 45% of AH respondents were employed at the time of the survey, 15% of whom were employed full time and still unable to house themselves. The 1997 team thought that their sampling procedure might have resulted in an underestimate of the number of people in this situation.

In the 2002 study, 50.2% (N=121) of AH and 28.2% (N=20) of RH respondents were working full time, part time or occasionally. Consequently, the evidence shows that there has been a 5.2% increase in the number of AH who are employed in some capacity (N=22, 18.2% were full time; N=15, 12.4% were part time and N=84, 69.4% worked occasionally). This finding corresponds with other studies which indicate that a significant number of Albertans work but are still poor. For example, one study found that “in seven of every ten families defined as poor (earning below the LICO rates), at least one person works”(1), p.1. Of the 20 RH individuals who worked in some capacity, 6 worked full time (N=30%), 5 worked part time (25%) and 9 worked occasionally (45%).

It is important to realize that many members of the RH group were youth, seniors and women fleeing violence, making employment a particularly difficult proposition.

Rather than asking for hourly wages, where rates tend to fluctuate particularly for casual labor, the 2002 survey inquired about the average amount earned per month through employment. For the AH group, the average monthly earnings of all employed individuals was $637.34/month. However, because the standard deviation was very high ($740.97), individual groups were examined. Those who reported working full time (N=22) earned an average monthly income of $1,377.27. Part time workers had a substantially lower income, at $786.79, and occasional workers followed at $395.62. For the RH group, the average monthly earnings of all employed individuals was $687.95. The standard deviation was again quite high ($481.12).
and therefore the subgroups were investigated. Those who reported working full time (N=5) earned an average of $1,150.00 per month. Part-time workers were again substantially lower at an average of $790.00 per month, and occasional workers followed at $355.56.

A substantial group (N=75, 32%) of the AH and RH (N=42, 59%) were not employed, but were forthcoming with regard to other sources of income. Income sources for this group are reported in Table 22.

**Table 22: Sources of Income for Unemployed Respondents**

<table>
<thead>
<tr>
<th>Sources of Income for Unemployed Respondents</th>
<th>1997</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Benefit (AISH, Child Credit, Pension, SFI)</td>
<td>29.0  28.3 (39)  62.7 (42)</td>
<td></td>
</tr>
<tr>
<td>Bottles and cans + panhandling</td>
<td>06.0  23.2 (32)  13.4 (9)</td>
<td></td>
</tr>
<tr>
<td>Family/friends</td>
<td>05.0  06.5 (9)  01.5 (1)</td>
<td></td>
</tr>
<tr>
<td>Criminal Activity (Incl. drugs or prostitution)</td>
<td>N/A  13.0 (18)  07.5 (5)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>N/A  27.5 (38)  14.9 (10)</td>
<td></td>
</tr>
</tbody>
</table>

A substantial number (28.3%) of the AH group receives government benefits such as AISH, SFI or a pension, but have insufficient income to afford stable housing. This makes logical sense given that average rents in Calgary at the end of 2001 were $450 - $470 for a bachelor apartment, $602 - $738 for a one bedroom and $658 - $846 for a two bedroom unit, depending on location in the city. (Richard Ellis, 2001). The mean income for AH and RH individuals who reported income from AISH was $825.06. Individuals depending on SFI have no real opportunity to obtain housing of their own (as opposed to shared housing), given that their total reported monthly income from SFI was $392.84. Even a bachelor apartment is beyond the means of SFI recipients in Calgary, since the reported SFI level is $62.84 per month below the lowest reported cost for this type of housing. This presents an impossible quandary for many AH and RH individuals. SFI levels do not allow them to obtain a permanent address, but without a permanent address SFI and other government benefits cannot be obtained except in very restricted circumstances.

“I can’t use social assistance because they will want me to return to rehab. We don’t have a fixed address and I need to get a rent report signed. I’m looking at getting on AISH but the problem of not having a fixed address comes up again. Calling ourselves common-law has also caused problems so she has now applied individually so we can’t say we are living together. I’m sick of it.” (Grant)

“I haven’t been back to social services. They give people a hard time who try to get assistance. Social Services don’t seem to want to help until you get a job. This is a catch-22 as you need the help to go out and find a job.” (Norm)

---

6 “Other” sources of income were quite varied but included working at “cash corner”, obtaining money from CUPS, emergency shelters, or social workers, selling prescription medications or Street Talk.

7 It is not known how individuals are managing to get their AISH, SFI or pension cheques while they are AH. This would be an interesting area of investigation.
Further analysis of the 2002 data should be carried out to determine how many of the
individuals who receive government benefits also resort to activities such as collecting bottles
and cans or criminal activity. Given the high number of unemployed AH and RH individuals who
collect bottles and cans, panhandle, or engage in criminal or other activities to earn income, it
is likely that a significant overlap exists. It is important to note that the “Government
Benefits” category includes all government benefits, including GST refunds. Therefore it is
likely that some RH individuals receive more than one government benefit, while others, such
as youth, receive none.

It may also be important to note that the unemployed RH population receives more government
benefits than the AH population, and that the unemployed RH group also reported less
bottle/can collection and panhandling, less dependence on family or friends for money, and
less criminal activity or other activity to earn money. However, this is correlational
information and does not indicate causality - in other words, it cannot be said that an increase
in government benefits causes a decrease in these activities.

It may be important to note that average monthly income for unemployed individuals who were
AH was $648.88 and, for RH respondents, $762.40. Also, regardless of the source of income
(employment, government benefits or street survival skills such as panhandling), respondents
were asked about any other sources of income. The vast majority indicated they had no other
sources of income other than those they had already discussed with the interviewers.

Further investigation was carried out to examine the need for additional funds to afford
housing (rent + utilities) as well as money for basics such as food, clothing and other
necessities. AH homeless individuals indicated that they would need $750/month on average
to be able to afford both rent and utilities. Given rental rates and associated costs in Calgary,
this is a conservative and realistic estimate. When asked how much additional money would be
required for basic needs such as food and clothing, AH respondents estimated an average of
$432/month. RH individuals estimated slightly higher on average, perhaps due to the inclusion
of families among the RH group. They estimated $799/month for rent and utilities with an
additional $443/month for food, clothing and necessities. Even their highest estimates would,
however, still leave them well below the LICO rates.

**Barriers to Employment**

“I used to work in daycare before Maddie was born. He has a heart problem. So does
Shannon. He’s going to need surgery soon to fix it.” (Diane)

“The staffing companies are a joke, though, paying $8/hour and then requiring that I
pay to rent a safety hat and for a ride to the job site. That cuts into my earnings for
a 5 hour shift. Plus they tend to have a list of favourites who get called first and
then they only call the others when they are desperate, which gives you very little
warning. The casual labour program at the DIC is better, but the wait list is usually
very long.” (Mark)
AH and RH respondents who were not employed at the time of the 2002 survey were asked about their interest in having a steady job. If they were interested in obtaining a job they were further asked about the barriers that prevented them from obtaining one. Of the 112 AH individuals who were not employed at the time of the survey, 75.9% indicated they would like to find employment - a difference of 16.9% from the 59% who reported they were highly motivated to find employment in the 1997 study. This rate was somewhat lower in the RH group, at 66.0% looking for employment. Table 23 reports the barriers that these respondents indicated are preventing them from finding work.

Table 23: Barriers to Employment

| Source | 2002 | 2002
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of 275 Total Responses</td>
<td>% of 112 Total Responses</td>
</tr>
<tr>
<td>1. Age</td>
<td>04.4 (12)</td>
<td>11.6 (13)</td>
</tr>
<tr>
<td>2. Clothes</td>
<td>05.1 (14)</td>
<td>04.5 (5)</td>
</tr>
<tr>
<td>3. Discrimination</td>
<td>02.2 (6)</td>
<td>00.8 (1)</td>
</tr>
<tr>
<td>4. Education</td>
<td>07.3 (20)</td>
<td>14.3 (16)</td>
</tr>
<tr>
<td>5. Experience (Lack of)</td>
<td>03.6 (10)</td>
<td>07.1 (8)</td>
</tr>
<tr>
<td>6. Health Problems</td>
<td>15.6 (43)</td>
<td>08.9 (10)</td>
</tr>
<tr>
<td>vi. Physical</td>
<td>(26)</td>
<td>(8)</td>
</tr>
<tr>
<td>vii. Mental/Emotional</td>
<td>(16)</td>
<td>(5)</td>
</tr>
<tr>
<td>viii. Substance Abuse</td>
<td>(17)</td>
<td>(3)</td>
</tr>
<tr>
<td>7. Housing (No fixed address for application forms)</td>
<td>13.8 (38)</td>
<td>03.6 (4)</td>
</tr>
<tr>
<td>8. Inadequate pay</td>
<td>03.3 (9)</td>
<td>03.6 (4)</td>
</tr>
<tr>
<td>9. Job market (no jobs available)</td>
<td>03.3 (9)</td>
<td>00.8 (1)</td>
</tr>
<tr>
<td>10. Knowledge about how to find work</td>
<td>00.0 (0)</td>
<td>00.8 (1)</td>
</tr>
<tr>
<td>11. Lack of Sleep</td>
<td>09.8 (27)</td>
<td>04.5 (5)</td>
</tr>
<tr>
<td>12. Literacy (Reading and writing)</td>
<td>01.1 (3)</td>
<td>02.7 (3)</td>
</tr>
<tr>
<td>13. Need of daycare or family supports</td>
<td>00.7 (2)</td>
<td>02.7 (3)</td>
</tr>
<tr>
<td>14. Pay would be garnisheed</td>
<td>01.1 (3)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>15. Shower facilities (no access)</td>
<td>04.0 (11)</td>
<td>00.8 (1)</td>
</tr>
<tr>
<td>16. Someone to get them going (i.e. to wake them up).</td>
<td>00.3 (1)</td>
<td>00.8 (1)</td>
</tr>
<tr>
<td>17. Telephone (no access to or problems using)</td>
<td>11.3 (31)</td>
<td>03.6 (4)</td>
</tr>
<tr>
<td>18. Transportation (no money for bus pass)</td>
<td>10.9 (30)</td>
<td>07.1 (8)</td>
</tr>
<tr>
<td>19. Shelter Policy (i.e. hours, access)</td>
<td>00.7 (2)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>20. Identification problems</td>
<td>01.1(3)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>21. Start Up Money (i.e. to reinstate trade qualifications)</td>
<td>00.3(1)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>22. Other</td>
<td>00.0 (0)</td>
<td>07.1 (8)</td>
</tr>
</tbody>
</table>
The 1997 report grouped barriers to employment into three categories: instrumental, market forces and health. Although it may be possible to create a similar measure by aggregating results from the 2002 study, there was insufficient information available from the 1997 report to do so reliably. Additionally, Sector Chairs and other stakeholders frequently requested that the 2002 report provide them with more suggestions as to what could be done to assist the AH and RH groups out of poverty. Consequently, a decision was made to leave the results intact as they were reported to the interviewers.

Caution should be exercised when comparing the 2002 results on barriers to work to the 1997 results. The 2002 percentages were based on total multiple responses (i.e. 85 AH individuals provided 275 answers for an average of 3.23 barriers per respondent). The 1997 results were based on the total number of respondents. This elevates the percentages in the 2002 study significantly, but clarifies the numbers of people within each group who are experiencing particular barriers. To take an example from 2002, thirty (30) AH respondents indicated that transportation was a barrier to obtaining work. As a percentage of total responses (N=275), this works out to 10.9%. As a percentage of total respondents (N=85), the percentage leaps to 35.3%. Hopefully, this illustration shows that the denominator used in calculating percentages is not trivial, and that comparisons between the two reports should be made carefully.

As can be seen from Table 23, instrumental issues continue to be barriers for AH and RH people in obtaining and keeping employment. As with other analyses, the AH and RH are not homogenous groups. For example, the most frequently identified barriers to employment for the AH, in order of importance, are health problems (15.6%), not having a fixed address (13.8%), not having access to or ability to use a telephone (11.3), not having transportation (10.9), lack of sleep (9.8%), lack of education (7.3%) and lack of appropriate clothes (5.1%). On the other hand, the most important barrier for the RH is lack of education (14.3%), followed by age (11.6), and health problems (8.9%), most often problems with physical health.

In an attempt to identify support needs as opposed to barriers, individuals who expressed an interest in finding work were also asked “What do you need to be able to get a job?” AH and RH responses can be seen in Table 24. Results from this question support one theme that has emerged from the 2002 study: transportation issues are a barrier for AH and RH people on a number of fronts, including obtaining housing, finding and keeping employment, and accessing health care. Although Table 24 above has been ordered according to the total score on each category across groups, the needs of AH and RH are considerably different. For instance, both groups need job training, general education, life skills, time management and counseling/treatment but these needs are mentioned with greater frequency in the RH population. Overall, the list of needs to support obtaining employment provide an indication of where local agencies can collaborate to assist AH and RH in preparing for, obtaining and keeping employment.

Table 24: What do you need to be able to get a job?

<table>
<thead>
<tr>
<th>Score</th>
<th>AH % of 182 Respondents</th>
<th>RH % of 39 Total Respondents</th>
<th>Combined % of 221 Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transportation (Costs Associated With)</td>
<td>57.7 (105)</td>
<td>76.9 (30)</td>
<td>61.1 (135)</td>
</tr>
<tr>
<td>2. Job Training</td>
<td>30.7 (56)</td>
<td>76.9 (30)</td>
<td>38.9 (86)</td>
</tr>
</tbody>
</table>
3. Telephone (Using or Accessing) 35.2 (64) 35.9 (14) 35.3 (78)
4. General Education 26.9 (49) 66.7 (26) 33.9 (75)
5. Basic Hygiene 25.3 (46) 20.5 (08) 24.4 (54)
6. Life Skills 13.2 (24) 35.9 (14) 17.2 (38)
7. Time Management (Keeping Appointments) 13.7 (25) 30.8 (12) 16.7 (37)
8. Counselling/Treatment 13.7 (25) 28.2 (11) 16.3 (36)
9. Reading Skills 13.7 (25) 20.5 (08) 14.9 (33)
10. Writing Skills 12.6 (23) 20.5 (08) 14.0 (31)

Another barrier, that of having one’s wages garnisheed, was investigated by asking respondents “If you got a job, is there a possibility that your pay might be garnisheed?” Interviewers were instructed to explain what “garnisheed” meant if necessary. 19% (N=40) of AH and 27% (N=12) of RH who answered the question indicated that this was a likelihood for them. This fact is likely to present a considerable disincentive to finding employment, particularly if the only work obtainable is at minimum wage.

Survival Skills
As pointed out in the 1997 survey, a range of survival skills is necessary to live successfully on the streets or without a home of one’s own. Respondents to the 2002 survey were asked if they had ever had to do things that they didn’t want to do just to survive. AH individuals answered in the affirmative 70.2% of the time, closely paralleled by RH respondents at 69.6%. Those who answered “yes” were asked to tell interviewers about what they had done. Results

“I lost my two front teeth in the car accident. Since I lost them it’s been hard to find a job because I work in the service industry. It’s also been hard to find a dentist to repair them. I’m in a catch-22. I need to get my teeth fixed to find work but I can’t find work because I need to get my teeth fixed.” (Terry)

“I had a bike to get to work but it was stolen.” (Greg)

“What do I need to get a job? Housing, appropriate clothing, socks, a haircut and new footwear.” (Ed)

“I had to turn down 4 or 5 interviews because I didn’t have transportation. No money to pay for transportation. Most places like the Salvation Army will give bus tickets to go to a job interview, but no resources for bus tickets to assume job.” (John)

“Help with transportation services would be helpful. I can’t afford a bus pass and it’s tough to get bus tickets. There is a wait list for only 10 bus tickets at CUPS, and only people who have secured a job via the DIC casual labour program can have tickets at that agency.” (Mathew)

“I’d like to get a job - I’m good with people and could be a good counter person. I could do swamping. But I’d like to go back and get my grade 12 and learn a trade - maybe welding. I don’t know how to do that. I’d like to be in a program where I could get paid for going and end up with some kind of work opportunity or experience.” (Rick)
are presented in Table 25. In order to facilitate comparisons with the 1997 data, results have been calculated as a percentage of the number of respondents rather than of the total number of responses.

**Table 25: Survival Skills**

<table>
<thead>
<tr>
<th>Survival Skill</th>
<th>1997</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Total Respondents (250)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AH</td>
<td>52.1</td>
<td>52.1</td>
</tr>
<tr>
<td>RH</td>
<td>27.1</td>
<td>27.1</td>
</tr>
</tbody>
</table>

| % of Total Respondents (165)               |      |      |
|AH                                         | 33.3 | 33.3 |
|RH                                         | 25.0 | 25.0 |

| % of Total Respondents (48)                |      |      |
|AH                                         | 17.0 | 17.0 |
|RH                                         | 16.7 | 16.7 |

The majority (52.1%) of AH and RH respondents have gone without food for 1 day or more. This is down by 9.9% from 1997. Access to food warrants further investigation. Going without food for a day or more sounds relatively innocuous. However, it may be informative to know that 20.3% of AH individuals have gone without food for 2 days, 20.3% for 3 days and 14.1% have gone for food for more than 5 days.

Many of the AH (50.3%) and, to a lesser degree, the RH (27.1%) have slept outside against their will in order to survive. In the case of the AH, 20.5% of individuals have slept outside more than 25 times. RH individuals were less forthcoming with this information. Overall, results show that the number of people who sleep outside to survive has dropped when comparing the 1997 and 2002 cohorts.

The 1997 study reported on some aspects of criminal behaviour related to survival. The number of people who report leaving restaurants without paying for their meal has risen slightly (15% in 1997, vs. 17% in 2002). The number of people who reported that they steal to survive is up markedly from 15% in 1997 to an average of 31% across the AH and RH samples. The 1997 study did not report on two items that figure largely among 2002 street survival skills. Drug dealing and doing drug related favors to survive are prominent survival strategies for both the AH (49.1%) and the RH (27.1%). Many AH (30.9%) and RH (35.4%) also use food banks, although they do not want to do so.

**Health Status**

A total of 139 AH (60%) and 47 (66%) RH individuals indicated that they had health problems which required treatment. Of these, 10% (N=14) of AH and 21% (N=10) of RH indicated that the health problem was exclusively mental health, 61% (85) of AH and 66% (31) of RH indicated that the problem was exclusively physical in nature. 29% (N=40) of AH and 13% (6) of RH indicated that they had both physical and mental health problems which required treatment.

Respondents from both the AH and RH groups were asked to specify their physical and mental health problems and most respondents complied. This data was examined in detail for
patterns. It was possible to classify mental health issues into patterns (i.e. to group types of depression together) in order to see trends. This has been done in a separate section below. However, the range of physical health issues was extensive and complex and answers were provided in lay terms and did not easily fit a classification scheme. It may prove beneficial for the CHF to have the data reviewed by a medical researcher to identify opportunities for organized medical intervention at the service provider level.

Although it was not possible to classify physical health problems, some further insight into them was possible. For example, of those individuals who indicated they had either a physical health problem or combined physical/mental health problems, 52% (N=69) of AH and 60% (N=28) of RH were getting treatment for their physical health condition. All individuals were asked if anything prevented them from following through on their physical health treatment, regardless of whether they were currently getting treatment. Of the 63 AH individuals who answered, the main reasons for not following through on treatment were lack of money (N=23, 37%), lack of access to medical care (N=12, 19%), support or education issues (N=7, 11%) and forgetting to take medication (N=7, 11%).

Respondents were also asked why they were not getting treatment. Again, the predominant answer was lack of money (N=21, 32%), followed by lack of access to medical care (N=11, 17%). It may be important to note that problems with understanding the instructions regarding treatment was the third most frequently mentioned reason why AH did not follow through on treatment at 9% (N=6). The concerns regarding cost and access to service as barriers to following through on treatment were echoed in the data collected from the Relatively Homeless group, although the order was reversed. Transportation/access to care was mentioned most frequently, followed by money/cost issues.

Having an Alberta Health card number is fundamental to obtaining health care services in the province, but 30.8% (N = 73) of AH and 14.1% (10) of the RH sample do not have one. This rate is somewhat lower than the 36% of respondents found in the 1997, and may be reflective of the lower numbers of AH and RH people who are from out of province. Individuals who responded that they did not have an Alberta Health Card were asked why they didn’t. 36.9% of AH individuals (N=24) indicated that they were in transit and had therefore not applied or were waiting for the 3 month waiting period to elapse. Cost was the second highest reason at 26.2% (N=17), followed by lack of knowledge on how to obtain a card (18.5%, N=12). RH indicated that cost was the primary barrier in 44.4% of cases (N=4).

Disability Assessment (WHODAS II)
The World Health Organization Disability Assessment Scale, Version II (6 Item Interviewer version) was used to objectively evaluate the level of disability among AH and RH respondents. The WHODAS II has been tested around the world with a wide variety of populations, including the mentally ill, and has good psychometric properties. Interviewers were provided with training and the necessary response cards to show to respondents so they did not have to remember the answer choices.

The WHODAS II asks a global question about health (“How do you rate your overall health in the past month?”) and investigates six areas of functioning: (1) understanding and communicating; (2) getting around; (3) self care; (4) getting along with others; (5) daily activities of living; and (6) participating in society. It further examines the impact of any disabilities on the individual over the past month.
Table 26(a): General Health in Past Month

<table>
<thead>
<tr>
<th>WHODAS II Scores for Global Health in the past month</th>
<th>2002</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>AH</td>
<td>RH</td>
</tr>
<tr>
<td>% of 237 Total Responses</td>
<td>% of 71 Total Responses</td>
<td></td>
</tr>
<tr>
<td>1. Very Good</td>
<td>16.0 (38)</td>
<td>08.5 (6)</td>
</tr>
<tr>
<td>2. Good</td>
<td>28.7 (68)</td>
<td>26.8 (19)</td>
</tr>
<tr>
<td>3. Moderate</td>
<td>35.9 (85)</td>
<td>40.8 (29)</td>
</tr>
<tr>
<td>4. Bad</td>
<td>16.0 (38)</td>
<td>19.7 (14)</td>
</tr>
<tr>
<td>5. Very Bad</td>
<td>03.4 (8)</td>
<td>04.2 (3)</td>
</tr>
</tbody>
</table>

The majority of respondents for both the AH and RH samples reported their general health level over the past month as moderate or better.

Table 26(b): WHODAS II Total Score

<table>
<thead>
<tr>
<th>WHODAS II Total Scores</th>
<th>2002</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Disability</td>
<td>AH</td>
<td>RH</td>
</tr>
<tr>
<td>% of 237 Total Responses</td>
<td>% of 71 Total Responses</td>
<td></td>
</tr>
<tr>
<td>1. Very Good</td>
<td>04.6 (11)</td>
<td>02.8 (2)</td>
</tr>
<tr>
<td>2. Good</td>
<td>48.9 (116)</td>
<td>50.7 (36)</td>
</tr>
<tr>
<td>3. Moderate</td>
<td>34.6 (82)</td>
<td>26.8 (19)</td>
</tr>
<tr>
<td>4. Bad/Severe</td>
<td>11.8 (28)</td>
<td>18.3 (13)</td>
</tr>
<tr>
<td>5. Very Bad/Extreme or Cannot Do</td>
<td>00.0 (0)</td>
<td>01.4 (1)</td>
</tr>
</tbody>
</table>

Total scores on the WHODAS II indicate that the majority (88.1%, N=209) of the AH sample, and 80.3% (N=57) of the RH sample have moderate or lower levels of disability. However, 11.8% (N=20) of the AH sample and 19.7% (N=14) of the RH sample have severe disabilities.

“I started drinking when I was 3. By 12 I was an alcoholic. Treatment didn’t work for me.” (Jesse)

Mental Health

Community stakeholders in the collaborative process indicated that it was important to have a measure of mental health for respondents. This challenge was approached in several ways. First, interviewers were trained to use the Mini Mental State exam to evaluate the mental state of respondents as much as possible from their interview process. Second, respondents were asked directly about their mental health and, third, the mental health portion of the Wisconsin Quality of Life (WQoL) instrument was incorporated into the survey. The WQoL is specifically designed for use with a wide variety of individuals, including those who are severely mentally ill. Unlike the WHODAS II, where higher scores indicate a more severe level of disability, higher scores on the WQoL are indicative of a more positive mental state. It is important to note that only the mental health subscale was used, not the entire WQoL measure. Therefore, the results speak only to mental health issues, not to quality of life in general. For the WQoL mental health subscale, the maximum range is from -15 (Extremely severe problems) to +15 (Very Good).
The RH group responses showed that 53.5% reported negative mental health overall (scores of -15 to -3), with 15.5% being neutral and 31% experiencing overall positive mental health (scores of +3 to +15). Of those experiencing negative mental health overall, 16.9% had scores at the bottom end of the scale (-12 or -15). To put this finding into some perspective, the seven people who scored -15 are indicating that, in the past month, they have been very lonely and remote from other people, bored, so restless that they couldn’t sit long in a chair, upset because someone criticized them, and depressed or very unhappy. The AH responses were somewhat similar, in that 48.9% of individuals were experiencing negative mental health overall, with 17.7% being neutral and the balance being positive. The 35 individuals at the lowest end of the scale (-12 or -15) represent 22.9% of the AH sample.

Mental health was further explored by asking respondents about their general outlook on life and about signals of emotional distress, such as feeling depressed, anxious or hearing voices. 24.4% (57) of AH individuals reported feeling generally confused, frightened, anxious or depressed. 48.3% (113) reported having some periods of anxiety or depression, and the remaining 27.4% (64) indicated that they felt calm and positive in outlook. 16.9% (12) of RH individuals reported that they felt generally confused, frightened, anxious or depressed. Another 62.0% (44) reported feeling some periods of anxiety or depression and the remaining 15 (21.1%) felt generally calm and positive in the past month. The 1997 report indicated that 81% of their sample considered life on the streets to be stressful. The 2002 study supports this with 72.7% of AH and 78.9% of RH individuals reporting elevated levels of stress.

When asked why they were feeling this way (i.e. depressed, anxious or hearing voices), the majority of AH respondents attributed their mental health status to their homelessness (N=92, 47%), to lost hope, 14% (N=28), to general stress related to their current situation, 11% (N=21) and to addictions issues 9% (N=18) and longing for lost family, 9% (N=17) respectively. 31% (N=48) of AH who responded said that their mental health problems bothered them a lot. RH respondents who answered the question (N=61) indicated that their housing situation was responsible for their mental health status (N=18, 30%), followed by general stress related to their current situation (N=11, 18%), having no money (N=10, 16%), and longing for lost family (N=7, 11%).

It may be important to note that 7.0% (5) of RH and 12.3% (24) of AH individuals who chose to answer the question indicated that they had been hearing voices in the past month. Furthermore, 44 (18.4%) of the AH reported that they had a mental health problem including depression (N=20, 47.7%), substance abuse (N=6, 13.7%), bipolar disorder (N=6, 13.7%) and depression co-morbid with other mental health issues such as anxiety (N=5, 11.4%). Of the 15 (21.1%) RH people who indicated they had a mental health problem, 8 (53.3%) reported this to be depression and 4 (26.7%) bipolar disorder.

It may further be important for mental health care providers to consider AH and RH individuals as at-risk groups for suicide. The 2002 survey found that 30.8% (N=63) of AH and 26.7% (16) of RH persons who answered the question had felt like killing themselves at least occasionally over the past 30 days. Furthermore, 32% (N=50) of the AH and 30% (N=18) of the RH respondents indicated that they had homicidal thoughts towards others at least occasionally. A small number of the AH(3%, N=5) and RH (2%, N=1), had homicidal thoughts most of the time or constantly.

The follow-up clinical interviews with people who had been homeless more than once in Calgary also offered an opportunity to identify the presence or absence of mental illness in this group. The interviewers identified a much higher rate of significant mental illness than was observed by surveyors, probably because the interviewers had extensive training in identifying mental illness, the context of the clinical interview was more private, and more time could be taken to hear an individual’s history. Some of the clinical interview participants were selected...
specifically because they were known by agency personnel to have a mental illness (n=6 of 61). However, most were not selected on this basis. The study team’s conclusion was that the proportion of the AH and RH populations who are experiencing significant mental illness is substantially under-estimated by a survey procedure (see qualitative data summary below).

Health Care Utilization
Respondents were asked whether there was a time in the past year when they had needed health care but did not receive it. Of the AH group, 30.3% (N=70) indicated that this had been the case. Of the RH group, 25.4% (N=18) had experienced this problem. The AH respondents indicated that they did not receive care because they did not have the money necessary for some aspect of obtaining the care (25.9%, N=21). For example, they might not have had the money for transportation to the service location, or for the prescription if one was necessary. This finding was virtually identical to that of the 1997 study. Long waiting lists were the next highest reason for not receiving service, with 19 respondents (23.5%) falling into this category. This is a considerable jump over the 1997 study when only 5% indicated that red tape and long waits in hospital emergency rooms prevented access to health care. The third most common barrier to receiving medical care when needed by the AH group was mistrust/apathy on the part of the respondents (N=18, 22.2%). This category included comments that the homeless person had become so convinced that they would not receive care appropriate to them that they had stopped seeking out the care they needed. For example, one individual said that he didn’t go to the hospital because there are “too many forms and I’m given the runaround.” Another stated that “people at hospitals are pricks to IV drug users and homeless” (this respondent was an intravenous drug user at the time of the survey). This finding is similar to the finding that 25% of individuals in the 1997 study reported that they did not seek care.

The RH had the issue of cost as a barrier to obtaining health care in common with the AH. Of respondents who answered the question, 21.1% (N=8) indicated that money was the primary reason they did not seek care. However, the next two most frequently mentioned reasons were different from those for the AH group. The RH respondents indicated that 21.1% (N=8) of the time transportation was the problem; they simply had no way to get to the service provider. A further 13.2% (N=5) had Alberta Healthcare Card problems.

Respondents were also asked a number of questions regarding their use of hospital services, including “In the past month, have you ever gone to emergency?” and “In the past year did you stay in the hospital overnight?” When respondents answered in the affirmative, they were further questioned regarding the length of stay and circumstances of each visit. 21% of the AH and 11% of the RH sample had gone to a hospital emergency room for treatment in the past month. The average number of visits was 1.62 for AH and 1.25 for RH. In addition, 27% (N=64) of AH and 26% (N=18) of RH respondents indicated that they had spent at least one night in a hospital in the past year. The average number of overnight hospital visits was 2.06 for AH and 1.22 for RH. The average length of stay was 4.7 days for AH and 4.6 for RH.

Health care service use was also examined from the perspective of substance abuse issues. As previously mentioned, 75% of AH and 65% of RH had a history of drug or alcohol abuse, and 46% of the AH and 31% of the RH have a current substance abuse problem. Respondents were further queried regarding their attempts to access help in this area. They were asked “Have you ever tried to get treatment for a drug or alcohol problem?” “Have you been able to get it?” and, if they were unable to access care, why they were not successful. Among the RH group, the majority (N=25, 78%) had attempted to get help and the vast majority of those (N=21, 88%) were successful in accessing the services they needed. When services were not accessed, it was most often due to the individual not being ready to enter treatment. The AH group had not been so assertive at seeking treatment. Of that group, 65% (N=84) of those who responded indicated that they had sought treatment. Considerably fewer were able to gain access to services (N=67, 64%) than their RH counterparts. Reasons for not being able access care included “Other” at 32% (N=14), long waiting lists (N=8, 18%) and inability to find
appropriate care (N=6, 14%). Upon further examination, the “Other” category for the AH group consisted largely of respondents indicating that they were not ready for treatment.

Service and Shelter Utilization
Respondents were asked where they went for services that were not necessarily shelters. For example, they were asked where they would go for physical health care. Respondents could provide as many answers as they desired and there was no limit placed on the number of agencies or services they could mention. Results for the 5 most frequently used services for both AH and RH individuals are listed in Table 27.

Table 27: Where do you go for physical health care?

<table>
<thead>
<tr>
<th>Service</th>
<th>2002</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>RH</td>
</tr>
<tr>
<td></td>
<td>% of 234 Respondents</td>
<td>% of 71 Respondents</td>
</tr>
<tr>
<td>1. CUPS</td>
<td>46.6 (109)</td>
<td>31.0 (22)</td>
</tr>
<tr>
<td>2. 8th &amp; 8th Clinic</td>
<td>44.0 (103)</td>
<td>32.4 (23)</td>
</tr>
<tr>
<td>3. Hospital (ER)</td>
<td>16.7 (39)</td>
<td>12.7 (9)</td>
</tr>
<tr>
<td>4. Walk-in Clinic</td>
<td>14.1 (33)</td>
<td>16.7 (12)</td>
</tr>
<tr>
<td>5. Family Doctor</td>
<td>12.8 (30)</td>
<td>31.0 (22)</td>
</tr>
</tbody>
</table>

As can be seen from the table, CUPS and the 8th and 8th Clinic are high on the lists of AH and RH individuals. Both groups also use Hospital Emergency rooms and walk-in clinics frequently. However, the RH are considerably more likely to see a family doctor than are the AH. It is perhaps important to note that, although respondents could have mentioned any services in the city, these five emerged as for the most frequently used by both groups.

Table 28: Where would you send a friend for mental health care services?

<table>
<thead>
<tr>
<th>Service</th>
<th>2002</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>RH</td>
</tr>
<tr>
<td></td>
<td>% of 235 Respondents</td>
<td>% of 71 Respondents</td>
</tr>
<tr>
<td>1. CUPS</td>
<td>28.1 (66)</td>
<td>21.1 (15)</td>
</tr>
<tr>
<td>2. Don’t know</td>
<td>25.6 (60)</td>
<td>31.0 (22)</td>
</tr>
<tr>
<td>3. 8th &amp; 8th</td>
<td>20.0 (47)</td>
<td>12.7 (9)</td>
</tr>
<tr>
<td>4. Hospital</td>
<td>18.7 (44)</td>
<td>21.1 (15)</td>
</tr>
</tbody>
</table>

Table 28 shows the four most frequent responses for both the AH and RH. The AH are more likely to use the 8th and 8th clinic than are the RH (20.0% vs. 12.7% respectively), but are less likely to use a hospital (18.7% vs. 21.1% respectively). However, what is perhaps most striking about the response to this question is that a substantial number of respondents in both groups do not know where to go for mental health services should the need arise. Given the number of respondents who reported mental health issues, this is a finding that requires a response from mental health service providers.

Respondents were asked specifically about their use of mental health services ("Since you have been without a home, have you used any mental health services?"). 19% (N=44) of AH respondents indicated that they had; however, it is interesting to consider what was reported
as a mental health service. The most prominent among AH respondents was the use of outpatient clinics (N=18, 31%) followed by hospital visits (N=12, 21%), Emergency Medical Services such as ambulances (N=9, 16%) and Emergency Room visits (N=8, 14%). RH respondents were more likely to have used a mental health service than their AH counterparts and were more likely to have accessed the services via a shelter. This is presumably because some of the RH were housed in transitional shelters, such as those for women fleeing violence. Individuals are allowed to stay longer at transitional shelters when compared to emergency shelters, which may explain this somewhat counterintuitive finding.

Looking for Work
Table 29 shows that there are some similarities and some striking differences between where AH and RH people look for work. Both groups use newspapers as their primary source of employment information. Likewise, both use “other” sources, despite the fact that the survey had a list of 20 possible sources of employment information. Both groups use the cash corner with similar frequency. However, the AH are much more likely than the RH to use word of mouth (23.4% vs. 12.9% respectively), and the Canada Employment Offices (20.8% vs. 9.7%). RH individuals are much more likely to contact their church for employment leads than are the AH (12.9% vs. 1.3% respectively).

Table 29: When you look for work, where do you go?

<table>
<thead>
<tr>
<th>Service</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
</tr>
<tr>
<td>1. Newspapers</td>
<td>41.6 (96)</td>
</tr>
<tr>
<td>2. Casual labour offices/private employment</td>
<td>38.5 (89)</td>
</tr>
<tr>
<td>3. Other</td>
<td>31.6 (73)</td>
</tr>
<tr>
<td>4. Word of mouth</td>
<td>23.4 (54)</td>
</tr>
<tr>
<td>5. Canada Employment Offices</td>
<td>20.8 (48)</td>
</tr>
<tr>
<td>6. Cash Corner</td>
<td>17.3 (40)</td>
</tr>
<tr>
<td>7. Church</td>
<td>01.3 (3)</td>
</tr>
</tbody>
</table>

Table 30: Where do you go for housing information?

<table>
<thead>
<tr>
<th>Service</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
</tr>
<tr>
<td>1. Newspapers</td>
<td>52.4 (122)</td>
</tr>
<tr>
<td>2. CUPS</td>
<td>26.2 (61)</td>
</tr>
<tr>
<td>3. Other</td>
<td>14.6 (34)</td>
</tr>
<tr>
<td>4. Word of mouth</td>
<td>13.3 (31)</td>
</tr>
<tr>
<td>5. Don’t Know</td>
<td>11.6 (27)</td>
</tr>
<tr>
<td>6. Calgary Housing Company</td>
<td>01.3 (3)</td>
</tr>
<tr>
<td>7. Kerby Centre</td>
<td>01.3 (3)</td>
</tr>
</tbody>
</table>
Again, both AH and RH individuals turn to the newspapers for information on housing. Both groups use “other” sources and word of mouth with fairly similar frequency. However, the AH are considerably more likely to use CUPS for housing information than are the RH (26.2% vs. 17.1% respectively). On the other hand, the RH are much more likely to use the Calgary Housing Company and the Kerby Centre than are the AH. The rather remarkable gap between the AH and RH samples in their use of the Calgary Housing Company warrants further investigation. It should be noted that seniors comprise a considerable sub-group in the RH sample, and it is likely that the Kerby Centre being reported as the fourth most frequent source of housing information for the RH group is an artifact of the sampling procedure.

When seeking non-medical help, approximately equal numbers of AH and RH individuals seek care from CUPS. However, that is where the similarities between the two samples ends on this point. AH individuals use “other” sources, friends/family and churches considerably less than RH. On the other hand, RH individuals use shelters and the Salvation Army less frequently than the AH.

**Table 31: Where do you go for non-medical help?**

<table>
<thead>
<tr>
<th>Service</th>
<th>2002 AH % of 233 Respondents</th>
<th>2002 RH % of 70 Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CUPS</td>
<td>39.1 (91)</td>
<td>37.1 (26)</td>
</tr>
<tr>
<td>2. Other</td>
<td>21.5 (50)</td>
<td>40.0 (28)</td>
</tr>
<tr>
<td>3. Don’t Know</td>
<td>15.9 (37)</td>
<td>10.0 (7)</td>
</tr>
<tr>
<td>4. Shelter</td>
<td>13.3 (31)</td>
<td>07.1 (5)</td>
</tr>
<tr>
<td>5. Salvation Army</td>
<td>11.6 (27)</td>
<td>04.3 (3)</td>
</tr>
<tr>
<td>6. Friends/family</td>
<td>06.4 (15)</td>
<td>12.9 (9)</td>
</tr>
<tr>
<td>7. Church</td>
<td>05.2 (12)</td>
<td>20.0 (14)</td>
</tr>
</tbody>
</table>

**SHELTER USE**

Respondents were asked to indicate the three shelters that they had used most often. Results are presented in Table 32.

“I don’t know where to look for any subsidized housing.” *(Mark)*

“The word on the street is that they (Calgary Housing Company) are empty because of the amalgamation. The other rumor is that they are putting them on the open market for more money.” *(Cathy)*

“We need people to come around (to the shelters) and talk about opportunities that are available - like school.” *(Joan)*
Table 32: Utilization of shelters

<table>
<thead>
<tr>
<th>Service/Shelter</th>
<th>AH % of 238 Respondents</th>
<th>RH % of 65 Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Drop-In Centre</td>
<td>51.7 (123)</td>
<td>30.8 (20)</td>
</tr>
<tr>
<td>2. CUPS</td>
<td>47.1 (112)</td>
<td>47.7 (31)</td>
</tr>
<tr>
<td>3. Mustard Seed</td>
<td>42.9 (102)</td>
<td>36.9 (24)</td>
</tr>
<tr>
<td>4. Centre of Hope</td>
<td>16.0 (38)</td>
<td>00.0 (0)</td>
</tr>
<tr>
<td>5. Salvation Army</td>
<td>15.1 (36)</td>
<td>24.6 (16)</td>
</tr>
<tr>
<td>6. Other</td>
<td>00.0 (0)</td>
<td>40.0 (26)</td>
</tr>
<tr>
<td>7. Women’s Shelters</td>
<td>00.4 (1)</td>
<td>32.3 (21)</td>
</tr>
</tbody>
</table>

Use of shelters for the AH is not particularly surprising; larger shelters can accommodate more people and they will therefore likely be mentioned by more respondents. The largest facility in the city, the Drop-In Centre, was named by 51.7% of respondents as being one of the three most frequently used shelters. This was followed closely by CUPS (47.1%) and the Mustard Seed (42.9%). It is apparent from this information that more explanation regarding what constitutes a “shelter” was necessary, since CUPS does not offer overnight accommodation. Further investigation of the data when time permits should allow this problem to be rectified. In addition, it may be useful to review the Salvation Army as a single entry rather than as it currently exists in its component parts (the Centre of Hope, the Booth Centre and the “Salvation Army”).

It should also come as no surprise that the RH use these services with less frequency (with the exception of CUPS which, as previously discussed, is an anomaly in the data coding). Instead, “Other” emerged as the second more frequently used shelter (first if CUPS is not counted) which makes sense given the definition of RH used in this study. The third most frequently used shelter for the RH group was the combined women’s shelters. This, too, makes sense, since the sampling procedure explicitly included women fleeing violence. These people were often staying at the women’s shelters or had been in the shelters in the past.

AH respondents were asked “Have you ever been denied access to a shelter in Calgary?” A total of 126 respondents (53%) indicated that they had been denied access at some time. Respondents were further questioned regarding the reasons for denied access. As with other survey questions, respondents could provide multiple answers to the question. By far the most prevalent reason for denial was that the facility was full (54%, N=91). Respondents also indicated that they were too drunk at the time they requested admission (11%, N=19), had been permanently barred (7.1%, N=12), temporarily barred (6%, N=10), were involved in a violent situation (5%, N=9) or had issues with the shelter hours (4%, N=7).

Respondents were also asked if there were any services or shelters that they had used in the past that they would not use again. They were also asked why this was the case. 40% (N=95) of AH indicated that there were shelters they had used that they would not use again. The reasons provided are presented in Table 33.
Table 33: Reasons for discontinuing use of shelters/services:

<table>
<thead>
<tr>
<th>Reason</th>
<th>AH % of 84 Respondents</th>
<th>RH % of 14 Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff problems</td>
<td>45.2 (38)</td>
<td>35.7 (05)</td>
</tr>
<tr>
<td>Client problems</td>
<td>22.6 (19)</td>
<td>28.6 (04)</td>
</tr>
<tr>
<td>Shelter/Service conditions (physical)</td>
<td>40.1 (34)</td>
<td>35.7 (05)</td>
</tr>
<tr>
<td>Shelter/Service policy</td>
<td>10.7 (09)</td>
<td>28.6 (04)</td>
</tr>
</tbody>
</table>

Both AH and RH persons discontinue using a shelter/service primarily due to interaction issues with staff or physical shelter conditions (often explained as the lack of cleanliness or the presence of alcohol and/or drugs).

“All the services that are offered are short-term. The shelters don’t really help people. What people need is affordable housing. Welfare also does not help. People need rent, not cash. People need a stable place in order to get their lives in order and to give themselves a boost. Shelters are not the answer.” (FR010407M)

“I didn’t know how hard it would be to get help when you’re well educated, clean and sober. Now I lie and tell people I have a grade 9 education and that I’m a fighter.” (FR0104007M)

“The system doesn’t look at the individual enough. Need to examine that many people on the street have come from similar dysfunctional backgrounds. The current system shuffles people from the left hand to the right hand.” (GR060907F)
QUALITATIVE RESULTS (CLINICAL INTERVIEWS)

A Grounded Theory Model of Homelessness Causation

One of the three mandates of the 2002 study was to map the current homelessness system, identify how individuals and families move through the system, and identify gaps in the current system. Despite the detailed attention given to developing the surveys for the AH and RH samples, the research team was keenly aware that information collected on a structured survey would not fully speak to this issue. What was needed were open-ended interviews carried out by professional interviewers with respondents who had been homeless in Calgary on more than one occasion. Consequently, the team developed a clinical interview process as detailed above and interviewed a total of 61 respondents, most of whom had been homeless more than once in Calgary. The remainder (N=6) were interviewed as representing the mentally ill population who would not consent to survey participation.

Individuals who had experienced homelessness more than once in Calgary were most likely to be able to speak to the current system of services for AH and RH people, describing how individuals and families move through the system and where service gaps or system barriers exist. The information collected from the clinical interviews was used to develop a grounded theory model of homelessness in Calgary, including risk factors associated with homelessness and variables associated with successful exit from poverty and housing difficulties. It is important to note that, at the time the clinical interviews began, the research team was still under the impression that a ‘system’ to move AH and RH individuals from homelessness to stable housing existed in Calgary and was describable. Our initial intention was to discover what that system was for the different sectors and/or demographic groups. To this end, a grounded theory approach was adopted as the most appropriate method of qualitative analysis.

The intention of grounded theory is specifically to generate or develop a theory that describes a social process such as movement through homelessness. The researchers, “study how people act and react to this phenomenon, collect primarily interview data, make multiple visits to the field, develop and interrelate categories of information, write theoretical propositions or hypothesis and present a visual picture of the theory” (Creswell, 1998, p. 56). Researchers typically conduct multiple interviews, based on several visits to the field. The purpose of collecting so much interview data is to reach a point of saturation; that is, a point where nothing new is being added to the process model or theory or to its sub-categories. The number of interviews obtained depends on when saturation occurs. The model building begins by coding the data into categories as it is collected. It may begin with open coding of initial categories and proceed to reassembly of the data in different ways through axial coding. The idea is to construct a model that is grounded in the data and speaks to the central phenomenon, it’s causal conditions, specific strategies (i.e., the actions or interactions that result from the central phenomenon), its context and intervening conditions (i.e. the narrow and broad conditions that influence the strategies), and its consequences (i.e. the outcomes of the strategies). Given the goals of the 2002 Calgary Homeless Foundation study, this approach was expected to be an appropriate and ultimately fruitful process.

The Calgary Process
The research team carefully considered the complexity of homelessness in Calgary, with particular regard to the various sectors. It was determined that the complex nature of the homelessness sectors was likely to require more than the normal number of interviews, and that these might need to be in greater depth than a simple examination of the homeless system in Calgary might provide. Consequently, a total of 61 interviews were carried out, with considerable care taken to ensure that individuals from each sector were heard from.

Interviewees were obtained from the random stratified sample process used to carry out the AH and RH interviews, with the addition of a small number of participants who were known to
be mentally ill (N=6). The clinical interview sub-group was compared to the study sample on a number of characteristics including gender, age, ethnicity, addictions and family status. The clinical interview sub-group did not differ significantly from the study sample in any way with the exception of age. The interview process interviewed less youth and seniors than would have been ideal to perfectly represent the study sample. Although 6 youth and 1 senior from the AH participated in a clinical interview, this is less than would be expected given the study sample composition. This finding is statistically significant with $\chi^2 (4, N= 228) = 16.36, p < .01$.

During the course of the survey, interviewers specifically asked how many times the respondent had been homeless. If they were homeless more than once, they were asked how many of those times had been in Calgary. If the respondent indicated that they had been homeless more than once in Calgary, they were invited to participate in a clinical interview (see Appendix E for the complete interview format). Respondents were provided with an appointment card and directed to CUPS to book a clinical interview time. Scheduling had been established to ensure that a qualified clinical interviewer was on site at CUPS during the majority of the hours that CUPS was open. Therefore, interviewers were often able to accommodate respondents very quickly. Clinical interview respondents were paid $15.00 for the interview, regardless of how long the process took. Most respondents were happy to spend as much time as it took to fully answer questions and explain their particular situation. Many were eager to assist in any way to prevent others from following in their footsteps. The interview length varied from about 40 minutes to two hours.

The System for Addressing Homelessness

As completed surveys began to arrive and clinical interviews got underway, a consistent message emerged. Respondents and interviewees did not perceive a system of assistance at all if, by ‘system’, we mean to imply an interacting network of services that is organized to provide continuity of intervention to the homeless. Instead, their perception of the services available to AH and RH individuals in Calgary was one of confusion, lack of information, an absence of coordination between services, and policies that often work against moving out of poverty and homelessness. Several interviewees expressed the belief that the services offered to homeless individuals were deliberately established to ensure that the poor never escaped from poverty. To use the words of one interviewee, “working with homeless people keeps the middle class employed.” Although this rather extreme view was not the norm, virtually all interviewees told stories about why it is impossible to get all the various pieces in place to find an affordable home and get out of poverty, and about how they eventually become discouraged and just stop trying.

The term ‘system’ implies a beginning or entry point, a logical or predictable sequence of interventions, and an end...presumably exiting homelessness. Based on the results of the clinical interview analysis, we must concur with the interviewees that there is no systematic process in place to assist AH and RH individuals out of poverty and into stable housing in Calgary. This statement should not be taken to mean that excellent services to assist the homeless do not exist in Calgary. Interviewees told inspiring stories about social service workers who actively advocated for them to obtain SFI while they lived in transitional housing (which would not normally qualify as “permanent housing”). They told of the Red Cross or CUPS providing damage deposits, or Child Welfare trying to advocate on their behalf with the Calgary Housing Company. However, these messages consistently spoke to the efforts of specific services rather than to a system that methodically helps people out of homelessness. The individual services may be excellent, but visible and strong links between them, and equitable access to them, do not exist in the eyes of the AH and RH. The common perception is that one must be “lucky” to get the services to work together.

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8 The same analysis was not possible for the RH group due to a coding error. However, it is likely that more seniors and youth from the RH sub-group participated in the clinical interview.
Consequently, it does not make sense to talk in terms of gaps in the system, other than those mentioned in the recommendations for this report (see below). Rather, the approach should be one of building on current strengths, which primarily serve the immediate needs of the AH and RH (i.e. overnight shelter and food), and adding in entirely new components designed to assist people to move out of homelessness and poverty in a sustainable way. The barriers to exiting homelessness and poverty are formidable (see some listings in the quantitative results sections above) and AH and RH people are usually left on their own to figure out what services are available, how to access them, and how to coordinate them. For individuals who may have low resilience to obstacles, poor planning skills and lower than average education levels, it may be impossible to move out without a linking mechanism that can assist them to draw on the strengths of the various service provider agencies and government support systems. For the moment, such a linking mechanism does not exist.

Clinical Interview Analysis
The second purpose of the clinical interviews was to inform the development of a model of the processes of moving into and out of homelessness in Calgary. With this goal in mind, the clinical interviews were painstakingly analyzed by three members of the core research team, in keeping with the best practices of grounded theory. Categories were developed and continually modified and refined based on information provided by the interviewees, using the constant comparative method. Saturation was reached when fewer than half of the interview protocols had been analyzed. However, all of the interviews were read through to ensure that no possible additional element was overlooked, and to select exemplars for the various categories of the model. The resulting categories and sub-categories were then used to develop a model of homelessness that incorporated the various factors that put individuals at risk of becoming homeless and, perhaps more importantly, determine their resilience to these risk factors and to systems barriers. The core category for the theory is the reproduction of homelessness, and the model is structured to visually represent the distal and proximal factors associated with moving into and out of homelessness.

It was hypothesized that the process of homelessness results from the interaction of multiple social, economic, familial and personal factors. The social and economic components of the process are related to social policy and economic cycles and provide the larger context within which individuals struggle to avoid or move out of homelessness. The capacity of individuals to succeed in moving out of homelessness - referred to here as resilience - exists on a continuum, with greater resilience and the presence of developmental assets being more likely to result in relatively rapid return to the mainstream culture, and lower resilience and relative absence of developmental assets being more likely to result in repeated cycles of homelessness. The interaction of personal resilience with social and economic factors is not uniform - that is, larger system factors are more or less likely to precipitate “chronic” homelessness depending on the number and severity of the personal risk factors an individual or family has experienced.

A second review of the interview protocols by two of the core research team, reading through each protocol and assessing fit with the model was used to validate the current draft. The research team encourages others to test the utility of the model’s elements for predicting homelessness and for suggesting effective intervention timing, content and processes. The draft model is presented below in its conceptual form and in a detailed description. Some sample participant vignettes are also provided to illustrate the processes described in the model.

It became increasingly clear early in the analysis process that homelessness is much more than just an event, or the experience of not having a place to live. Other research has also shown that it is a gradual process that “entails a great deal of loss”. That was certainly the case with the respondents who participated in the 2002 CHF study. Consequently, the model reflects a unifying theme of loss that runs through the narratives of interviewees. The model was also structured to include early childhood and continue through adulthood, in keeping with
the experiences of respondents. The current draft of the model is primarily cyclical in nature, and is intended to represent both the discrete components that contribute to the outcome of homelessness and the overall process that reproduces homelessness over time. Although it is possible for some people to successfully move out of homelessness, there are significant barriers to doing so for most homeless persons. Some people experience one brief, isolated episode of homelessness in their lives, but many others remain homeless for extended periods of time, or cycle in and out of homelessness repeatedly. (81)

Once an initial draft of the model had been developed, and exemplars extracted from the interview protocols, the literature was searched for other models of the same or similar processes. Several possible resources were identified, and some confirmation was obtained that the model derived from this study is compatible with those developed in other initiatives. Future revisions of the model will allow it to build on related work, such as that of Scholte. (82) Although Scholte worked primarily with children, his socio-ecological model addressed components which are subsumed in the Model of Homelessness presented here, such as “at risk” family or school situations. It is important to note that Scholte’s model explained 30-40% of the variance in problem behaviour syndromes such as delinquency, running away from home and drug addiction. The authors encourage similar refinement and testing of the Model of Homelessness presented in this study. The advantage of developing a predictive model is that it allows intervention before problems become plain to see and affords an opportunity to avoid homelessness and its consequent personal and societal costs.

Although a system for assisting individuals out of poverty and homelessness does not exist per se in Calgary (or in any other jurisdiction we are aware of), this does not mean that patterns of homelessness do not exist, or that there cannot be a coordinated way to deal with the problem on a permanent basis. The model illustrated below, based on the clinical interview data, has been developed to assist in designing such a system. The design process is likely to be complicated, since it will necessarily involve confronting obstacles in the form of entrenched social policies, values and beliefs about the poor and homeless, and about the appropriate interest and roles of society in managing the conditions in which our children are raised.

The model is first presented in conceptual terms, and followed by a discussion of its various components.

<table>
<thead>
<tr>
<th>Family of Origin</th>
<th>High Resilience and/or Positive Developmental Assets</th>
<th>Street Conditions</th>
<th>Proximal Social Policy</th>
<th>Housing Conditions (Non-Govt)</th>
<th>NGO System of Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental addictions</td>
<td>Leaving school early</td>
<td>Low Resilience and/or Negative Developmental Assets</td>
<td>Early parenting</td>
<td>Poor planning skills</td>
<td>Attachment Disorder</td>
</tr>
<tr>
<td>Parental abuse</td>
<td>Early leaving</td>
<td>Traumatic relationship</td>
<td>Loss of Aspirations</td>
<td>Leaving home early</td>
<td></td>
</tr>
<tr>
<td>Traumatic relationship</td>
<td>Unplanned/frequent moves</td>
<td>Out-of-home placement</td>
<td></td>
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</table>

Social Policy changes over time according to societal values. It addresses issues of poverty, child protection, health and education among others.

Family of Origin can be a positive influence (green) or negative (red). Most chronically homeless interviewed had difficulties with their family of origin.

Individual factors include the presence of learning disabilities, physical/mental illness prior to homelessness, early addictions, early bereavement and personality factors.

High Resilience & Positive Developmental Assets are the opposite or absence of negative characteristics (i.e. not leaving school early, employability skills).

Street Conditions include sleep deficits, shelter conditions and policies, transportation problems, exposure to drugs, alcohol, abuse & stigma.

Proximal Social Policy includes housing factors (i.e. non-profit housing), economic factors (i.e. welfare rates) and practices (such as residency requirements for welfare).

Non-Governmental Housing Market includes the vacancy rate, market rents, landlord/tenant practice, illegal suites, and damage deposits.

NGO System of Help includes the comprehensiveness and cohesion of services, whether there is a central access point and the practice model used (extent of outreach).
Model Components:
Although the model can be explained in terms of families and their social contexts, for simplicity it will be explained here from the perspective of single individuals.

As can be seen from the model, the hypothesis is that ongoing social policy, particularly policies that perpetuate child poverty, act as the social context that influences both the conditions in an individual’s family of origin and the negative life events to which he/she is exposed. When a negative life event such as homelessness occurs, the individual’s capacity to cope with the situation will be substantially determined by the capacity for resilience and the presence or absence of critical developmental assets, which are themselves products of social and individual factors, family of origin experiences, and negative life events. Thus, although street living conditions, proximal social policy (e.g. minimum wage, eligibility criteria for SFI, etc.) and non-governmental systems of help may be similar for all homeless people living in a particular environment, the person who enters these conditions with higher resilience and more developmental assets is more likely to overcome the challenges the situation presents and move out of poverty and homelessness relatively quickly. Those who are less resilient, however, or have multiple developmental asset deficits, are more likely to remain homeless or to experience repeated cycles of homelessness. Thus, individual resilience becomes the critical outcome of distal social policy, family of origin influences and adverse life events and, in turn, becomes the context within which the individual approaches dealing with homelessness.

1. Key Risk Factors/Causal Conditions:

a. Distal Social Policy
Distal social policy refers to the societal constraints and contexts that were in place when the individual was born and growing up. These can have a profound influence on the individual by way of their caregivers. For instance, the day-to-day experiences of children who grow up in poverty are more likely to be impoverished in a number of ways, and their resilience to life events such as homelessness is likely to be substantially reduced. How strong the impact is for any given child is mediated by the type and extent of the stressor, and the capacity of the child’s primary caregivers to cope effectively with it. Social policy issues which emerged as particularly influential included:

i. Poverty (Child/Family)
   1. Minimum wage laws
   2. SFI (welfare) rates and accompanying access policies
   3. Disability support levels and access (i.e. WCB, AISH, PDD, private insurance)

ii. Child Protection
   1. Laws, policies and social expectations regarding abuse and neglect, especially the absence or ineffectiveness of early intervention in child neglect and abuse
   2. The effectiveness of the foster care system
   3. Laws, policies and social practices regarding access to good quality childcare and to early childhood education
   4. Domestic violence laws and practices (e.g., removal of abused partner and children from the home, failure to consistently apply laws).

iii. Health (Mental and Physical)
   1. Lack of access to health care, mental health care, and addictions services
   2. Inadequate discharge planning (partly resulting from a lack of appropriate, supported transitional housing for persons coming out of institutions)

iv. Education
   1. Reduced access to appropriate education (especially early childhood education, post-secondary education for youth coming out of the child welfare system, and support for single parents to receive further education and training while receiving social support)
2. Need for revised interrelationships of SFI, student loans and various education re-entry programs
3. Access to educational supports (for example, remedial efforts for children who are learning disabled)
   v. Lack of continuity of health care and social policy across and within provinces - especially problematic as at-risk families move frequently.

b. Family of Origin
The family environment during childhood is influenced by distal social policy, as noted above, and has a profound impact on children's lived experience. Family of origin factors are a complex component of the model. Their negative or positive impact on the individual will vary with factors such as access to stable adult figures within and outside the family. For example, several interviewees described the difficulties involved in having alcoholic or abusive parents, but the positive influence of other individuals, such as a grandmother, a teacher, or a family friend (though these, too, were often absent as a result of the family's frequent moves and consequent social isolation). Responses from interviewees lead to the hypothesis that the following are the most influential family-of-origin risk factors in the reduction of individual resilience to homelessness:
   i. Parental addictions (alcohol, drugs or gambling);
   ii. Poverty;
   iii. Abuse (of the child or any other immediate family member);
   iv. Traumatic relationship breakdowns, particularly between parents, but also including loss of a parent through accident or illness;
   v. Unplanned and frequent family moves;
   vi. Adoption (specifically in the Aboriginal interviewees);
   vii. Use of the foster care system or other removal from the family to an unstable environment;
   viii. Resulting disruptions of the child's education, and extended family and peer relationships.

c. Adverse Life Events in adolescence and early adulthood
Negative life events are unexpected occurrences that impact the individual either directly or through their family of origin. Influential events which emerged out of the clinical interviews include:
   i. Job Loss (involuntary) due to any reason, including economic downturn or injury;
   ii. Domestic violence in the nuclear family (i.e. not family of origin, which is included above);
   iii. Relationship breakdown in youth or adult years that precipitates a period of financial and personal instability including loss of:
      o Parents (e.g. unresolved grief after the death of a parent, loss of a previously stable home life due to loss of a parent);
      o Spouse
      o Work relationships

d. Individual Factors
Individual factors are characteristics or qualities unique to the person, including characteristics acquired as a result of a chaotic or violent family of origin. These factors profoundly affect the way in which the individual reacts to becoming homeless, their resilience to street conditions, and the likelihood of becoming chronically homeless. These include:
   i. The presence of any learning disabilities;
   ii. The presence of a significant mental or physical illness prior to homelessness;
   iii. Addictions and age of their onset;
   iv. Personality factors derived from attachment disorders; and
   v. Relative presence or absence of developmental assets.
2. Resilience

Sufficient information was gathered from interviews to develop profiles of Non-Resilient and Resilient individuals with regard to capacity to cope with and find a way out of homelessness. Although these profiles are in the developmental phase, they are presented here for review (see below). It is important to note that negative life events alone may be sufficient to create low levels of resilience, even in situations where the individual has had the benefit of multiple protective factors in childhood. For example, some homeless individuals who participated in the clinical interviews had stable family histories but were now clearly acutely disorganized by the early stages of a psychotic illness, or by a significant trauma in the recent past. The former group is unlikely to find a way out of homelessness without substantial assistance, while the latter is less likely to remain homeless once the initial trauma is reduced and developmental assets are again brought to bear on problem-solving.

Non-Resilient Homeless (tending to repeat cycle of homelessness)

Parenting received
- Abuse/neglect/domestic violence;
- Frequent family moves (N>5), with consequent social isolation;
- Nutritional deficits;
- Parental and early childhood addictions;
- Lack of social supports or family network;
- Mental or physical health problems (e.g. FAS, ADHD, conduct disorders); and
- Chaotic family environment.

Childhood Development Consequences re: loss of developmental assets:
- Lack of interpersonal intelligence, resulting in dysfunctional interpersonal relationships and poor interpersonal judgment (i.e. manifests in adolescence and adulthood in poor roommate choices, poor parenting decisions, inability to sustain relationships);
- Untreated health problems (mental, physical, dental);
- Vulnerability to re-abuse in other relationships;
- Undiagnosed learning disabilities;
- Social isolation and/or ostracism;
- Lack of role models for appropriate behaviour;
- Attachment disorders with consequent loss of skills for time estimation, etc.;
- Skill development deficits (both employment-related literacy/numeracy skills and interpersonal skills);
- Interrupted education and early school leaving;
- Unresolved grief;
- Early sexual activity, child bearing, leaving home, and addictive behaviour;
- Loss of hope/aspirations;
- Sense of being an outsider/rootlessness;
- Fearfulness/suspicion of authorities;
- No experience or skills for leisure activities/constructive time management;
- Reduced capacity to focus on goals and maintain them;
- Reduced ability to deal with disappointment or rejection;
- Increased tendency to avoid interpersonal contexts; and
- Reduced ability to deal with complexity (easily discouraged, easily offended, expects to fail).

Resilient Homeless (tend not to repeat)

Parenting received
- lower incidence of abuse/neglect or, if abuse or neglect is present, it is relatively mild, occurs only in late childhood, or, if family does not move frequently, is buffered by a supportive adult inside or outside the family;
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- Fewer than 5 family moves in childhood;
- No nutritional deficits;
- No parental addictions or, if present, are better managed;
- Family has some social supports or extended family network. Child has at least one significant stable, positive adult contact;
- Reduced or absent mental or physical health problems. If present, are diagnosed early and better managed; and
- Organized family environment.

Childhood Development Consequences
- Better inter-personal judgment and fewer dysfunctional interpersonal relationships (i.e. better roommate choices, better parenting capacity);
- Fewer untreated health problems (mental, physical, dental);
- Less vulnerable to re-abuse;
- Fewer undiagnosed learning disabilities;
- Less social isolation and/or ostracism;
- Available role models for appropriate behaviour;
- Less likely to experience attachment disorders;
- Fewer skill development deficits;
- Education is not significantly interrupted;
- No unresolved grief;
- Sexual activity, child bearing, leaving home, all occur at older ages;
- Addictive behaviour either later in development or absent;
- Maintains hope/ has personal aspirations;
- Less sense of being an outsider;
- Less fearfulness/suspicion of authority;
- Increased repertoire and skills for leisure activities; and
- Normal capacity to focus on goals and maintain them

3. Conditions of Homelessness
The conditions of homelessness are those factors which form the immediate environment of the AH or RH person. These include the conditions on the street at the time, as well as relevant government policies and non-governmental organization systems of help. How an AH or RH person reacts to these aspects of the environment will depend to a large degree on their own experiences and on the individual factors above, which manifest as greater or lesser resilience to these conditions.

- Street Conditions
  - Sleep deficits;
  - Hours of shelter operation;
  - Shelter conditions (cleanliness, available facilities);
  - Shelter policies;
  - Transportation problems;
  - Difficulty saving money while living on the street;
  - Absence of a system to support exiting from homelessness;
  - Theft/loss of possessions;
  - Boredom, lack of meaningful work and recreational activities;
  - Exposure to drugs/alcohol;
  - Exposure to interpersonal abuse/violence; and
  - Barriers to self care.

- Proximal Social Policy (Government)
  - Housing factors
    - Vacancy rate and cost of rents;
    - Housing Administration (policy barriers);
o Access-gatekeeping;
o Staff attitude and errors;
o Communication breakdowns (i.e. voice mail);
o Appearance of favoritism;
o Lack of affordable housing;
o Lack of supported housing; and
o Reliance on illegal suites (with consequent tenant vulnerability).

- Economic Policy
  o Minimum wage levels below poverty line (no “living wage” policy);
  o SFI rates, access, policy, staff;
  o AISH rates, access, policy, staff; and
  o Low Income Cutoff (LICO) for poverty line.

- Institutional Practices
  o Foster care;
  o Child protection funding and policy;
  o Child support enforcement problems;
  o Response to domestic violence;
  o Mental Health Act content and interpretation;
  o Institutional discharge planning from prisons and hospitals;
  o Access to health care, mental and physical, for diagnosis and treatment; and
  o Pattern of practice of helping professions (e.g., lack of sufficient outreach focus).

- NGO System of help
  - Experience of the person as they interact with the services available (refers to whether there is a system with continuity and a clear path, or whether services are fragmented and require that the homeless person have skills for interpreting, accessing, coordinating and managing the services available independently);
  - no centralized access point for services;
  - each piece (i.e. SFI, housing that will accept SFI, childcare, healthcare) has its own barriers and elements are therefore difficult to coordinate;
  - Absence of some services (i.e. identification clinic or legal aid clinic);
  - Accessibility of services, given transportation issues;
  - Presence/absence of an organized process to educate homeless and at-risk homeless persons on what services are available;
  - Daycare barriers;
  - Hours of operation (i.e. working poor cannot access services which run 8-4); and
  - Available funding for damage deposits.

The conditions of homelessness as detailed above become distal social policy over time. In other words, the decisions that are in place today, such as SFI policy or substandard housing and so forth, will form the backdrop against which young people born to homeless and at-risk individuals and to families living in poverty become more or less resilient to future challenges.

It is apparent that, although the model itself looks simple, it, like homelessness, is complex. It may be of some benefit to readers to consider the model and it's utility in light of some descriptions pulled from the clinical interviews. The following examples have not been chosen to be representative, but rather to demonstrate the impact of distal social policy, family of origin, negative life events and individual factors on resilience and, further, how high or low resilience is highly influential in determining whether the individual will move out of homelessness or experience repeated cycles. The
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stories described here have been altered slightly to protect the privacy of the respondents, but no material facts have been altered. The descriptions are given, as far as possible, using the individual’s own words or emphasis.

Examples from the Clinical Interviews:

High resilience, with situational or episodic homelessness
This group has little or no identifiable childhood trauma, excessive moves, parental addictions, etc. Their homelessness may have immediate causes related to life events, but appears likely to be temporary. They may still require assistance of various kinds, but this too is likely to be shorter term (6 to 12 months). The exception is the group of individuals who had good developmental beginnings but, usually in adolescence, developed a mental illness or a serious addiction. These individuals are likely to remain in the homeless population about the same way as the low resilience individuals do. For example, we interviewed more than one young man who clearly had come from a stable home, had loving and stable parents, and relatively uninterrupted education and peer relations, but who has developed a personality disorder or an early psychosis.

Peter

Peter had heard that the job climate was better in Alberta and headed here to look for work. Previously, he had been looking for work in Nanaimo and then in Edmonton. He left stable housing in Nanaimo to come to Alberta. He had a job lined up in Red Deer before he left, but it fell through when he got here. He then moved to Edmonton looking for work and stayed in shelters, then moved on to Calgary. He finds that Calgary is very expensive - there is no low income, affordable housing. He has some savings, has just bought a cell phone and begun looking for work again. He wants to find work, then a nearby place to live. He plans to stay at the shelter for the maximum 60 days and work full time. He “has worked non-stop since I was 15”, so thinks he should be able to land on his feet. But the past 9 months have been very difficult and he is discouraged. He has no addictions issues at this time, though he did when he was an adolescent. He has not spoken to Social Services because he feels that they “give people a hard time. They don’t want to help you until you get a job. This is a catch-22 as you need the help to get the job.” He feels that it is up to him to make his way out.. He uses various services to assist with resume writing, and consults the HRDC job bank information. He is unaware of where to look for help with housing - “not knowing is my worst enemy.”

Bill

Bill is suffering the after-effects of a very serious motor vehicle accident. Prior to the accident, he had been earning $60,000 a year. Now, he has no income at all. Two years ago, he graduated from university with an MBA in Economics. He moved to a large city for a new job, but had nowhere to stay and ended up in a shelter for a month. Some time later, he was offered a transfer to another city closer to his family home, which he accepted. He was driving there to take up his new position when the MVA occurred. He was seriously injured and is currently unable to work. He returned to his previous home and lived on his savings for a while. He had a permanent address there until one month ago, when his savings ran out. He decided to return to his family’s home in Abbotsford BC. and is now backpacking his way home, stopping off in Calgary. At the time of the interview, he had been staying for the last month outside with a friend “due to the good weather and the fact that no one bugs you.”

He lost his ID in the car accident, and finds that not having it makes it difficult to access any resources. His emotional state and his physical health are quite fragile right now and he feels like giving up. He is reluctant to go home but feels it is the only solution at the moment. His parents have different religious beliefs from him, that make it difficult for him to stay with them. He knows that he doesn’t want to be homeless much longer. Storage is also a problem - he has a lot of stuff and has nowhere to leave it. “People need a place to put their things.” He has found this a universal problem wherever he has traveled on his journey toward home. He believes that his sobriety also makes it difficult to get help - he thinks agencies are only willing to help if you have a drug or alcohol problem. He does have a
friend with him now who has an addictions problem, and he often feels he is babysitting this man. He is frustrated because he sees that, for many people, homelessness is a lifestyle choice and they “feed off the system. Ironically these are the people who hate the system and are the least likely to change”. He presently feels that in order to get any help he must lose everything, including all his belongings, and be really desperate. “There does not seem to be any middle ground.”

He lost his front two teeth in the car accident. Since losing his teeth, it has been very difficult to find a job, although he has tried. He has not been able to find a free dental service to repair his teeth. He finds he is in a catch 22 - he needs to get his teeth fixed to find work, but can’t find work because he is missing his teeth. He also broke several ribs in the accident and has found recovering on the street to be very difficult. He has also found it difficult to eat properly and finds he spends most of his day going from service to service (Salvation Army, Drop-in Centre and Mustard Seed) just to feed himself. He says that the shelters in some of the other cities he has passed through are very good and more like hostels - they have mandatory showers and could provide a clean change of socks and underwear. This was much more hygienic.

He feels that there is no way to keep housing at this point, assuming he could find it, and he doesn’t care any more. He knew what the consequences would be while he was heading home. He didn’t realize, though, how hard it would be to get help when one is well educated, clean, and sober. He said he now lies and tells people he has a grade nine education and is a fighter. He said all the services that are being offered are short-term. The shelters don’t help someone like him, and what people really need is affordable housing. Welfare also does not help - people need rent, not cash. People need a stable place in order to get their lives in order and to give themselves a boost. Shelters are not the answer. For himself, he feels he needs a free, effective ID clinic. A proper storage facility is also a must. At this point he is just living day-by-day. He is trying to be persistent and not make any big plans, since they only result in discouragement.

Allan

This participant appeared to the interviewer to be very frail and probably clinically depressed. His illness (currently diagnosed as chronic fatigue syndrome) seems to be the largest reason for his homelessness. He has also been diagnosed with epilepsy and may have diabetes. He finds it very difficult to be in poor health and live on the streets. Sometimes, he says, he needs to rent a room at a hotel to sleep just to survive. He has also been in a physically abusive relationship, which resulted in his having to leave his apartment and move to the streets the first time. He has recently had all his ID stolen, and things are looking pretty bleak to him. When he is living on the street, he associates with people with substance abuse issues (i.e. crack-cocaine) and has made some attempts to move into apartments with various ones of these people: however, these have all ended badly, due to roommates’ drug and alcohol problems. He may have had some problem with alcohol himself in the past, but “watches his drinking” now and did not appear to the interviewer to be a chronic alcoholic. He seems to be embroiled in a battle with AISH and his employment-related pension over an over-payment of benefits, and sees himself as coming out on the losing end. He has been homeless in Calgary on and off for the last two years. Before that, he had “never even heard about this lifestyle”.

He became frustrated at this point in the interview and stated that he had a good education and a good job before his illness and the conflict over his disability entitlement. His finances are his biggest concern. He cannot work, but is supposed to pay back a pension overpayment which is now being garnished from his AISH checks. He is still trying to pay this back after two years on the street.

He is angry -people seem to classify him as stupid because he is on the street. These are circumstances that he never thought could happen to him. He is mad at the ‘bullshit’ he has had to put up with. He still does not understand why his disability over-payment is being deducted from his pension. He thinks about returning to work but knows he has not kept up, and his age is against him. He thinks he might want to go back to school to try something like social work.
He feels that he really needs a damage deposit, but he had received one previously through CUPS and is not eligible to receive another one. The first one was lost because the apartment was in the name of his roommate, and they were evicted due to the roommate’s drug abuse problems. Currently, he is hoping that he may still be able to get one through the Red Cross. For the moment, he is focused on trying to keep up his storage payments.

He believes that, if he had $1,000 a month, he could live and wouldn’t be in this position. He thinks he would probably still need to use the food bank and the interfaith for clothes to make ends meet. He feels that at this time he will never be out of homelessness. He would like to be able to find a one-bedroom apartment where he could live on his own with some Home Support. He will need to pawn his jewelry soon and feels that the Red Cross is his last chance for help.

**Jim**

Jim is 28, and has no history of childhood trauma, no addictions, no mental illness and is not on SFI. He completed grade 12 and then remained at home with family, working, until age 20. He then moved in with friends and worked full time. He states that he never really got along with his family - they are strict and religious and he would rebel and get into arguments with his father. However, when his parents moved to Calgary, he followed them here after a few months. He started to work at a retail store, living with his parents. Then another employee, a woman, stole money from the store till and blamed him for the theft. He felt betrayed, as he had thought she was his friend. He was fired from his job and his parents kicked him out of home because he was not working. He then began staying on the street, working casual labour contracts.

The last time he had a permanent address was now four years ago, when he shared a condo townhouse with three friends, one of whom owned the condo due to a WCB compensation settlement for a severe work injury. He stayed there for a year, working full time for a moving company, but he “got sick of the job, having to work 6 days a week, and quit.” He then had a fight with the friend who owned the condo, over the friend’s maltreatment of his two cats. He moved out and went back to the shelters, where he stayed on and off for 2 years. He then found a place with another friend for several months, but this friend, he says, was “just like a big child with temper tantrums”. He attributes his homelessness to the fact that rent is so high and that roommates you meet on the street are completely unreliable. He has trouble holding down a job while living on the street because he can’t get a good sleep and has to get up very early for the casual labour spots. “It’s hard to work full time if you have to be up and out of the shelter at 6:30 a.m. seven days a week.” He has no money for transportation to get to other workplaces and has become discouraged and given up.

He has a girlfriend who helps him stay on the straight and narrow - she lives in Bowness with her parents and says he can’t have anything to do with alcohol or drugs, so he stays pretty straight. He sees her about two hours every day. She is 24 and deaf, living with her parents. He has learned sign language to communicate with her better and hopes this might lead to better work. However, when away from her he does use marijuana - mostly, he says, to cope with his life.

He had been on SFI for a month once when he broke his finger at work, but hasn’t used SFI otherwise. He thinks that the hassles around applying are too much (rent reports, work confirmations) and the money is “not enough to help anyone anyway.” He had almost gotten another job recently, but the hours were too long and would have prevented him from seeing his girlfriend.

He would like to have subsidized housing for himself and his girlfriend, and a job with better than minimum wages so he could save. He also says that he needs to do some work on himself. “I need to change how I react to people - I have too short a fuse. I am working on it.”

**Moderate resilience problems, exacerbated by life events:**

This group may show some developmental trauma, but buffered by other relationships. Homelessness results from a life event such as mental illness, accident, trauma, or situational factors such as job loss.
or relationship breakdown. Whether these individuals remain homeless is influenced by service access, assistance obtained with mental health problems, and the availability of supported transitional housing.

**David**

David was considered by the interviewer to have a personality disorder. He grew up in small towns in Saskatchewan, with both parents present throughout his childhood. He was one of 6 children and describes his parents as having been very supportive and without major mental health, addiction or employment problems. He attended school routinely through grade 10, then dropped out “because school was too boring.” He had a reading disability and found school discouraging. He left home at 16 “to get out and work.” Over the next nine years, he worked in various jobs for brief periods, and had a common-law relationship and two children. Eventually he and his partner moved to Alberta looking for work in the oil industry. Throughout this time, housing was “stable, with us renting homes or apartments.”

His common-law partner “eventually kicked me out” as his drug use became heavier and he was involved in criminal activity. He went to Spy Hill Correctional Centre for 18 months, then moved in with a friend in Calgary. He continued to work, and to live in rental properties for the next 5 years. He also moved in with a second common-law partner. Together, they moved for one year to BC and then returned to Calgary. Soon after they returned to Calgary he was laid off.

At this point, he says, “I realized that crime was easier than working, and started into credit card fraud.” This began a pattern of being in jail for most of the 1990s. His second common-law partner left him in the mid-nineties. When he was out of jail, he stayed with friends and accessed welfare benefits. During his brief times out of jail, he became addicted to morphine and “began to steal to support my habit.” At the time of the interview, David had been out of jail “just since the spring.” He received addiction treatment in jail and believes it helped, though he is still using.

Currently, he is looking for a steady job, and hopes that once he has that he will be able to get a place again. However, he also thinks that he will continue to steal in order to obtain money for his continuing drug habit.

**Brad**

Brad’s upbringing was characterized by multiple moves that may have disrupted his development significantly. He also developed an addiction to cocaine in late adolescence. “My dad worked for the RCMP and we moved around a lot. Besides the advantages of seeing the world, I had problems making friends because we never knew how long we’d be in one place. Once we got settled and started to make friends, we were moving again. In Ottawa I got a little rebellious when we had to move again. I was partying with friends and even running away from home for a few days to stay with a friend, but I still went to Newfoundland with my family.”

He left his family in Newfoundland when he came to Calgary at age 21. He had no job or residence and ended up staying at a shelter. “That was my first experience in a shelter and I ended up staying for 2 years. I was in tip-top shape during this time, always working and always with money, but I could never manage to save up the damage deposit and first month’s rent. I guess my bad habits, smoking tobacco, occasional social drinking and leisure activities kept me from accumulating any money. I became comfortable at the shelter, moving from the mats to the dorms. It was a choice. I never was able to get (or keep) a consistent job.”

“Finally, I got a temporary job through the ACE program. The job lasted seven months. When I returned to the shelter, everything seemed to change for me. I came back with more money, made different friends and some bad choices. It was as if I went back to my teenage years - I rebelled against the job. I started doing heavy drugs (cocaine) and this went on for about 18 months. I had
steady employment in the construction business, using the daily cash supply to pick up alcohol, cocaine and tobacco. Every day was the same routine. I continued to live at the shelter. Finally, an old friend from the past introduced me to a family that seemed to care about me. With their support and the support of the shelter’s counseling staff I was able to leave the shelter and get addiction treatment.”

“Until May 2002, I was sharing accommodations with that family. I lived in a basement suite and paid rent from my SFI. I was there for 8 months. Before that I had been in a drug rehab program for 30 days. This family was instrumental in getting me to go to treatment. I had a 2-year history of cocaine by then. I got rent money from welfare for a month after treatment, then started to work in construction again. I got along well with the family and enjoyed the contact with their two children (ages 4 and 5). I stayed clean during this time, attending Cocaine Anonymous meetings.”

“Then, in May, my check from work bounced. I couldn’t pay the rent and I decided to leave. I could have stayed longer, but didn’t feel it was right to remain in their house without paying the rent money. I couldn’t freeload. I still stay in touch with them. I came to the shelter and met up with my old acquaintances, started partying and eventually started using again.”

“Now, I get odd jobs through the casual labor office to pay for the cocaine. I started feeling restricted at the shelter. I prefer to sleep outside in a tent. I have all my sleeping gear upstairs and set up my tent in a place I know I’ll be safe. Usually I come to a shelter for one night to take a shower and clean up. I usually stay for 2 weeks in one camping place and then move. It’s more peaceful, better to get fresh air. I don’t miss the shelter, and I don’t want to be down there no more. I know what to expect down here, it’s the same cycle, the same routine. Unless you’re ready to change, you’re always going to come back. Now it’s my second time down here. I’m sick of it, I’m wasting my education.”

“Since I’ve been using, my parents to this day still don’t realize that I have a problem. There’s been times that I’ve called them planning to tell them and I can’t. I freeze when I hear how happy they are. They know I’ve been staying at the shelter, though. I imagine there might have been some help that I could have gotten from people in Calgary, but I didn’t look into it. Maybe a little help from social services or human resources, but I didn’t want to go there. I was going to go into Fresh Start at AADAC a few weeks ago, but just before I went in I had an employment opportunity. I took the employment offer instead. As long as I still want to use, I won’t want help. All I would have to do is go talk to shelter staff to get into treatment. Instead, I’m taking an employment offer in Edmonton (leaving tonight). The guy in Edmonton offered me a job with a clean crew (mandatory drug tests). When I was working with him before I did road trips and wasn’t interested in drugs.”

Matthew

This 36-year-old man still suffers from unresolved grief about the loss of his mother when he was 13. In many respects, his development seems to have been arrested at that point and he has probably always been functioning with significant depression. He has used drugs on and off to cope with this, but is currently abstaining.

“Family life was good until I turned 13. I lived with my mom and dad, and younger brother in Calgary. When I was 9 years old, my mom was diagnosed with breast cancer and she died when I was 13. After my mom died, my dad wasn’t the same. He never showed feelings and always had a smile on his face. He started hiding feelings, and that’s what I did for a number of years. I didn’t have a real conversation with my dad until the Christmas of 1999 - it was always superficial. When my mom died, my dad started working a lot. I had the responsibility of taking care of my little brother, organizing the house and going to school. I skipped out of school a lot and my brother didn’t really spend much time at home either. We all used to be all happy before my mom died, sharing stuff and then that all stopped. I basically became withdrawn, had some friends but couldn’t talk to them. Everyone was coming to me with their problems instead. A quiet house. I finished high school though.”
“Most of the times, it [cause of problems with housing] seems to be the wrong roommate, or a good friend you can associate with, but don’t have him as a roommate. It started in 1986, at age 20. I was living at home with my dad at the time and he decided to get remarried. I didn’t get along with his new wife and decided to leave. I took all my money out of the bank and hooked up with a friend. We stayed in a hotel room for the first 2 weeks and then lived on the streets for 5 months. My friend taught me the ropes of living on the streets, sleeping in stairwells, newspaper bins, etc. My friend decided to move to Edmonton and so I booked myself into Booth Centre. I stayed at Booth Centre for 2 months and was then able to convince my dad to help me out for a bit. I was able to get a room and board place at that point. That started a cycle of moving in and out of either room and board or apartment situations, and back out onto the street. It all depended on who I was hanging out with. I was usually able to find some work, save some money, get a place, start using drugs again and then either get kicked out or not be able to make rent. I must have gone back to the Booth Center at least 4 or 5 times over 5 years. If the weather was nice, I would sleep outside.”

“I was finally able to find a stable job and I worked at it job for over a year, eventually moving in with a friend again. After a year, I rented the top floor of a house. I saw the ad for it in paper. For the first three months, I lived alone and then a good friend moved in for approximately 3 ½ years. Near the end, I started to have to cover the rent and bills for him. Then the rent went up and I wasn’t able to afford the place anymore. We moved out of the house and into another place that was a little bit cheaper. My roommate had just gotten a job, but three months later he just left. I couldn’t afford rent alone, so I moved in with some friends. I changed jobs and worked at a new job for a year before being laid off. I stayed at another friend’s place, living off EI and occasional jobs for 7 months. I eventually had to move out due to my roommates. I moved into Booth Centre, where I stayed for 6 months until my recent job.”

“I was trying to find solid work but I would usually work for one week and be let go with comments that I was too self-conscious and slow. I finally found a job cooking at nights and managed to save up enough money by working for 3 months. I got most of a damage deposit and first month’s rent. Next paycheck I was able to pay the rest. For the first little while, I didn’t have any furniture, so the caretaker gave me a few things. I worked for two months and then started to work at [retail store]. The weird shifts there, (starting at 4:00 a.m) made it difficult to coordinate transportation. I worked for one month and then had to quit. I had to access welfare benefits. Between roommates and the welfare cheque, I was able to cover the rent. When I wasn’t working I stayed at home and kept to myself. I tried my best to avoid drugs.”

“Roommates have always been a problem for me. Once I realized I needed roommates, problems with my housing became more obvious. The first roommate I found was problematic because of his drinking. He lasted three months and then decided to move out. Then a friend moved in with me, and he was involved in drinking and drugs. I was trying to quit the drugs. This arrangement lasted two months and then he moved. The last roommate lasted for one month. Things were going well until he made the mistake of drinking and he had a fight with the guy upstairs. I was blamed for the fight and we were both kicked out. There were no warnings before eviction - it was an illegal suite. Police were called out and the person upstairs involved in the fight had a black eye. My roommate was charged and the next day the landlady gave me until the weekend to clear out. Since I had nowhere to put my stuff or move to, I picked up what I could carry and moved out to the shelter again. I tried to get into the Booth, but I owed money from a previous stay and had to repay it before accessing their services.”

“The cost of housing has gone up and is a lot higher than the wages offered nowadays. I can’t afford a place that costs $600, and still get food, transportation and bills. You’re looking at approximately $1800 to start up. If there were more jobs that paid better, it would be easier to afford things. That’s why people can’t afford things. At least 50% of people don’t like living with roommates, because they’re unpredictable. I had one roommate who was a crack addict. I came home and the TV and stereo were gone. I’d like to find a decent job that pays decent so that I could do without roommates. And drugs - I’ve never been in treatment, I do my own treatment, decide to stop by myself. I’ve stopped alcohol for 2 years, pot for 9 months; but I still smoke too much tobacco.”
“If I had seen problems in any situation ahead of time I could have done something. Sometimes I see something before it happens, but it sort of takes time to register. If I’d have the extra boost or confidence to overcome adversity, rather than assume that the worst is going to happen. But it’s like “here we go again” - I have to start over.”

Fred

This 33-year-old aboriginal man was born in a small town near the reservation where he grew up. His mother and father are now separated. They had seven children. He lived with his parents until he was 8, then with his grandmother until he was 12. He then moved back and forth between his mother and his grandmother (different towns in Manitoba) until his grandmother died. He left school in grade 11 to marry his girlfriend, who was pregnant - they moved together into a rooming house and then an apartment. For a time, he worked for a graphics company as a shipper-receiver. In 1989 he and his common-law wife moved in with his older sister’s family to share rent. Then his second child was born and they moved to a house while his wife attended school and he worked full time at a community centre. However, both he and his wife were drinking heavily and they moved many times as a result of trouble with alcohol-related disputes. The couple broke up in 1992 and he stayed in Winnipeg with a male friend, living in a duplex and working as a roofer. In 1994 he moved to Vancouver to live with another sister and worked in the fisheries until he was laid off.

At this point he got some help through an aboriginal student loan plan and attended school, which he did not complete, again due to alcohol problems. He stayed in Vancouver for a while, washing windows, but again lost his job and had to go to temp jobs. He then left with friends to go on a visit to northern Alberta and then to Edmonton. While in Edmonton, he met a new girlfriend and moved into her house, paying the utilities as his share. They had a son together, but the relationship broke up in 2001 due to alcoholism. He came to Calgary in October 2001 to get away from his ex-partner, and has been on the street since then. He has worked at several jobs in this period, each time losing them due to drinking, or “just walking away.” He states that he is a binge drinker who has not been able to stop. He was on welfare briefly in December last year, but was cut off when he could not provide a job confirmation. He has been in various alcohol treatment facilities, without success.

He attended the interview with a new girlfriend, and feels that he will have to get straight now that they are together, because she needs someone to look after her - she is also currently homeless.

Low resilience, probable chronic homelessness:
Individuals and families in this grouping have long histories of childhood trauma, interrupted education, social isolation and, frequently, continuing mental health and addiction problems. Their past patterns show repeated episodes of homelessness, and the future seems unlikely to provide a change in this pattern without systematic, carefully focused, and outreach-oriented interventions. They lack the capacity to make an organized plan for moving out of homelessness, are repeatedly victimized due to poor interpersonal judgment, and have few or no aspirations for the future.

Janet

Janet has recently left an extremely abusive relationship. She lost custody of four children permanently several years ago. She is struggling with alcoholism while trying to get off the street.

“I lived in Ontario from when I was born until I was 21. My father was an alcoholic, and I was in and out of foster homes my whole life. I got married young, but my husband was abusive and I was really beaten down by the end of it. He was a heavy drinker and I had started drinking too. He was getting more and more controlling and jealous and was always around. We would be in a place for a month or two and he would stop paying the rent and we would be kicked out. I finally had enough and decided to move out. I had nowhere to go and started drinking again.”
“I had been homeless off and on in Calgary for about 6 years while we were married and now again. Probably I’ve been homeless about 10 times. I had 5 children, but one is dead, and the other four are in custody. My ex and I used to go to Inn From the Cold, sometimes for 6 months or more.”

“I have been using the [shelters] as much as I can for the past 3 months. Right now I am looking for full time work. Saving in Calgary is really tough - it’s very expensive. I am looking for a waitress job or another job in fast food, but it’s hard when you don’t have a steady phone that people can call. I am looking for a place with my boyfriend, but I have to get a job first. Calgary needs more low-income housing and transitional housing. There are places for couples with children, but not for couples alone. It makes it hard to stay together on the street.”

Ed

This 45-year-old man clearly has a history of serious mental illness, but is not currently receiving treatment. He is one of the transient mentally ill who tend to drift from place to place in response to the demands of delusions, the restlessness that often typifies their illness, or in search of some sort of peace. His childhood environment was chaotic, but he was able to pull himself through with the help of some supportive figures in his life - mostly associated with his sports activities. However, he appears to have had prodromal symptoms in high school and a full first psychotic break sometime during his first year of university. He had subsequent episodes, but did marry twice and has two children with whom he is not in contact. Over the last several years, he has been in the habit of wandering across the country and back, staying in shelters and picking up casual work when necessary. His account was rambling and sometimes tangential, but the overall history is fairly clear.

“I lived in Halifax with my family - Mom and Dad and four brothers - until grade 4. My father worked for a transport company and then was transferred to Ontario. Our family broke up when I was in grade 9 and me and my younger brother went into foster care. I don’t really understand why. Life was pretty chaotic in the years leading up to my parents’ divorce. My mom was pretty impulsive and we did move around a lot during that time. My dad was unemployed and, at the end, we started living in motels and even with my eldest brother at one point. I remember missing school at times just because my parents decided to go visit someone or some place. I was in trouble with the law in junior high school for shoplifting and went to court. I failed grade 9. I started playing basketball after failing a grade, and that helped me focus. I improved my marks in grade 12 to get a student loan for university. I succeeded and entered university, but didn’t last one year— it was too hard.”

“I had been living in an apartment in BC when I was admitted to hospital. I was picking cigarette butts in the lobby of the hospital (as I often did in the past) but must admit that I was talking strange - crazy. They admitted me to the hospital for 2 months and then transferred me to a psychiatric hospital. I don’t know why I was admitted or what they were treating me for. They started off with an injection and then I had to take pills. They discharged me to a group home. I received follow-up treatment and support in this place but I didn’t like it there. They gave me a bus pass for a year and $20 for spending each week. One day I started playing the sports lottery and won $52. I tried again the next day on a “crossword” lottery and won $28. I decided to use the money to get a bus ticket and come to Calgary. I came in January without warning anyone in advance.”

“I had intended to go [to a shelter] because that’s where I had stayed when I was here in the past. I arrived in town too early in the day to get in, so I went to [alternate shelter]. I stayed from January until one week ago. I decided to go to the Booth so that I can claim a residence for welfare benefits.”

“When I was in BC they didn’t think I was normal. When you get living in a place too long you eventually get uncomfortable. I used to get messages from television. That’s why I was dying in BC, really hot. One guy who used to sit with me at the shelter got a job. He helped me move to 4th floor. I’ve basically had to do it on my own. AISH wants a copy of my divorce papers, and I haven’t figured out how to get those documents. Canada Disability says I can’t apply because I didn’t contribute for a number of years. There may be a way around the application process but they may want a medical
report if they process my case. I currently have no ID. If I move to a better place, I'll miss coming in here [shelter], greatest place I've been in a long time. Never played so many games of cribbage.”

The interviewer’s comments were: Given the recent history, disorganized thought processes and vague history, appears to have a history of treatment for mental illness (probably schizophrenia). Insight and judgment are lacking. Queried follow-up with mental health resources both in BC and Alberta, but he denied any need.

Anne

This young woman, age 18, was very unkempt. She had been homeless on and off since age 12. Her mother was a drug addict and she showed some evidence of FAS. She and her sister were in and out of foster homes until she ran away at age 12. She reconnected with her biological sister at 16. She is now trying to get home to her sister in Toronto. She claims that she has kicked her crack-cocaine / heroin addiction, but is still drinking and using marijuana heavily. She has been in Calgary six weeks and has made limited use of the shelters, preferring to sleep rough.

“I am staying on the street, wherever it is warm. I usually sleep outside, under a bridge or underneath the Centre of Hope. One year ago I lived with my sister in Toronto, recovering from crack-cocaine and heroin addictions. I was there for two years. For the whole two years I was trying to get cleaned up. Sometimes I panhandled in the day and then come home and give my sister the money I made. This money would go towards rent and groceries. At the time I was just learning how to live again. My sister was recovering at the same time from alcohol addiction but was working. It was her idea that I come and live with her to begin recovering. My sister’s rules were very strict and I was better. I could survive on my own with the skills I had though. I left on good terms with my sister. She wants me to come back.”

She hitchhiked with her boyfriend here from Toronto, but they broke up on the way. Her boyfriend and she were planning to get a place together when they got here. He stole a stereo from one of the people they got a ride from, and she broke up with him as a result. She traveled on her own from Manitoba to Calgary. She thinks she will be able to make it on her own here and has already saved $130 dollars, probably from prostitution. She has been homeless on and off for six years, including the three years prior to living with her sister. She spent a year and a half living on the streets in the Bronx, New York. She developed a crack-cocaine /heroin addiction at that time, and had her jaw broken. She has no presentable clothes for an interview as they were stolen. Her hygiene and general physical condition was extremely poor. It has been difficult for her to be presentable, but at the time of the interview she had been working at the Stampede cleaning up after the grandstand show.

She has limited work experience, as she has been on the streets since she was 12. She has only worked a few months at each of the many jobs she has had. She thinks it will cost her $170 to get back to Toronto, and she needs another $50 for expenses. She plans to be gone as soon as she gets the money together. However, it appeared to the interviewer that she was using drugs again and probably would not be able to act on her current plan anytime soon.

Steve

There is no family history for this participant as he is unable to provide a coherent account. Although the respondent was appropriate upon first being approached for the interview, and easily engaged in conversation, this calm and reasonably coherent presentation changed as the interview process continued. Answers became more tangential and his history was difficult to piece together. Some of this presentation seemed to be intentional evasion, as the respondent was clearly aware of his surroundings and was oriented to time (able to recall his last meeting with his psychiatrist last week). He was, however, distracted during the latter part of the meeting and admitted to discontinuing his medication one week ago, which likely also played a role in his presentation. At times, he seemed to be experiencing hallucinations. This mixed presentation made for a difficult interview and
necessitated some corroboration from shelter staff to clarify historical issues—particularly as they related to his interactions with the shelter. This was done once the interview was complete. The information gained from shelter staff is included to substantiate the respondent’s account.

“I ran away from home at the age of 17, moving to Vancouver. I stayed at the Salvation Army for one night, moved to a halfway house at the YMCA for 2 weeks and finally a boarding house for 6 months. I worked for a while at CPR. I returned to Calgary at 18.”

(Respondent’s history became very vague, almost tangential at this point, as he seemed to resist elaborating on his history—it was clear that he has cycled in and out of hospital over the course of his life—possibly as many as 21 times – with a lengthy admission to AHP during the 80s—possibly for as long as 12 years. This admission appears related to a criminal charge involving a bank robbery. (Confirmed by shelter staff). He stated that he has been in and out of hospital, typically discharged to live on the streets, throughout his adult life. Shelter staff reported a pattern of numerous stays at the shelter, punctuated by either admissions to hospital or bans from the shelter related to incidents of indecent sexual exposure or smoking in the bathrooms. The respondent claimed that he had lived at the York Hotel for as many as 9 years in the 90’s. Shelter staff confirmed that the respondent lived at the York but could not confirm the length of stay, except to say that he likely also lived with his father during this time. The respondent admitted to a history of legal involvement, which was confirmed by staff, and was mostly on indecent exposure charges. The respondent has also lived with his sister at different times, ultimately having to return to the shelter when the situation becomes untenable. The respondent has stayed at various shelters and sleeps rough at other times. Most recently, about a year ago:

“I was admitted to the Peter Lougheed Center. I was discharged to [sheltered living environment] where I lived with a couple of other people. Staff provided daily supports around meal preparation and activities of daily living. They provided me with a supply of tobacco. My sister manages my money (trustee). I got along with both of my roommates, except for one occasion where I got into a physical altercation with one of the men. My sister brought me to see my psychiatrist on a monthly basis and the staff made sure that I took my medication on a daily basis. One day I came home and my mattresses were outside. All my belongings were taken out of the house so I came back to the shelter.” (Shelter staff report that the respondent was being inappropriate with housing staff around exposing himself and, due to this problematic behaviour, was asked to leave).

Although the respondent has been banned from the shelter on a number of occasions, they inevitably take him back. Their relatively successful strategy has been to control his cigarette intake by keeping his cigarettes at the front desk, forcing him to come and ask for them one at a time. He has been placed in a dorm, limiting his access to female residents at night. This allows staff to maintain the respondent when he is well psychiatrically. The remaining issue is treatment compliance. When treated, the respondent is calm and cooperative. It typically takes 2-3 months off his medication to see increased activity, irritability and disorganization.

He believes he is homeless now because of “no money, don’t have a job”. Probably his history of non-compliance with treatment and poor coping skills are the principal factors. He claims that what he needs is “Three meals a day and bed at night time, and a coke once and a while.” He recently discontinued treatment with his psychiatrist, on the understanding that, if he continues to refuse treatment, his AISH will be discontinued.

Susan

This participant is a nearly forty-year-old woman who has been involved in the sex trade for many years. She was born in Regina and lived there 26 years before moving to Calgary. She has been in Calgary for 14 years. She originally moved to Calgary with her ex-husband. She grew up in a chaotic family with an alcoholic mother, and frequent physical violence between her parents. She has three younger brothers. She moved out of home to her own place when she was 13 and was back briefly only
twice after that. She supported herself with a part-time job at a racetrack, supplementing her income via prostitution. She has continued to be involved off and on in the sex trade, occasionally still taking clients when she needs to make some quick money.

Most recently, she was working as a masseuse until February 2001, but did not have the money to renew her massage license. She is very frustrated about this, as she was making up to $4000 a month, and “everything has gone downhill since I let my license expire.” It would now cost her $1200 and an additional 100 hours of training to renew her license. She had been renting a home for seven and a half years until they were evicted last summer. The household included herself, her two children, her boyfriend, and a roommate. She paid $850 a month for this house, and feels that she “brought up my children, several ex-boyfriends and a few dogs in that house.” There was “a lot of wear and tear on the place” when they left. She had turned the basement into a jam room for the band she and her boyfriend belong to, and is now being sued for damages to the house. They were evicted by the landlord for not paying the rent. She was often late with the rent in the last two years, as she spent her time jamming with her band and not working. She also has a bad VLT habit and feels that too much of her money goes to this.

She and her common-law partner have now been homeless intermittently since last August. They lived in a U-Haul for almost a month while she was trying to finish a vocational training program. They had rented the U-Haul for three days and had enough money together for a damage deposit on another house, but they couldn’t find anything and this stretched into three weeks living out of the U-Haul. She is now being charged for theft of the U-Haul. During this month they lived on the money they were going to use to get another place. They did finally find a place in September 2001 and were there until April 2002. They were evicted by a sheriff for non-payment of rent and lost most of their belongings, which they had to abandon on the front lawn. They have been homeless since and have been couch surfing with other band members.

Susan has a 13 year-old daughter by her ex-husband, and her 16 year-old son recently moved out of her ex-husband’s home and is living with his girlfriend. She is worried about him, however, because he recently had his jaw broken and wired shut due to a fight. She is having a hard time getting him the liquid foods that he needs.

Currently, she has a room with her boyfriend at their band’s lead singer’s house. They have been there two weeks and still owe her friend half a month’s rent. Prior to this they were staying with another friend on their couch for two weeks. They are currently using the food bank a lot.

She believes that her number one problem is herself - she has taken things for granted and made some poor choices. She has also lost a lot of money due to gambling. Her money went to pot, alcohol, and methamphetamine, all of which she still uses “a little bit.” She also had a cocaine addiction but had been off it for five years until a relapse on crack-cocaine and alcohol last year, just prior to losing their house. She is off most drugs again now, but still uses meth as it “helps with the music.” She feels she needs to get a house before she can deal with her addictions. She has been on SFI since November 2001. They are using the food bank and she is using some of the casual labour places. She is still seeing the odd old client here and there to make ends meet, but thinks she may need to pick up more clients to make rent at their band mate’s house.

She believes that the system “doesn’t look at the individual enough. They need to understand that many people on the street have come from bad backgrounds. The current system shuffles people from the left hand to the right hand.” She is still trying to figure out where to go to get help. She has Metis status, but does not want to fall back on it. She is concerned for her son’s health and about getting him the food he needs. She also wants to get her family back together. She feels that people have gone out on a limb for them in the past, and is starting to think about this more as she is going to be 40.
Discussion

Although the following discussion focuses on results from the quantitative analysis, the qualitative analysis tended to support these findings and add depth to them.

AH

From the evidence gathered in the 2002 study, it appears that the homeless population may have changed considerably since 1997. AH males are older, while AH females are younger than in 1997. Both groups have less education than in 1997 and are less likely to be significantly connected to marital partners. When compared directly against 1997 results (i.e. calculating percentages based on the total number of responses) lack of work is less likely to be identified as the primary reason that respondents provide for their current situation. Instead, health problems top the list for AH males and females, followed by the cost of rent and family problems. However, when asked what actually caused them to be homeless on this occasion, having insufficient funds for rent was key for all groups. AH males indicated that the immediate cause for their homelessness was lack of work/lost job and insufficient funds for rent. AH females indicated domestic difficulties and insufficient funds for rent. Youth have additional reasons for being homeless, which are not shared by the older AH cohort.

The evidence also shows that both the frequency and duration of homelessness has increased since 1997. The number of people who have experienced homelessness more than once has increased considerably. In 1997 only 15% of respondents had been homeless for more than 1 year and only 5% had been homeless for more than 5 years. The latter were considered to be chronically homeless by the 1997 team. In 2002, 26% of male AH respondents indicated that it had been more than a year since they had their last home and 10% indicated that it had been more than 5 years. Female AH respondents indicated that 23% had not had a home for more than one year but less than 5 years and 6.3% had not had a home for more than 5 years. In order to more accurately compare 2002 and 1997 results, the male and female groups must be combined, resulting in a 9% increase in the number of people who have not had a home for more than one year but less than 5, and a 3% increase in the number of people who have not had a home for more than 5 years.

27% (N=65) of AH individuals in the 2002 study had spent at least 15 years in the city. 16% of were born here. Although it is not entirely clear from the data available from the 1997 report, it appears that this is a 6% increase over 1997. Virtually all other individuals who were AH in the 2002 study, and were not from Calgary, were from other parts of Alberta or had arrived in Calgary from other Canadian provinces. Only 2 individuals out of 309 were from outside of Canada, a drop of 7% from 1997. 61.6% of respondents reported that they had been in Calgary for more than one year. Age was a significant factor in duration of stay in Calgary, with younger people accounting for a disproportionately large number of those who have been in the city a shorter period of time, and seniors accounting for a disproportionately large number of those who have been in the city for 15 years or more.

When AH males migrate to Calgary, they usually do so for economic reasons, including hoping to find work, but they are also likely to be seeking a better life than the one they left behind. AH women are equally likely to arrive for economic and family reasons although they, too, are seeking a better life.

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9 The classification of “moved to Calgary” in the 1997 report is not clear. Respondents were asked “Have you lived in Calgary all of your life?” If they had not been born in Calgary, they were asked to provide the length of time that they had resided in Calgary in weeks/months/years. What is not clear from the available data is how the responses were subsequently classified. The results were not reported as the number of people born in Calgary. Therefore, when the 1997 study states that 21% had not moved to Calgary, it cannot necessarily be assumed that this means 21% were born in the city (although this may be the case). For instance, a decision may have been made in the analysis to include all those people who had lived in Calgary for more than 75% of their lives, or who had moved here as children, in the category of people who had not moved here, since migration issues would be unlikely to be a critical part of the reasons they were homeless. However, the most important point to take away from this discussion is that the majority of AH respondents in 2002 were either long term residents of Calgary (27%) or from other parts of the province (32%).
What they find, however, are high rents - the primary reason provided by AH for not having a permanent home were factors associated with high rents (i.e. being unable to afford the damage deposits or the rents or not having sufficient funds to take the steps necessary to obtain and keep a job). Damage deposits/start up costs were reported 10.3% more often than in 1997. Rental rates were reported 7.1% more often as the primary barriers to having a permanent home than they were in 1997. This is despite the fact that 5.2% more AH individuals are working in some capacity. On average, employed AH people earn $1,377.27 per month for full time work, $786.79 per month for part time and $395.62 for occasional work. Individuals who are not employed, including those who do not work because they are disabled, report average monthly incomes of $648.88 while their unemployed RH counterparts report $762.40.

It is important to note that both the AH and the RH groups reported considerably higher levels of motivation to find work than the 1997 sample did. The primary barriers to employment for the AH group were health problems, not having a fixed address to put on application forms, and not having access to a telephone.

There are some positive differences between the experiences of the 1997 and 2002 cohorts. For instance, the number of people who report that they have gone without food for more than 1 day has dropped by 9.9% since 1997. Similarly, there has been an 8.7% drop in the number of people who report that they have slept outside at least once during their current episode of homelessness. However, a number of survival strategies that were not examined by the 1997 study proved to be important factors for AH and RH people, including dealing drugs or doing drug related favours, and using food banks. The number of people who report that they do not have an Alberta Healthcare Card has dropped by 5.2% since 1997, although cost continues to be an important reason for people not having health cards.

Approximately half of the AH group were experiencing mild to severe mental health problems, moderate general health and moderate levels of disability as measured by the Wisconsin Quality of Life and WHODAS II. 48.3% of the AH group reported having periods of anxiety or depression at least some of the time during the past month. 30.8% of the AH group had felt like killing themselves during the past month. Problems accessing health care when it was needed jumped from 20% in 1997 to 30.3% in 2002; an increase of 10.3%. Again, lack of money is one of the primary reasons for not accessing health care. Respondents indicated that they could not afford the transportation to get to care, or the costs of medications or some other aspect of care. The majority of AH people have current untreated dental problems, and almost half of the AH sample have a current substance abuse problem.

RH

RH individuals are older than their AH counterparts. The reasons they gave for their current situation were somewhat different from those given by the AH group, in that the male RH respondents indicate lack of supported housing closely followed by high rents as accounting for their current situation. RH females indicate that high rents are the problem. When asked what the immediate cause of their homelessness was, both RH females and RH males indicated that lack of social service benefits and insufficient funds for rent were key.

Evidence from the RH group shows that they have experienced housing problems just as often as their AH counterparts (5.5 times for AH, 5.7 times for RH). The RH group has considerably longer tenure in Calgary than the AH group, with 74.7% having been in the city for more than one year. When RH individuals migrate to Calgary, their reasons for doing so differ considerably between the male and female groups. While both are drawn primarily due to family and friends moving here or already living in the city, males are also drawn for economic reasons, which females did not mention. Both groups are seeking a better life. Like their AH counterparts, what they find when they arrive are unexpectedly high rents. The primary reasons provided by RH for not having a permanent home were factors associated with high rents (i.e. being unable to afford the damage deposits or rents, or not having sufficient funds to take the steps necessary to obtain and keep a job).
Fewer RH people work when compared with their AH counterparts, although this is likely due to the fact that many of the RH group were youth, seniors and women fleeing violence (most often with children). Each of these groups faces considerable barriers to employment, even without housing difficulties to contend with. The RH group also earns less than the AH, reporting $1,150.00 per month for full time work, $790.00 for part time and $355.56 for occasional. Although 66% of RH indicated they would like to find employment, they experienced barriers due to their age and education.

The majority of RH are experiencing negative mental health overall, moderately good general health and a lower level of disability than the AH group. The majority of RH individuals reported that they had some periods of anxiety and/or depression over the past month. A significant minority, 26.7% had felt like killing themselves in the past month. A significant number of both the AH and RH groups did not know where to go for mental health care services.

Although RH individuals do not experience problems accessing health care as much as the AH group, they still reported a 25.4% rate of access issues. This is a 5.4% increase over the rate reported in the 1997 report for AH. Dental problems are a concern for 45.1% of the RH group, and 31% have a current substance abuse problem. These are both lower than the rates for the AH group.

It is possible that the changes noted above are due to the differences in sampling methodology utilized by the two studies. The 1997 study worked with a smaller number of agencies, primarily serving the singles population. The 2002 study worked with a large variety of agencies working with all of the different sectors. In addition, 35.6% (110) of the 2002 surveys were administered on the street in locations such as bottle depots, Olympic plaza, and areas known to be frequented by sex trade workers.

It is likely that the 2002 survey provides a more accurate picture of the experience of AH and RH across the sectors. Therefore, the research team feels confident in stating that, with the exception of the reduction in the percentage of AH people who go for long periods of time without food or who are forced to sleep outside, the situation for AH and RH people in Calgary has grown more grave since 1997. More of the AH work, but they are less likely to be able to afford damage deposits, rent, or health and dental care. The gap in education levels between individuals who are homeless and those who are not is continuing to grow. While it is clear that AH and RH people in Calgary can survive, in that they can find overnight accommodation and food, it is also clear that an organized system to move AH and RH people out of poverty and homelessness in a sustainable way has yet to be developed.
Recommendations

Recommendations to Reduce Homelessness

Local Initiatives:

1. **Offer a “One-Stop” Approach to Accessing Services:**
   Although individual services are often excellent, there is no systematic process in place to offer a “one-stop” approach to accessing them. AH and RH individuals must focus much of their attention on daily survival needs. The evidence shows that they also have significant barriers to accessing services for mental and physical health conditions, and insufficient funds for public transportation to get to service locations. Furthermore, a large proportion of the AH and RH population has low resilience characteristics associated with developmental trauma, loss of developmental assets, mental health problems and addictions. Most services for the homeless cannot realistically be based on an office-practice model that requires them to find their way through the system and its many barriers unaided.

2. **Develop Community Outreach Teams for connecting homeless persons to services:**
   The goal of these teams should be to coordinate currently available services and advocate for RH and AH individuals to obtain equitable access to appropriate programs. This mandate includes actively working in an ombudsperson role where necessary when homeless people experience difficulties with services (for example, if they have been barred for life, or have an interpersonal problem with a specific staff person). By actively assisting AH and RH people to engage available services, these teams will be well placed to help people permanently out of poverty and homelessness.

   The teams should be community based, inter-disciplinary and inter-agency, and modeled on an assertive outreach approach. The teams should be prepared to take responsibility for pulling elements of the system together to support their clients, and be willing to work primarily in the community, rather than in office-based practice. It would be logical to provide space in the same area as the “one-stop” services recommended above.

   These teams should address many of the barriers that AH and RH people experience, including: problems obtaining Alberta Healthcare Cards or SFI; replacing lost identification; accessing healthcare; finding housing that will accept SFI; and mediating landlord and roommate disputes. For these teams to be successful, they must be staffed with people knowledgeable about what services are available in the community and from government sources, and strongly linked to relevant agencies such as the Calgary Housing Company, police services and mental health services. Resources currently exist in Calgary to help train such teams. It is possible that existing agencies could initially collaborate to form demonstration teams, using existing staff positions where possible and requesting funding for additional staff as necessary.

3. **Establish Administrative/legal advocacy groups to serve AH and RH people.**
   a) 19% of AH individuals do not have an Alberta Healthcare card because they do not know how to obtain one. Substantial numbers of people have lost their identification and are unable to replace it. Individuals often speak of problems with landlords and roommates that are legal in nature (i.e. being locked out of an apartment that they paid for in full or in part, by a roommate or landlord; having items stolen by roommates or landlords; being evicted for no apparent reason, with no notice and so on). Individuals also often speak of legal issues with employers, such as not getting paid, not having their WCB claim processed, or being removed from long term insurance disability benefits without justification.
   b) This group could potentially work with the CHF, appropriate community partners and the legal community to find creative ways to address the issue of garnisheed wages as an
employment disincentive. For example, perhaps funds could be established to allow a phased in approach to paying childcare or other related supports so that, as stable earnings go up, garnishees phase in. In any event, wages should not be garnisheed until the individual in question is earning above the poverty line.

Often nothing is done about these issues because the respondents either do not know how to solve the problem or are unable to attend to it because survival issues take priority. However, the problems continue to face them as they attempt to make better lives for themselves. A centrally located legal advocacy office is needed to assist with these problems (perhaps with the “one-stop” service recommended above).

4. Increase the transparency and accountability of the Calgary Housing Company (CHC).

The Calgary Housing Company has the very difficult task of allocating a limited supply of social housing in a context where demand far exceeds supply. The waiting list is long, and tenant length of stay extends as the shortage of other affordable housing options worsens. As of September 30, 2002, the CHC’s current waiting list stood at 2000. However, this already difficult situation is also exacerbated by that fact that CHC’s current processes and practices mystify and frustrate many of the homeless individuals the research team interviewed. Stories abound of lost files, individuals who are told they are getting housing, only to be told that they aren’t and vice versa, waiting lists that are years long while apartments and townhouses sit empty. In the absence of information to refute these views, some individuals do not apply. They assume that the stories are true, and that there is therefore no point in applying. This belief may account, in part, for the very low level of access by the AH sample to units managed by the Calgary Housing Company. It is therefore recommended that the Calgary Housing Company arrange for an external evaluation of its processes, information flow, and outcomes, with particular emphasis on outcomes for the persons served. It is further recommended that the evaluation findings be used to improve services and outcomes and to inform a campaign that would begin to rebuild a positive relationship with the community.

It should be pointed out that the recommendation for an external evaluation is not a reflection on the ability of Calgary Housing Company staff to improve their own programs. Rather, it is an acknowledgement that Program Evaluation is a specialized discipline that most organizations do not need on a full time basis. Consequently, most evaluators are external to the organization. The goals of an evaluation may be formative (to assist a program as it develops) or summative (to make a statement of value on the objective outcomes achieved by the program) or both. It would also be particularly useful for Calgary Housing Company to undertake an external evaluation at this point in time because such a venture would provide objective evidence of the effectiveness of the organization in achieving it’s goals. In addition, it can provide evidence of the areas that need to be improved (such as, for instance, the need to increase housing stock in order to meet it’s goals) to assist the organization as it continues to improve its services. Finally, an external evaluation process adds credibility that helps to ensure the results will be well received by the various stakeholder groups such as the persons served, funders and other community service providers.

5. Provide monthly transit passes to AH and RH people.

At a minimum, passes should be provided to people who are actively seeking employment. However, this might be further expanded to all AH and RH individuals so they can access other services such as health care.

a) People need dependable access to transportation if they are to find and maintain jobs and housing and access health care and other necessary services.

b) Currently, people may obtain a single bus ticket if they know where to find them and arrive early enough to obtain the few that are available. If the tickets run out that day, the person may be unable to get to work and, in any event, will almost certainly be late if they do manage to obtain other transportation. Attempting to work in such uncertainty exacerbates the problem if an individual is already hard to employ.
c) Individuals attempting to use the public transit system but unable to pay for a ticket may be fined significant amounts which they have no way to pay other than serving days in jail.

d) It is important to the dignity of homeless individuals that they not be easily identified. Consequently, monthly bus passes should not be different from those used by other transit system rider groups such as students. In this way, the passes will be distinguishable by the transit authority but not by others (such as potential employers).

e) Passes should be provided at the discretion of the front line service agencies, who know their clientele better than any other organization(s) in the city can.

6. Increase short and long-term transitional housing for all sectors.
   a) Overnight shelters fill an immediate need and are an essential part of Calgary’s response to homelessness. However, they are not intended to provide the stable housing and support services that are necessary to assist individuals who want to find and keep work. Such persons need a permanent address to put on application forms, to receive and make telephone calls, and to use as a base to find and keep employment. Steps have been made in the shelters towards these goals - for example, the access to computers and telephones etc. at the Centre of Hope was frequently mentioned as an invaluable resource. However, these resources are insufficient to maintain stable access to work.
   b) Supported housing for persons with mental illnesses and/or addictions is a high priority need. In the absence of support, these individuals are unlikely to succeed in remaining housed, and will continue to suffer increasing medical and dental problems. Transitional beds in supported living environments are especially necessary for individuals leaving psychiatric facilities. Without these facilities, too often mentally ill individuals who have been stabilized in hospital are returned to street living conditions, where they deteriorate rapidly.
   c) Increased access to transitional housing is needed to assist women fleeing violence and their children. These facilities should incorporate a longer stay policy than is available in most current facilities to allow sufficient time for family stabilization, and re-entry to work or education.

7. Clarify and ease the way in to the mental health system.
   Despite the fact that many of the AH and RH respondents indicated that they had mental health problems, including about 30% who had suicidal ideation, more than 25% do not know how or where to access mental health care. This issue can be addressed at the local level but also provincially.

8. Focus on the Prevention of Homelessness:
   The CHF, community agencies, and funders should develop an approach to funding prevention efforts directed at assisting at-risk individuals, including children, and families to avoid homelessness. A state of the science review on homelessness prevention should be completed to confirm the findings of this report and identify best practices in this area. The results of the current study, and those included in the literature review, suggest that there are clear risk factors that can be identified in early childhood. Systematic primary and secondary prevention programs are likely to provide better outcomes in the long term than crisis oriented interventions can, and should be supported as a long-term strategy aimed at reducing the reproduction of homelessness.

   CHF and the Calgary community have developed a ‘sector based’ approach to serving the homeless population. Although an in-depth examination of the literature on each of the sector areas is beyond the scope of the current report, sectors are encouraged to undertake such a review for their specific areas. This recommendation is based on the assertion by Begin et al (1999) that the underlying problems and potential solutions for homelessness may vary considerably based on characteristics such as gender, age and ethnicity.
10. Carry out additional analysis on the dataset collected in the 2002 study.
Suggested additional analysis include, but are not limited to the following:

a) Examine the data by sector groups on each of the major sections of this report. Carry out statistical analysis, including effect size, between each sector group and the larger group. This analysis will help to better distinguish the characteristics and needs of each group, including points of intersections between groups. Furthermore, it will avoid washing out important characteristics of sub-groups which otherwise go unacknowledged due to larger group trends (i.e., the women fleeing violence group mentioned that they need daycare, but the stratified sample was arranged such that there were insufficient numbers of individuals who fit the WOMEN FLEEING VIOLENCE classification to make this a key recommendation for the overall AH or RH groups).

b) Examine the raw data to understand the supports that are used to care for individuals who would otherwise be cared for by the AH or RH (question E7b).

c) Examine the qualitative responses to question EMS9 (“Can you tell me what things you have tried to get off the street, i.e. to find or keep a home”)

d) Examine the qualitative responses to question EMSS3 (Youth Only) (“What does your perfect place look and feel like”)

Systemic Changes:

11. Address systemic issues which sustain homelessness:
In order to be successful, the system must address ways to:

a) obtain a living wage for employees and for those who are unable to work;

b) remove barriers to re-entering education;

c) greatly increase the supply of supported, transitional housing for all sectors; and

d) provide advocacy services for individuals in the AH and RH populations.

12. Lobby to raise the minimum wage in Alberta:
The collective efforts of the Calgary Homeless Foundation and its agency, funders and political partners should be vigorously dedicated to raising the minimum wage in Alberta in order to assist people out of poverty. Those who work for minimum wage and have no other source of financial support (e.g., family contributions) cannot hope to remain stably housed, or, if they are already homeless, earn sufficient money to establish savings that would allow them to move back into the housing market. In effect, the combination of low SFI rates, regulations that exclude the homeless from access to SFI, and a low minimum wage rate, both precipitates homelessness and acts as a powerful barrier to movement out of homelessness.

13. Lobby to change the welfare system in Alberta:
The collective efforts of the Calgary Homeless Foundation and its agency, funders and political partners should be vigorously dedicated to changing SFI policy in order to assist people out of poverty. The current level and administration of SFI, for example, perpetuates poverty in at least three ways:

e) Alberta's Supports for Independence allowance (SFI) cannot be obtained by individuals who do not have a permanent address. Although some transitional housing facilities have occasionally been declared “permanent” addresses for some individuals, these exceptions are not consistent. The barrier to be overcome here is the one that prevents a homeless person from obtaining temporary SFI as a step toward finding housing.

f) At its current level, SFI is inadequate to meet the basic essentials of life. The Calgary rental housing market provides few options for the homeless. Given the actual cost of rents in Calgary, it is virtually impossible for an individual or family on SFI to afford housing, let alone have sufficient money remaining to pay for other monthly living costs.
AISH recipients are somewhat better able to afford housing, but are nevertheless kept in poverty due to low AISH payment levels.

g) Without a stable home address, it is very difficult for individuals to seek or maintain employment.

Research on poverty in Canada supports the necessary increases in SFI rates. For example, “a single parent with two children ages 3 and 7 receives $11,852 a year. The same parent earning Alberta’s minimum wage for a 37-hour week would make $15,220 (including GST rebate and government benefits). Both of these incomes are well below any of the urban Low Income Cutoff rates (LICOs) for a three-person household. The lowest LICO for a household of three is $20,790 - the rate for an urban center with a population of 30,000 or under”. (1), p.vi Although Alberta’s SFI rates are supplemented by the provision of health benefits, they remain inadequate to provide the necessities of life.

14. Request a Government Review of Provincial Housing Authorities:
There is a strong need for a review of the mandates, policies and procedures of the Provincial Housing Authorities. This review should consider whether the current mandates, policies and procedures of the Authorities consider and respond to the issues of housing our homeless. The information resulting from such a review is also essential to allow community funders and front-line agencies to understand what housing is actually available, how it is allocated, and who is and is not eligible to benefit from it. The accurate communication of this information to the community, including the homeless population, would be of considerable assistance in addressing disparate, contradictory, and mistaken beliefs about the mandates, policies and procedures of the Housing Authorities. It is also needed to support a more positive, collaborative climate between the Authorities and the community agencies and individuals that interact with them.

These are daunting goals that will not be accomplished in the short term. They require long-term vision, service innovation, and community coordination. However, the progress to date in Calgary, particularly in the community’s efforts to enact a shared plan for addressing homelessness, makes it likely that the Calgary collaboration will find ways to succeed in this very difficult task.

Recommendations for further research
In order to make evidence based decisions about preventing homelessness or reducing its duration and impact, service providers, funders and policy makers require good quality research. The study of homelessness is still fairly new and not well understood. However, the empirical evidence base has grown considerably and researchers are suggesting avenues for investigation based on findings so far. The following is a short list of some of the thematic areas for research that emerged out of the current review. As mentioned above, research into homelessness would benefit from a rationalized and cohesive research agenda being established on the basis of a state of the science review.

1. Preventing homelessness is cheaper than dealing with it after the fact. Therefore research should investigate ways to prevent homelessness.
2. Evidence linking program activities with a desired outcome should be carefully considered.(12)
3. Better cost evaluations require better and more data and a more comprehensive set of questions that touch on both micro and macro issues.
4. Increasingly create evidence-based policies founded upon research.
5. Develop benchmarking measures for performance.(83) The collaboration of Calgary service providers and funders should connect with other service organizations from across Canada to learn from each other and establish benchmarks for best practice. For example, the Housing Research unit at CMHC tracks best practices on homelessness in its socio-economic series.(84)
6. Hwang asserts that more research is needed to identify better ways to deliver health care to the homeless population.(9)
7. With regard to the mentally ill, substance abuse and dual diagnosis groups, research should move away from the conception of community integration as a unidimensional concept and instead focus
on the characteristics of supported and independent housing that are associated with positive consumer-level outcomes.(85)

8. The WHO definitions of AH and the RH were quite useful for this study and, based on results, it is believed that AH and RH are not homogenous groups. More research is needed in this area.

9. The model should be further developed to increase utility both for predicting who is at risk of becoming homeless and to address causal links to homelessness.

10. It is likely that individual sectors will be interested in having an analysis done of the data for their particular sector. The aboriginal sector has already approached the research team with such a request. There is considerable benefit in undertaking such an effort, but it is beyond the scope and budget of the current project. The CHF may wish to consider how to best handle these requests when they come. The data belongs to the Calgary Homeless Foundation and has been provided to CHF in the most popular statistical package for this type of research (SPSS version 10.0 for windows).

11. Given the need to build a system to address moving people out of poverty and homelessness rather than focusing simply on immediate survival needs, it would be beneficial to undertake a state of the science review. Such a review would focus on learning what has been successful in other jurisdictions to effectively move people out of homelessness.
References

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52. Davis M, Vlan der Stoepe A. The transition to adulthood for youth who have serious emotional disturbance: developmental transition and young adult outcomes. J Ment Health Adm 1997;24(4):400-427.
# Appendix A:

## Service Delivery Programs by Demographic Group (Sector)

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<td>o YMCA Sheriff King</td>
</tr>
<tr>
<td></td>
<td>o YMCA Safe Haven</td>
</tr>
</tbody>
</table>
It is important to note that this is just a list of the agencies. The research team carried out a significant portion of the surveys via outreach on the street in locations such as Olympic Park, bottle recycling locations and areas frequented by sex workers.
Appendix B:

2002 May 3 Workshop Definitions Exercise

Discussion: Survey Process

Task #1: Definition of Homelessness

Background:¹

The research team is continuing to consider with the appropriate definition of homelessness for this study. The difference between those with shelter and those without seems obvious, at first glance: to be “homeless” is to be without a place in which to live. The issue surrounding this situation is complex, however, and is expressed through a set of definitions. For example, there is clearly more than one answer to the question of who is to be classified as homeless; some writers even maintain that there are almost as many definitions as there are studies on the subject. To reflect the significance of the variations in the definitions, some researchers refer to a “continuum of homelessness”.

At one extreme on this continuum, a “homeless” person is defined solely with reference to the absence of shelter in the technical sense; this is obviously the most restrictive definition. But, although a large sector of the community has adopted this definition, and uses the term “homeless” exclusively to describe people living on the street or in emergency shelters, and although all of the researchers and field workers agree that such people certainly ought to be characterized as homeless, many think that this is too restrictive a definition.

At the other extreme, researchers propose a broad and inclusive definition such as that adopted by the United Nations when it declared the International Year of Shelter for the Homeless. According to this definition, a “homeless” person is not only someone without a domicile who lives on the street or in a shelter, but can equally be someone without access to shelter meeting the basic criteria considered essential for health and human and social development. These criteria would include secure occupancy, protection against bad weather, and personal security, as well as access to sanitary facilities and potable water, education, work, and health services. The right to a home from this perspective is seen as a basic humanitarian principle as recognized in the Universal Declaration of Human Rights.

Some researchers modify the meaning of homelessness according to the goals of the research. However, most researchers in Canada use the UN definition of homelessness. In our survey of agencies and sector chairs for the CHF 2002 Study, most agreed that the definition of the homelessness as defined by the community stakeholder consultation process (see below) did define homelessness. However, a significant number also indicated that the definition was seriously limited by specifying “night-time” residence. Also, there was little consensus about the meaning of “hidden homeless” but a significant number of sectors indicated that the “hidden homeless” made up the majority of the population that they serve...in other words that the “homeless” and “hidden homeless” were essentially the same population from their perspective.

Consider the following definitions and rank them in order of preference (1=top preference, 4=last preference). When doing this, please keep in mind the inclusive nature of the study:

1. to develop an accurate profile of homeless persons (this must specifically include the hidden homeless);
2. to develop an accurate profile of those at risk of becoming homeless;
3. to develop a map of the current system: how people move through it, including barriers and gaps encountered;

The definitions have been placed in order from most restrictive to least. Definition #4 has been added for perspective since (a) it builds upon the UN definition, (b) it represents a more inclusive perspective than the UN definition, which is often held out as being the most inclusive and (c) it was developed by homeless people.

<table>
<thead>
<tr>
<th>#</th>
<th>Quote</th>
<th>Source</th>
<th>Your Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A homeless individual/family is a family/individual who lacks a fixed, regular, and adequate night-time residence or has a primary night-time residence that is a supervised, public or privately operated shelter.</td>
<td>CAC, 2002</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>A homeless individual/family is a family/individual who lacks a fixed, regular, and adequate residence or has a primary residence that is a supervised, public or privately operated shelter.</td>
<td>Adapted from CAC, 2002</td>
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<td>3</td>
<td>Absolute homelessness or shelterless refers to individuals living in the street with no physical shelter of their own, including those who spend their nights in emergency shelters. Relative homelessness refers to people living in spaces that do not meet the basic health and safety standards including: 1. Protection from the elements; 2. Access to safe water and sanitation; 3. Security of tenure and personal safety; 4. Affordability; 5. Access to employment, education and health care; 6. Provision to minimum space to avoid overcrowding.</td>
<td>United Nations</td>
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<td>4</td>
<td>The challenges and issues faced due to, and the feelings resulting from being relatively homeless are rarely different from those involved in being absolutely homeless. Any such differentiation is more semantic than experiential. Therefore, to truly define homelessness you must consider 3 factors: 1. You must be willing to consider the subjective as well as the objective assessment of homelessness because “home” means different things to different people.</td>
<td>Organic Intellectuals (2001) The View from the Sidewalk. Social Alternatives Unit, B.C. Ministry of Community, Aboriginal and</td>
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<td></td>
<td>definition is a personal one.</td>
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<td>2.</td>
<td>The definition of “home” must be consensual between society and individual. For instance an upper class woman who is abused at home may be seen by society as having a home but considered by herself to be homeless. The society and individual do not agree and therefore the classification is HOMELESS.</td>
<td>Women’s Services.</td>
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<td>3.</td>
<td>Housing standards must be in place:</td>
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<td>a.</td>
<td>30% or less of income on rent</td>
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<td>b.</td>
<td>Protection from elements</td>
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<td>c.</td>
<td>Personal Safety</td>
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<td>d.</td>
<td>Security of Tenure</td>
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<td>e.</td>
<td>Access to air and light</td>
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<td>f.</td>
<td>Self contained</td>
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<td>g.</td>
<td>Minimum size of 325 sq ft (self-contained) or 290 sq. ft (common areas).</td>
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<td>h.</td>
<td>Protection from harassment</td>
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<td>i.</td>
<td>Ability to have pets</td>
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<td>j.</td>
<td>Protection from noise violations</td>
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<tr>
<td>k.</td>
<td>Access to telephone and mail</td>
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<td>l.</td>
<td>Access to electric or other power</td>
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<td>m.</td>
<td>Access to storage</td>
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<td>n.</td>
<td>Access to food/clothing</td>
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<td>o.</td>
<td>Access to other places for exercise/recreation</td>
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<td>p.</td>
<td>Freedom to come and go</td>
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<td>q.</td>
<td>Freedom to have friends over</td>
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<td>r.</td>
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<td>s.</td>
<td>Access to day-care and other support services</td>
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<td>Access to living supports</td>
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<td>Access to a community</td>
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<td>Source</td>
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<td>v.</td>
<td>Access to safe water and sanitation</td>
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<td>w.</td>
<td>Ability to cook</td>
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<td>x.</td>
<td>Access to health care</td>
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<td>y.</td>
<td>Access to education and employment opportunities</td>
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<td>z.</td>
<td>Access to and influence over “decision makers” and the decisions implemented that concern one’s housing.</td>
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Appendix C:

May 3 Workshop Attendees

In Attendance [may not be entirely accurate – some individuals joined different groups, attended on behalf of others on the original confirmation list, may not have completed the attendance sheet, etc.]

Group 1 (Helen Gardiner, Yasmin Dean):
Dean, Yasmin, City of Calgary
Jang, Collin, HRDC (Funder)
Laing, Bonnie, CAC (All Sectors)
McDowell, Theresa, Inn From the Cold (Families)
te Linde, John (CAC)
Toews, Adele, Mustard Seed Ministry (Singles)

Group 2 (Kathy Cairns, Katie Black):
Black, Katie, City of Calgary (Singles)
Braul, Lawrence (Seniors)
Carry, Sharon, Bow Valley College (All Sectors)
Hill, Colin, EXIT Community Outreach (Youth)
Langdon, Jean, Discovery House (WFV)
Lundquist, Lorraine, CHC (Families)
Manley, Stephen, Alberta Municipal Affairs (Funder)
Newman, Debbie, CAC/Drop-In Centre
Roberts, Terry, CHF (All Sectors)

Group 3 (Richard Alarie, Cathy Leipciger)
Adams, Bev, AMHB
Felesky, Stephanie, CAC (Funder)
Hubele, Ralph (Seniors)
Joo, Andrew, Drop-In Centre
Martin, John, Alberta Community Development (Funder)
McGregor, Derek, Rockyview Child & Family Services (Youth)
Murray, Debra, Red Cross (Aboriginal)

Group 4 (Tom Strong, Gisele Marcoux)
Cameron, Trish (Mental Health)
Clarkson, Sandra, HRJ Consulting Ltd. (Funder)
Coppus, George, CAC
Friesen, Lorie, CWES (WFV)
Goard, Carolyn, Sheriff King (WFV)
Hodgkinson, Terry, CMHC (Funder)
Neilson, Carrie, City of Calgary (Aboriginal)
Staines, David, Calgary John Howard Society (Youth)

Group 5 (Tom Briggs, Lori Shortreed)
Cummings, Ermine, Awotaan (WFV)
Easton, Susan, Rockyview Child & Family Services (Funder)
Gill, Wayne (Funder)
Penman, Colin, CAC (Families)
Shortreed, Lori, PDD (All Sectors)
Welsh, Kari, Youth Criminal Defence Office (Youth)
Wilson, Helen, CFEP (Funder)
Wood, Cathy, Aventa (Addictions)

Cancelled/Unable to Attend:
Kiely, Jerilynn, City of Calgary (All Sectors)
Melchior, Lorraine, CUPS (Families)
Peterson, Stacey, Simon House (Addictions)
Pinnow, Joanne (Funder)
Appendix D:
Quantitative Data Collection Instruments
2002 CALGARY HOMELESS FOUNDATION STUDY

SCREENING QUESTIONNAIRE

1 Please note that surveyors should not attempt to accrue survey numbers throughout the survey. In other words, each new day will begin with survey # 01. For example, if Helen Gardiner is interviewing her third participant on July 4, 2002, and the participant is a woman, the participant number would be HG 03 04 07 F.
2002 Calgary Homeless Foundation Study
Survey

Instructions to Surveyor:

1. Approach individual you believe fits the profile as you have been trained.
2. Explain your intentions to the person.
3. Ask them if they have participated in the study already.
4. If they have not, ask them whether they would be interested in participating.
5. If “Yes”, ASK THEM THE SCREENING QUESTIONS.
6. If “No”, thank the person and GO TO P.3 (MENTAL STATE EVALUATION).

Screening Questions:

1. Are you currently spending most of your nights in shelters or sleeping rough (on streets, under bridges, in abandoned buildings)? □ Yes □ No
   
   If “Yes”, END SCREENING HERE. THEY ARE ABSOLUTELY HOMELESS. GO TO Q7. [If “No”, GO TO Q2.]

2. Do you currently have a place of your own? □ Yes □ No [If “Yes”, GO TO Q3.] [If “No”, GO TO Q5.]

3. INTERVIEWER: If the person has a place of their own, ASK: (IF PERSON ANSWERS “YES” TO #2 AND “NO” TO ANY OF #3, THEY ARE RELATIVELY HOMELESS).
   
   a. Does your place protect you from the weather? □ Y □ N
   b. Do you have safe water to drink? □ Y □ N
   c. Do you have a washroom you can use? □ Y □ N
   d. Are you safe in your place? □ Y □ N
   e. Can you stay in your place as long as you want or need to? □ Y □ N
   f. Can you afford your place? □ Y □ N
   g. Do you have enough room in your place? □ Y □ N
   h. Can you get to work or find work from your place? □ Y □ N
   i. Can you get to school from your place? □ Y □ N
   j. Can you get to health care? □ Y □ N

4. Do you feel that you are currently in a position of being at risk of losing your home? □ Yes □ No [If “Yes”, GO TO 4A.] [If “No”, GO TO DECISION FOLLOWING 6A.]
   
   a. [INTERVIEWER: If “Yes”, ASK:] So, what are some of the reasons you feel you are currently at risk of losing your home?
      □ Can’t afford the rents
      □ Family problems (includes abuse)
      □ Fleeing violence
      □ Haven’t been able to find or keep a good job
      □ Health problems (INTERVIEWER: Probe for physical or mental (emotional) or substance abuse) □ Physical □ Mental/emotional □ Substance abuse
      □ Landlord problems/eviction
      □ Lost job
      □ No money/resources to find a job (bus passes, etc.)
      □ There is no one to help me (lack of social/personal support)
      □ Other (specify): _________________________________________________________

5. INTERVIEWER: (FOR THOSE PEOPLE WHO DON’T use shelters, sleep rough or have a place of their own), ASK:
   
   o Where are you staying now? (INTERVIEWER: Reassure the interviewee that you do not need to know names or addresses...just the type of accommodation).
6. Is there anything wrong with where you are staying now?  
   □ Yes  □ No  [If “Yes”, GO TO 6A.]  [If “No”, GO TO DECISION FOLLOWING 6A.]
   a. [INTERVIEWER: If “Yes”, ASK:] Can you tell me a little bit about where you are actually staying, i.e., a description of some sort, and about some of the things that might be wrong with it.____________________________________________________
      ____________________________________________________________
      ____________________________________________________________

   BASED ON THEIR ANSWERS, DECIDE WHETHER THEY ARE:

   □ Absolutely Homeless/Shelterless  □ Relatively Homeless  □ Not appropriate for study

   Your Reasoning:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

   7. How old are you now?  _________ (years) (This is not a screening question but is necessary to correctly classify people into demographic groups and to ensure the correct questions are asked).

   THEN:

   If the individual consents to participate:

   1. If they are either absolutely or relatively homeless, ask them if they would like to complete the survey.
   2. Advise them that the survey asks quite a few questions and will take approximately 1 hour to complete.
   3. Advise them that the participation payment is $10.

   If they agree to continue:

   4. Go to survey for ABSOLUTELY HOMELESS/SHELTERLESS OR
   5. Go to survey for RELATIVELY HOMELESS (HIDDEN)

   If the individual refuses or is not appropriate for the study:

   Thank the person for their time and move on.
MENTAL STATE EVALUATION

[To be completed either immediately (a) upon the individual refusing to participate, or (b) following administration of the survey for ABSOLUTELY HOMELESS/SHELTERLESS or RELATIVELY HOMELESS (HIDDEN)]

SURVEYOR: Q1 AND Q2 ARE FOR YOUR EYES ONLY. [DO NOT READ OUT LOUD - REQUIRES A JUDGMENT CALL ON YOUR PART.]

1. SURVEYOR: BASED ON YOUR INTERACTION WITH THE RESPONDENT, Do you think this individual is mentally ill?
   - Definite
   - Possible
   - No evidence of mental illness

   (If definite or possible, indicate observed items below, omitting any that you are unsure of.)

<table>
<thead>
<tr>
<th>Appearance</th>
<th>☐ appropriate</th>
<th>☐ no obvious odour</th>
<th>☐ calm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ neglected</td>
<td>☐ moderate body odour</td>
<td>☐ anxiety</td>
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<td></td>
<td>☐ bizarre</td>
<td>☐ strong body odour</td>
<td>☐ sad</td>
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<td>☐ angry</td>
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<tr>
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<tr>
<td>Memory</td>
<td>☐ good</td>
<td>☐ fair</td>
<td>☐ organized/alert</td>
</tr>
<tr>
<td></td>
<td>☐ poor</td>
<td></td>
<td>☐ disorganized</td>
</tr>
<tr>
<td>Smell/hygiene</td>
<td>☐ no obvious odour</td>
<td>☐ fair</td>
<td>☐ slowed</td>
</tr>
<tr>
<td></td>
<td>☐ moderate body odour</td>
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<td>☐ speeded</td>
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<td></td>
<td>☐ strong body odour</td>
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<tr>
<td>Orientation</td>
<td>☐ good</td>
<td>☐ fair</td>
<td>☐ organized/alert</td>
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<tr>
<td>(time, place, person)</td>
<td></td>
<td></td>
<td>☐ disorganized</td>
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<td></td>
<td>☐ fair</td>
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<td>☐ slowed</td>
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<td>☐ speeded</td>
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<tr>
<td>Motor activity</td>
<td>☐ coordinated</td>
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<td></td>
<td>☐ uncoordinated</td>
<td>☐ anxious</td>
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<td>☐ tremulous</td>
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<td></td>
<td>☐ rigid</td>
<td>☐ angry</td>
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<td>☐ restless</td>
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<td>Mood</td>
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<td>Speech</td>
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<td>☐ slowed</td>
<td>☐ disorganized</td>
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<td>☐ rambling</td>
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<td>Attitude</td>
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<td>☐ suspicious/wary</td>
<td>☐ visual</td>
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<td>☐ hostile</td>
<td>☐ none observed</td>
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<td>Hallucinations</td>
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<tr>
<td>Physiologic Signs</td>
<td>☐ flush</td>
<td>☐ control</td>
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<td>☐ pallor</td>
<td>☐ persecution</td>
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<td>☐ perspiration</td>
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<td>☐ shakiness</td>
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<td>☐ tremors</td>
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<td>Delusions</td>
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<td>☐ grandiosity</td>
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<td>☐ none observed</td>
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<td>Concentration</td>
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<td>☐ appears impaired</td>
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2. SURVEYOR: BASED ON YOUR INTERACTION WITH THE RESPONDENT, Do you think this individual is under the influence of alcohol or drugs?
   - Definite
   - Possible
   - No evidence of alcohol or drugs

   (If definite or possible, indicate observed items below, omitting any that you are unsure of.)
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<th>Appearance</th>
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<td>• disorganized</td>
</tr>
<tr>
<td></td>
<td>• slowed</td>
</tr>
<tr>
<td></td>
<td>• speeded</td>
</tr>
<tr>
<td>Attitude</td>
<td>• co-operative</td>
</tr>
<tr>
<td></td>
<td>• suspicious/wary</td>
</tr>
<tr>
<td></td>
<td>• hostile</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>• auditory</td>
</tr>
<tr>
<td></td>
<td>• visual</td>
</tr>
<tr>
<td></td>
<td>• none observed</td>
</tr>
<tr>
<td>Physiologic Signs</td>
<td>• flush</td>
</tr>
<tr>
<td></td>
<td>• pallor</td>
</tr>
<tr>
<td></td>
<td>• perspiration</td>
</tr>
<tr>
<td></td>
<td>• tears</td>
</tr>
<tr>
<td></td>
<td>• shakiness</td>
</tr>
<tr>
<td></td>
<td>• tremors</td>
</tr>
<tr>
<td>Delusions</td>
<td>• control</td>
</tr>
<tr>
<td></td>
<td>• persecution</td>
</tr>
<tr>
<td></td>
<td>• grandiosity</td>
</tr>
<tr>
<td></td>
<td>• none observed</td>
</tr>
<tr>
<td>Concentration</td>
<td>• good</td>
</tr>
<tr>
<td></td>
<td>• appears limited</td>
</tr>
<tr>
<td></td>
<td>• appears impaired</td>
</tr>
</tbody>
</table>
2002 CALGARY HOMELESS FOUNDATION STUDY

SURVEY FOR THE

RELATIVELY HOMELESS (HIDDEN)

1 Please note that surveyors should not attempt to accrue survey numbers throughout the survey. In other words, each new day will begin with survey # 01. For example, if Helen Gardiner is interviewing her third participant on July 4, 2002, and the participant is a woman, the participant number would be HG 03 04 07 F.
SURVEY FOR THE RELATIVELY HOMELESS (HIDDEN)

INTERVIEWER: This survey is ONLY for those people who answered “YES” TO #2 AND “NO” to any of #3, “YES” TO #4 AND #6, or BASED ON YOUR DECISION were deemed to be relatively homeless.

UNLESS OTHERWISE INDICATED, DO NOT READ THE CHECKLISTS...LET THE PERSON ANSWER AND CODE THEIR ANSWERS AS YOU GO ALONG. PROVIDE PROMPT CARDS WHEN APPROPRIATE.

A. HOW THEY CAME TO BE RELATIVELY HOMELESS

INTERVIEWER: I’m going to start off by asking you some questions about how you came to be living where you are.

1. How long have you lived in Calgary? (INTERVIEWER: If queried, qualify with “this time”.)
   _______ # of Weeks _______ # of Months _______ # of Years _______ All their life

2. Where did you live before coming to Calgary (INTERVIEWER: Also specify country if outside Canada.)
   ___________ Location (if any) ___________ Province ___________ Country

3. (INTERVIEWER: If new to Calgary or previously lived elsewhere, ASK:) Did you have a home before you came to Calgary? ☐ Yes ☐ No

4. What brought you to Calgary?
   □ Always come here part of the year (seasonal)
   □ Better access to services (health or social)
   □ Economy is better (more jobs available)
   □ More or better shelter accommodations
   □ Relatives, friends or family already live here
   □ Other (specify) __________________________________________________________________________

5. Did you have your own place to stay when you moved to Calgary? ☐ Yes ☐ No (If “Yes”, GO TO Q7.)
   (If “No,” ASK:)
   a. Where did you stay? ________________________________________________________________
   b. Is that where you expected to stay? ☐ Yes ☐ No (If “Yes”, GO TO Q6.)
   c. (If “No”, ASK:) Where did you expect to stay? _______________________________________

6. Is this the first time you have ever had housing problems? ☐ Yes ☐ No (If “Yes”, GO TO Q7.)
   (If “No”, ASK:)
   a. [INTERVIEWER: Probe for number of previous occurrences of housing problems.] ________ times
   b. How many of those times have been in Calgary? ________ times

7. What are some of the reasons you are having housing problems this time?
   □ Could not access appropriate housing or services to address alcohol or drug problems
   □ Could not access appropriate housing or services to address their disability needs
   □ Could not access appropriate housing or services to address their mental health needs
   □ Could not find employment
   □ Did not have family to provide support
   □ Family problems (includes abuse)
   □ Fleeing violence
   □ Health problems (INTERVIEWER: Probe for physical or mental (emotional) or substance abuse:)
     □ Physical □ Mental/emotional □ Substance abuse
   □ Lack of supported housing
   □ Landlord problems/eviction
   □ Lost job
Rent was too high
Services did not address their cultural needs
Services were physically hard to get to
Wage too low to afford shelter and basic needs
Was released from custody
Other (specify) __________________________________________________________________________

YOUTH ONLY (for those younger than 24):
- Could not access financial assistance because they were under 16
- Could not access housing because they were under 18
- Could not access services because they were truant from school
- Could not access SFI (adult welfare) because they were under 18 and not married
- Had their Child Welfare Status terminated
- Had to wait too long for services
- Only needed access to financial assistance but did not want other child welfare services
- Professionals did not understand what their needs were
- Professionals were unable to help them

YOUTH ONLY:

8. Would you be interested in going back home (i.e., do they want to)?  ☐ Yes  ☐ No  [If “No”, GO TO B1.]
   a. (If “Yes”, ASK:) Could you return home if you wanted to?  ☐ Yes  ☐ No
   b. (If “Yes” or “No”, ASK:) What would you need to make it possible for you to return home (i.e.,
      what would have to happen)?__________________________________________________________
         ________________________________________________________________________________

INTERVIEWER: Thanks. Now I would like to ask you about your housing needs and what might be keeping you
from getting the housing that you need.

B. HOUSING NEEDS, BARRIERS AND GAPS

1. What kind of housing do you need right now? (i.e., the first step)
   ☐ Current situation is best
   ☐ Don't know
   ☐ Independent living in own home or apartment with a rent subsidy
   ☐ Independent living in own home or apartment without a rent subsidy*
   ☐ Living in an institution (nursing home, hospital)*
   ☐ Living in semi-independent accommodation (group home or supported housing)*
   ☐ Living with immediate family (such as spouse, parents, or children)*
   ☐ Living with other relatives (such as aunts, uncles, grandparents)*
   ☐ Room and board or a hostel*
   ☐ Sharing accommodation with roommates or friends*
   ☐ Support for finding a job while looking for housing
   ☐ Support for single fathers
   ☐ Other (specify)*  ________________________________________________________________
   a. * ASK: Would you be able to afford that on your own, or would you need some help?
      ☐ On their own  ☐ Would need some help

2. In the long term, what kind of home would you like to have?
   ☐ Current situation is best
   ☐ Don't know
   ☐ Independent living in own home or apartment with a rent subsidy
   ☐ Independent living in own home or apartment without a rent subsidy*
   ☐ Living in an institution (nursing home, hospital)*
   ☐ Living in semi-independent accommodation (group home or supported housing)*
Living with immediate family (such as spouse, parents, or children)*
Living with other relatives (such as aunts, uncles, grandparents)*
Room and board or a hostel*
Sharing accommodation with roommates or friends*
Other (specify)*

a. *ASK: Would you be able to afford that on your own, or would you need some help?
   ☐ On their own ☐ Would need some help

INTERVIEWER: Now I would like to ask you a couple of questions about your experiences, if any, with shelters in Calgary.

3. Have you ever tried to get into a shelter in Calgary? ☐ Yes ☐ No (If “No”, GO TO NEXT SECTION.)

4. Have you ever been denied access to a shelter in Calgary? ☐ Yes ☐ No (If “No”, GO TO NEXT SECTION.)
   a. (If “Yes”, ASK:)
      1. Can you tell me the name of the shelter?
      2. What was the reason you were denied access?
      3. Where did you sleep that night?

<table>
<thead>
<tr>
<th>Shelter</th>
<th>Reason</th>
<th>Where Slept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Barred. If barred, ☐ Perm ☐ Temp</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shelter hours (e.g., hours of work don’t fit shelter rules)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Too drunk or stoned</td>
<td></td>
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<tr>
<td></td>
<td>Under Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Violence (e.g., got into a fight with another resident)</td>
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<td></td>
<td>Other (specify)</td>
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</tbody>
</table>

5. Have you ever been denied access to another shelter in Calgary? ☐ Yes ☐ No (If “No”, GO TO NEXT SECTION.)
   a. (If “Yes”, ASK:)
      1. Can you tell me the name of the shelter?
      2. What was the reason you were denied access?
      3. Where did you sleep that night?

<table>
<thead>
<tr>
<th>Shelter</th>
<th>Reason</th>
<th>Where Slept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Barred. If barred, ☐ Perm ☐ Temp</td>
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<td>Full</td>
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<tr>
<td></td>
<td>Shelter hours (e.g., hours of work don’t fit shelter rules)</td>
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<td></td>
<td>Too drunk or stoned</td>
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<tr>
<td></td>
<td>Under Age</td>
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<tr>
<td></td>
<td>Violence (e.g., got into a fight with another resident)</td>
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<tr>
<td></td>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

INTERVIEWER: Thank you. Now I would like to ask you about your current income situation.

C. CURRENT INCOME

1. Are you currently employed? ☐ Yes ☐ No (If “No”, GO TO Q2.)
   (If “Yes”, ASK:)
   a. Are you employed full time, part time or occasionally? ☐ FT ☐ PT ☐ Occasionally
   b. Roughly how many hours per week do you work at your job? ____________ hours

2. How much money do you currently make every month? $____________________dollars

3. How much money do you think you would need each month in order to afford rent and utilities? $____________________dollars

4. How much additional money would you need for the basics such as food, clothing and other necessities? $____________________dollars (INTERVIEWER: Make sure this amount EXCLUDES the amount needed for rent and utilities.)
5. Where does your **REGULAR** money come from? (INTERVIEWER: This includes “Employment”, if indicated “Yes” to Q1, in addition to any other sources as indicated below. **CHECK AS MANY AS APPLY.**)

- AISH
- Alimony
- Bottles and cans
- Cash Corner
- CCTB (Child Credit Tax Benefit)
- Child and Family Services
- Criminal activity (B&E, shoplifting, selling drugs, etc.)
- CUPS (emergency fund)
- Drugs (e.g., selling dime bags)
- EI
- Employment
- Family/friends
- Insurance
- Legal guardian
- No regular income
- Panhandling
- Pension (OAS, GIS, CPP, Disability (LTD))
- Private pension (WCB)
- Prostitution/sex trade (e.g., the stroll)
- Selling medications
- SFI
- Shelter (specify)
- Social Worker
- Street Talk
- Student funding
- Other (specify)

6. What other sources of income do you have?

- _________________________________________________________________________
- _________________________________________________________________________
- _________________________________________________________________________

7. Have you ever been desperate for money (i.e., have you ever not been able to make ends meet)?

- Yes  [ ]  No  [ ]

(If “No”, GO TO Q8.)

a. (If “Yes”, **ASK:**) When you are desperate for money, where do you go or what do you do?

- AISH
- Alimony
- Bottles and cans
- Cash Corner
- Child and Family Services
- Criminal activity (B&E, shoplifting, selling drugs, etc.)
- CUPS (emergency fund)
- Drugs
- EI
- Employment
- Family/friends
- Insurance
- Legal guardian
- No regular income
- Panhandling
- Pension (OAS, GIS, CPP, Disability (LTD))
- Private pension (WCB)
- Prostitution/sex trade (e.g., the stroll)
- Red Cross
- SFI
- Shelter (specify)
- Social Worker

---

2002 Calgary Homeless Foundation Study - FINAL Survey Relatively Homeless - July 4, 2002
8. **INTERVIEWER: IF RESPONDENT INDICATES THAT THEY ARE NOT EMPLOYED, ASK:** Would you like to have a job (i.e., a steady income)? □ Yes □ No (If “No”, GO TO 8b.)

   a. (If “Yes”, **ASK:** What’s getting in the way?
      □ Age (too old or too young)
      □ Clothes (no proper clothing for job or interviews)
      □ Discrimination (racism)
      □ Education
      □ Experience (i.e., don’t have enough experience)
      □ Health problems (INTERVIEWER: Probe for physical or mental (emotional) or substance abuse:)
         □ Physical □ Mental/emotional □ Substance abuse
      □ Housing (i.e., no fixed address to put on applications)
      □ Inadequate pay
      □ Job market (i.e., no jobs available)
      □ Knowledge (lack of knowledge about how to find work)
      □ Lack of sleep
      □ Literacy (reading and writing)
      □ Need daycare or other family supports
      □ Not eligible (i.e., immigration status)
      □ Pay would be garnisheed (e.g., creditors after them, alimony, etc.)
      □ Shower facilities (no access to showers)
      □ Someone to get them going (i.e., to wake them up)
      □ Telephone (no access to a telephone or no number to call them back at)
      □ Telephone (problems using)
      □ Transportation (money for or bus pass)
      □ Other (specify) ___________________________________________________________________

   b. (If “No”, **ASK:** Why not? ____________________________________________________________________

9. **What do you need to be able to get a job?** [**INTERVIEWER STATE:** There are many things that can prevent people from getting or keeping work. I am going to read you a list of possible barriers. Can you tell me if any of them apply to you.]

   □ Basic hygiene
   □ Counselling/treatment
   □ General education
   □ Job training (e.g., skills to get a job)
   □ Life skills
   □ Reading
   □ Time management (keeping appointments)
   □ Transportation (costs associated with)
   □ Using or accessing a telephone
   □ Writing

   a. Is there anything that we have missed? □ Yes □ No (If “No”, GO TO Q10.)

   b. (If “Yes”, **ASK:**) What? ____________________________________________________________________

10. **If you got a job, is there a possibility that your pay might be garnisheed?** [**INTERVIEWER:** Explain if necessary.] □ Yes □ No (If “No”, GO TO NEXT SECTION.)

   a. (If “Yes”, **ASK:**) Why? ____________________________________________________________________
D. HEALTH

DISABILITY ASSESSMENT (WHODAS II)

INTERVIEWER: I’m going to talk about a number of activities that most people do every day. I would like you to think back over the PAST MONTH and, to the best of your knowledge, answer these questions thinking about how much DIFFICULTY you had while DOING each of the ACTIVITIES. For each question, please give me just ONE response. Please refer to these cards (SHOW PROMPT CARDS) for the possible answers. [Interviewer: Do not read points beneath headings unless additional explanation is necessary.]

<table>
<thead>
<tr>
<th>H1</th>
<th>How do you rate your overall health in the past month?</th>
<th>Very good</th>
<th>Good</th>
<th>Moderate</th>
<th>Bad</th>
<th>Very Bad</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

In the past month, how much difficulty did you have in...

<table>
<thead>
<tr>
<th>CS1</th>
<th>Understanding and communicating.</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme/ Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Concentrating or remembering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Finding solutions to problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Learning something new</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Generally understanding and communicating with people</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CS2</th>
<th>Getting around.</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme/ Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Standing for long periods</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>o Standing up from sitting down</td>
<td></td>
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<tr>
<td></td>
<td>o Moving around</td>
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<tr>
<td></td>
<td>o Difficulty with walking a long distance, such as a kilometer</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CS3</th>
<th>Self care.</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme/ Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Washing your whole body</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Getting dressed</td>
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<tr>
<td></td>
<td>o Eating</td>
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<tr>
<td></td>
<td>o Coping on your own</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>CS4</th>
<th>Getting along with others.</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme/ Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Dealing with people who are strangers</td>
<td></td>
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<tr>
<td></td>
<td>o Maintaining a friendship</td>
<td></td>
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<td></td>
<td>o Getting along with people who are close</td>
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<td></td>
<td>o Controlling feelings</td>
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</table>

<table>
<thead>
<tr>
<th>CS5</th>
<th>Daily activities.</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme/ Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Getting these activities done</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Doing these activities well</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Doing them as quickly as needed</td>
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</table>

<table>
<thead>
<tr>
<th>CS6</th>
<th>Participating in society, (i.e., coping)</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme/ Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o The world and other people creating problems</td>
<td></td>
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<tr>
<td></td>
<td>o Discrimination problems (i.e., racism)</td>
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<tr>
<td></td>
<td>o Problems in living with dignity</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>o Problems joining in community activities</td>
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</table>

<table>
<thead>
<tr>
<th>H2</th>
<th>Overall, in the past month, how much did all of these difficulties interfere with your life?</th>
<th>Not at all</th>
<th>Mildly</th>
<th>Moderately</th>
<th>Severely</th>
<th>Extremely</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>H3</th>
<th>Overall, in the past month, how many days were these difficulties present?</th>
<th>RECORD NUMBER OF DAYS:</th>
<th></th>
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### MENTAL HEALTH (FROM WISCONSIN QOL)

**INTERVIEWER:** For this next section, please understand that we’re not trying to judge you in any way. We just want to get a sense of what your world is like for you. I’m now going to ask you a few questions about how you have FELT in the PAST MONTH; and could please tell me, just yes or no, whether you have had any of these feelings. So, in the past month, have you felt:

<table>
<thead>
<tr>
<th>Answer/Score</th>
<th>Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>P1 3</td>
<td>0</td>
</tr>
<tr>
<td>P2 -3</td>
<td>0</td>
</tr>
<tr>
<td>P3 -3</td>
<td>0</td>
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<tr>
<td>P4 3</td>
<td>0</td>
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<tr>
<td>P5 -3</td>
<td>0</td>
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<tr>
<td>P6 3</td>
<td>0</td>
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<tr>
<td>P7 -3</td>
<td>0</td>
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<tr>
<td>P8 3</td>
<td>0</td>
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<tr>
<td>P9 -3</td>
<td>0</td>
</tr>
<tr>
<td>P10 3</td>
<td>0</td>
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</tbody>
</table>

**INTERVIEWER STATE:** For the next question, please just choose one answer.] During the past month, would you say that you have:

- 3  generally felt calm and positive in outlook OR
- 0  been having some periods of anxiety or depression OR
- -3  generally been confused, frightened, anxious or depressed

**INTERVIEWER:** There are many aspects of emotional distress including feeling depressed, feeling anxious or hearing voices. In the past month, have you experienced any of these symptoms?

- Feeling Depressed [ ] Yes [ ] No
- Feeling Anxious [ ] Yes [ ] No
- Hearing Voices [ ] Yes [ ] No (If “No” to all, GO TO NEXT SECTION.)

(If “Yes” to any of the above, ASK:)

a. Why [do you think you] have you felt this way?

b. How much distress have these symptoms caused you?

- 3  None  1.5  A little  0  Some  -1.5  A moderate amount  -3  A lot
c. **INTERVIEWER:** Ask prior to each question... ] In the past month,

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Most of the time</th>
<th>Constantly</th>
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</thead>
<tbody>
<tr>
<td>How much have they interfered</td>
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<tr>
<td>with your daily life?</td>
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<tr>
<td>Have you felt like killing</td>
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<td>yourself? (i.e., had</td>
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<tr>
<td>suicidal thoughts)</td>
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<td>Have you felt like harming</td>
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<td>others? (i.e., had</td>
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<tr>
<td>homicidal thoughts)</td>
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</table>

|                                 |       |              |            |                  |            |
| Have you felt like killing      |       |              |            |                  |            |
|      yourself? (i.e., had       |       |              |            |                  |            |
|      suicidal thoughts)         |       |              |            |                  |            |
| Have you felt like harming      |       |              |            |                  |            |
|      others? (i.e., had         |       |              |            |                  |            |
|      homicidal thoughts)       |       |              |            |                  |            |

d. **[INTERVIEWER:** If person answered anything other than “Never”, **ASK: ]** Have you felt this way because a friend or a family member was depressed or hurt themselves, etc.?   Yes   No

**INTERVIEWER:** Thank you very much. That’s a tough section to get through. I appreciate your honesty. Now I’d like to move on to some general health questions.

**GENERAL HEALTH QUESTIONS:**

1. Do you have any HEALTH CONDITIONS that require treatment?   Yes   No   (If “No”, **GO TO Q2.**)

   (If “Yes”, **ASK:**)

   a. **[INTERVIEWER:** Probe for what kind of health problem.]**

      i.   Mental health problem (specify) ______________________________

      ii.  Physical health problem (specify) _____________________________

   b. Are you currently getting treatment for the condition(s)? (SEE **MEDS SPECIFIC QUESTION BELOW**)

      i.   Mental health problem   Yes   No

      ii.  Physical health problem   Yes   No   (If “No” to both, **GO TO Q1bC.**)

   A. **(If “Yes” to either of the above, **ASK:**)** Does anything prevent you from following through on your treatment?

      i.   Mental health problem   Yes   No

      ii.  Physical health problem   Yes   No   (If “No” to both, **GO TO Q1c.**)

   B. **(If “Yes” to either of the above, **ASK:**)** What prevents you from following through on your treatment?

      | Mental | Physical |
      |--------|---------|
      | Clarity (of instructions) |       |
      | Doesn’t trust system (doctors, hospitals, etc.) |       |
      | Doesn’t like side effects |       |
      | Forgets to take medication |       |
      | Lack of access to medical care (transportation) |       |
      | Lack of money/cost |       |
      | Literacy/comprehension (understanding) |       |
      | Sells medications |       |
      | Stolen medication |       |
      | Support/education |       |
      | Other (specify) |       |

   C. **(If “No”, **ASK:**)** Why aren’t you getting treatment?
c. Have you been prescribed MEDICATION for the condition(s)?

i. Mental health problem  
   Yes  No  
   (If “No” to both, GO TO Q2.)

ii. Physical health problem  
   Yes  No  
   (If “No” to both, GO TO Q2.)

A. (If “Yes” to either of the above, ASK:) Does anything prevent you from taking your medication?

i. Mental health problem  
   Yes  No  
   (If “No” to both, GO TO Q2.)

ii. Physical health problem  
   Yes  No  
   (If “No” to both, GO TO Q2.)

d. (If “Yes” to either of the above, ASK:) What prevents you from taking your medication?

   □ Clarity (of instructions)       □ Mental        □ Physical
   □ Doesn’t trust system (doctors, hospitals, etc.)  □ Mental       □ Physical
   □ Doesn’t like side effects       □ Mental        □ Physical
   □ Forgets to take medication       □ Mental        □ Physical
   □ Lack of access to medical care (transportation)       □ Mental        □ Physical
   □ Lack of money/cost       □ Mental        □ Physical
   □ Literacy/comprehension (understanding)  □ Mental       □ Physical
   □ Sells medications       □ Mental        □ Physical
   □ Stolen medication       □ Mental        □ Physical
   □ Support/education     □ Mental        □ Physical
   □ Other (specify)  _________________________________

2. When was the last time you went to a doctor?  _____________________ (# of days/weeks/months/years)  
   [INTERVIEWER: Circle whichever is appropriate.]

3. In the past month, have you ever gone to emergency?  Yes  No  (If “No”, GO TO Q4.)

   (If “Yes”, ASK:)

   a. How many times have you gone in the past month?  _____________ times

   b. Can you tell me what that visit/those visits was/were for?

      Detail (Optional)

      Time1
      □ Mental health problem  _________________________________
      □ Physical health problem  _________________________________

      Time2
      □ Mental health problem  _________________________________
      □ Physical health problem  _________________________________

4. In the past year, did you stay in the hospital overnight?  Yes  No  (If “No”, GO TO Q5.)

   (If “Yes”, ASK:)

2002 Calgary Homeless Foundation Study - FINAL Survey Relatively Homeless - July 4, 2002
a. How many times did you stay in the hospital overnight in the past year? _______________ times

b. Can you tell me roughly how many nights you stayed in each time? 
   _______ Time1  _______ Time2  _______ Time3  _______ Time4  _______ Time5

c. Can you tell me what each stay was for?
   Detail (Optional)

   Time1
   □ Mental health problem
   □ Physical health problem

   Time2
   □ Mental health problem
   □ Physical health problem

   Time3
   □ Mental health problem
   □ Physical health problem

   Time4
   □ Mental health problem
   □ Physical health problem

   Time5

5. Since you have been having housing problems, have you used any mental health services?  ☐Yes  ☐No
   (If “No”, GO TO Q6.)

   a. (If “Yes”, ASK:) What mental health services have you used?
      □ EMS (Emergency Medical Services, e.g., ambulance)
      □ ER
      □ Hospitalization
      □ Outpatient treatment (e.g., at clinic) (specify) ________________________________
      □ Treatment at hospital emergency
      □ Other (specify) ____________________________________________________________

6. Do you have an Alberta Health Care Number?  ☐Yes  ☐No  ☐Don't Know
   (If “Yes” or “Don’t know”, GO TO Q7.)

   a. (If “No”, ASK:) Why Not?
      □ Can’t afford it
      □ Legal reasons
      □ Don’t know how to get one (if came from elsewhere)
      □ Don’t want to be registered (legal reasons)
      □ Don’t want to be registered (paranoia)
      □ In transit (if in transit, can’t get; 3-month waiting period)
      □ Lost it

7. During the past YEAR, was there ever a time when you needed health care but did not receive it?  ☐Yes  ☐No
   (If “No”, GO TO Q8.)

   (If “Yes”, ASK:

   a. Thinking of the most recent time, what was the type of care that was needed?
      □ Emotional or mental health problem
      □ Physical health problem
      □ Prenatal care
      □ Regular check-up
      □ Other (specify) ____________________________________________________________

   b. Thinking again of the most recent time, why didn’t you get care?
      □ Alberta Health Care card problem (e.g., doesn’t have one - access limited)
      □ Fear (i.e., afraid of diagnosis, afraid of hospital or medical staff, afraid of being tracked)
      □ Hours of service (i.e., couldn’t get there within operating hours)
      □ Lack of knowledge (i.e., did not know where to go or how to get there)
      □ Mistrust (i.e., didn’t believe they would get help appropriate for them)
      □ Money (i.e., no money for prescription, or transportation etc.)
      □ Transportation problems (no way to get there)
8. When was the last time you went to a dentist? (INTERVIEWER: Probe for months/years.)
   _____________ Months  _____________ Years

9. Do you have any dental problems right now?  [ ] Yes  [ ] No  [ ] Don’t know (If “No” or “Don’t know”,
   GO TO Q10.)
   a. (If “Yes”, ASK:) What are they? _______________________________________________________

10. Do you currently have any problems with alcohol and/or drugs?  [ ] Yes  [ ] No

11. Have alcohol or drugs ever been a problem for you?  [ ] Yes  [ ] No
   a. (If “Yes”, ASK:) Have they played a part in causing you to have housing problems?
      [ ] Yes  [ ] No (If “No”, GO TO Q12.)
      (If “Yes”, ASK:)
      i. Since they have played a part, have you ever tried to get treatment for a drug or alcohol
         problem?  [ ] Yes  [ ] No
      ii. Have you been able to get it?  [ ] Yes  [ ] No
      iii. (If “No”, ASK:) Can you tell me why you were unable to get treatment?
           [ ] Couldn’t afford it
           [ ] Couldn’t find appropriate care
           [ ] Didn’t meet treatment requirements (i.e., dual diagnosis)
           [ ] Full (long waiting list)
           [ ] Other (specify) _______________________________________________________

12. If you needed help with an addiction problem now, where would you go?
      [ ] 8th & 8th clinic
      [ ] AADAC
      [ ] AIDS Calgary
      [ ] Alcoholics Anonymous
      [ ] Alexandra Community Health Centre
      [ ] Alpha House
      [ ] Aventa
      [ ] Church
      [ ] Cocaine Anonymous
      [ ] CUPS
      [ ] Don’t know
      [ ] ER
      [ ] FreshStart
      [ ] Gambling Anonymous
      [ ] Hospital outpatient program
      [ ] Landers
      [ ] Love Addicts Anonymous
      [ ] Narcotics Anonymous
      [ ] Native Addiction Services
      [ ] Other Community agencies (specify) _______________________________________________________
      [ ] Other 12-step programs (specify) __________________________________________________________
      [ ] Outreach workers (downtown)
      [ ] Oxford House
      [ ] Renfrew
      [ ] SafeWorks
      [ ] Servants Anonymous
INTERVIEWER: Thank you. Now I would like to talk to you about the services you use in Calgary.

E. SERVICES USED IN CALGARY

KNOWLEDGE OF COMMUNITY RESOURCES:

1. When you need PHYSICAL health care, where do you go (e.g., for an infection)?
   - 8th & 8th Clinic
   - Alexandra Community Health Centre
   - CUPS
   - Don’t know
   - Family Doctor
   - Hospital (ER)
   - Other Community Health Centres (specify)
   - Walk-in Clinic
   - Other (please)

2. If you had a friend who needed MENTAL HEALTH CARE, where would you send them?
   - 8th & 8th Clinic
   - Alexandra Community Health Centre
   - Church
   - CUPS
   - Don’t know
   - ER
   - Family doctor
   - FAOS
   - Hospital
   - Hospital outpatient program
   - Other community agencies (specify)
   - Outreach workers
   - Psychiatrist
   - Public health
   - Shelter (specify)
   - Walk-in clinic/mental health clinic (specify)
   - Other (specify)

3. When you LOOK FOR WORK, where do you go?
   - Canada Employment Offices (HRDC)
   - Cash corner
   - Casual labour offices/private employment agencies (e.g., LabourReady, TaskForce)
   - Churches (please specify)
   - Community agencies/centers (specify)
   - Community Connections (Centre of Hope)
   - CUPS
   - Don’t know
   - Drop-In Centre (Casual Labour Office)
   - Government offices (specify)
   - Harry Hays Building (punch out)
   - Kerby Centre
   - Library
   - Mennonite Central Committee
   - Mustard Seed (Creative Centre)
Newspapers
Outreach workers
Somewhere downtown (specify) ____________________________________________________________
Word of mouth
Youth Employment Centre
Other (specify) __________________________________________________________________________

4. Where do you go for HOUSING INFORMATION?
Alpha House
Calgary Housing Company
Church (specify) ________________________________________________________________
Community agencies (specify) _________________________________________________________
CUPS
Don’t know
Drop-In Centre
Homeless Foundation Registry
Inn from the Cold
Kerby Centre
Mustard Seed
Newspapers
Pounding the pavement (looking for “for rent” signs)
Salvation Army
Shelters (specify) ________________________________________________________________
Women’s shelters
Word of mouth
Other (specify) __________________________________________________________________________

5. Where do you go for NON-MEDICAL HELP for yourself or your family or friends?
8th & 8th Clinic
Alexandra Community Health Centre
Church
Community agencies (specify) _________________________________________________________
CUPS
Day care subsidies
Don’t know
Exit
Friends/family
Inn From the Cold
Salvation Army
School
Shelter (specify) ________________________________________________________________
Walk-in Clinic
Women’s shelters
Other (specify) __________________________________________________________________________

6. Is there anyone you take care of such as children, family, or friends?  □ Yes  □ No  (If “No”, go to Q7.)
   a. (If “Yes”, ASK:) Who do you take care of?  [INTERVIEWER: Probe for how many and their ages.]

   Number  Age(s)
   □ Child ___________________ ____________________
   □ Non-relative/friend (youth: each other) ________________ ________________
   □ Parent ___________________ ____________________
   □ Partner ___________________ ____________________
   □ Relative other than above ___________________ ____________________
   □ Sibling ___________________ ____________________
   □ Other (specify) ______________________ ___________________ ____________________

7. Are there other people that you would take care of if you weren’t having housing problems?
(If “Yes”, ASK:)

a. Who are they? [INTERVIEWER: Probe for how many and their ages.]

<table>
<thead>
<tr>
<th>Number</th>
<th>Age(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Child</td>
<td></td>
</tr>
<tr>
<td>□ Non-relative/friend</td>
<td></td>
</tr>
<tr>
<td>□ Parent</td>
<td></td>
</tr>
<tr>
<td>□ Partner</td>
<td></td>
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<tr>
<td>□ Relative other than above</td>
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<tr>
<td>□ Sibling</td>
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<tr>
<td>□ Other (specify)</td>
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</table>

b. Where are they now? (e.g., with family, friends, child welfare, hospital)

<table>
<thead>
<tr>
<th>Explanation</th>
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<tbody>
<tr>
<td>□ Child</td>
</tr>
<tr>
<td>□ Non-relative/friend</td>
</tr>
<tr>
<td>□ Parent</td>
</tr>
<tr>
<td>□ Partner</td>
</tr>
<tr>
<td>□ Place (location) individual came to Calgary from (from QA2, p.1)</td>
</tr>
<tr>
<td>□ Relative other than above</td>
</tr>
<tr>
<td>□ Sibling</td>
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<tr>
<td>□ Other (specify)</td>
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MOVEMENT THROUGH THE SYSTEM:

1. Since you have been experiencing housing problems, what are the three places you have used most often either for services and/or shelter? (INTERVIEWER: PLEASE (A) CHECK EITHER SERVICE AND/OR SHELTER, (B) NUMBER APPROPRIATE SELECTIONS AS RESPONDENT NAMES THEM, AND (C) MAINTAIN SAME ORDER THROUGHOUT THE SECTION. FOR EXAMPLE, IF CUPS IS MENTIONED FIRST IT BECOMES SERVICE/SHELTER #1 FOR ALL FOLLOW-UP QUESTIONS).

<table>
<thead>
<tr>
<th>Service</th>
<th>Shelter</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 8th &amp; 8th Clinic</td>
<td>□ AMHB (mental health)</td>
</tr>
<tr>
<td>□ Centre 110</td>
<td>□ Church</td>
</tr>
<tr>
<td>□ CUPS</td>
<td>□ Detox centre</td>
</tr>
<tr>
<td>□ Drop-In Centre</td>
<td>□ Exit Drop-in</td>
</tr>
<tr>
<td>□ Hospital Emergency rooms</td>
<td>□ Inn From the Cold</td>
</tr>
<tr>
<td>□ Mustard Seed</td>
<td>□ Salvation Army (Booth Centre, Centre of Hope)</td>
</tr>
<tr>
<td>□ Shelter (specify)</td>
<td>□ Side Door (Avenue 15)</td>
</tr>
<tr>
<td>□ Social Services</td>
<td>□ Walk-in clinic</td>
</tr>
<tr>
<td>□ Women’s shelter (specify)</td>
<td>□ Other (specify)</td>
</tr>
</tbody>
</table>
2. Can you tell me roughly how often you used each of them in the last month?

Service/Shelter #1: ____________ □ Daily OR _______ # times per week OR _______ # times per month
Service/Shelter #2: ____________ □ Daily OR _______ # times per week OR _______ # times per month
Service/Shelter #3: ____________ □ Daily OR _______ # times per week OR _______ # times per month

3. What do you get when you go there?

Service/Shelter #1 (NAME) ___________________________________________________________________
☐ Advocacy
☐ Basic needs (food, water, shelter)
☐ Clothing
☐ Counselling
☐ Employment
☐ Food (specifically)
☐ Friends
☐ Help when you need it
☐ Medical care
☐ Mental health care
☐ Personal hygiene (personal items, shower)
☐ Sleep (place to stay)
☐ Telephone
☐ Other (specify) _________________________________________________________________________

Service/Shelter #2 (NAME): ___________________________________________________________________
☐ Advocacy
☐ Basic needs (food, water, shelter)
☐ Clothing
☐ Counselling
☐ Employment
☐ Food (specifically)
☐ Friends
☐ Help when you need it
☐ Medical care
☐ Mental health care
☐ Personal hygiene (personal items, shower)
☐ Sleep (place to stay)
☐ Telephone
☐ Other (specify) _________________________________________________________________________

Service/Shelter #3 (NAME): ___________________________________________________________________
☐ Advocacy
☐ Basic needs (food, water, shelter)
☐ Clothing
☐ Counselling
☐ Employment
☐ Food (specifically)
☐ Friends
☐ Help when you need it
☐ Medical care
☐ Mental health care
☐ Personal hygiene (personal items, shower)
☐ Sleep (place to stay)
☐ Telephone
☐ Other (specify) _________________________________________________________________________

4. What do you like about each service/shelter? (INTERVIEWER: Prompt... What makes it the best place for you?)
Service/Shelter #1 (NAME): ________________________________________________________________
☐ Access (easy to get to)
☐ Better quality services (i.e., beds are better, rooms have doors)
☐ Friends are there
☐ Privacy
☐ Safe
☐ Staff
☐ Other (specify) ________________________________________________________________

Service/Shelter #2 (NAME): ________________________________________________________________
☐ Access (easy to get to)
☐ Better quality services (i.e., beds are better, rooms have doors)
☐ Friends are there
☐ Privacy
☐ Safe
☐ Staff
☐ Other (specify) ________________________________________________________________

Service/Shelter #3 (NAME): ________________________________________________________________
☐ Access (easy to get to)
☐ Better quality services (i.e., beds are better, rooms have doors)
☐ Friends are there
☐ Privacy
☐ Safe
☐ Staff
☐ Other (specify) ________________________________________________________________

5. Are there any services and/or shelters that you have wanted to use but not been able to? ☐ Yes ☐ No (If “No”, GO TO Q6.)

   a. (If “Yes”, ASK:) Which places are they?
      ☐ 8th & 8th Clinic
      ☐ Alexandra Community Health Centre
      ☐ Church
      ☐ Community health centres (specify) __________________________________________________
      ☐ CUPS
      ☐ ER
      ☐ Hospital inpatient (specify) _______________________________________________________
      ☐ Hospital outpatient program (specify) _____________________________________________
      ☐ Shelter (specify) _____________________________________________________________
      ☐ Treatment center or program (specify) ____________________________________________
      ☐ Walk-in clinic
      ☐ Wood’s Homes
      ☐ Other (specify) _____________________________________________________________

6. Are there any services and/or shelters that you have used but wouldn’t use again? ☐ Yes ☐ No (If “No”, GO TO Q7.)

   (If “Yes”, ASK:)

   a. What services and/or shelters have you used but wouldn’t use again?
      ☐ 8th & 8th Clinic
      ☐ Alexandra Community Health Centre
      ☐ Alpha House
      ☐ AMHB (mental health)
      ☐ Church
      ☐ Community health centres (specify) ______________________________________________
      ☐ CUPS
      ☐ Detox
      ☐ Drop-In Centre
Exit Drop-in
Food banks
Hospital emergency rooms
Hospital outpatient programs
Mustard Seed
Salvation Army (Booth Centre, Centre of Hope)
Shelter (specify)
Side Door (Avenue 15)
Social Services
Walk-in clinic
Women’s shelter (specify)
Other (specify)

b. Why did you stop using them? (i.e., location, ease of access, quality of service, staff)

Service/Shelter #1 (NAME): ____________________________________________________________
REASON: ___________________________________________________________________________
___________________________________________________________________________________

Service/Shelter #2 (NAME): ____________________________________________________________
REASON: ___________________________________________________________________________
___________________________________________________________________________________

Service/Shelter #3 (NAME): ____________________________________________________________
REASON: ___________________________________________________________________________
___________________________________________________________________________________

7. Are there some services and/or shelters you would never use, even though they might have something you need?  □ Yes  □ No

a. (If “Yes”, ASK:) Which services and/or shelters are they and why would you never go there?

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<th>Service</th>
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8. You told me when we started that [INTERVIEWER: Refer to Screening Questions # 3 and #4 for examples of problems experienced in current housing situation, e.g., not having safe water to drink or not being able to afford rent, etc., and ASK:] How frequently in the last month have you changed where you stay at night [includes use of shelters]?
□ As often as I can
□ Daily
□ Less than once per month (i.e., not at all)
□ Weekly
□ Monthly

9. [INTERVIEWER STATE: We are really trying to understand how we can help people to find and keep good housing. Can you tell me what things you have tried to make that happen (i.e., to find or keep a home)? ____________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

a. (INTERVIEWER: If other than “nothing”, ASK:) Why do you think what you’ve tried hasn’t worked for you? ____________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
SURVIVAL SKILLS:

1. Where do you go for food?
   - Avenue 15
   - Churches
   - CUPS
   - Drop-In Centre
   - Exit
   - Food Bank
   - Friends
   - Grocery store
   - Mustard Seed
   - Outreach workers
   - Shelter (specify) _______________________________________________________________________
   - Side Door Program
   - Other (specify) ________________________________________________________________________

2. Have you ever had to do things that you didn't want to do just to survive?  □ Yes  □ No (If “No”, GO TO NEXT SECTION; BUT, IF YOUTH, GO TO Q3.)
   a. (If “Yes”, ASK:) Can you tell me what they are?
      - Bootlegging
      - Bottles or cans collection
      - Done favours (drug-related)
      - Drug dealing
      - Dumpster dining
      - Food bank (used a food bank)
      - Gone without food for a day (INTERVIEWER: Probe for number of days.) __________ days
      - Had sex with someone for money, food or shelter (including hitchhiking)
      - Left restaurant without paying
      - Manipulated people
      - Panhandled
      - Slept in a park or out of doors (INTERVIEWER: Probe for number of times.) __________ times
      - Stealing/theft
      - Other (specify) ___________________________________________________________________

YOUTH ONLY:

3. INTERVIEWER ASK: If you could imagine yourself in the future, in your perfect place, with your pictures hanging on the walls, maybe a pet, etc., what kinds of things that are in your life now or things that you have to do now would you leave behind (i.e., what does your perfect place look and feel like)? ________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

F. DEMOGRAPHICS

INTERVIEWER: We're almost done. I just have some questions to ask you about your background.

QUESTIONS FOR ALL PARTICIPANTS:

1. Are you a Canadian citizen?  □ Yes  □ No (If “Yes”, GO TO Q2.)
   a. (If “No”, ASK:) Are you a landed immigrant?  □ Yes  □ No
   b. (If “No”, ASK:) Are you a refugee claimant?  □ Yes  □ No

2. What is your current marital status? (SELECT THE SINGLE BEST OPTION)
   - Cohabitating (common law)
   - Divorced
   - Married
   - Never married/single
3. What is your ethnic background/origin?
   ☐ White ☐ Aboriginal ☐ Black ☐ Asian ☐ Other (specify) ________________________________

4. What was the last grade you completed? ______ (INTERVIEWER: Specify grades 1–12 or post-secondary.)

5. INTERVIEWER: RECORD SEX AS OBSERVED. IF UNCERTAIN, ASK: What do you consider yourself to be?)
   ☐ Male ☐ Female ☐ Transgender ☐ Unknown

6. Did you ever attend a residential school? ☐ Yes ☐ No ☐ Don’t know

7. Did either of your parents attend a residential school? ☐ Yes ☐ No ☐ Don’t know

8. Have you ever been in jail? ☐ Yes ☐ No  (If “No”, GO TO Q9.)
   (If “Yes”, ASK:
   a. How many times? ______________
   b. How long for each time?
      i. Time 1 ______________ duration
      ii. Time 2 ______________ duration
      iii. Time 3 ______________ duration

9. Have you [or IF APPLICABLE your children] ever been involved with Children’s Aid or Child Welfare (i.e., had a social worker)? ☐ Yes ☐ No

10. Were you ever adopted? ☐ Yes ☐ No

11. Have you ever lived in an institution other than a jail or a residential school (e.g., a hospital)?
    ☐ Yes ☐ No  (If “No”, GO TO GENERAL COMMENTS SECTION, UNLESS ABORIGINAL OR YOUTH.)
   (If “YES”, ASK:)
   a. Which one? ____________________________________________
   b. For how long? ____________ (# of days/weeks/months/years) [INTERVIEWER: Circle whichever is appropriate.]

ADDITIONAL QUESTIONS FOR ABORIGINAL PARTICIPANTS ONLY:


2. If “First Nations”, (INTERVIEWER: Probe for which Nation/Settlement/Northern Community they belong to.)
   ____________________________Nation
   ____________________________Settlement (if Metis)
   ____________________________Northern Community (if Inuit)

3. What part of Canada are you from? (INTERVIEWER: Record as much detail as given.)
   __________________________________________Province

4. How long have you been away from the Reserve/Settlement/Northern Community?
   _____ # of Weeks   _____ # of Months   _____ # of Years ☐ Not applicable (never lived on Reserve/in Settlement/in Northern Community)
5. How often do you go back to the Reserve/Settlement/Northern Community?  
   ______ (# of times per year)  □ Never

6. Why did you leave the Reserve/Settlement/Northern Community the last time?  
   □ Adequate education resources not available  
   □ Family problems (including abuse)  
   □ Illness/disability  
   □ No available employment  
   □ No available housing  
   □ Other resources (medical, legal, etc.) not available  
   □ Problems in the community  
   □ Other (INTERVIEWER: Probe for specific reason.) ____________________________________________

7. Did the Band or Metis Nation ever provide you with housing?  □ Yes  □ No

8. If you could, would you return to your Reserve/Settlement/Northern Community?  □ Yes  □ No  (If “No”, GO TO Q8b.)  
   a. (If “Yes”, ASK:) What would you need to make it possible for you to return? (INTERVIEWER: Do not read the following categories, but code response.)  
      □ Available Housing  
      □ Education resources  
      □ Employment  
      □ Family Mediation  
      □ Good Housing  
      □ Other resources (medical, legal, etc.)  
      □ Other (INTERVIEWER: Probe for specific reason.) ____________________________________________
   b. (If “No”, ASK:) If not, why not (i.e., why wouldn’t they go back)? ______________________________  
      ……………………………………………………………………………………………………………………………………………………………

ADDITIONAL QUESTIONS FOR YOUTH (UNDER 24) PARTICIPANTS ONLY:

INTERVIEWER: Refer to general demographics question #9. If respondent answered “No”, GO TO Q2. If respondent indicated that they have been involved with Children’s Aid or Child Welfare, ASK:

1. Do you currently have Child Welfare status?  □ Yes  □ No  (If “Yes”, GO TO Q2.)  
   a. (If “No”, ASK:) When was it terminated? __________ (year)

2. Have you ever tried to obtain financial assistance (SFI) and been declined?  □ Yes  □ No  
   a. (If “Yes”, ASK:) Why were you declined?  
      □ Could not access SFI (adult welfare) because they were under 18 and not married  
      □ Could not access financial assistance because they were under 16  
      □ Needed access to financial assistance but did not want other child welfare services  
      □ No fixed address  
      □ Other (specify) ________________________________________________________________

GENERAL COMMENTS (FOR ALL PARTICIPANTS):  

INTERVIEWER ASK: Is there anything else you would like to add? Anything you thought we should have asked that we didn’t? Anything we missed?  □ Yes  □ No  

If “Yes”, specify:  
……………………………………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………………………………
SURVEYOR: Please remember to (a) thank the participant for their involvement, (b) reassure them that their contribution is important and (c) complete and issue a payment voucher (or pay cash, if applicable).

BEFORE PROCEEDING TO NEXT INTERVIEW:

GO BACK TO P.3 OF SCREENING QUESTIONNAIRE AND

COMPLETE THE MENTAL STATE EVALUATION ON YOUR OWN.
Please note that surveyors should not attempt to accrue survey numbers throughout the survey. In other words, each new day will begin with survey # 01. For example, if Helen Gardiner is interviewing her third participant on July 4, 2002, and the participant is a woman, the participant number would be HG 03 04 07 F.
SURVEY FOR THE ABSOLUTELY HOMELESS/SHELTERLESS

INTERVIEWER: This survey is ONLY for those people who answered “YES” to the question “Are you currently spending most of your nights in shelters or sleeping rough (on streets, under bridges, in abandoned buildings)?”

UNLESS OTHERWISE INDICATED, DO NOT READ THE CHECKLISTS...LET THE PERSON ANSWER AND CODE THEIR ANSWERS AS YOU GO ALONG. PROVIDE PROMPT CARDS WHEN APPROPRIATE.

A. HOW THEY CAME TO BE WITHOUT SHELTER

INTERVIEWER: I'm going to start off by asking you some questions about how you came to be without a home.

1. How long have you lived in Calgary? (INTERVIEWER: If queried, qualify with “this time”.)
   _______ # of Weeks   _______ # of Months   _______ # of Years   _______ All their life

2. Where did you live before coming to Calgary (INTERVIEWER: Also specify country if outside Canada.)
   ___________ Location (if any)   ______________ Province     __________________Country

3. (INTERVIEWER: If new to Calgary or previously lived elsewhere, ASK:) Did you have a home before you came to Calgary?  ☐ Yes  ☐ No

4. What brought you to Calgary?
   [ ] Always come here part of the year (seasonal)
   [ ] Better access to services (health or social)
   [ ] Economy is better (more jobs available)
   [ ] More or better shelter accommodations
   [ ] Relatives, friends or family already live here
   [ ] Other (specify) __________________________________________________________________________

5. Did you have your own place to stay when you moved to Calgary?  ☐ Yes  ☐ No (If “Yes”, GO TO Q7.)
   (If “No,” ASK:)
   a. Where did you stay?_______________________________________________________________
   b. Is that where you expected to stay?  ☐ Yes  ☐ No (If “Yes”, GO TO Q6.)
   c. (If “No”, ASK:) Where did you expect to stay? _______________________________________

6. Is this the first time you have ever been without a home?  ☐ Yes  ☐ No (If “Yes”, GO TO Q8.)
   (If “No”, ASK:)
   a. [INTERVIEWER: Probe for number of previous occurrences of housing problems.] _________ times
   b. How many of those times have been in Calgary?  _________ times

7. When was the last time you had a home?
   ☐ Less than 1 year  ☐ More than a year but less than 5 years  ☐ More than 5 years

YOUTH ONLY:

   a. [INTERVIEWER: if person indicates that the last time they had a home was “Less than 1 year” ago, ASK:] Would you be interested in going back home (i.e., do they want to)?  ☐ Yes  ☐ No
   b. (If “Yes”, ASK:) Could you return home if you wanted to?  ☐ Yes  ☐ No
   c. (If “Yes” or “No”, ASK:) What would you need to make it possible for you to return home (i.e., what would have to happen)?______________________________________________________________
8. How did you lose your housing this time? (INTERVIEWER: Prompt... What are some of the reasons?)

- Could not access appropriate housing or services to address alcohol or drug problems
- Could not access appropriate housing or services to address their disability needs
- Could not access appropriate housing or services to address their mental health needs
- Could not find employment
- Did not have family to provide support
- Family problems (includes abuse)
- Fleeing violence
- Health problems (INTERVIEWER: Probe for physical or mental (emotional) or substance abuse:)
  - Physical
  - Mental/emotional
  - Substance abuse
- Lack of supported housing
- Landlord problems/eviction
- Lost job
- Rent was too high
- Services did not address their cultural needs
- Services were physically hard to get to
- Wage too low to afford shelter and basic needs
- Was released from custody
- Other (specify) __________________________________________________________________________

YOUTH ONLY (for those younger than 24):

- Could not access financial assistance because they were under 16
- Could not access housing because they were under 18
- Could not access services because they were truant from school
- Could not access SFI (adult welfare) because they were under 18 and not married
- Had their Child Welfare Status terminated
- Had to wait too long for services
- Only needed access to financial assistance but did not want other child welfare services
- Professionals did not understand what their needs were
- Professionals were unable to help them

INTERVIEWER: Thanks. Now I would like to ask you about your housing needs and what might be keeping you from getting the housing that you need.

B. HOUSING NEEDS, BARRIERS AND GAPS (Temporary/Short-Term Emergency/Transitional)

1. What kind of housing do you need right now? (i.e., the first step)
   - Current situation is best
   - Don't know
   - Independent living in own home or apartment with a rent subsidy
   - Independent living in own home or apartment without a rent subsidy*
   - Living in an institution (nursing home, hospital)*
   - Living in semi-independent accommodation (group home or supported housing)*
   - Living with immediate family (such as spouse, parents, or children)*
   - Living with other relatives (such as aunts, uncles, grandparents)*
   - Room and board or a hostel*
   - Sharing accommodation with roommates or friends*
   - Support for finding a job while looking for housing
   - Support for single fathers
   - Other (specify)* __________________________________________________________________________

   b. *ASK: Would you be able to afford that on your own, or would you need some help?
      - On their own
      - Would need some help

2. In the long term, what kind of home would you like to have?
   ____________________________________________________________________________________
Current situation is best
Don't know
Independent living in own home or apartment with a rent subsidy
Independent living in own home or apartment without a rent subsidy*
Living in an institution (nursing home, hospital)*
Living in semi-independent accommodation (group home or supported housing)*
Living with immediate family (such as spouse, parents, or children)*
Living with other relatives (such as aunts, uncles, grandparents)*
Room and board or a hostel*
Sharing accommodation with roommates or friends*
Other (specify)* _________________________________________________________________________

b.  * ASK: Would you be able to afford that on your own, or would you need some help?
☐ On their own  ☐ Would need some help

3. What do you think are the main reasons why you don’t have permanent housing?
☐ Can’t afford the damage deposit (i.e., initial set-up costs)
☐ Can’t afford the rents
☐ Don’t know how to go about finding housing
☐ Haven’t been able to find or keep a good job
☐ Health problems [INTERVIEWER: Probe for physical or mental (emotional) or substance abuse]
☐ Physical  ☐ Mental/emotional  ☐ Substance abuse
☐ Lack of suitable housing available (including waiting lists for housing)
☐ No money/resources to find a job (bus passes, etc.)
☐ Prefer living on the streets
☐ There is no one to help me (lack of social/personal support)
☐ Other (specify): __________________________________________________________________________

[INTERVIEWER: Now I would like to ask you a couple of questions about your experiences with shelters in Calgary.]

4. Have you ever tried to get into a shelter in Calgary?  ☐ Yes  ☐ No  (If “No”, GO TO NEXT SECTION.)

5. Have you ever been denied access to a shelter in Calgary?  ☐ Yes  ☐ No  (If “No”, GO TO NEXT SECTION.)

a.  (If “Yes”, ASK:)
1. Can you tell me the name of the shelter?
2. What was the reason you were denied access?
3. Where did you sleep that night?

<table>
<thead>
<tr>
<th>Shelter</th>
<th>Reason</th>
<th>Where Slept</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
<td>☐ Barred. If barred, ☐ Perm ☐ Temp</td>
<td>________________</td>
</tr>
<tr>
<td></td>
<td>☐ Full</td>
<td></td>
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<td></td>
<td>☐ Shelter hours (e.g., hours of work don’t fit shelter rules)</td>
<td></td>
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<tr>
<td></td>
<td>☐ Too drunk or stoned</td>
<td></td>
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<td></td>
<td>☐ Under Age</td>
<td></td>
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<tr>
<td></td>
<td>☐ Violence (e.g., got into a fight with another resident)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Other (specify)</td>
<td>________________</td>
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<tr>
<th>Shelter</th>
<th>Reason</th>
<th>Where Slept</th>
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<tbody>
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<td>☐ Full</td>
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<td></td>
<td>☐ Shelter hours (e.g., hours of work don’t fit shelter rules)</td>
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<td>☐ Under Age</td>
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<td></td>
<td>☐ Violence (e.g., got into a fight with another resident)</td>
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<tr>
<td></td>
<td>☐ Other (specify)</td>
<td>________________</td>
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</tbody>
</table>

[INTERVIEWER: Thank you. Now I would like to ask you about your current income situation.]
C. CURRENT INCOME

1. Are you currently employed?  ☐ Yes  ☐ No  (If “No”, GO TO Q2.)

   (If “Yes”, ASK:)
   c. Are you employed full time, part time or occasionally?  ☐ FT  ☐ PT  ☐ Occasionally
   d. Roughly how many hours per week do you work at your job?  _____________ hours

2. How much money do you currently make every month?
   $____________________ dollars

3. How much money do you think you would need each month in order to afford rent and utilities?
   $____________________ dollars

4. How much additional money would you need for the basics such as food, clothing and other necessities?
   $____________________ dollars (INTERVIEWER: Make sure this amount EXCLUDES the amount needed for rent and utilities.)

5. Where does your REGULAR money come from?  (INTERVIEWER: This includes “Employment”, if indicated “Yes” to Q1, in addition to any other sources as indicated below. CHECK AS MANY AS APPLY.)
   ☐ AISH
   ☐ Alimony
   ☐ Bottles and cans
   ☐ Cash Corner
   ☐ CCTB (Child Credit Tax Benefit)
   ☐ Child and Family Services
   ☐ Criminal activity (B&E, shoplifting, selling drugs, etc.)
   ☐ CUPS (emergency fund)
   ☐ Drugs (e.g., selling dime bags)
   ☐ EI
   ☐ Employment
   ☐ Family/friends
   ☐ Insurance
   ☐ Legal guardian
   ☐ No regular income
   ☐ Panhandling
   ☐ Pension (OAS, GIS, CPP, Disability (LTD))
   ☐ Private pension (WCB)
   ☐ Prostitution/sex trade (e.g., the stroll)
   ☐ Selling medications
   ☐ SFI
   ☐ Shelter (specify) ________________________________________________________________
   ☐ Social Worker
   ☐ Street Talk
   ☐ Student funding
   ☐ Other (specify) ________________________________________________________________

6. What other sources of income do you have? ____________________________________________
   ________________________________________________________________
   ________________________________________________________________

7. Have you ever been desperate for money (i.e., have you ever not been able to make ends meet)?
   ☐ Yes  ☐ No  (IF “No”, GO TO Q8.)
b. (If “Yes”, ASK:) When you are desperate for money, where do you go or what do you do?
- AISH
- Alimony
- Bottles and cans
- Cash Corner
- Child and Family Services
- Criminal activity (B&E, shoplifting, selling drugs, etc.)
- CUPS (emergency fund)
- Drugs
- EI
- Employment
- Family/friends
- Insurance
- Legal guardian
- No regular income
- Panhandling
- Pension (OAS, GIS, CPP, Disability (LTD))
- Private pension (WCB)
- Prostitution/sex trade (e.g., the stroll)
- Red Cross
- SFI
- Shelter (specify)
- Social Worker
- Stealing
- Street Talk
- Student funding
- Other (specify)

8. INTERVIEWER: IF RESPONDENT INDICATES THAT THEY ARE NOT EMPLOYED, ASK: Would you like to have a job (i.e., a steady income)?  □ Yes  □ No (If “No”, GO TO Q8b.)

b. (If “Yes”, ASK:) What’s getting in the way?
- Age (too old or too young)
- Clothes (no proper clothing for job or interviews)
- Discrimination (racism)
- Education
- Experience (i.e., don’t have enough experience)
- Health problems (INTERVIEWER: Probe for physical or mental (emotional) or substance abuse:)
  □ Physical
  □ Mental/emotional
  □ Substance abuse
- Housing (i.e., no fixed address to put on applications)
- Inadequate pay
- Job market (i.e., no jobs available)
- Knowledge (lack of knowledge about how to find work)
- Lack of sleep
- Literacy (reading and writing)
- Need daycare or other family supports
- Not eligible (i.e., immigration status)
- Pay would be garnisheed (e.g., creditors after them, alimony, etc.)
- Shower facilities (no access to showers)
- Someone to get them going (i.e., to wake them up)
- Telephone (no access to a telephone or no number to call them back at)
- Telephone (problems using)
- Transportation (money for or bus pass)
- Other (specify)

b. (If “No”, ASK:) Why not?

9. What do you need to be able to get a job? [INTERVIEWER STATE: There are many things that can prevent people from getting or keeping work. I am going to read you a list of possible barriers. Can you tell me if any of them apply to you?]
Basic hygiene
- Counselling/treatment
- General education
- Job training (e.g., skills to get a job)
- Life skills
- Reading
- Time management (keeping appointments)
- Transportation (costs associated with)
- Using or accessing a telephone
- Writing

a. Is there anything that we have missed? □ Yes □ No (If “No”, GO TO Q10.)

b. (If “Yes”, ASK:) What? ........................................................................................................

10. If you got a job, is there a possibility that your pay might be garnisheed? [INTERVIEWER: Explain if necessary.] □ Yes □ No (If “No”, GO TO NEXT SECTION.)

a. (If “Yes”, ASK:) Why? ........................................................................................................

D. HEALTH

DISABILITY ASSESSMENT (WHODAS II)

INTERVIEWER: I’m going to talk about a number of activities that most people do every day. I would like you to think back over the PAST MONTH and, to the best of your knowledge, answer these questions thinking about how much DIFFICULTY you had while DOING each of the ACTIVITIES. For each question, please give me just ONE response. Please refer to these cards (SHOW PROMPT CARDS) for the possible answers. [Interviewer: Do not read points beneath headings unless additional explanation is necessary.]

<table>
<thead>
<tr>
<th>H1</th>
<th>How do you rate your overall health in the past month?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past month, how much difficulty did you have in...</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</table>

<table>
<thead>
<tr>
<th>CS1</th>
<th>Understanding and communicating.</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Concentrating or remembering</td>
<td></td>
</tr>
<tr>
<td>o Finding solutions to problems</td>
<td></td>
</tr>
<tr>
<td>o Learning something new</td>
<td></td>
</tr>
<tr>
<td>o Generally understanding and communicating with people</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CS2</th>
<th>Getting around.</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Standing for long periods</td>
<td></td>
</tr>
<tr>
<td>o Standing up from sitting down</td>
<td></td>
</tr>
<tr>
<td>o Moving around</td>
<td></td>
</tr>
<tr>
<td>o Difficulty with walking a long distance, such as a kilometer</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CS3</th>
<th>Self care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Washing your whole body</td>
<td></td>
</tr>
<tr>
<td>o Getting dressed</td>
<td></td>
</tr>
<tr>
<td>o Eating</td>
<td></td>
</tr>
<tr>
<td>o Coping on your own</td>
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<table>
<thead>
<tr>
<th>CS4</th>
<th>Getting along with others.</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Dealing with people who are strangers</td>
<td></td>
</tr>
<tr>
<td>o Maintaining a friendship</td>
<td></td>
</tr>
<tr>
<td>o Getting along with people who are close</td>
<td></td>
</tr>
<tr>
<td>o Controlling feelings</td>
<td></td>
</tr>
<tr>
<td>CS5</td>
<td>Daily activities.</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>o Getting these activities done</td>
</tr>
<tr>
<td></td>
<td>o Doing these activities well</td>
</tr>
<tr>
<td></td>
<td>o Doing them as quickly as needed</td>
</tr>
<tr>
<td>CS6</td>
<td>Participating in society. (i.e., coping)</td>
</tr>
<tr>
<td></td>
<td>o The world and other people creating problems</td>
</tr>
<tr>
<td></td>
<td>o Discrimination problems (i.e., racism)</td>
</tr>
<tr>
<td></td>
<td>o Problems in living with dignity</td>
</tr>
<tr>
<td></td>
<td>o Problems joining in community activities</td>
</tr>
<tr>
<td>H2</td>
<td>Overall, in the past month, how much did all of these difficulties interfere with your life?</td>
</tr>
<tr>
<td>H3</td>
<td>Overall, in the past month, how many days were these difficulties present?</td>
</tr>
<tr>
<td>H4</td>
<td>In the past month, for how many days were you totally unable to carry out your usual activities because of any health condition [can mean physical or mental (emotional)]?</td>
</tr>
<tr>
<td>H5</td>
<td>In the past month, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities because of any health condition?</td>
</tr>
</tbody>
</table>

CS6a. **INTERVIEWER:** In relation to CS6, **ASK:** How does looking like you are on the street, e.g., your appearance or how you think you might appear to others, affect you (i.e., how does it make you feel)? ___________________ _______________________________________________________________________________________________

**MENTAL HEALTH (FROM WISCONSIN QOL)**

**INTERVIEWER:** For this next section, please understand that we're not trying to judge you in any way. We just want to get a sense of what your world is like for you. I'm now going to ask you a few questions about how you have FELT in the PAST MONTH; and could please tell me, just yes or no, whether you have had any of these feelings. So, in the past month, have you felt:

<table>
<thead>
<tr>
<th>1.</th>
<th>Answer/Score</th>
<th>Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>P1</td>
<td>3</td>
<td>0</td>
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<tr>
<td>P2</td>
<td>-3</td>
<td>0</td>
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<tr>
<td>P3</td>
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<td>P4</td>
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<td>0</td>
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<td>P5</td>
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<td>P6</td>
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<td>P7</td>
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<td>P8</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>P9</td>
<td>-3</td>
<td>0</td>
</tr>
<tr>
<td>P10</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
2. **INTERVIEWER STATE:** For the next question, please just choose one answer. During the past month, would you say that you have:
   - 3️⃣ generally felt calm and positive in outlook OR
   - 0️⃣ been having some periods of anxiety or depression OR
   - -3️⃣ generally been confused, frightened, anxious or depressed

3. There are many aspects of emotional distress including **feeling depressed**, **feeling anxious** or **hearing voices**. In the past month, which of these have you experienced?

   - i. Feeling Depressed  [ ] Yes  [ ] No
   - ii. Feeling Anxious  [ ] Yes  [ ] No
   - iii. Hearing Voices  [ ] Yes  [ ] No  *(If “No” to all, GO TO NEXT SECTION.)*

   *(If “Yes” to any of the above, ASK:)*

   a. Why [do you think you] have you felt this way?

   b. How much distress have these symptoms caused you?

      - 3️⃣ None  1.5️⃣ A little  0️⃣ Some  -1.5️⃣ A moderate amount  -3️⃣ A lot

   c. **INTERVIEWER:** Ask prior to each question… In the past month,

<table>
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<tr>
<th>How much have they interfered with your daily life?</th>
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<tr>
<td>Never</td>
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<tr>
<th>Have you felt like killing yourself? (i.e., had suicidal thoughts)</th>
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<td>Never</td>
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<tr>
<th>Have you felt like harming others? (i.e., had homicidal thoughts)</th>
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<td>Never</td>
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   d. **INTERVIEWER:** If person answered anything other than “Never”, **ASK:** Have you felt this way because a friend or a family member was depressed or hurt themselves, etc.?  [ ] Yes  [ ] No

**INTERVIEWER:** Thank you very much. That’s a tough section to get through. I appreciate your honesty. Now I’d like to move on to some general health questions.

**GENERAL HEALTH QUESTIONS:**

1. Do you have any HEALTH CONDITIONS that require treatment?  [ ] Yes  [ ] No  *(If “No”, GO TO Q2.)*

   *(If “Yes”, ASK:)*

   b. **INTERVIEWER:** Probe for what kind of health problem.

      i.  [ ] Mental health problem (specify)  
      ii. [ ] Physical health problem (specify)  

   b. Are you currently getting treatment for the condition(s)? (SEE M Edwards SPECIFIC QUESTION BELOW)

      i.  Mental health problem  [ ] Yes  [ ] No
      ii. Physical health problem  [ ] Yes  [ ] No  *(If “No” to both, GO TO Q1bC.)*

   A. *(If “Yes” to either of the above, ASK:)* Does anything prevent you from following through on your treatment?

      i.  Mental health problem  [ ] Yes  [ ] No
ii. Physical health problem  □ Yes □ No (If “No” to both, GO TO Q1c.)

B. (If “Yes” to either of the above, ASK:) What prevents you from following through on your treatment?

C. (If “No”, ASK:) Why aren’t you getting treatment?

C.     Have you been prescribed MEDICATION for the condition(s)?

i. Mental health problem  □ Yes □ No (If “No” to both, GO TO Q2.)

ii. Physical health problem  □ Yes □ No (If “No” to both, GO TO Q2.)

A. (If “Yes” to either of the above, ASK:) Does anything prevent you from taking your medication?

i. Mental health problem  □ Yes □ No

ii. Physical health problem  □ Yes □ No

B. (If “Yes” to either of the above, ASK:) What prevents you from taking your medication?

2. When was the last time you went to a doctor? ___________________ (# of days/weeks/months/years)

[INTERVIEWER: Circle whichever is appropriate.]
3. In the past month, have you ever gone to emergency?  □ Yes □ No  (If “No”, GO TO Q4.)

(If “Yes”, ASK:)

c. How many times have you gone in the past month?  _____________ times

d. Can you tell me what that visit/those visits was/were for?

Detail (Optional)

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<td>Mental health problem</td>
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<td>Physical health problem</td>
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4. In the past year, did you stay in the hospital overnight?  □ Yes □ No  (If “No”, GO TO Q5.)

(If “Yes”, ASK:)

d. How many times did you stay in the hospital overnight in the past year?  _____________ times

e. Can you tell me roughly how many nights you stayed in each time?  

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<th>Time3</th>
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f. Can you tell me what each stay was for?

Detail (Optional)

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<td>Mental health problem</td>
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<td>Physical health problem</td>
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5. Since you have been without a home, have you used any mental health services?  □ Yes □ No  (If “No”, GO TO Q6.)

a. (If “Yes”, ASK:) What mental health services have you used?

| EMS (Emergency Medical Services, e.g., ambulance) |
| ER |
| Hospitalization |
| Outpatient treatment (e.g., at clinic) (specify) |
| Treatment at hospital emergency |
| Other (specify) |

6. Do you have an Alberta Health Care Number?  □ Yes □ No  □ Don’t Know  (If “Yes” or “Don’t know”, GO TO Q7.)

a. (If “No”, ASK:) Why Not?

| Can’t afford it |
| Legal reasons |
| Don’t know how to get one (if came from elsewhere) |
| Don’t want to be registered (legal reasons) |
| Don’t want to be registered (paranoia) |
| In transit (if in transit, can’t get; 3-month waiting period) |
7. During the past YEAR, was there ever a time when you needed health care but did not receive it?
   □ Yes  □ No  (If “No”, GO TO Q8.)

   (If “Yes”, ASK: )

   a. Thinking of the most recent time, what was the type of care that was needed?
      □ Emotional or mental health problem
      □ Physical health problem
      □ Prenatal care
      □ Regular check-up
      □ Other (specify) ___________________________________________________________________

   b. Thinking again of the most recent time, why did you not get care?
      □ Alberta Health Care card problem (e.g., doesn’t have one - access limited)
      □ Fear (i.e., afraid of diagnosis, afraid of hospital or medical staff, afraid of being tracked)
      □ Hours of service (i.e., couldn’t get there within operating hours)
      □ Lack of knowledge (i.e., did not know where to go or how to get there)
      □ Mistrust (i.e., didn’t believe they would get help appropriate for them)
      □ Money (i.e., no money for prescription, or transportation etc.)
      □ Transportation problems (no way to get there)
      □ Turned away (illness not significant enough)
      □ Wait was too long
      □ Other (specify) ___________________________________________________________________

8. When was the last time you went to a dentist? (INTERVIEWER: Probe for months/years.)
   ___________ Months  ___________ Years

9. Do you have any dental problems right now?  □ Yes  □ No  □ Don’t know  (If “No” or “Don’t know”,
   GO TO Q10.)
   a.  (If “Yes”, ASK: ) What are they? ________________________________________________________________

10. Do you currently have any problems with alcohol and/or drugs?  □ Yes  □ No

11. Have alcohol or drugs ever been a problem for you?  □ Yes  □ No
   a.  (If “Yes”, ASK: ) Have they played a part in causing you to become homeless?  □ Yes  □ No  (If
      “No”, GO TO Q12.)

      (If “Yes”, ASK: )

      iii. Since they have played a part, have you ever tried to get treatment for a drug or alcohol
           problem?  □ Yes  □ No

      iv. Have you been able to get it?  □ Yes  □ No

      iii.  (If “No”, ASK: ) Can you tell me why you were unable to get treatment?
            □ Couldn’t afford it
            □ Couldn’t find appropriate care
            □ Didn’t meet treatment requirements (i.e., dual diagnosis)
            □ Full (long waiting list)
            □ Other (specify) ________________________________________________________________

12. If you needed help with an addiction problem now, where would you go?
   □ 8th & 8th clinic
   □ AADAC
   □ AIDS Calgary
   □ Alcoholics Anonymous
INTERVIEWER: Thank you. Now I would like to talk to you about the services you use in Calgary.

E. SERVICES USED IN CALGARY

KNOWLEDGE OF COMMUNITY RESOURCES:

1. When you need **PHYSICAL** health care, where do you go (e.g., for an infection)?
   - [ ] 8th & 8th Clinic
   - [ ] Alexandra Community Health Centre
   - [ ] CUPS
   - [ ] Don’t know
   - [ ] Family Doctor
   - [ ] Hospital (ER)
   - [ ] Other Community Health Centres (specify) _______________________________________________________
   - [ ] Walk-in Clinic
   - [ ] Other (please) ____________________________________________________________________________

2. If you had a friend who needed **MENTAL HEALTH CARE**, where would you send them?
   - [ ] 8th & 8th Clinic
   - [ ] Alexandra Community Health Centre
   - [ ] Church
   - [ ] CUPS
   - [ ] Don’t know
   - [ ] ER
   - [ ] Family doctor
   - [ ] FAOS
   - [ ] Hospital
   - [ ] Hospital outpatient program
   - [ ] Other community agencies (specify) ____________________________________________________________
   - [ ] Outreach workers
   - [ ] Psychiatrist
3. When you **LOOK FOR WORK**, where do you go?
- Canada Employment Offices (HRDC)
- Cash corner
- Casual labour offices/private employment agencies (e.g., LabourReady, TaskForce)
- Churches (please specify)
- Community agencies/centers (specify)
- Community Connections (Centre of Hope)
- CUPS
- Don't know
- Drop-In Centre (Casual Labour Office)
- Government offices (specify)
- Harry Hays Building (punch out)
- Kerby Centre
- Library
- Mennonite Central Committee
- Mustard Seed (Creative Centre)
- Newspapers
- Outreach workers
- Somewhere downtown (specify)
- Word of mouth
- Youth Employment Centre
- Other (specify)

4. Where do you go for **HOUSING INFORMATION**?
- Alpha House
- Calgary Housing Company
- Church (specify)
- Community agencies (specify)
- CUPS
- Don't know
- Drop-In Centre
- Homeless Foundation Registry
- Inn from the Cold
- Kerby Centre
- Mustard Seed
- Newspapers
- Pounding the pavement (looking for “for rent” signs)
- Salvation Army
- Shelters (specify)
- Women's shelters
- Word of mouth
- Other (specify)

5. Where do you go for **NON-MEDICAL HELP** for yourself or your family or friends?
- 8th & 8th Clinic
- Alexandra Community Health Centre
- Church
- Community agencies (specify)
- CUPS
- Day care subsidies
- Don't know
- Exit
- Friends/family
- Inn From the Cold
- Salvation Army
6. Is there anyone you take care of such as children, family, or friends?  □ Yes  □ No  (If “No”, go to Q7.)
   a. (If “Yes”, ASK:)  Who do you take care of?  [INTERVIEWER: Probe for how many and their ages.]

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<td>Non-relative/friend</td>
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<td>Other (specify)</td>
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7. Are there other people that you would take care of if you were not homeless?  □ Yes  □ No  (If “No”, GO TO NEXT SECTION.)
   a. Who are they?  [INTERVIEWER: Probe for how many and their ages.]

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<td>Other (specify)</td>
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b. Where are they now? (e.g., with family, friends, child welfare, hospital)

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<th>Explanation</th>
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MOVEMENT THROUGH THE SYSTEM:

1. Since you have been without a home, what are the three places you have used most often either for services and/or shelter?  [INTERVIEWER: PLEASE (A) CHECK EITHER SERVICE AND/OR SHELTER, (B) NUMBER APPROPRIATE SELECTIONS AS RESPONDENT NAMES THEM, AND (C) MAINTAIN SAME ORDER THROUGHOUT THE SECTION. FOR EXAMPLE, IF CUPS IS MENTIONED FIRST IT BECOMES SERVICE/SHELTER #1 FOR ALL FOLLOW-UP QUESTIONS).]
2. Can you tell me roughly how often you used each of them in the last month?

Service/Shelter #1: ____________

Daily OR _______ #times per week OR _______ #times per month

Service/Shelter #2: ____________

Daily OR _______ #times per week OR _______ #times per month

Service/Shelter #3: ____________

Daily OR _______ #times per week OR _______ #times per month

3. What do you get when you go there?

Service/Shelter #1 (NAME): ___________________________________________________________________

Advocacy
Basic needs (food, water, shelter)
Clothing
Counselling
Employment
Food (specifically)
Friends
Help when you need
Medical care
Mental health care
Personal hygiene (personal items, shower)
Sleep (place to stay)
Telephone
Other (specify) ___________________________________________________________________________

Service/Shelter #2 (NAME): ___________________________________________________________________

Advocacy
Basic needs (food, water, shelter)
Clothing
Counselling
Employment
Food (specifically)
Friends
Help when you need
Medical care
Mental health care
Personal hygiene (personal items, shower)
Sleep (place to stay)
Telephone
Other (specify) ___________________________________________________________________________
4. What do you like about each service/shelter? (INTERVIEWER: Prompt... What makes it the best place for you?)

Service/Shelter #1 (NAME): ________________________________________________________________
☐ Access (easy to get to)
☐ Better quality services (i.e., beds are better, rooms have doors)
☐ Friends are there
☐ Privacy
☐ Safe
☐ Staff
☐ Other (specify) _______________________________________________________________________

Service/Shelter #2 (NAME): ________________________________________________________________
☐ Access (easy to get to)
☐ Better quality services (i.e., beds are better, rooms have doors)
☐ Friends are there
☐ Privacy
☐ Safe
☐ Staff
☐ Other (specify) _______________________________________________________________________

Service/Shelter #3 (NAME): ________________________________________________________________
☐ Access (easy to get to)
☐ Better quality services (i.e., beds are better, rooms have doors)
☐ Friends are there
☐ Privacy
☐ Safe
☐ Staff
☐ Other (specify) _______________________________________________________________________

5. Are there any services and/or shelters that you have wanted to use but not been able to?  ☐ Yes ☐ No (If "No", GO TO Q6.)

b. (If "Yes", ASK:) Which places are they?
☐ 8th & 8th Clinic
☐ Alexandra Community Health Centre
☐ Church
☐ Community health centres (specify) ___________________________________________________________________
☐ CUPS
☐ ER
☐ Hospital inpatient (specify)
☐ Hospital outpatient program (specify) ___________________________________________________________________
☐ Shelter (specify) ___________________________________________________________________
☐ Treatment center or program (specify) ___________________________________________________________________
6. Are there any services and/or shelters that you have used but wouldn't use again? □ Yes □ No (If “No”, GO TO Q7.)

(If “Yes”, ASK):

a. What services or shelters have you used but wouldn't use again?

☐ 8th & 8th Clinic
☐ Alexandra Community Health Centre
☐ Alpha House
☐ AMHB (mental health)
☐ Church
☐ Community health centres (specify) ____________________________________________________
☐ CUPS
☐ Detox
☐ Drop-In Centre
☐ Exit Drop-in
☐ Food banks
☐ Hospital emergency rooms
☐ Hospital outpatient programs
☐ Mustard Seed
☐ Salvation Army (Booth Centre, Centre of Hope)
☐ Shelter (specify) _____________________________________________________________________
☐ Side Door (Avenue 15)
☐ Social Services
☐ Walk-in clinic
☐ Women’s shelter (specify) ___________________________________________________________
☐ Other (specify) _____________________________________________________________________

b. Why did you stop using them? (i.e., location, ease of access, quality of service, staff)

Service/Shelter #1 (NAME): ____________________________________________________________
REASON: ___________________________________________________________________________
___________________________________________________________________________________

Service/Shelter #2 (NAME): ____________________________________________________________
REASON: ___________________________________________________________________________
___________________________________________________________________________________

Service/Shelter #3 (NAME): ____________________________________________________________
REASON: ___________________________________________________________________________
___________________________________________________________________________________

7. Are there some services and/or shelters you would never use, even though they might have something you need? □ Yes □ No

a. (If “Yes”, ASK:) Which services and/or shelters are they and why would you never go there?

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8. You told me when we started that you spend most of your nights in shelters or sleeping rough. How frequently in the last month have you changed where you stay at night [includes use of shelters]?
As often as I can
☐ Daily
☐ Less than once per month
☐ Weekly
☐ Monthly

9. **INTERVIEWER STATE**: We are really trying to understand how we can help people to get out of homelessness. Can you tell me what things you have tried to get off the street (i.e., to find or keep a home)?

________________________________________________________________________________
________________________________________________________________________________

a. **(INTERVIEWER: If other than “nothing”, ASK:)** Why do you think what you’ve tried hasn’t worked for you?

________________________________________________________________________________
________________________________________________________________________________

**SURVIVAL SKILLS:**

1. Where do you go for food?

☐ Avenue 15
☐ Churches
☐ CUPS
☐ Drop-In Centre
☐ Exit
☐ Food Bank
☐ Friends
☐ Grocery store
☐ Mustard Seed
☐ Outreach workers
☐ Shelter (specify)
☐ Side Door Program
☐ Other (specify)

2. Have you ever had to do things that you didn’t want to do just to survive?  
☐ Yes  ☐ No  **(If “No”, GO TO NEXT SECTION; BUT, IF YOUTH, GO TO Q3.)**

a. **(If “Yes”, ASK:)** Can you tell me what they are?

☐ Bootlegging
☐ Bottles or cans collection
☐ Done favours (drug-related)
☐ Drug dealing
☐ Dumpster dining
☐ Food bank (used a food bank)
☐ Gone without food for a day **(INTERVIEWER: Probe for number of days.)** ________ days
☐ Had sex with someone for money, food or shelter (including hitchhiking)
☐ Left restaurant without paying
☐ Manipulated people
☐ Panhandled
☐ Slept in a park or out of doors **(INTERVIEWER: Probe for number of times.)** ________ times
☐ Stealing/theft
☐ Other (specify)

**YOUTH ONLY:**

3. **INTERVIEWER ASK:** If you could imagine yourself in the future, in your perfect place, with your pictures hanging on the walls, maybe a pet, etc., what kinds of things that are in your life now or things that you have to do now would you leave behind (i.e., what does your perfect place look and feel like)?

________________________________________________________________________________
________________________________________________________________________________
F. DEMOGRAPHICS

INTerviewer: We're almost done. I just have some questions to ask you about your background.

QUESTIONS FOR ALL PARTICIPANTS:

1. Are you a Canadian citizen?  [ ] Yes  [ ] No  (If “Yes”, GO TO Q2.)
   a.  (If “No”, ASK:) Are you a landed immigrant?  [ ] Yes  [ ] No
   b.  (If “No”, ASK:) Are you a refugee claimant?  [ ] Yes  [ ] No

2. What is your current marital status? (SELECT THE SINGLE BEST OPTION)
   [ ] Cohabitating (common law)
   [ ] Divorced
   [ ] Married
   [ ] Never married/single
   [ ] Separated
   [ ] Single parent
   [ ] Widowed

3. What is your ethnic background/origin?
   [ ] White  [ ] Aboriginal  [ ] Black  [ ] Asian  [ ] Other (specify) ___________________________________

4. What was the last grade you completed?   _______  (INTERVIEWER: Specify grades 1–12 or post-secondary.)

5. INTERVIEWER: RECORD SEX AS OBSERVED.  IF UNCERTAIN, ASK: What do you consider yourself to be?)
   [ ] Male  [ ] Female  [ ] Transgender  [ ] Unknown

6. Did you ever attend a residential school?  [ ] Yes  [ ] No  [ ] Don’t know

7. Did either of your parents attend a residential school?  [ ] Yes  [ ] No  [ ] Don’t know

8. Have you ever been in jail?  [ ] Yes  [ ] No  (If “No”, GO TO Q9.)
   (If “Yes”, ASK:)
   a.  How many times?  ____________________
   b.  How long for each time?
      i.  Time 1 ________________ duration
      ii. Time 2 ________________ duration
      iii. Time 3 ________________ duration

9. Have you [or IF APPLICABLE your children] ever been involved with Children’s Aid or Child Welfare (i.e., had a social worker)?  [ ] Yes  [ ] No

10. Were you ever adopted?  [ ] Yes  [ ] No

11. Have you ever lived in an institution other than a jail or a residential school (e.g., a hospital)?
   [ ] Yes  [ ] No  (If “No”, GO TO GENERAL COMMENTS SECTION, UNLESS ABORIGINAL OR YOUTH.)
   (If “Yes”, ASK:)
   a.  Which one?  ___________________________________________________________
   b.  For how long?  ____________ (# of days /weeks/months/years)  [INTERVIEWER: Circle whichever is appropriate.]
ADDITIONAL QUESTIONS FOR ABORIGINAL PARTICIPANTS ONLY:


2. If “First Nations”, (INTERVIEWER: Probe for which Nation/Settlement/Northern Community they belong to.)
   ____________________________ Nation
   ______________________________ Settlement (if Metis)
   ______________________________ Northern Community (if Inuit)

3. What part of Canada are you from? (INTERVIEWER: Record as much detail as given.)
   ______________________________ Province

4. How long have you been away from the Reserve/Settlement/Northern Community?
   _____ # of Weeks   _____ # of Months   _____ # of Years   ☐ Not applicable (never lived on Reserve/in Settlement/in Northern Community)

5. How often do you go back to the Reserve/Settlement/Northern Community?
   _____ (# of times per year)   ☐ Never

6. Why did you leave the Reserve/Settlement/Northern Community the last time?
   ☐ Adequate education resources not available
   ☐ Family problems (including abuse)
   ☐ Illness/disability
   ☐ No available employment
   ☐ No available housing
   ☐ Other resources (medical, legal, etc.) not available
   ☐ Problems in the community
   ☐ Other (INTERVIEWER: Probe for specific reason.) ______________________________

7. Did the Band or Metis Nation ever provide you with housing? ☐ Yes ☐ No

8. If you could, would you return to your Reserve/Settlement/Northern Community? ☐ Yes ☐ No (If “No”, GO TO Q8b.)
   a. (If “Yes”, ASK:) What would you need to make it possible for you to return? (INTERVIEWER: Do not read the following categories, but code response.)
      ☐ Available Housing
      ☐ Education resources
      ☐ Employment
      ☐ Family Mediation
      ☐ Good Housing
      ☐ Other resources (medical, legal, etc.)
      ☐ Other (INTERVIEWER: Probe for specific reason.) ______________________________
   b. (If “No”, ASK:) If not, why not (i.e., why wouldn’t they go back)? ______________________________
      ______________________________

ADDITIONAL QUESTIONS FOR YOUTH (UNDER 24) PARTICIPANTS ONLY:

INTERVIEWER: Refer to general demographics question # 9. If respondent answered “No”, GO TO Q2. If respondent indicated that they have been involved with Children’s Aid or Child Welfare, ASK:

1. Do you currently have Child Welfare status? ☐ Yes ☐ No (If “Yes”, GO TO Q2.)
   a. (If “No”, ASK:) When was it terminated? ____________ (year)

2. Have you ever tried to obtain financial assistance (SFI) and been declined? ☐ Yes ☐ No
a. (If “Yes”, ASK) Why were you declined?

☐ Could not access SFI (adult welfare) because they were under 18 and not married
☐ Could not access financial assistance because they were under 16
☐ Needed access to financial assistance but did not want other child welfare services
☐ No fixed address
☐ Other (specify) ___________________________________________________________________

GENERAL COMMENTS (FOR ALL PARTICIPANTS):

INTERVIEWER ASK: Is there anything else you would like to add? Anything you thought we should have asked that we didn’t? Anything we missed? ☐ Yes ☐ No

If “Yes”, specify:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

NOTE TO INTERVIEWER: If the person has been homeless in Calgary multiple times (Q6, p.1), please (a) explain that we are interested in learning more from people who have been in their situation and would like to interview them in more depth at a later time to understand their personal experience; advise them they would be paid for their time, (b) ask them if they would be interested in participating, and (c) explain the appointment procedure to them.

Are they willing to be interviewed? ☐ Yes ☐ No

a. If “Yes”, complete and issue appointment information card.
b. If “No”, thank participant for their assistance.

SURVEYOR: Please remember to (a) thank the participant for their involvement, (b) reassure them that their contribution is important, and (c) complete and issue a payment voucher (or pay cash, if applicable).

BEFORE PROCEEDING TO NEXT INTERVIEW:

GO BACK TO P.3 OF SCREENING QUESTIONNAIRE AND COMPLETE THE MENTAL STATE EVALUATION ON YOUR OWN.
Appendix E: 
Qualitative Data Collection Instruments
2002 Calgary Homeless Foundation

1 Hour Clinical Interview

A Methodology to obtain first person qualitative information from people who have been homeless and/or relatively homeless in Calgary more than twice

This work has been adapted and utilized with the permission of the developers

Primary researchers - Deborah Kraus and Judy Graves

Consulting Team:
Jim Woodward & Associates Inc.
Eberle Planning and Research
Deborah Kraus Consulting
Lisa May & Associates
Judy Graves

Respondent ID¹:  _____ _____  _____ _____  _____ _____  _____ _____  _____
Surveyor Initials           Survey #                   DD                       MM                M/F

Interview Location:  _________________________________________________

¹ Please note that surveyors should not attempt to accrue survey numbers throughout the survey. In other words, each new day will begin with survey # 01. For example, if Helen Gardiner is interviewing her third participant on July 4, 2002, and the participant is a woman, the participant number would be HG 03 04 07 F.
Executive Summary

The purpose of this report is to present a methodology to gather first person qualitative information from people who are currently and relatively homeless. This work was originally undertaken as a component of regional research on the incidence and nature of homelessness in the Greater Vancouver region, carried out during 2001-2002. The findings of that research are reported in the other volumes of the Research Project on Homelessness in Greater Vancouver (April, 2002). The work is now being utilized with permission of the primary authors in the 2002 Calgary Homeless Foundation study. It has been adapted to prevent overlap in questions between the primary survey and the clinical (qualitative) interview.

The goal of this methodology is to provide a tool that will enable community groups or agencies to:

- Obtain qualitative information about the homeless population, including women and men, families with children, seniors, Aboriginal people, people with mental and physical health issues, and people who are chronically and episodically homeless;
- Put a face on homelessness;
- Inform the development of appropriate policy and program responses and target scarce resources as effectively as possible;
- Document the life experiences of people who become homeless and the situations/processes that led them to become homeless;
- Document the kinds of services, programs or other assistance that have been found helpful for people to exit homelessness, and to identify what services are missing, and what are the barriers to accessing services;
- Identify prevention strategies; and
- Support a communications strategy.

The steps that were followed to develop this methodology include:

1. A review of approaches used in Canada and the United States to gather first person qualitative information from homeless and formerly homeless people.
2. Key informant interviews with individuals most closely involved in eight (8) of the examples identified in the above-noted review.
3. Development of a draft methodology to conduct personal interviews with people who are homeless and formerly homeless.
4. Two focus group meetings with people who were currently and formerly homeless to obtain their input on the draft methodology and interview guide.
5. Pilot interviews with four (4) individuals who were homeless and with three (3) people who had experienced homelessness in the recent past.
6. Review of the methodology by a professional qualitative research consultant.
PART I. INTRODUCTION & CONSENT

A. Approach (Individuals will have volunteered to participate during the completion of either the Absolutely Homeless or Relatively Homeless surveys)

Hello, my name is____________________________.

1. Thank you for agreeing to talk to me. As you know from completing the Homeless survey, we are trying to understand more about how people become homeless in Calgary and what they do to get out of being homeless. Since you have had housing problems more than once in the Calgary area, your experience can teach us a lot.

Offer some sort of refreshment (small snack or coffee)

2. The interview will take about 1 hour of your time. I will ask the questions, and I will [write down and/or tape record] your answers.

3. I will give you $15 as an honorarium for your participation.

4. Your participation is entirely voluntary, and you can stop the interview at any time.

5. We will protect your privacy and not release your identity to anyone.

6. I can interview you here or (suggest alternative where the interviewee might be more comfortable), whichever you prefer.

7. Do you agree to participate: ☐ Yes ☐ No

8. I will sign my name to indicate that that you have agreed to participate as set out above. (We are not asking you to sign, so your identity can be kept confidential and anonymous.)

__________________________________________  ________________________________
Date                                              Research assistant
Part B. Additional Information

The purpose of this research is to learn more about the causes of homelessness, about what might be done to prevent people from becoming homeless, and about what people need to get and keep affordable housing. One of the goals is for this information to be used to help shape government policies and programs.

Some important points about this interview are that:

- Your participation is entirely voluntary
- We will not ask you your name, so your identity will be anonymous
- You can choose not to answer any question or can stop the interview at any time
- Your participation does not affect your use of services in any way
- Your interview will be kept confidential with the exception of myself and [X] working under the direction of [name of project sponsor]. All notes from your interview will be stored securely at the [project sponsor’s office] for one year and then disposed of.

Your verbal agreement to participate indicates that:

- You have read this letter describing the research project and procedures, or it has been read to you
- You have considered the information
- You understand that your agreement to participate in this interview is voluntary.
PART II. ADDITIONAL DEMOGRAPHIC INFORMATION/FAMILY OF ORIGIN

I’m going to start by asking you a few simple questions about your age and background. We are asking everyone these questions so we can describe the range of different people we interviewed in our study. We are not going to ask you your name, so the information will be anonymous.

<table>
<thead>
<tr>
<th>Question</th>
<th>Probe for interviewer:</th>
</tr>
</thead>
</table>
| 1. What is your first language?                                          | English  
Other________________________________                      |
| 2. Where did you spend most of your time growing up?                     | City/town__________________________________________________  
Region_____________________________________________________________  
Province___________________________________________________________  
Country____________________________________________________________  |
| 3. Where did you live before that?                                       | City/town__________________________________________________  
Region_____________________________________________________________  
Province___________________________________________________________  
Country____________________________________________________________ |
PART III. QUESTIONS - People who are homeless/relatively homeless

A. Current living situation

I am now going to ask you some questions about your current living and sleeping situation.

1. Where did you stay/sleep last night?

   Probe: In a shelter, outside somewhere, inside at a friend’s place, other __________

2. How long have you been staying there?

   Probe: A few nights? A few weeks? Longer?
3. When was the last time you had a permanent address (stayed in one place for 6 months or more)?

   *Probe: How long ago?*

4. What type of housing were you living in?

   *Probe: Apartment? House? Room?*
5. Did you live there alone or were you sharing?

6. Were you staying for free or did you pay rent?
7. How long did you live there?

8. Tell me a bit more about your life at that time?

   *Probe: Did you have a job? Were you in school? Source of income?*
B. Causes of homelessness

9. Tell us what happened - what were the circumstances that led to your moving out?

   *Probe:* (e.g. Couldn’t afford the rent, evicted, relationship ended, housing condemned, issues with landlord, other...)

10. Then what happened - how did you end up on the street?

   *Probe:* What happened?
11. Have there been other times in your life when you didn’t have a place to live - homeless? If yes, tell me about it.

   Probe: How long ago? How long was it before you found a place to stay? Where did you find to live?

12. What would you say is the main/biggest reason why you don’t have a place of your own to live in right now?
13. Can you think of any other reasons why?

    Probe: Examples might include issues with landlord, lack of housing, low income, lack of support networks, lack of references, discrimination...

14. Are there any factors related to your health or lifestyle that are affecting or have affected your housing situation?

    Ask about:
    • Physical health - describe
    • Mental health - describe
    • Addictions - describe
    • Other - describe
C. Prevention

15. Did you go to anyone for help or advice before you lost your housing? If yes, what did they do?

16. Is there anything that anyone could have done to help you keep your place?
17. When you first lost your housing, is there anything that could have been done to help you get another place to live?

D. Help now

18. Since you have been on the street, has anyone helped or tried to help you:

   (a) Get a place to live? If yes, who and what happened?
(b) With income assistance? If yes, who and what happened?

(c) With other kinds of assistance? If yes, who and what happened?
19. What kind of services do you think would help you right now?

20. What would you say are some of the barriers/hassles that keep you from getting these services?
E. Services or other type of help needed/wanted

21. If you had some choices of the type of housing where you could live right now, what would you choose?

    \textit{Probe: Would you want to stay where you are? Move inside?}
    \textit{Probe: Would you want your own apartment with a private kitchen and bathroom? Shared housing? Place where meals are provided? Places that have full or part-time support staff? Places where it is OK to use drugs and alcohol? Places where no drugs or alcohol are permitted?}

22. What would you need to get the housing you want?

    \textit{Probe: This could be something new - it doesn’t have to be something that already exists}
23. If you had housing, what do you think would help you KEEP it?

24. If you were to get housing, is there anything you would miss about your current life? Explain.....
F. Background

I have just a few last personal questions.

25. To the best of your memory, how often did you or you and your family move when you were growing up. Do you think it was:

☐ 1 or 2 times  ☐ 3-5 times  ☐ 6-10 times  ☐ more than 10 times

26. Do you have any pets?  ☐ Yes  ☐ No

G. Reporting back

27. We are wondering if people we interview would be interested in attending a follow-up meeting to discuss the results of the interviews. If this were an option, would you be interested in attending some type of follow-up meeting?  ☐ Yes  ☐ No

28. If there were to be a follow-up meeting, would you prefer to:

(a) Have a private meeting with the other people who were interviewed, or  
(b) Participate in a meeting that would include government representatives, service providers, and other people who are homeless or formerly homeless?

Thank you very much for your time

☐ Pay honorarium

Signature of interviewer to confirm that honorarium was paid

☐ Ask if they have any comments about the interview process/questions

H. Interview and Note-Taker Comments

Record observations, thoughts, impressions, or questions arising from the interview