

Panel Study on Persons Who Are Homeless in Ottawa: Phase 1 Results¹

Final Report

Prepared for:

City of Ottawa
Housing Branch
Ottawa, Ontario

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NOTE

This report has been modified from the original report, submitted in December 2003. It was found that four of the participants included in the original report had been interviewed twice. Their information has been eliminated from this report, and some other minor modifications have been made. These changes do not affect the overall findings of the study.

ACKNOWLEDGEMENTS

A sincere thank you to the City of Ottawa, without whose recognition of the long-term significance of panel research and the willingness to direct federal research funds to its initiation, this project would not have been possible.

Thank you to all of the agencies, organizations, groups and individuals who contributed to the project either as part of the Research Team (Appendix A) or as members of the Community Advisory Committee (Appendix B). Both committees were instrumental in refining the overall study design, sampling frames and questionnaire content. Thank you as well, to the representatives of the 14 community agencies (Appendix C) where respondents were interviewed. Without your active support, we would not have been successful in our efforts to recruit over 400 participants to our study.

We also want to thank the interviewers without whom this study would not have been successful: Abdulkani Barrow, Sophie Hyman, Rebecca Nemiroff, Elyse Sevigny, Suzanne Lacasse, Anne Harewood, Noah Spector, Clem Guénard, Cheryl Blum, Lesley Fleming, and Mariette Blouin.

Most importantly, thank you to the participants who gave so generously of their time to share their experiences with us. As we acknowledged from the outset, the interview questions sometimes raised difficult memories. We sincerely hope that the information you provided will be used by all levels of government and by health and social service agencies in the important work of ending and preventing homelessness.

EXECUTIVE SUMMARY

Context and Objective:

- The Panel Study on Homelessness was developed in response to the City of Ottawa's interest in facilitating research between researchers at the Centre for Research on Community Services and the Institute of Population Health at the University of Ottawa, Carleton University, City of Ottawa's Housing Branch, and the Alliance to End Homelessness in Ottawa.
- The purpose of the Panel Study is to examine the pathways into and out of homelessness by following persons who are homeless over time. The research objective for the first wave of the study was to interview a representative sample of current residents of Ottawa emergency shelters in order to gather descriptive data on demographic characteristics, housing history, health status, and health and social service utilization.

Methodology:

- The methodology for the project was developed in a collaborative manner based on input from university researchers, community agency personnel, emergency shelter staff, and the City of Ottawa's Housing Branch. The project built on a previous survey of persons who were living in emergency shelters in Ottawa (Farrell, Aubry, Klodawsky, & Pettey, 2000). As well, procedures for locating these individuals were developed to locate and re-interview these individuals one and two years after their interview in order to ascertain their living situation.
- The interview protocol asked respondents about their housing histories, income histories, employment histories, social networking, personal empowerment, living conditions, social services utilization, health status, health care utilization, childhood stressors, substance use, and demographic characteristics.
- The project took place between October 2002 and October, 2003. Sampling guidelines for the study were developed for each of five sub-groups: adult men, adult women, female youth, male youth and adults in families. Depending on the subgroup, sampling strategies involved either quota sampling or population sampling. Quota sampling involved selecting participants based on characteristics of the subgroup population provided by shelters. Shelter staff used the sampling guidelines developed for the project to identify appropriate participants. The overall goal was to interview 80 individuals in each of these categories. Trained graduate students and other experienced interviewers conducted individual interviews.
- A total of 412 individuals were interviewed in the study, including 87 adult men, 85 adult women, 79 male youth, 78 female youth, and 83 adults in families.

Select Key Findings:

Noteworthy characteristics of the surveyed population were:

- Individuals in families displayed profiles that were most distinct from the other sub-groups.
- The respondents generally are quite isolated: most individuals are single, separated, divorced or widowed.
- The majority of youth have dropped out of school and have not completed high school.
- Most adults in families who are homeless are single mothers.
- There is a high proportion of people of aboriginal descent among single adults and youth, relative to their proportion in the Ottawa population.

Housing history of respondents revealed:

- Most respondents had moved several times within the last three years, both within the City of Ottawa and between different regions of the country.
- Most respondents had experienced homelessness on multiple occasions.
- Most respondents had experienced a relatively brief period in their most recent episode of homelessness (that is, less than six months).
- Adult males were more likely than others to have arrived in Ottawa just prior to their most recent episode of becoming homeless.
- Families tended to exhibit somewhat less mobility than was the case for the other subgroups.

Findings concerning the reasons for homelessness showed:

- The most commonly cited reason for homelessness was eviction, followed by an inability to pay the rent, and conflict with family, spouse, partner, or roommates.
- Adults within families cited economic difficulties as the most common reason precipitating their homelessness, followed by spousal abuse.
- Single adults cited eviction and economic reasons as the two most common reasons for their losing housing.
- Youth identified family difficulties as the most common reason precipitating their homelessness.
- Problems in the areas of physical health, mental health, and substance abuse were indicated by a minority of respondents as contributing to their homelessness.

Prominent findings relating to health status of respondents included:

- Overall, the reported physical health status of survey respondents was comparable to the general population.
- Despite these similarities in overall perceived physical health, survey respondents reported a much higher level of prevalence of a number of chronic physical health conditions as compared to the Canadian population.
- All of the subgroups of survey respondents with the exception of adults within families, had a much higher risk of suffering injuries that limited normal activities.

- In comparison to a general population sample, survey respondents reported a significantly lower level of mental health.
- A significant minority (i.e. 30%-40%) acknowledged alcohol abuse and drug abuse problems.

Results concerning the use of health and social services relative to housed Canadians indicated:

- Survey respondents had less contact in the past twelve months with general practitioners, dentists, orthodontists, and physiotherapists.
- Survey respondents were more likely to have been an overnight patient in a hospital, nursing home, or convalescent home.
- Survey respondents were more likely to identify having unmet health care needs particularly relating to mental health problems.

Conclusions:

Policy and program implications of the findings include:

- Need for involvement by all levels of government because of the complexity of the problem, the jurisdictions of relevant policies and programs to address the problem, and the mobility of the population
- Need for the development of policies and programs targeting problems related to income, housing, education, family violence, child welfare, mental health and addictions which contribute to homelessness
- Need for the development of safe, affordable permanent housing through a revitalized social housing sector
- Need for a range of health and social services addressing the unique needs of the different subgroups of persons who are homeless.

INTRODUCTION

Context and Rationale for the Study

A review of health and social science literature on homelessness to date has revealed that the large majority of empirical studies published in refereed academic journals have been conducted in the United States and provide only a “snapshot” of individuals’ current conditions, rather than understanding the change in conditions over time and both the pathways into, and out of, homelessness. Longitudinal studies that collect data on the same individuals over time are scarce in the current research literature on homelessness, and there are virtually no Canadian-based longitudinal studies. Again, the research is dominated by an understanding of the American context, not accounting for differences in the social safety-net, health and social service provision and the current context within Canada. The paucity of Canadian longitudinal research restricts our understanding of the course of homelessness; the factors that help individuals escape homelessness, and the effectiveness of services and supports developed to address and end homelessness.

Studies conducted in the 1980s focused especially on estimating the number of persons who were homeless and describing their characteristics (Bassuk, 1984; Canadian Council of Social Development, 1987; U.S. Department of Housing and Urban Development, 1984). In the context of the growing extent and diversity of people who are facing homelessness, research during the 1990s examined the consequences of homelessness on health (Daly, 1990; Winkleby & White, 1992; Wright, 1990) and attempted to develop etiological or “pathway” models of homelessness (Shinn & Gillespie, 1994; Susser, Moore, & Link, 1993; Timmer, Eitzen, & Talley, 1994; Weitzman, Knickerman, & Shinn, 1990). These more recent studies were also intended to help with the development of policies and programs created to address homelessness-related problems (Canadian Mortgage and Housing Corporation, 1999; Fitzgerald, 1995; Humphreys & Rosenheck, 1998; Toro et al., 1997).

Our review of the current literature identified approximately 50 studies on persons who are homeless that can be characterized as longitudinal in which data is collected on individuals over a period of time. A number of the longitudinal studies evaluated the impact of psychosocial interventions for persons with psychiatric disabilities who are homeless (e.g., Bebout, Drake, Zie, Gregory & Harris, 1997; Humphreys & Rosenheck, 1998; Morse, Classy, Allen, Templehoff & Smith, 1992; Toro et al., 1997). Some longitudinal research has used a panel study design to examine the utilization of health and social services (e.g., Kreider & Nicholson, 1997; Wong, 1999), the patterns and course of homelessness (e.g., Sosin, Piliavin & Westerfelt, 1990), and the prevalence of HIV and HIV risk behaviour (e.g., Clatts, Davis, Sotheran & Atillasoy, 1998; Sobo, Zimet, Zimmerman & Cecil, 1997).

Other longitudinal research focused on documenting the experiences and consequences of homelessness among specific subgroups of the homeless population such as women (e.g., Browne & Bassuk, 1997), families (e.g., Shinn, 1997; Stretch & Krueger, 1992), children (e.g., Clatts et al., 1998; Zima et al., 1999), and men (e.g., Lam et al., 1995; Concover et al., 1997). Much of the research has been focused on sub-groups or consequences, with few studies examining changes in multiple domains such as health, housing and service

utilization patterns, and linking these changes to pathways involved in leading persons out of homelessness and supporting them within permanent housing.

Certainly one of the most important characteristics of longitudinal research is its ability to capture changes in the lives of individuals over a time interval. However, this is most useful when a time interval that is sufficiently long to allow change to occur (e.g., 12 months) is used. Using a shorter time interval may potentially jeopardize the findings by not allowing a sufficient interval for change. Consistent with methodology used in large-scale Canadian longitudinal data collection by Statistics Canada, the current study involved the first wave of a panel study.

Establishing a “first wave” study provides two important benefits to homelessness research on a local and national level. First, it permits the development of a local tracking system to ensure that persons who are homeless can be located and interviewed at meaningful time intervals (i.e., 12 months and potentially longer intervals) to examine the factors that lead the persons in and out of homelessness. Second, it contributes to the current understanding of homelessness in the Canadian context and the influence of social, economic and service-related variables on homelessness and on accessing and maintaining permanent housing.

The first wave of the homelessness study will provide descriptive data on the demographic characteristics, housing history, health status, and health and social service utilization and needs of persons who are homeless in Ottawa. It will also implement a set of tracking procedures facilitating the one-year and potentially longer-term follow-ups of persons who are homeless in Ottawa.

The Panel Study on Homelessness is one response to the City of Ottawa’s interest in facilitating collaborative research between university researchers at the Centre for Research on Community Services and the Institute of Population Health at the University of Ottawa, Carleton University, Ottawa’s Housing Branch, and the Alliance to End Homelessness. The project built on the methodology used in a previous study in Ottawa by the researchers which surveyed persons who are homeless (Farrell et al., 2000), as well as developing a protocol to enable these individuals to be located after one and two years in order to ascertain their circumstances, particularly as they relate to homelessness.

Consistent with the definition of absolute homelessness adopted by the City of Ottawa, “homelessness” in the current study is defined as “a situation in which an individual or family has no housing at all, or is staying in a temporary form of shelter” (Region of Ottawa-Carleton, 1999, p. 2). This definition is consistent with that adopted in other regions of North America and in the academic research literature.

Research Questions

This document reports the progress of the first phase of the Panel Study. The research questions presented in the project proposal were the following:

1. What is the housing history of persons who are homeless in Ottawa?
2. What are the reasons for homelessness as perceived by persons who are homeless?
3. How does the health status of persons who are homeless compare to housed Canadians?
4. How does the health service utilization pattern (i.e., type and intensity) of persons who are homeless compare to that of housed Canadians?
5. What are the most pressing health needs of persons who are homeless?

In the course of developing the first wave interview schedule, these questions were modified to also include social service needs and utilization.

Format of the Report

The Report:

- Outlines the methodology developed for this project, including the collaborative processes that led to implementation of the study.
- Provides an overview of the findings organized by the research questions guiding the study.
- Identifies limitations of the study.
- Concludes with discussion of policy and program implications emerging from the findings.

METHODOLOGY

The project began with two distinct steps. The first was the development of a draft interview schedule that would be used as the basis of consultation with various stakeholders. The second was the establishment of various consultation mechanisms for introducing the study and involving stakeholders in refining the research instruments. Together these steps supported the development of a draft questionnaire that was used in the pilot study.

Development of Interview Schedule/Consultation with Community Stakeholders

The questionnaire used in the 1999 survey of persons who are homeless in Ottawa by the Centre for Research on Community Services at the University of Ottawa served as the starting point for the current study (Farrell et al., 2000). Tim Aubry, Fran Klodawsky, (principal co-investigators), Elizabeth Hay (project manager), and Susan Farrell (co-investigator) evaluated the various aspects of this questionnaire for its applicability to the Panel Study. Also discussed was the extent to which the relevant questions had succeeded in their intended objectives. Where shortcomings were identified, alternatives were sought. Additional instruments were added when necessary, drawing upon other established measures wherever possible.

In order to draw most effectively on the knowledge available at the universities and in the community, the investigators established two mechanisms of input and feedback: the Research Team and the Community Advisory Committee. The Research Team consisted of faculty members with a wide range of disciplinary backgrounds whose expertise would complement those of the primary investigators. In the early stages of development, members were consulted with regard to the interview protocol and the sampling strategy (see Appendix A for a list of members).

The Community Advisory Committee consisted of representatives of a wide variety of organizations whose members had some involvement with homeless or formerly homeless persons. In this case, the objective was to include anyone with some expertise that was complementary to others in the Committee. For this reason, we have not been restrictive in the composition and size of this group. Meetings were held to introduce the study and generate support for it, to discuss the interview protocol, and to seek input on the challenges of data collection (see Appendix B for a list of members).

In addition to these two groups, the investigators and project manager also made site visits to 14 of the emergency shelters in the region, in order to introduce the study and to request the support of the managers (see Appendix C). In all cases, the shelter management was supportive of the objectives and willing to participate in the study. This support was essential to the study's success since respondents were recruited through an introduction by shelter staff.

The feedback received through these collaborative processes was invaluable to the development of the draft interview protocol.

The Pilot Study

An interviewers' manual was prepared and interviewers were trained for the pilot study in June 2002. Twenty participants were interviewed between July 12th and July 19th representing individuals from the different subgroups of persons who were homeless. These interviews took place at The Salvation Army Booth Centre, The Mission, the Carling Family Shelter, Cornerstone, Youth Services Bureau's (YSB) Young Women's Emergency Shelter, Shepherds of Good Hope, Interval House, and the YMCA-YWCA. Following the interviews, a debriefing took place and extensive revisions were made to the interviewer protocol based on the experiences of the pilot study. A revised copy of the interview protocol was submitted to the City of Ottawa's Project Coordinator on September 13, 2002.

Sampling Strategy

Our sampling strategy was devised to capture the range of key characteristics within each of the various sub-groups, as well as the emergency facilities they utilized. This decision was based upon extant studies including our own previous survey (Farrell et al., 2000), that indicate that homeless men and women, male and female youth, and families each constitute groups of individuals with characteristics that are distinct from one another.

Eighty individuals who were homeless were to be identified to represent each of the main subgroups defined by sex and age, namely adult males, adult females, youth males, and youth females. Youth males and youth females were defined as adolescents between the ages of 16 and 19 years old. Eighty individual adults within families were also to be selected. Hew Gow, a sampling expert at Statistics Canada was consulted to help develop the sampling strategies. Different sampling strategies were used for each of the different sub-groups.

Persons were first met in emergency shelters, as previous research had indicated that over time shelter users make up a very large majority of the homeless population in the City of Ottawa (Farrell, Aubry, & Reissing, 2002).

Adult Men - A quota sample of shelter users was utilized to select the 80 adult male participants based on the distribution of length of stay of the population of residents in the men's shelters in 2001. The sample of adult men has representation proportionate to the relative numbers of potential participants at each shelter. Data collection for the adult male sample was as follows:

Table 1: Adult Men Sample

ADULT MEN					
Length of Stay	# Req'd	# Done	Shelter	# Req'd	# Done
< 7 days	28	30	The Salvation Army Booth Centre	26	28
7-29 days	25	26	The Mission	26	27
30-80 days	13	16	Shepherds of Good Hope	28	31
>80 days	14	13	Other		1
Unknown		2			
TOTAL	80	87		80	87

Adult Women: A quota sample was used to try to select 80 adult women participants from shelters for women fleeing violence and from Cornerstone. This sample was stratified according to citizenship and length of stay based on the profile of residents staying at Cornerstone just prior to the launching of the study. The goal for this sample was to have representation proportionate to the relative numbers of potential participants at each shelter. It was not possible to achieve these targets for several reasons but primarily because it was difficult to recruit immigrant and refugee women. These women were reluctant to participate for several reasons. Having recently arrived from outside Canada, some were pre-occupied with past trauma and/or trying to establish themselves in a new country. Others were suspicious of the motives of researchers asking personal information of them because of past experience. Because the residents of some of the shelters, such as La Présence, are primarily new Canadians, landed immigrants or refugees, we were not able to meet our quota for specific shelters.

As it became clear that it would not be possible to recruit adequate numbers of adult females from the shelters originally identified, residents of Oshki Kizis Lodge and Catholic Immigration Centre (CIC) - Reception House were also invited to participate as well as homeless clients of St. Joe's Women's Centre drop-in program, Shepherds of Good Hope Drop-In Program and The Soup Kitchen. Table 2 indicates the shelter or drop-in centre from which the adult women study participants were recruited, and the participants' citizenship and lengths of stay in the shelter.

Table 2: Adult Women Sample

ADULT WOMEN					
Length of Stay (days)	# Req'd	# Done	Shelter	# Req'd	# Done
<14	27	31	La Présence	10	2
14-26	13	16	Nelson House	4	2
27-61	14	17	Interval House	3	2
>62	26	17	Cornerstone	54	51
Other		4	YM/YWCA	6	2
Total	80	85	Oshki Kizis Lodge		8
			Shepherds of Good Hope Drop-In Program and The Soup Kitchen		4
<u>Citizenship</u>			Centre 454		3
Canadian	60	67	Maison d'Amitié	3	1
Other	20	18	YSB Drop-In Centre		1
Total	80	85	CIC Reception House		4
			YSB Young Women's Shelter		2
			Mission		1
			St.-Joe's Women Centre		1
			Immigrant Women's Services		1
			Total	80	85

Male Youth: A population sample (i.e., all youth in recruitment locations were invited to participate) from The Salvation Army Young Men's Shelter, supplemented by participants of the YSB Drop-In Centre was used to select the male youth participants. The reason for using a population strategy was the expectation that the full sampling period of four months would be required to develop the sample for this subgroup. Forty participants were to be selected from each location until the targeted number of 80 participants was reached. In spite of daily calls to monitor male youth entering the shelter and at least thrice weekly (sometimes daily) visits to the YSB Drop-In Centre, there were insufficient numbers of male youth available to participate in the study. In an attempt to recruit more male youth, research staff also interviewed at Operation Go Home. There were very few refusals to participate and we are quite confident that all homeless youth using these shelters were invited to participate in the study.

Female Youth: A population sample from the YSB Young Women's Emergency Shelter, supplemented by participants from the YSB Drop-in Centre was used to select the female youth participants. As with the male youth, the reason for using a population strategy was the expectation that the full sampling period of four months would be required to develop the sample for this subgroup. Forty participants were to be selected from each location until the targeted number of 80 participants was reached. Problems

similar to those encountered with the male youth sample were encountered when trying to recruit female youth. Interviewers monitored activity at the shelter to ensure that all new residents were invited to participate. Interviewers at the YSB Drop-In Centre and Operation Go Home recruited as many new homeless female youth as were available and willing to participate over the data collection period.

Table 3: Male/Female Youth Samples

Male Youth	Req'd	Done	Female Youth	Req'd	Done
The Salvation Army	40	26	YSB Young Women's Emergency Shelter	40	35
YSB Drop-In Centre	40	39	YSB Drop-In Centre	40	36
Operation Go Home		9	Operation Go Home		3
The Mission		1	Cornerstone		3
Shepherds of Good Hope		3	Interval House		1
Total	80	79	Total	80	78

Families: A quota sample was used for family participants from shelters for women fleeing violence and the City of Ottawa's Family Shelters. This sample was stratified according to citizenship based on 2001 data on family shelter residents. Similar to the other subgroups, the sample of individuals in families was to have representation proportionate to the relative numbers of potential participants at each shelter. Data collection for the family sample was as follows:

Table 4: Family Sample

FAMILIES					
Shelter	# Req'd	# Done	Citizenship	# Req'd	# Done
La Présence	2	0	Canadian (60%)	48	51
Nelson House	3	0	Other (40%)	32	32
Interval House	6	4			
Maison d'Amitié	4	1			
YM/YWCA	4	0			
Carling Family Shelter	40	57			
Forward Family Shelter	21	15			
CIC Reception House		4			
YSB Drop-In		1			
Oshki Kizis Lodge		1			
Total	80	83	Total	80	83

Interview Protocol

A combination of quantitative and qualitative interview methods were used for data collection. Quantitative measures were chosen based on their relevance, previous use and ease of administration with the studied population as well as their well-established

psychometric properties. They included questions from the National Population Health Survey (NPHS) (Statistics Canada, 1999) (to allow comparison of responses to those of housed Canadians collected from Statistics Canada) and health indices that measure different facets of health status, health service utilization and health-related quality of life. In addition, social support, physical health, and mental health status were assessed using validated measures. Also, a Housing, Income, and Employment Timeline was used to examine a participant's history in the areas of housing, homelessness, employment, and income. In cases where no measures existed for a variable, they were created and psychometric properties will be determined.

Qualitative measures were created and integrated into the interview protocol in order to provide more in-depth information as well as provide participants with an opportunity to share their experiences and perceptions. A narrative approach focussed on participants' experience while homeless, particularly their perceptions of determinants of their homelessness.

The interview protocol was organized as follows:

- Section A - Housing History
- Section B - Social Support
- Section C - Personal Empowerment
- Section D - Life Satisfaction
- Section E - Living Conditions
- Section F - Health Status
- Section G - Social Services Utilization
- Section H - Health Care Utilization
- Section I - Childhood Stressors
- Section J - Substance Use and Abuse
- Section K - Demographic Information
- Section L - Wrap-Up

A copy of the interview protocol is provided in Appendix D.

Procedures

The methodology was approved by the Social Sciences Research Ethics Board at the University of Ottawa. Eleven interviewers were hired and trained to conduct interviews. Interviewers were either graduate students in Clinical Psychology or Social Work or individuals who had extensive interviewing experience or experience working with persons who are homeless. Interviews were done in English (356), French (30) and Somali (14) by these interviewers. The services of cultural interpreters, available through the Cultural Interpretation Centre and Immigrant Women's Services, were used for 16 other interviews (Somali-4, Arabic-5, Spanish-3, Cantonese-1, Lingala-1, Russian-1, Ukrainian-1).

Interviews were conducted in a private area in emergency shelters or drop-in centres. Interviewers used response cards to assist respondents with structured questions (i.e.,

questions with a set of response alternatives). The length of interviews ranged from 50 to 150 minutes with the average being 75 minutes.

RESULTS

The presentation of the results will be broken down into sections beginning with a demographic profile of respondents followed by the presentation of data, which responds to the research questions guiding the first phase of the study.

Profile of Respondents

The respondents were asked questions about a wide range of demographic characteristics, including age, sex, marital status, sexual orientation, citizenship status, cultural identity, educational attainment and interest, and employment status.

Sex. The nature of the sampling by subgroup defined by sex and age resulted in a relatively equal representation of men (n = 182; 44%) and women (n = 228; 55%) in the sample. The greater number of female respondents was the result of the much higher proportion of female adults in families (n=69) than male adults in families (n=14). Only two individuals identified themselves as being transgendered.

Age. As shown in the following table, there is a fairly even distribution of adult males and adult females between the ages of 20-49 years old. There are smaller numbers of adult men (15%) or women (15%) who fall between 50 and 59 years of age. Interestingly, there are only three seniors (60 years old or greater) in the sample.

Table 5: Age of Adult Respondents⁴

Age Groups	AF (n = 84)	AM (n = 87)	FA (n = 82)
< 20	0	0	1 (1%)
20-29	17 (20%)	18 (21%)	25 (31%)
30-39	25 (30%)	30 (34%)	36 (44%)
40-49	26 (31%)	25 (29%)	16 (20%)
50-59	14 (17%)	13 (15%)	3 (4%)
>59	2 (2%)	0	1 (1%)

Note – AF = Female Adults; AM = Male Adults; FA = Adults in Families.

Marital Status. A large majority of respondents across all the subgroups was single, divorced, separated, or widowed, and only 15% of respondents were married, in a common-law relationship, or living with a romantic partner. Even among adults in families, only 29% of those interviewed were in a relationship. It is important to note that the reliance on emergency shelters for sampling contributed to the preponderance of single persons since, only the family shelters and those serving women who are victims of domestic abuse allow adults and children to stay together. The remaining emergency shelters house single individuals segregated by sex. Nonetheless, these findings also probably reflect the social isolation experienced by many persons who are homeless.

⁴ There was one participant in the family sub-group who was 17 years of age.

Education. As presented in the following table, a majority of male adults (56%), female adults (63%), and adults in families (61%) had completed at least high school. Moreover, almost one-third of each of these subgroups had schooling beyond high school. In contrast, 89% of male youth and 88% of female youth had completed Grade 11 or less.

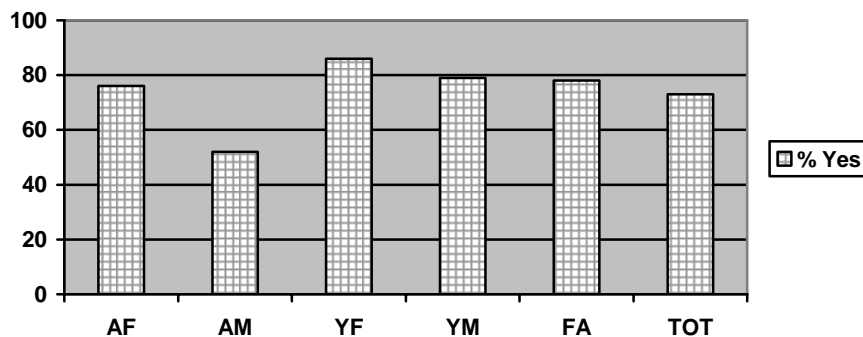
Table 6: Level of Education Attained

Level of Education Attained	AF (n = 82) (%)	AM (n = 86) (%)	YF (n = 77) (%)	YM (n = 78) (%)	FAM (n = 82) (%)	TOTAL (N = 405) (%)
Grade 8 or less	13	14	16	17	12	14
Grade 9 and 10	20	16	46	50	16	29
Grade 11	6	14	26	22	10	15
High school complete w/o diploma	4	4	5	3	4	4
High school with diploma	18	19	8	5	26	15
Other - post-secondary	39	33	0	4	33	23

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA = Adults in Families

One-third of female youth (33%) reported that they still attended school while only 10% of male youth stated that they were still in school. As shown in Figure 1 below, three-quarters of those participants not currently in school in all of the subgroups except for the adult men, expressed an interest in returning to school. This expressed interest ranged from a low of 52% among male adults to 84% among female youth.

Figure 1: Interest in Returning to School (N = 346)

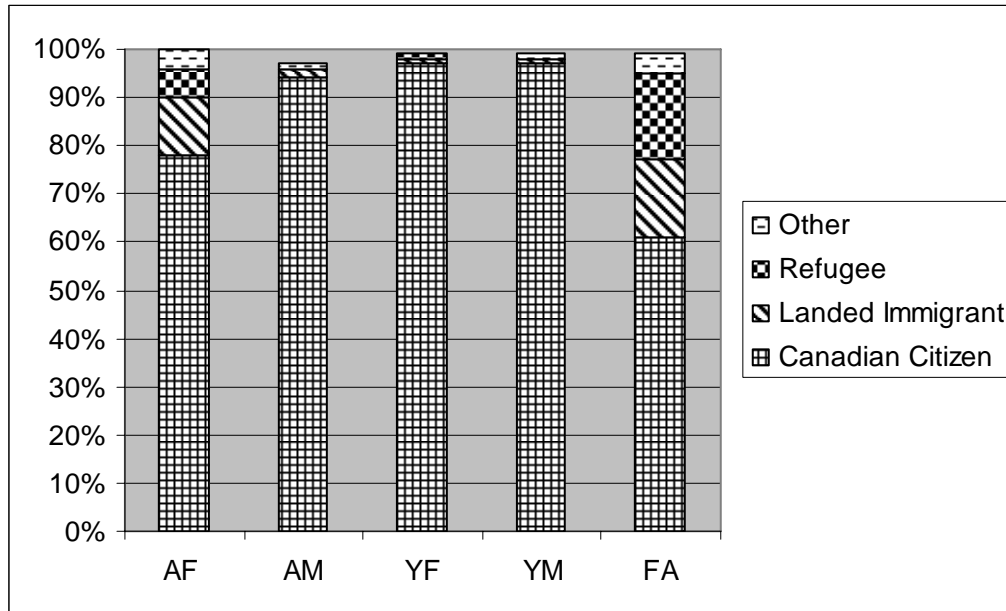


Note – Only participants not currently in school were asked this question. AF = Female Adults (n = 72); AM = Male Adults (n = 85); YF = Female Youth (n = 51); YM = Male Youth (n = 67); FA = Adults in Families (n = 68); TOT = (n = 343)

Employment. Not surprisingly given their homelessness, only a very small proportion of respondents (11%) were working for pay. This ranged from a low of 5% among adults in families to a high of 13% among female youth.

Citizenship. As shown in Figure 2, a large majority of male adults (94%), male youth (97%), and female youth (97%) identified themselves as Canadian citizens. Among female adults, 22% were non-Canadians, with the largest proportion among these individuals identifying themselves as landed immigrants. Among adults in families, 39% were non-Canadian with 18% identifying themselves as political refugees and another 16% reporting being landed immigrants. The nature of the sampling for these latter two subgroups, which involved using citizenship as a selection criterion, contributed to the larger presence of non-Canadians.

Figure 2: Immigration Status (N = 402)



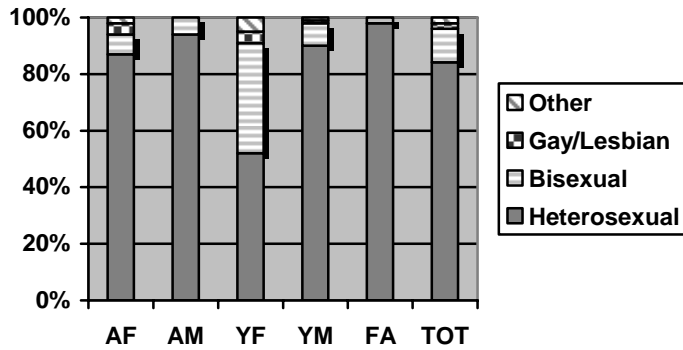
Note – AF = Female Adults (n = 82); AM = Male Adults (n = 83); YF = Female Youth (n = 76); YM = Male Youth (n = 78); FA = Adults in Families (n = 83)

Aboriginal or Inuit Identity. In answering a question about cultural group identity, a significant proportion of respondents (17%) relative to their representation in the Ottawa population (1.1%)⁵, indicated being aboriginal. Having an aboriginal background was especially high among female adults (26%) and youth (i.e., 20% of male youth and 19% of female youth). Among male adults, 10% indicated having an aboriginal identity and this was also the case for 7% of adults in families. Three adult females indicated having an Inuit identity.

Sexual Orientation. As shown in the Figure 3 below, only 2% of respondents identified themselves as having a gay or lesbian sexual orientation. Another 12% of respondents identified themselves as bisexual. No respondents among the male adults or adults in families described their sexual orientation as gay or lesbian. However, in all the subgroups there were individuals who identified themselves as bisexual. This ranged from a low of 2% (n = 2) among adults in families to a high of 39% among female youth.

⁵ Based on 2001 Census data (Statistics Canada, 2003)

Figure 3: Sexual Orientation (N = 407)



Note – AF = Female Adults (n = 83); AM = Male Adults (n = 86); YF = Female Youth (n = 77); YM = Male Youth (n = 78); FA = Adults in Families (n = 83); TOT = Total

Other Notable Respondent Characteristics. Among female youth who were mothers (n = 13), more than half (54%) had children who were in the care of the Children’s Aid Society, and this was also the case for almost one-fifth (18%) of the adult women who were mothers (n=58). A small number of women (n=15) were also pregnant at the time of the interview. Among this group, almost half were female youth (n=8) representing 11% of that subgroup. The remaining women who were pregnant included both single female adults (n=4) and adults in families (n=3).

1. Housing History:

What is the Housing History of Persons Who are Homeless in Ottawa Broken Down by Different Subgroups Defined by Age and Sex?

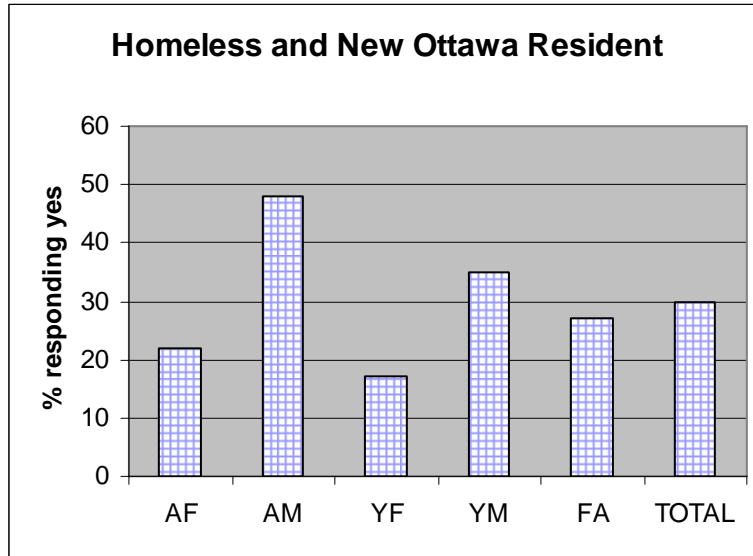
Respondents were asked to provide a detailed accounting of their housing histories over the previous three years, as well as their lifetime experiences of homelessness. In this section, six elements of respondents’ housing histories are described:

- their place of residence just prior to becoming homeless this time;
- the length of their residency in Ottawa;
- the length of time they have been homeless most recently;
- the number of times they have moved over the past three years;
- the number of times they have experienced homelessness over their lifetimes; and,
- their knowledge of and experience with social housing

Place of Residence Just Prior to Becoming Homeless This Time. As shown in Figure 4, an examination of respondents’ length of homelessness relative to their residency in Ottawa revealed that almost one-third (30%) were homeless upon moving to Ottawa, indicating that a significant minority of participants in the study had moved to Ottawa without secure housing arrangements. Among the subgroups of respondents, female youth had the lowest percentage of individuals (17%) who were simultaneously homeless and new residents to Ottawa followed closely by adult women (22%) and families (27%). On the other hand, almost one-half of male adults (48%) were homeless at the time of moving to Ottawa. Although these data appear to reinforce the perception

that many persons who are homeless in Ottawa are non-residents, further analysis is required to examine whether these individuals have been Ottawa residents in the past.

Figure 4: Homeless and New Ottawa Resident (N = 412)



Note – AF = Female Adults (n = 86); AM = Male Adults (n = 87); YF = Female Youth (n = 78); YM = Male Youth (n = 79); FA = Adults in Families (n = 83)

Length of Residency in Ottawa. In contrast to the sizeable minority who arrived in Ottawa homeless, many respondents were long time residents of the city. The average length of residency for respondents in the study was a little over nine years (109 months). Generally, adult females had lived here the longest (11.9 years) and male youth had the shortest local residencies (6.6 years). As shown in Table 7 below, the sample of respondents is split between recent to medium-term residents of Ottawa (49%) (i.e., five years or less) and longer-term residents of Ottawa (51%) (i.e., five years or more).

Table 7: Length of Residency in Ottawa for Different Subgroups

How long have you lived in Ottawa?	AF (n = 85) (%)	AM (n = 87) (%)	YF (n = 78) (%)	YM (n = 79) (%)	FA (n = 83) (%)	TOTAL (N = 416) (%)
less than six months	24	45	22	28	23	28
six months to one year	6	1	3	9	8	5
one year to five years	17	13	10	18	22	16
five years to ten years	17	12	13	13	18	14
greater than ten years	38	30	53	33	29	36

Note – AF = Female Adults; AM = Male Adult; YF = Female Youth; YM = Male Youth; FA = Adults in Families

Two-thirds of the respondents (66%) had lived in Ottawa for at least one year. Over half the participants from each of the subgroups sampled in the study were residents of Ottawa for one year or more. Over three-quarters of female youth (76%) and over two-

thirds of adults in families (69%) had lived in Ottawa for more than one year. Among longer-term residents of Ottawa, over one-third of the respondents (36%) had been in Ottawa for greater than ten years. This latter category ranged from a low of 29% for adults in families to a high of 53% for youth females.

Length of Time Homeless. As presented in Table 8, the length of time for the current episode of homelessness was relatively brief for a majority of respondents. Sixty-six percent of respondents had been homeless for six months or less. Among the subgroups, 86% of adults in families had been homeless less than six months. This is likely a reflection of the recent priority by the City of Ottawa to assist families to move into permanent housing. Over one-third of male adults (34%) and of male youth (41%), and almost one-third of female youth (31%) reported having been homeless for more than one year suggesting that these three subgroups experience more difficulty exiting homelessness than the other subgroups.

Table 8: How long have you been homeless?

How long have you been homeless?	AF (n = 85) (%)	AM (n = 87) (%)	YF (n = 78) (%)	YM (n = 79) (%)	FA (n = 83) (%)	TOTAL (N = 412) (%)
less than six months	72	56	63	50	86	66
six months to one year	12	8	6	10	10	9
one year to five years	12	29	31	38	5	22
five years to ten years	5	5	0	3	0	2
greater than ten years	0	2	0	0	0	1

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA = Adults in Families

Number of Times Homeless. These data reveal that the “length of homelessness” data reported above, gives a very partial picture. In terms of their lifetime experiences of homelessness, most respondents had been homeless multiple times- on average four times. The distribution of number of times homeless for each subgroup is presented below in Table 9. An examination of this distribution shows that two-thirds of the respondents (67%) had experienced multiple episodes of homelessness in their lives. Youth respondents appeared particularly vulnerable for encountering further homelessness after exiting it, as 33% of male youth and 32% of female youth had had more than five episodes of homelessness. Adults in families had experienced the smallest number of episodes; even so, 54% of families had been homeless two or more times.

Table 9: Number of Times Homeless

Number of times homeless	AF (n = 85) (%)	AM (n = 87) (%)	YF (n = 78) (%)	YM (n = 78) (%)	FA (n = 83) (%)	TOTAL (N = 412) (%)
Once	32	29	33	23	46	33
Twice	32	25	14	20	29	24
three times	13	13	13	9	10	11
four times	7	13	5	5	10	8
five times	9	8	3	10	2	7
more than five times	7	12	32	33	4	17

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA = Adults in Families

Number of Moves. Consistent with the multiple episodes of homelessness experienced by a majority of our respondents, a review of their housing histories showed them having moved frequently over the past three years. Two-thirds of the respondents (67%) had moved three or more times. Families appeared to have the most stable housing with over one-half of adults in families (59%) experiencing two or less moves. In contrast, female youth reported experiencing the least stable housing with one-half of them (50%) having had five or more moves in the past three years.

Social Housing. Respondents were asked whether they had ever lived in social housing, in Ottawa or elsewhere. (No definition for “social housing” was provided, so it is likely that any rent-geared-to-income unit might have been identified as social housing). About one-fifth of respondents (21%) said ‘yes’ to this question. Not surprisingly, considering typical eligibility criteria, this was the case for many more women and families than for men. Of the subgroups, greater percentages of female adults (33%) and adults within families (31%) had lived in social housing, in contrast to 6% of male adults and 14% of male youth.

Most respondents (70%) were aware of the waiting list for social housing in Ottawa with adults in families (90%) and female adults (89%) being the most aware. These two subgroups were also the most likely to be on the waiting list for social housing, with 85% of adults in families and 65% of female adults being on the list. Of these individuals, 44% of adults in families and 33% of female adults were on the priority list. In contrast, only 30% of male adults were on the waiting list and 14% of these individuals described themselves as being on the priority list. The large majority of respondents indicated that they found it easy to apply for social housing.

2. Reasons for Homelessness:

What Are the Reasons for Homelessness as Perceived by Persons Who are Homeless Broken Down by Different Subgroups Defined by Age and Sex?

In response to an open-ended question asking respondents about the main reason for their current homelessness, the most frequent explanation given by respondents (29%) was eviction (by landlord, parents or guardians, or other). Inability to pay the rent because of

financial difficulties was the second most common reason (24%) followed closely by conflict with parents, family members, partner, or room-mates (19%). However, it is important to note that when reasons for evictions were explained, they often included being in arrears in rent, suggesting that economic reasons for homelessness are even more common than indicated above. Other reasons given for current homelessness included, in descending order, substance (drug and/or alcohol) abuse for 8% of respondents, spousal abuse (7%), and moving to the city (5%).

Some differences in the rank order of cited reasons for homelessness emerged among the subgroups, although the universe of most cited reasons remained similar. Among adults in families, the inability to pay the rent was the most frequently cited reason (46%), followed by spousal abuse (24%), and eviction (8%). For male adults, inability to pay the rent was the most cited reason (31%), followed by evictions (21%), substance abuse (14%), conflict with another person (11%) and relationship break-up (10%). Female adults reported eviction as the most common reason (21%), followed by inability to pay the rent (18%), substance abuse (drug and/or alcohol) (13%), and spousal abuse (11%).

Both male and female youth identified difficulty living with family as the most prominent reason for their current homelessness. Among male youth, eviction by parents or guardians was cited by 42%, followed by parental conflict or conflict with family (18%), inability to pay the rent (15%), and eviction by the landlord or other (13%). Similarly, for female youth, parental conflict or conflict with family or guardians (27%) and eviction by parents (27%) were the most commonly identified reasons. These were followed by eviction by landlord or other (15%), and parental abuse (12%).

In addition to being asked about the main reason causing their homelessness, respondents also were asked specifically if problems related to physical health, mental health, alcohol use, long-term physical disabilities or childhood stressors contributed to current or past episodes of homelessness. Table 10 provides a breakdown by subgroup, of the percentage of respondents identifying these factors as contributors. Combined with the main reasons cited for current homelessness by respondents, the picture that emerges is of a range of factors contributing to homelessness that vary across the subgroups.

Table 10: Factors Contributing to Homelessness

Factors Contributing to Homelessness	AF (n = 85) (%)	AM (n = 87) (%)	YF (n = 78) (%)	YM (n = 79) (%)	FA (n = 83) (%)	TOTAL (N = 412) (%)
Problems with physical health	27	33	4	5	6	15
Childhood Stressors	37	32	55	47	6	35
Drinking	19	31	9	13	1	15
Mental health problems	25	21	34	21	5	21
Long Term Disabilities or Handicaps	17	18	5	8	5	11

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA = Adults in Families

Overall, 15% of respondents identified physical health problems as contributing to them becoming homelessness. This perceived contributor was most prevalent among male adults (33%) and female adults (27%). Eleven per cent of the respondents identified long-term physical disabilities as a contributor to their homelessness with this factor being most prevalent among female adults (17%) and male adults (18%).

In comparison to physical health, mental health problems were perceived as a factor contributing to homelessness by a somewhat larger proportion of respondents (21%). Over one third of female youth (34%) and one-quarter of female adults (25%) identified their mental health problems as a contributor to homelessness. Alcohol use was identified by 15% of respondents as a contributing factor to homelessness and this factor was most prevalent among male adults (31%) and female adults (19%).

The respondents also were asked about a wide variety of childhood stressors. Over one-third of the respondents (35%) felt that one or more of them had contributed to their homelessness, with adults in families, at 6%, much less likely to make this link than the other subgroups. Experiences of physical or sexual abuse, or witnessing abuse, were common among female adults and female and male youth. When asked if they had been physically abused by someone close to them, 65% of female youth, 49% of male youth and 39% of female adults answered 'yes'. Forty four percent of female adults and 42% of female youth reported having experienced sexual abuse. Sixty percent of female youth, 50% of male youth and 49% of female adults said they had witnessed abuse in their family.

Another area of note involves respondents' experiences of foster homes, group homes and time spent in a prison, detention centre or correctional centre. Many youth reported having spent time away from their family home during their childhood, including 46% of male youth and 35% of female youth who reported having lived in group homes. Single male respondents were more likely to have spent time in a prison, detention centre or correctional centre, with 61% of male youth and 44% of male adults indicating that they had had this experience. Given the preponderance of males typically housed in such facilities, it is also noteworthy that 35% of female youth had spent time there.

3. Health Status:

How does the health status of persons who are homeless compare to housed Canadians?

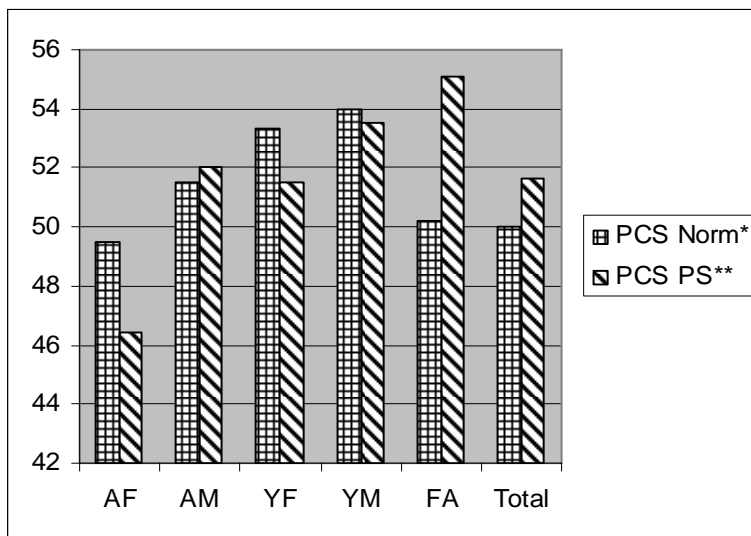
To answer this question, our results will be broken down into three areas, physical health, mental health, and substance use (alcohol, drug, and cigarettes). We used the 36-item short form (SF-36) in the study, a well-known screening instrument that provides a self-report measure of physical health and mental health relative to a general population that can be matched by age and sex (Ware, Kosinski, & Gandek, 2002). In addition, our survey included a series of questions about chronic conditions and injuries that are part of the NPHS a longitudinal survey of over 17,000 households across Canada about the current state of health and health care needs. Results of the NPHS questions from respondents participating in our survey were compared to the subgroup of the 1998-99 NPHS survey matched by age and sex.

In addition to the NPHS questions on chronic conditions, we added some of our own questions that asked about other physical health and mental health chronic conditions. In order to screen for alcohol and drug use among our respondents, we used the CAGE, a 4-item scale identifying the presence of alcohol use problems (Chan, Pristach, & Welte, 1994; Mayfield, McLeod, & Hall, 1974), and the Drug Assessment Screening Test (DAST), a 20-item scale identifying for the presence of drug use problems (Skinner, 1982).

Physical Health. In order to determine the level of physical health of our survey respondents in relation to the general population, we calculated the physical health summary score on the SF-36 for the overall sample and for the distinct subgroups in our study. The physical health summary score is a composite of items on the SF-36 asking about physical functioning (e.g., ability to walk different distances, ability to climb stairs, ability to engage in vigorous activities), bodily pain, perceived general health, and physical role functioning (e.g., accomplished less than liked in daily activities, relative amount of time on regular daily activities) (Ware, Kosinski, & Gandek, 2002). Lower scores on the scale reflect limitations in self care, physical, social, and role activities, the presence of tiredness, the presence of pain, and the perception that one’s health is “poor”. Higher scores represent no physical limitations or disabilities being present, the presence of high energy, and the perception that one’s health is “excellent”.

As shown in Figure 5 below, overall, respondents had standardized scores⁶ on the physical health summary measure of the SF-36 that did not differ significantly from that estimated from a representative sample of the 1998 general population in the United States.

Figure 5: Comparison of Panel Study Respondents Subgroups to Matched Respondents in the Normative Sample: Scores on the SF-36 Physical Health Summary Scale (N = 400)



*Physical Component Summary Average Score for SF-36 Normative Sample ** Physical Component Summary Average Score for Panel Study Respondents Note – AF = Female Adults (n = 83); AM = Male Adults (n = 82); YF = Female Youth (n = 78); YM = Male Youth (n = 76); FA = Adults in Families (n = 81)

⁶ Standardized scores involve converting the raw score to a scaled score based on a normative sample of the 1998 general U.S. population (Ages 18-64) (n = 6742) where the mean is 50 and the standard deviation is 10.

An examination of the subgroups in comparison to a cohort from the 1998 U.S. normative sample matched on sex and as closely as possible on age (i.e., 18-64 years of age) was conducted. As shown in the above figure, there were significant differences between the subgroups of female adults and adults in families when compared to their counterparts in the normative sample. Female adults from our study emerged as having a significantly lower score on the physical health summary score than a cohort with a similar age range from the normative sample⁷. On the other hand, the subgroup of adults in families had a significantly higher score on the physical health measure when compared to a subgroup of adult males and females with a similar age range from the normative sample⁸. A possible reason for these differences is the overall younger make-up of the family subgroup relative to the other survey adults and to the NPHS comparison group.

Table 11 compares our sample with the NPHS sample on percentage reporting the presence of chronic physical health conditions. There were differences in self-reported prevalence rates between the two groups for a number of conditions. Specifically, greater prevalence in the homeless subgroups was found for respiratory conditions (asthma, chronic bronchitis, or emphysema), arthritis or rheumatism, back problems, migraine headaches, and stomach or intestinal ulcers.

Table 11: Chronic Conditions – Comparisons of Panel Study Respondents to Respondents from the National Population Health Survey

Chronic Conditions	AF (n = 84) (%)		AM (n = 87) (%)		YF (n = 78) (%)		YM (n = 78) (%)		FA-M (n = 14) (%)		FA-F (n = 69) (%)	
	PS	NPHS	PS	NPHS	PS	NPHS	PS	NPHS	PS	NPHS	PS	NPHS
Asthma, Chronic Bronchitis or Emphysema	36	9	26	9	41	12	22	11	0	9	17	9
Arthritis or Rheumatism	32	18	19	11	14	1	13	1	29	11	9	18
Back Problems, excluding Arthritis	49	15	21	14	26	4	12	3	29	14	15	15
High Blood Pressure	19	13	13	10	5	0	5	0	0	10	6	13
Migraine Headaches	36	11	15	4	41	6	8	4	14	4	13	11
Diabetes	8	7	6	4	5	0	4	1	7	4	1	7
Epilepsy	4	1	2	1	3	0	1	0	0	1	0	1
Heart Disease	4	4	12	5	1	0	6	0	7	5	1	4
Cancer	7	2	2	2	3	0	1	0	0	2	1	2
Stomach or intestinal ulcers	14	3	6	3	9	1	3	1	14	3	0	3

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA-M = Adults in Families – Males; FA-F = Adults in Families - Females PS = Panel Study; NPHS = National Population Health Survey

⁷ t (3030) = 2.81, p. < .005.

⁸ t (5099) = 4.32 p. < .0001

The self-reported prevalence rates for these conditions appeared particularly high for female adults and female youth. Both of these subgroups scored significantly lower on average on the physical health scale of the SF-36. Approximately one-third of female adults reported having a respiratory condition (36% vs. 9% for NPHS cohort), arthritis or rheumatism (32% vs. 18% for NPHS cohort), and migraine headaches (36% vs. 11% for NPHS cohort). Almost half of female adults indicated that they had back problems (49% vs. 15% for NPHS cohort). Among female youth, over one-third reported the presence of respiratory problems (41% vs. 12% for NPHS cohort) and migraine headaches (41% vs. 6% for NPHS cohort) and over one-quarter (26% vs. 4% for NPHS cohort) stated that they had back problems.

Respondents were also asked about the presence of a small number of other physical health conditions in addition to the NPHS questions. Again, female adults seemed the most vulnerable to some of these conditions, namely hepatitis (19%), pneumonia (12%), and skin infections (11%). Male adults also reported a relatively high rate of hepatitis (13%). Also noteworthy, 8% of female youth indicated that they had pneumonia.

Mental Health. In order to determine the level of mental health of our survey respondents in relation to the general population, we calculated the mental health summary score on the SF-36 for the overall sample and for the distinct subgroups in our study. The mental health summary score is a composite of items on the SF-36 asking about the presence of depression and anxiety symptoms, social functioning, vitality (e.g., energy, fatigue), and emotional role functioning (e.g., amount of time on regular activities, amount accomplished in regular activities) (Ware, Kosinski, & Gandek, 2002). Lower scores on the scale reflect the presence of psychological distress, and social/role limitations because of emotional problems. Higher scores represent the presence of positive affect, and the absence of psychological distress and limitations in social/role activities due to emotional problems.

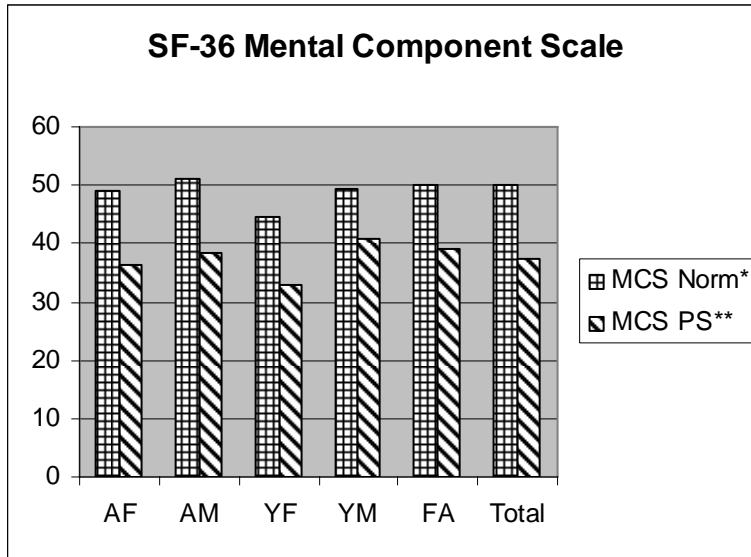
Figure 6 provides a comparison of our survey respondents and the normative sample of respondents from the 1998 survey of the U.S. general population. Overall, the total group of respondents had a lower average mental health summary score than those individuals from the SF-36 normative sample with a similar age range (i.e., 18-64 years old)⁹. As well, differences emerged between all the subgroups in our survey with respective subgroups of respondents in terms of sex and age in the SF-36 normative sample¹⁰. These differences indicated that all of the subgroups reported significantly lower levels of mental health than their matched counterparts in the general population. Based on the nature of the mental health items in the SF-36, survey respondents reported especially higher levels of depressive and anxiety symptoms than the general population sample. The cross-sectional nature of the survey (with data collected at only one time point so far) precludes being able to determine any order of causality between homelessness and mental health problems. It is likely that mental health difficulties are both a contributor to and a consequence of homelessness.

⁹ Total group of respondents: $t(7140) = 23.99, p < .0001$

¹⁰ Adults in families: $t(5099) = 10.00, p < .0001$; adult male: $t(2141) = 12.13, p < .0001$;

adult female: $t(3040) = 10.98, p < .0001$; male youth: $t(124) = 4.59, p < .0001$; female youth: $t(231) = 7.33, p < .001$.

Figure 6: Comparison of Panel Study Respondents Subgroups to Matched Respondents in the Normative Sample: Scores on the SF-36 Mental Health Summary Scale (N = 381)



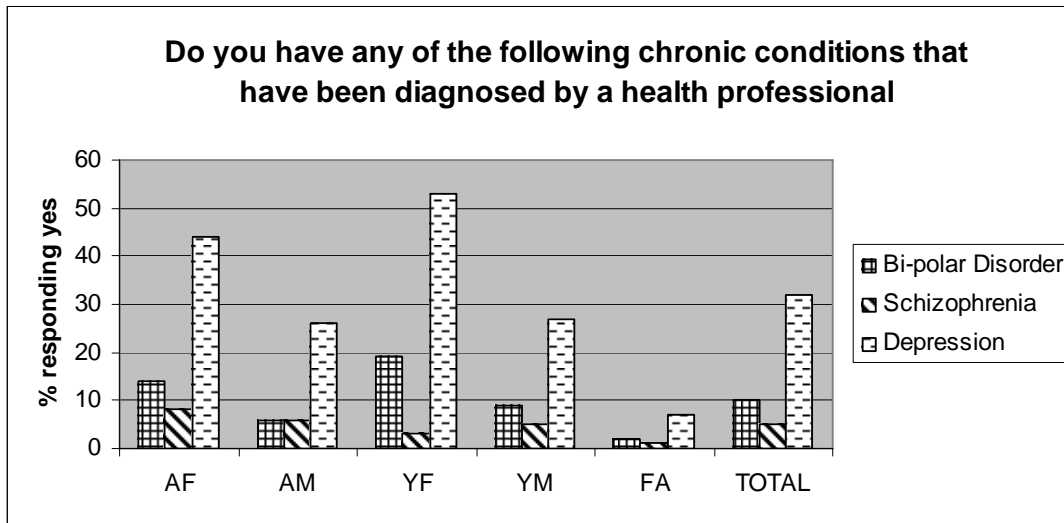
* Mental Component Summary Average Score for SF-36 Normative Sample
 ** Mental Component Summary Average Score for Panel Study Respondents

Note – AF = Female Adults (n = 74); AM = Male Adults (n = 78); YF = Female Youth (n = 76);
 YM = Male Youth (n = 74); FA = Adults in Families (n = 79)

Our survey also included items asking about the presence of such chronic mental health conditions as bipolar disorder, schizophrenia, and depression. Among these conditions, depression proved to be the most prevalent with 31% of all respondents identifying it as being present. In contrast, only 10% of respondents reported having been diagnosed with bipolar disorder and 5% with schizophrenia. It is probable that our survey underestimates the true prevalence of these latter two conditions since individuals with these conditions are less likely to be identified by shelter staff as a potential participant, or to volunteer to be a survey respondent. As well, the diagnosis is based on self-report requiring that respondents be aware of the nature of any mental health problems and be comfortable disclosing it.

As shown in Figure 7, 44% of female adults and 53% of female youth indicated having been diagnosed with depression. These subgroups also had the highest levels of bipolar disorder, with 14% of female adults and 19% of female youth stating that they had been diagnosed with it. Schizophrenia proved to be most prevalent among female adults with 8% of them reporting having been diagnosed with this disorder. Similar to other characteristics, adults in families had the lowest percentage of either men or women reporting the presence of a diagnosed mental health condition.

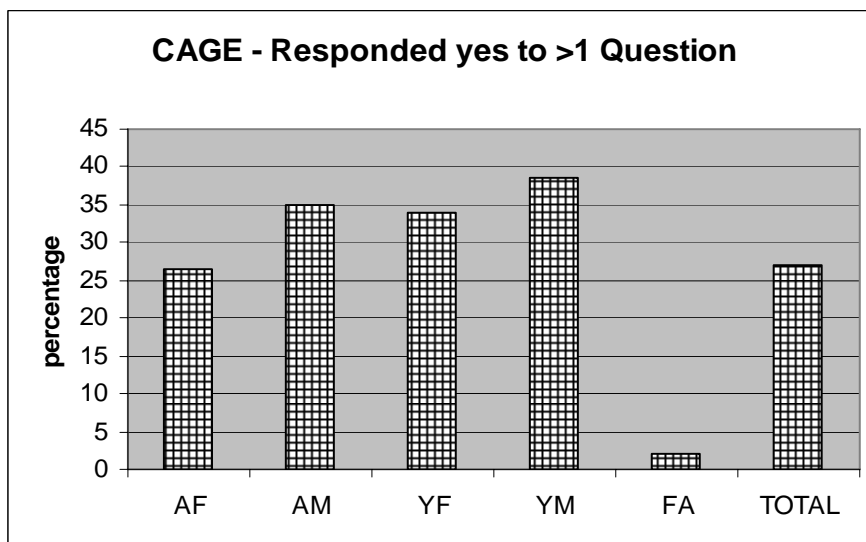
Figure 7: Chronic Mental Health Conditions Broken Down by Subgroups (N = 413)



Note – AF = Female Adults (n = 84); AM = Male Adults (n = 87); YF = Female Youth (n = 81); YM = Male Youth (n = 78); FA = Adults in Families (n = 83)

Substance Use. Based on responses to the CAGE¹¹, 27% of respondents in our survey were identified as abusing alcohol. As shown in Figure 8, a substantial minority of individuals were screened to have a drinking problem in all of the subgroups with the exception of adults in families (2%). Over one-third of male youth (39%) and adult males (35%) had CAGE scores consistent with alcohol abuse.

Figure 8: % with CAGE Scores Indicative of Alcohol Abuse (N = 407)

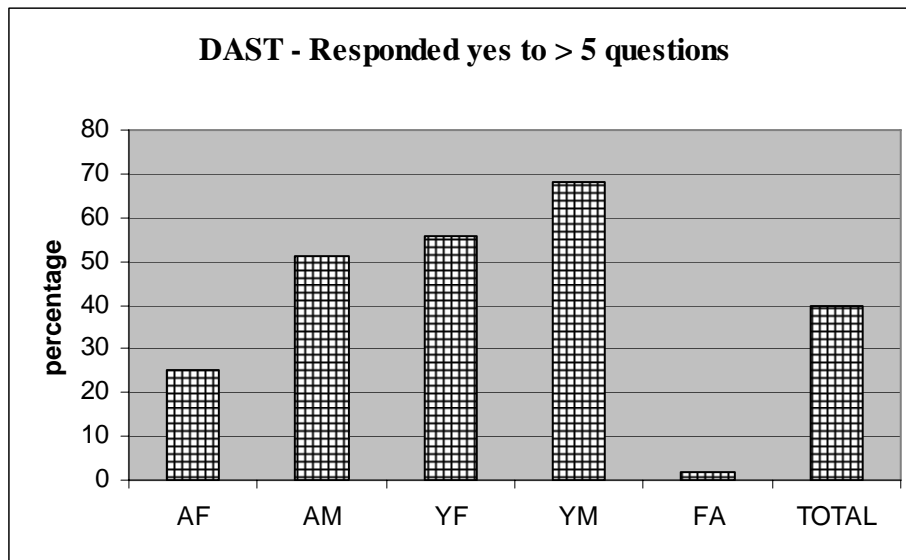


Note – AF = Female Adults (n = 83); AM = Male Adults (n = 86); YF = Female Youth (n = 77); YM = Male Youth (n = 78); FA = Adults in Families (n = 83)

¹¹ A score of 2 or greater on the 4-item CAGE is considered indicative of the presence of alcohol abuse.

Figure 9 provides the percentage of respondents with drug use problems as identified by the DAST. Based on responses to the DAST¹², 40% of respondents were identified as abusing drugs. Similar to the pattern of alcohol abuse among the subgroups, there was very little drug abuse prevalent among the adults in families (n=2; 2%). On the other hand, over one-half of the female youth (56%) and male youth (68%) reported drug use patterns on the DAST that were indicative of abuse. As well, 51% of male adults had DAST scores consistent with drug abuse.

Figure 9: % with DAST Scores Indicative of Drug Use Problems (N = 409)



Note – AF = Female Adults (n = 84); AM = Male Adults (n = 86); YF = Female Youth (n = 77); YM = Male Youth (n = 79); FA = Adults in Families (n = 83)

Respondents were also asked a small number of additional questions about drug use, overdoses and injection needle use. Almost one-quarter (22%) indicated that they had overdosed at some point in their life on drugs. This experience proved to be most prevalent among female youth (38%) followed by female adults (27%), male adults (25%), male youth (22%), and adults in families (1%). Of those having overdosed (n = 90), almost one-half (48%) of respondents indicated that it had been intentional (n=43).

Almost one-fifth of respondents (19%) reported having injected drugs. Among the subgroups, this was the case for over one-third of male adults (36%) and almost one-quarter of female adults (23%). Eighteen per cent of male youth, 16 % of female youth and 3% of adults in families had injected drugs. Of those having injected drugs (n = 77), a very high percentage (94%) indicated that were able to access clean needles. However, almost one-third of them (31%) admitted to having shared needles with others. This was most prevalent among adult females (53%) followed by adult males (36%).

¹² A score of 6 or more on the DAST is considered indicative of the presence of drug abuse.

Finally, respondents were also asked if they smoked cigarettes. The smoking prevalence among respondents was 74%. Smoking was most common among male adults (92%) and male youth (87%). A majority of adult females (71%) and female youth (77%) were also smokers. Smoking was least prevalent among adults in families (42%).

4. Health and Social Service Utilization:

How does the health and social service utilization pattern (i.e., type and intensity) of persons who are homeless compare to that of housed Canadians?

To answer this question, a series of questions about health and social service utilization patterns that had been part of the National Population Health Survey were also asked of the individuals who participated in the panel study. These questions addressed three topics:

- Contact with health-related service providers in the last twelve months,
- Overnight patient in a hospital, nursing home or convalescent home in the last twelve months, and
- Unmet health care needs.

In addition, respondents were asked about their use of local social services.

Contact with Service Providers in the Last Twelve Months. As indicated in Table 12, the panel study respondents showed a pattern of health service utilization that was quite distinct from the NPHS. Relative to comparable NPHS respondents, our survey respondents were less likely to have had contact with general practitioners or family physicians, dentists, and orthodontists but were more likely to have had contact with other specialist doctors, nurses, psychologists or counselors, and social workers or outreach workers.

Table 12: Contact with Health Care Service Providers in Last 12 Months

Type of service provider	AF (n = 85) (%)		AM (n = 87) (%)		YF (n = 78) (%)		YM (n = 79) (%)		FA-F (n = 69) (%)		FA-M (n = 14) (%)	
	PS	NPHS	PS	NPHS	PS	NPHS	PS	NPHS	PS	NPHS	PS	NPHS
General Practitioner	74	86	53	72	63	78	48	64	81	86	36	72
Other specialist doctor	44	29	23	19	45	82	23	14	29	29	14	19
Nurse for care or advice	40	8	23	5	38	8	40	4	26	8	21	5
Dentist or orthodontist	16	58	17	53	35	76	21	71	22	58	14	53
Physiotherapist	6	8	7	6	6	4	9	4	3	8	0	6

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA-F = Female Adults in Families; FA-M = Male Adults in Families

A majority of both our survey respondents and NPHS respondents had contact with a general practitioner or family physician in the last 12 months. However, on average, our survey respondents were less likely to have seen these service providers relative to their NPHS cohort group. The gap was more dramatic with regard to contact with a dentist or orthodontist where the percentage of survey respondents having contact was more than 30% lower on average than NPHS participants. This gap in accessing a

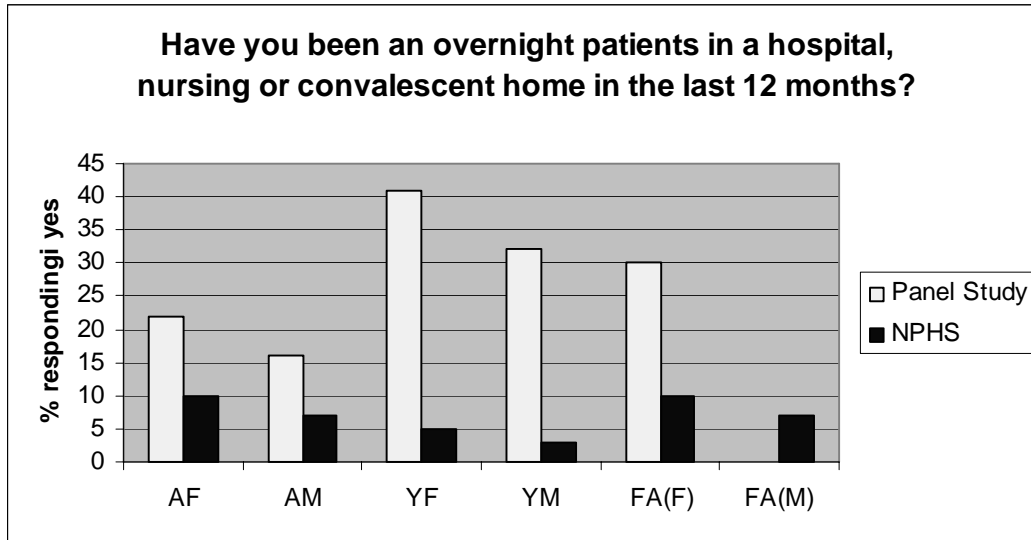
dentist or orthodontist ranged from a 50% difference for male youth (21% for respondents in our study vs. 71% among NPHS respondents) to a 36% difference for single men (17% vs. 53%) and female adults in families (22% vs. 58%).

With regard to “other specialist doctors”, female adults (44%), male adults (23%) and male youth (23%) from the panel study had significantly more contact with these service providers than similar cohorts of NPHS respondents (29% for adult females, 19% for male adults, and 14% for male youth) . In contrast, among female youth, the contact rate was 37% lower among panel study respondents (45%) than it was for the NPHS (82%). Contact with a nurse for care or advice was significantly higher for all of the panel study sub-groups, ranging from a low of 23% for adult men to a high of 40% for adult women and male youth. In contrast, less than 10% of all of the comparable NPHS cohorts reported having seen a nurse.

Contact with Other Service Providers. The panel study also revealed that many more female respondents (69% of female youth and 55% of female adults) than male respondents (44% of male youth and 29% of male adults) had contact with shelter workers in the last twelve months. Contact with a spiritual or traditional healer also took place for about 7% of respondents overall, with a high of 14% among adult females and a low of 2% among adult males. In addition, in response to a question about contact with a psychologist or counsellor in the past 12 months, female respondents (19% of adult females and 36% of female youth) were the most likely to answer affirmatively. Among males, 9% of male adults and 15% of male youth reported having contact with these types of professionals.

Overnight patient in a Health Care Facility. Figure 10 presents a comparison of panel study respondents with NPHS respondents on being an overnight patient in a health care facility. All of the panel study subgroups except for male adults within families (n=14), were more likely to have been an overnight patient in a health care facility (i.e., hospital, nursing home or convalescent home) in the last 12 months than were the NPHS respondents. Single adults and female adults in families within our survey were two to three times more likely to have been an overnight patient than their counterparts in the NPHS. Among youth the differences were even more pronounced. Specifically, male youth were 10 times more likely than their NPHS counterparts to have been an overnight patient (32% vs. 3%). Meanwhile, female youth were 8 times more likely to have been an overnight patient than their NPHS peers (41% vs. 5%). These findings are consistent with the much higher level of injuries experienced by youth in the panel study relative to their peers in the NPHS.

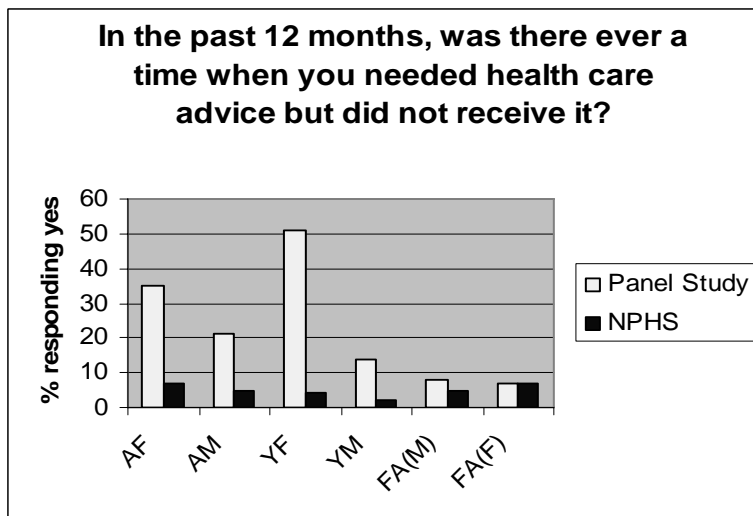
Figure 10: % Who Had Been an Overnight Patient in a Health Care Facility.



Note – AF = Female Adults (n = 83); AM = Male Adults (n = 86); YF = Female Youth (n = 78); YM = Male Youth (n = 78); FA (F) = Female Adults in Families (n = 69); FA (M) = Male Adults in Families (n = 14)

Unmet Health Care Needs. Overall, panel study respondents were more likely than NPHS respondents to answer ‘yes’ to the question “During the last 12 months, was there ever a time when you needed health care or advice but did not receive it?” Figure 11 shows the comparison of our survey respondents to the NPHS sample to questions related to unmet health care needs broken down by subgroups.

Figure 11: % Identifying Unmet Health Care Needs



Note – AF = Female Adults (n = 81); AM = Male Adults (n = 86); YF = Female Youth (n = 78); YM = Male Youth (n = 77); FA (F) = Female Adults in Families (n = 68); FA (M) = Male Adults in Families (n = 13)

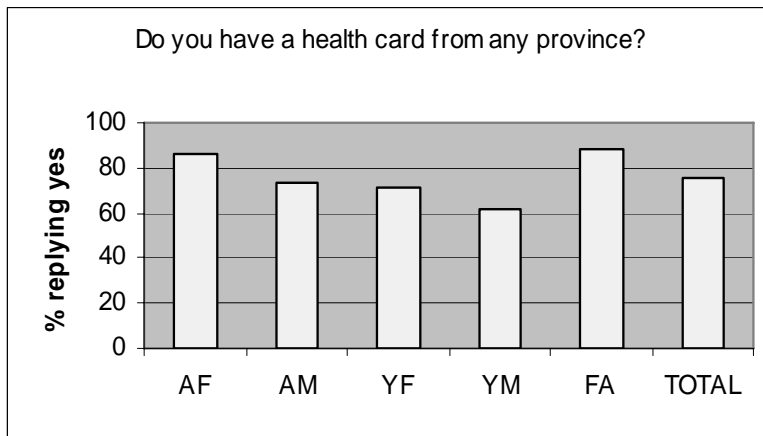
Differences between our survey respondents and NPHS respondents in terms of identifying unmet health care needs were greater for women than for men (i.e., 47%

higher for female youth; 28% higher for female adults; 16% higher for male adults, and 12% higher for male youth).

Single adults and youth in our survey identified treatment of a physical health problem as being the most common unmet health care need. This was followed by treatment of an emotional or mental health problem for single adults and female youth and treatment of injuries for male youth.

Health Card: As shown in Figure 12, 75% of panel study respondents indicated that they had a health card. The rate varied from a high of 88% for adults within families to a low of 65% for female youth. Of those without a health card, most (82%) indicated that they previously had a health card.

Figure 12: % of Respondents With a Health Card (N = 408)



Note – AF = Female Adults (n = 83); AM = Male Adults (n = 86); YF = Female Youth (n = 78); YM = Male Youth (n = 78); FA = Adults in Families (n = 83)

Social Service Utilization. Respondents were asked about the help they received from drop-in centres, city social services, housing or employment services, as well as from outreach workers. They also were asked about any problems they had with these services. As Table 13 below indicates, some services appear to be especially popular. Respondents from all sub-groups other than families were frequent users of the drop-in centres, with male youth (81%) and female youth (69%) especially drawn to them. In contrast, only 11% of adults in families used drop-in services, but instead, were most likely to utilize city social services (82%). The utilization rates for city social services among the single respondents varied quite widely, from a low of 16% among male adults to a high of 54% among female adults. About one-third of youth also used city social services.

Table 13: % Using Different Social Services

	AF (n = 83) (%)	AM (n = 86) (%)	YF (n = 78) (%)	YM (n = 78) (%)	FA (n = 83) (%)	TOT (N = 408) (%)
Drop-In Centres (e.g. Centre 454, The Well, St. Joe's Women's Centre)	57	49	69	81	11	53
City of Ottawa People Services (e.g. Employment and Financial Assistance, Public Health and Long-Term Care, Housing)	54	16	37	31	82	44
Housing Services (e.g. Housing Help, Action Logement)	40	13	30	15	24	25
Employment Services (e.g. Causeway, The Salvation Army)	10	21	18	24	4	15
Outreach Workers	49	12	37	49	13	32

Note – AF = Female Adults; AM = Male Adults; YF = Female Youth; YM = Male Youth; FA = Adults in Families

Housing and employment services had substantially lower utilization rates, at 25% and 15% overall. Female adults (40%) and female youth (30%), were much more likely to use housing services than were male adults (13%), male youth (15%), or adults in families (24%). Employment services, in contrast, were most commonly frequented by male youth at 24% while adults in families (4%) and female adults (10%) were least likely to use them. The groups most likely to have received help from social workers or outreach workers were single female adults (49%), male youth (49%), and female youth (37%). Adults in families (13%) and adult men (12%) were less likely to have received help from these types of services.

5. Most Pressing Needs:

What are the most pressing health needs of persons who are homeless?

This section of the report summarizes our findings broken down into seven areas:

- Diversity and Mobility of the Population
- Education and Employment
- Family Difficulties
- Physical Health Status and Problems
- Prominence of Mental Health Difficulties
- Substance Abuse Problems
- Most Pressing According to Subgroups

Diversity and Mobility of the Population. The survey results confirm our previous findings that each of these subgroups has some distinct characteristics, albeit with considerable overlap, and that the distinctions between the groups are multifaceted (Farrell et al., 2000). In most areas examined in our study, the characteristics of adults in families diverge significantly from those of the other subgroups.

Related to the diversity of the different subgroups, some generalizations emerged:

- Adults in families are more likely to become homeless for economic reasons and less likely because of interpersonal or health reasons.
- The homeless population generally does not include seniors, probably due to a combination of premature death and the easier availability of low cost seniors' housing.
- The respondents generally are quite isolated: most individuals are single, separated, divorced or widowed.
- Most adults in families are single mothers.
- There is a high proportion of people of aboriginal descent among single adults and youth, relative to their proportions in the Ottawa population.

Related to the mobility of our participants, our findings revealed the following:

- Most respondents had moved several times within the last three years, both within the City of Ottawa and between different regions of the country.
- Male youth especially had moved multiple times within the last three years.
- Most also had experienced homelessness on multiple occasions and as well most had experienced a relatively brief period in their most recent episode of homelessness (that is, less than six months).
- Adults in families tended to exhibit somewhat less mobility than was the case for the other subgroups.
- Adult males were more likely than others to have arrived in Ottawa just prior to their most recent episode of becoming homeless.

Employment and Education. Only about 11% of respondents are currently working for pay even though a majority of single adults and adults in families have at least a high school education. As a group, respondents had a lower level of education than the general population in Ottawa. Most youth have Grade 11 or less and most of them are not enrolled in school. A clear majority of those not in school indicated an interest in returning to school.

Family Difficulties. Family difficulties appear especially prominent in the case of youth, whose most recent experience of homelessness was explained as being the result of family difficulties, including parental conflict, parental eviction, and parental abuse, in over 50% of the cases. In addition, there are numerous indications that violence and conflict within current families and/or within families of origin is significant for all of the subgroups. Although this topic requires further investigation, the following observations are noteworthy:

- 65% of female youth and 49% of male youth indicated that they had been physically abused by someone close to them;
- 35% of female youth and 46% of male youth had lived in a group home during their childhood or adolescence. As well, 62% of male youth had spent time in a detention or correctional centre.
- In each of the subgroups of women, a sizeable minority indicated that they had had a miscarriage due to assault or injury (12% of adult females, 16% of youth females and 10% of women in families)
- At the time of interview, 15 women were pregnant, including eight female youth, four adult females and three women in families.
- Among the 12 female youth who were mothers, more than half (n = 7; 58%) had children who were in the care of the Children's Aid Society.

Physical Health Status and Problems. Two subgroups of respondents reported a lower level of physical health than their counterparts based on sex and age in the general population, namely female youth and female adults. All of the panel study respondents reported a higher prevalence of a number of chronic physical health conditions, including: respiratory conditions, arthritis or rheumatism, back problems, and migraines. In line with their lower reported levels of physical health, the subgroup of single women was more likely to indicate the presence of these conditions than other respondents. In addition to the relatively high prevalence of these chronic conditions, the panel study also revealed relatively high rates of the following conditions among certain subgroups: hepatitis among single women (19%) and single men (13%), HIV or AIDS among single women (5%) and single men (6%); and pneumonia among single women (12%) and female youth (8%).

All of the subgroups with the exception of adults in families had a much higher risk of suffering injuries that limited normal activities. Relative to adults in the general population, single adults were three times more likely to suffer injuries. Among youth, panel study respondents were four times more likely to be injured than youth in the general population. The panel study respondents were especially more likely to experience injuries involving fractures, sprains, and cuts. These results underline the danger associated with being homeless.

Mental Health Status and Problems. In comparison to a general population sample, the panel study respondents reported a significantly lower level of mental health. In fact, the respondents indicated that mental health difficulties, including depression, anxiety, and difficulties carrying out normal activities, were more prevalent among all the subgroups when compared to their peers in the general population with the exception of the subgroup of male youth respondents. In addition, over one third the respondents (34%) reported having been diagnosed with depression, schizophrenia, bipolar disorder or more than one of these conditions. Single adults and youth were much more likely to have been diagnosed with these disorders than were adults in families. Of these mental health conditions, depression was the most prominent with about one-third of the respondents identifying this as a diagnosed condition. This condition was most prevalent among single women and female youth, where it was reported by approximately one-half of all respondents within these subgroups. The presence of bipolar disorder was also most

significant within these same subgroups, with approximately one in six single women and one in five female youth reporting they had been diagnosed with this condition.

In line with previous research on homelessness, we expect that mental health difficulties both contribute to and result from being homeless for the panel study respondents. The prevalence and severity of mental health problems experienced by them suggest that these difficulties present a significant obstacle to the respondents successfully accessing and maintaining permanent housing.

Substance Abuse. Our screening for substance abuse revealed a significant minority acknowledging difficulties in the areas of alcohol and drug abuse. Again, adults in families had a different profile than was true of the other subgroups, with only a small number (< 10%) reporting problems in these areas. One-quarter to over one-third of single adults and youth reported consuming alcohol at a level that was problematic. Drug abuse was more prevalent than alcohol abuse, particularly among single men and youth, with over one-half of individuals in these subgroups indicating a drug abuse problem.

Most Pressing Needs According to Subgroups. To some extent, the subgroups of single individuals are more similar than different in relation to housing history, health status, and health and social service utilization. However, an examination of the data suggests specific needs predominating for each of these subgroups.

In our view, for youth, whether male or female, a return to school emerges as the most pressing need once they have been able to achieve some stability in housing. The fact that almost half of the male youth and over three-quarters of female youth in our study have not completed high school combined with the large majority of both subgroups not attending school portends a limited and marginal life course. In particular, unless these youth obtain further schooling, it will be very difficult for them to find a place in the workplace and become economically self-sufficient. Long-term, it places them at high risk for repeated episodes of homelessness.

Another challenge faced by the youth in our study is more immediate and relates to their social isolation and mental health issues associated with family problems that include for many of them a history of physical and/or sexual abuse, as well as placement in the care of CAS. Consequently, they lack the social support and personal resources needed to successfully transition from adolescence to adulthood.

Among single female adults, needs related to physical and mental health are predominant. In particular, single women were the only subgroup that were experiencing levels of physical health that were, on average, significantly lower than their counterparts in the general population. A sizeable minority of single women in our sample also reported the presence of such chronic health conditions as respiratory problems, arthritis, back problems, and migraines.

In addition, single women also reported lower levels of mental health than women in the general population. Indeed, over half of our single female adult respondents reported having a chronic mental health problem of depression, bipolar disorder, or schizophrenia.

In the face of these significant health challenges, one-third of them stated that they had needed health care in the past year but failed to receive it.

Among single men, needs related to substance abuse emerge as particularly prominent. Over one-third of respondents in this subgroup reported drinking problems while close to one-half acknowledged drug use problems on the screening measures that we used. Moreover, related to drug use, over one-third of single men reported having injected drugs and close to one-third identified drinking as a contributing factor to their homelessness.

Similar to youth subgroups and the subgroup of single women, mental health difficulties also appear present for single men as they reported a significantly lower level of mental health when compared to their counterparts in the general population. Difficulties relating to addictions and mental health are compounded by the fact that close to one-half the single men we interviewed were homeless upon moving to Ottawa. This fact is likely to make it more difficult for them to access treatment in these areas.

Finally, adults in families emerge as quite distinct from the other subgroups when it comes to health needs. Unlike the other subgroups, only a very few respondents in this subgroup reported alcohol or drug use that was problematic. As well, their levels of physical health were comparable to that of the general population. They did report experiencing a lower level of mental health on average than the general population but this is likely due, in large part, to their situation of homelessness as only a small number of respondents in this subgroup reported having chronic mental health problems. Their response to the question of needing health care and not receiving it was comparable to the general population with less than 10% answering in the affirmative.

In line with this different pattern of health needs relative to other subgroups, an inability to pay the rent was cited by almost half of respondents in this subgroup as the reason for their homelessness while another quarter identified spousal abuse. It appears that for a large number of families in our study, homelessness is a consequence in large part of poverty and secondly to domestic problems rather than to an interaction of the economic, social, and health factors which appear present in other subgroups.

Limitations of the Research Findings

Our study has a number of limitations that need to be taken into account in the interpretation of the results:

1. The paucity of data presently available on adult and youth shelter users and the lack of any data on youth who are homeless but not using shelters, limit the ability to determine how representative the sample is of the homeless population in Ottawa.
2. Stratified sampling based on population data on the criteria of length of homelessness and citizenship was used to recruit participants among single adults and families living in emergency shelters. This type of sampling was used to produce samples of subgroups that were representative estimates of the homeless

- population. However, there were refusals by selected individuals among these sub-groups which may serve to bias the sample in ways that are not readily evident. As well, it was not possible to recruit the targeted number of participants in the longest length of stay category among the single adult women subgroup.
3. The research design was a one-time survey that produced a profile of the characteristics of persons who are homeless. This type of cross-sectional design precludes being able to draw any conclusions about cause and effect relationships between these characteristics.
 4. The study was conducted over a 13 month period (October, 2002 – October, 2003) producing a snapshot of people who were homeless in Ottawa during that particular period. It is possible that the make-up of the homeless population may change over time in response to changing social and economic conditions in the city.
 5. Information collected in the study was of a self-report nature which, depending on the subject areas being queried, may be prone to some inaccuracy as a result of less than accurate recall, lack of information, or discomfort with self-disclosure.

CONCLUSIONS

Even at this early stage of analysis, it is possible to identify policy and program implications of our findings. Homeless persons in Ottawa are a heterogeneous population who have experienced many difficulties in their lives. The findings described above suggest that ending homelessness for this population will involve not only safe, affordable permanent housing but also a range of health and social service support embedded in appropriate delivery mechanisms.

Based on our findings, we believe that there are seven key areas where policy and program interventions need to be targeted in order to address homelessness: income support, housing, education, family violence, criminal justice, child welfare, and mental health and addictions. As well as acknowledgment of these various sectoral needs, there is an equally pressing requirement to recognize the political fact that these sectors are the responsibility of senior levels of government and that as a result, communication and coordination issues are inherent in the development of effective solutions.

From the perspective of the City of Ottawa, there are a number of conclusions that can be drawn. First, ending homelessness in Ottawa is not something that the City of Ottawa will be able to achieve on its own. As indicated above, some homeless people are quite mobile and a substantial minority arrived in Ottawa without a place to live. Whether or not these individuals previously lived in Ottawa or not, it is impossible to precisely distinguish homeless people in Ottawa from those in Toronto or Vancouver. In addition, the educational attainment of respondents, particularly among the youth subgroups, the preponderance of family breakdown and violence, and/or the need for mental health and addictions services, also indicates the need for involvement of governments with jurisdiction over the child welfare, education, health care, social service, and criminal justice systems.

Given the multifaceted nature of the problems faced by those who are homeless, the City of Ottawa needs to explore all possible avenues for interagency cooperation, coordination and support, both spatially and temporally. Spatially, it is clear that homeless persons and families require much more than a nightly place to sleep. Temporally, the preponderance of multiple episodes of homelessness among the respondents suggests that appropriate services are needed not only while individuals are homeless but also when they are housed. These findings provide support for the City of Ottawa's decision over the last number of years to place some focus on the prevention of homelessness.

A major reason precipitating homelessness among our respondents involved their inability to pay their accommodation costs. In addition, most of our respondents relied on income support as only a small minority was employed. Living in poverty is a situation that places adults in families, single adults, and youth at significant risk of losing their housing. In the case of Ottawa, where our study was conducted, income support levels have remained at the same level in Ontario since the provincial government cut back social assistance levels in 1996 even though rental costs have increased substantially. Increased income support on its own would prevent some families and individuals from losing their housing and becoming homeless.

Related to the paucity of affordable housing available in Ottawa, there has been virtually no new development in the social housing sector for the last number of years as a result of the federal and provincial governments withdrawing their support for development in this sector. Forty percent of respondents, representing especially adults in families and female adults indicated that they were on the waiting list for social housing. However, only a small number of these are likely to move out of homelessness into social housing. This is an area where the federal and provincial governments will need to be involved in committing resources to municipalities for renewing this critical segment of the housing sector.

Although the subgroups differ in the nature of required supports, it is clear that a substantial proportion of individuals need help in a variety of realms. One strategy may be to identify likely “bundles” of support among the various subgroups and to begin to organize the delivery of such bundles in a manner that allows them to be provided both in the emergency facilities and beyond. For example, among adults in families, a significant proportion identify poverty and family violence as the main reason for being homeless. Such explanatory factors suggest that education or job training and low cost child care may be an appropriate bundle of supports that might be offered while the adults are in the emergency shelter but more importantly, that follow them when they move to permanent housing.

In contrast, among youth who have recently graduated from a foster or group home, another bundle of services might be much more appropriate. Specifically, programs that are effective at assisting youth to transition from adolescence to adulthood appear to be necessary, particularly for those youth leaving the child welfare system. These programs will need to focus on assisting youth to meet their housing and educational needs while addressing their mental health and social isolation problems. The high proportion of youth found in our study to have difficult family histories and to have dropped out without completing high school suggest that they are vulnerable to a long-term marginal existence and chronic homelessness.

In the case of single adults, programs that target housing, vocational training needs, mental health, and addictions problems appear to be particularly important. The intensity of services needed in these areas will vary and a continuum of services addressing these areas seems necessary. In particular, some adults will benefit from shorter-term outreach or community support types of services while others require longer-term more intensive transitional housing.

It is noteworthy that our findings revealed high levels of mental health problems and addictions among single adults who also identified the treatment of emotional or mental health problems as an unmet need. Clearly, efforts to improve the access and use of health and social services that address both mental health problems and addictions by persons who are homeless in Ottawa appear necessary. This appears to be particularly the case for many single men who are new residents to Ottawa. In the case of single women, it appears that facilitating their access to health care for physical health problems in addition to mental health services, is required.

Such bundles also contain implicit suggestions about prevention. If inadequate income support programs and the loss of affordable housing have contributed to the increases of homelessness in different parts of Canada, what is the role of the federal and provincial governments to address these issues? If family violence is a frequent contributing factor for homelessness, are there legislative, policy or program changes that would reduce the tendency of women and children to lose access to the family residence when they escape a violent spouse? Do the high proportions of foster or group care graduates who are homeless suggest a need for legislative, policy and/or program adjustments that help youth leaving these facilities to establish secure housing and stable lifestyles?

Does the current configuration and location of health and social services limit the access of some individuals, particularly those presenting with more severe mental health and/or addictions problems? What changes are needed to make these services more available and relevant for this population? Addressing the issues raised by these questions certainly is outside the sole authority of the City of Ottawa. At the same time, though, appropriate, coordinated and sustainable responses that seek to end homelessness will not be possible without the City's active engagement in developing effective responses to the issues raised above.

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APPENDIX A – Research Team

Four meetings (March 21st, May 24th, June 21, December 12th) of the *Research Team* were held to review the work plan, discuss the content of the interview protocol, develop a sampling strategy, discuss the challenges of data collection and develop a publication policy.

The members of the research team are:

University of Ottawa:

Tim Aubry, Co-Principal Investigator, Susan Farrell, Robert Flynn, Betsy Kristjansson, Daniel Coulombe, Elizabeth Hay (School of Psychology)
Tiina Podymow, Jeff Turnbull (Faculty of Medicine)
Peter Tugwell (Institute of Population Health)
Caroline Andrew (Department of Political Science)
Doug Angus (Faculty of Administration)

Carleton University:

Fran Klodawsky, Co-Principal Investigator, Department of Geography
Benham Behnia, Karen Schwartz (School of Social Work)

Saint Paul University:

Manal Guirguis-Younger (Department of Pastoral Studies)

University of Saskatchewan:

Evelyn Peters. Dr. Peters is a Canada Research Chair with expertise in urban aboriginal issues - an area of research expertise we have not been able to involve locally.

Human Resources Development Canada:

Shannon Nix. A representative from HRDC was invited to join the Research team because we thought it was important to keep open a line of communication between the Secretariat and the study – as a result the Secretariat has been aware of this research initiative and also has been able to inform others about our activities.

APPENDIX B – Community Advisory Committee

Three meetings of the *Community Advisory Committee* (May 21st, June 27th, December 12th) were held to introduce the study, to discuss the interview protocol and to discuss the challenges of data collection.

The members of the committee are:

Tim Aubry ,Co-PI, University of Ottawa
Joanne Lowe, Canadian Mental Health Association, Ottawa Branch
Fran Klodawsky, Co-Principal Investigator, Carleton University
Diane Morrison, The Mission
Mary Ann Glazer, Shepherds of Good Hope
Tom Sidney, Operation Go Home
Denise Valley, Youth Services Bureau
Perry Rowe, The Salvation Army
Martine Dore, Cornerstone
Anne Hodge, Maison D’Amitié
Manal Guirguis-Younger, Saint Paul University
Brian Tardif, Citizen Advocacy
Vivien Runnels, Saint Paul University
Lisa Addario, Legal Consultant
Roland de Montigny, Options Bytown
Lyallen Hayes, Interval House
Carl Nicholson, Catholic Immigration Centre
Houda Dirieh, Community Representative
Andrea McCoy-Naperstkov, Carling Family Shelter
Lyn Atterbury, Rideauwood Addiction and Family Services
Amy J. Nahwegahbow, Aboriginal Friendship Centre
Hindia Mohamoud, Social Planning Council of Ottawa
Elizabeth Hay, Project Coordinator, University of Ottawa

A meeting was held with the *City of Ottawa’s Housing Branch* on May 16th to introduce the study to them and to ask for their advice and suggestions regarding the development of the interview protocol. When the study’s interim report was presented, further discussions were held with the City concerning options for data analysis and presentation of results.

APPENDIX C – Consultation with Shelter Representatives

Meetings and/or telephone conversations were held with the following *shelter representatives* to explain the study, to ask for input regarding the interview protocol, and to solicit their support. All the shelters agreed to participate in the study:

- Laird Eddy, Chaplain, The Mission
- Mary Ann Glazer, Executive Director, Shepherds of Good Hope
- Major Stan Folkins, Executive Director, Perry Rowe, Director of Client Services, and Michael Cairns, Director of Men’s Shelter, The Salvation Army Booth Centre
- Rob Boyd, Manager, Housing and Support Services, Ottawa YMCA-YWCA
- Lyallen Hayes, Executive Director, Interval House
- Denise Valley, Director, Young Women’s Emergency Shelter, Youth Services Bureau
- Anne Hodge, Executive Director, and staff of Maison d’Amitié
- Connie Woloschuk, City of Ottawa’s Residential Services, Andrea McCoy Naperstchow and Robert Currie, City of Ottawa’s Family Shelter
- Sue Garvey, Executive Director, Cornerstone
- Sister Michèle, La Présence
- Jane Beauchamp, Executive Director, Nelson House
- Tom Sidney, Operation Go Home
- Heng Chau, Catholic Immigration Centre - Reception House
- Mary Martha Hale, Centre 454
- Shining Water Diabo, Oshki Kizis Lodge

Consultation was also undertaken with the *Research and Evaluation Group of the Alliance to End Homelessness* (June 21st) and the *Youth Housing Development Team* (June 26th).

Ongoing collaboration with these key stakeholders and members of the research team guided the methodology of the study, helped shape the research questions, ensured the continued cooperation of city shelters and drop-in centres and informed the data analysis.

APPENDIX D – Interview Protocol

The Interview Protocol is attached as a separate document.