



# **Homeless Count – 2005 Victoria, BC**

**Revised: August 15, 2005**

## Acknowledgements

### MESSAGE FROM COOL AID'S BOARD CHAIR

In 2004, the City of Victoria, along with 9 other municipalities in the Greater Victoria area, proclaimed **January 15 'Homeless Day'**. Together, the municipalities agreed to the following:

- ◆ It is recognized that the number of homeless is increasing and having a negative effect on the health of the community and on the health of individuals.
- ◆ There remains a civic commitment to increase the quality of life for all citizens by promoting and advocating for supported housing for the homeless.

On January 15, 2005, more than 150 community volunteers walked the city's streets to count Victoria's homeless. Forty-three routes encompassing three municipalities were surveyed, and geographical maps of homeless districts were created to assist volunteers. On a night when temperatures dropped to -10C, 168 people were found sleeping outside in the freezing temperatures, and another 500, including more than 100 children and parents, were found in emergency shelters and roadside motels throughout the city.

Evidence from the 2005 Homeless Count surveys showed that:

- on average, homeless persons are without a home for 20 months
- average age of a homeless person is 33.6 years, and the majority are men
- majority of homeless have been in Victoria for more than 5 years
- nearly ½ of the homeless self-identify as First Nations
- 60% of the homeless do not receive income assistance from government

On behalf of the Society's Board of Directors and staff, I would like to extend my sincere appreciation and a big thank you to the following individuals who gave generously their time and energy to ensure the inaugural Homeless Count was a success:

- ◆ The homeless, who courageously participated in the Count by sharing with us their personal experiences dealing with life on the streets. These stories, in addition to the volume of data collected, will allow us to gain a greater understanding of the breadth and depth of the challenges you face, and work towards long-term solutions to homelessness in Victoria.

- ◆ Tom Moore, for his vision and passion for establishing January 15 as Homeless Day and Victoria's first count of our city's homeless.
- ◆ The 200+ volunteers who generously gave their time to participate in and assist with the Count. We were overwhelmed by your support, and the passion each of you showed towards ensuring the success of this inaugural Count.
- ◆ Staff from the Open Door, Salvation Army Addictions Rehabilitation Centre, Mustard Seed, City of Victoria, District of Saanich, Victoria Police Department, Victoria Native Friendship Centre, Burnside Gorge Association, Co-ordinated Housing Registry, and Cool Aid who worked together to provide leadership and guidance.
- ◆ Vancouver Island Health Authority, the City of Victoria, and the National Homelessness Initiative SCIPI Fund for funding the collection and analysis of the Count and survey data.
- ◆ Dr. Crockett, professor emeritus, faculty of Medicine, UBC, and Carol Finnie for preparing this report.
- ◆ A special thanks to Cool Aid staff who for their extraordinary efforts in making the 2005 Count a success, including: Carol Finnie (former CEO of the Society) and Trudy Norman (Manager, Planning) for their leadership; Derek Book (GIS Consultant) for mapping out the walk and preparing all GIS maps for volunteers; Melanie Clarke (Manager, Human Resources) for her efforts in training and coordinating volunteers; Don McTavish (Manager, Shelters) for coordinating volunteers and working with other city shelters to ensure an accurate count; and, Dana Oshiro (Manager, Communications) for creating all materials and overseeing public communications before, during and after the Count.

The Cool Aid Society also thanks the following generous individuals and organizations for their donations to the Homeless Count:

- First Metropolitan United Church
- Aaron Lucke and Starbucks
- AIDS Vancouver Island
- Anonymous Donation in memory of Toby
- Budget Rentals
- Burnside Gorge Association

- Canadian Tire Gordon Head
- Capital Iron
- Charlayne Thornton- Joe
- Chez Terry Pet Supplies
- Congregation Emanu-El
- Dennis Jempson and Salvation Army ARC
- Dorothy Rosenberg
- Jeanine Bandcroft
- Judy Graves and the City of Vancouver
- Mennonite Central Committee's Employment and Community Development Fraser Valley Homelessness Count
- Mirage Coffee
- Monk Office Supplies
- Open Door Inner City Ministry
- Robbins Parking
- Sandy Carter Photography
- St. Andrew's Presbyterian Church
- Susan Farell and the Royal Ottawa Hospital
- Thrifty Foods
- Tom Harris Cellular
- Victoria Foundation
- Zellers

The 2005 Count was a great success, and we look forward to translating this year's information into action as we work to eliminate homelessness from our community.

On behalf of Cool Aid's Board, staff, and partners, thank you!

Sincerely,

Gretchen Brewin, Cool Aid Board Chair (2004/05)

## **Executive Summary**

The results of the survey done as part of the Homeless Count - 2005 project on January 15, 2005 raised the following points for discussion.

Homelessness affects all age groups and is not just a risk for the young. The average age was 33.5 years. The majority of the homeless come from Victoria, not from somewhere else which is a common misperception. The average length of time without a home was one year, eight months. About half of the participants reported that they do not receive any income supplements.

The most frequent reasons for homelessness are abuse, addiction, conflict/breakdown and eviction. A majority of the participants reported health problems and a substantial proportion reported problems getting follow-up care. Up to 40 percent may have a psychiatric diagnosis and street drugs use is significantly related to the presence of psychiatric disorders

More than 60% of the participants of this study were male. Most of the male participants were Caucasian and the female participants were First Nations. However, on the night of the survey, there were more First Nation individuals reporting that they had shelter that evening. The data provide little evidence of significant differences between cultural groups within the homeless participants of this study.

There were clear-cut differences in the shelter needs of homeless men and women. The male participants tended to be more chronic and to report more drug-related behavior. The female participants were less chronic and more often came from troubled family circumstances.

The younger homeless appear to have different shelter needs than older homeless participants. Older homeless participants reported more chronic housing problems.

Alcohol use appears to serve as a gateway to the development of other types of problems including difficulties in the participant's personal life, mental health issues, and the use of street drugs. Yet, a substantial portion of the sample did not use alcohol or street drugs.

The participants in this survey indicated differing patterns of problems associated with finding shelter. Groups based on age, cultural identity, and gender reported distinctive patterns of reasons for not having a home.

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## **Introduction**

On January 15, 2005, the Victoria Cool Aid Society sponsored the first Homeless Count in Victoria. This event received support by the mayors and municipalities in the Greater Victoria area who were the first in Canada to proclaim Homeless Day and January 15 was the nominated day.

On January 15, 2005, more than 150 community volunteers participated in a "rough count" of the homeless. Pairs or groups of volunteers were assigned specific geographical routes in the Greater Victoria area between the hours of 12 midnight and 6 am to conduct the rough count. The estimates of the number of absolute homeless from the rough count and from the use of the shelters indicated about 700 people. It should be noted that 47 children were dependent on someone who was homeless.

The volunteers encouraged the homeless individuals to respond to a paper-and-pencil survey. In addition, clients who were staying in temporary shelters or receiving food from social service agencies were encouraged to complete the survey.

January 15, 2005 was a very cold night for Victoria with temperatures below freezing. The volunteers encountered a homeless person shortly after 11 pm who they sent to hospital because of fear of hypothermia. Also, it was observed during the night of the count that most of the available 24 hour public establishments were full with people, many of who were possible homeless.

This report documents responses by 175 homeless individuals to the survey. This information provides the first comprehensive profile on the homeless in the Greater Victoria area. The information will be used to help guide program development and inform business case development on the needs for shelter, housing and health care for the marginalized and homeless.



## **Methodology**

The process of collecting and analyzing the data from the Homeless Survey, 2005 involved three related components.

### Step 1, Data Collection and Coding

The data was collected on January 15, 2005 as part of the Homeless Count, 2005 project. Each survey was coded separately. Problems of interpretation of responses were resolved through consultation. The data was scanned for outliers to insure quality of input.

A manual to guide the entry of data into a machine-readable format was developed. The development of this manual allowed for the responses to the individual items to be entered in an objective and standard fashion. The use of a standard format of data entry facilitates the sharing of this information to other interested parties and subsequent efforts at collecting data about shelter-needs. Finally, this manual describes some recommendations with respect to future data-collection projects aimed at identifying shelter/housing needs and evaluating the impact of ongoing programs.

### Step 2, Descriptive Analysis

This stage of analysis focused on generating a descriptive profile of the social background, housing needs, and concurrent problems affecting the individuals using temporary shelters in the Greater Victoria catchment area.

### Step 3, Inferential Analysis

It is important to note that there is no such thing as a "typical" homeless client. Rather, these individuals have a range of problems from basic housing and shelter needs to addiction and mental health issues. Accordingly, this stage of the analysis involved comparing individuals with more chronic housing problems with those individuals with more acute housing needs. This comparison focuses on the impact of homelessness on the individual in terms of rates of mental and physical health problems.

## Results

### Who were the Participants?

There were 220 potential participants of this survey, 175 of them provided at least partial data (79.6%). Relative to public opinion surveys this is a high participation rate. Because participants were not required to answer all of the questions, individual base-rates were used to calculate percentages. Basic demographic information is summarized in the sections below.

More than 60% of the participants of this study were male. Most of the male participants were Caucasian and the female participants were First Nations.

### How Many were Shelterless on the Evening of the Survey?

Of the 174 participants who described their housing status, 83.9% (n = 146) of them indicated that they did not have shelter for the evening. On average, the participants indicated that they had been without a consistent place of shelter for 1 year and 8 months (Mean = 1.691, SD = 3.149).

### Reasons for Homelessness

- **The most frequent reasons for homelessness are abuse, addiction, conflict/breakdown and eviction**

The following figure, REASONS documents the reasons given for homelessness. The participants indicated that they had lost their access to shelter through a variety of reasons. Issues of abuse, addictions, conflict / breakdown, being evicted, ineligibility for income assistance and not being able to find adequate shelter were among the most frequently endorsed reasons for homelessness. Preference was cited by male participants as a reason for not making use of available shelters. The reasons for homelessness differ accordingly to gender. Female participants reported more issues with respect to abuse, moved/stranded, and being evicted. Male participants reported more problems with ineligibility for income assistance, addictions and financial problems.

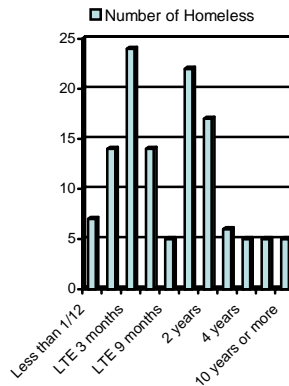
Abuse (14.6%)	Choice (3.2%)
Addiction (14.6%)	Pet Problems (1.9%)
Conflict / Breakdown (12.7%)	Work Injury (0.6%)
Evicted (11.4%)	Freedom (0.6%)
Ineligible (10.7%)	Lazy (0.6%)
Can't find place (8.2%)	Hospital / Treatment (0.6%)
Moving / Stranded (7.6%)	Government (0.6%)
Financial (5.6%)	Fire (0.6%)
Corrections (4.4%)	Discrimination (0.6%)

**Figure 1: REASONS**

## How Long Without a Home?

- **The average length of time without a home was 1 year, 8 months**

There was a wide range from less than 2 weeks and 24 years. These differences as illustrated in figure CHRONIC below reflects the variety of shelter needs ranging from acute to chronic. The average length of time without a home was 1 year, 8 months (sd = 3.1 months). Of the respondents, 73.5% indicated that they had been sleeping outside for 1 to 6 months (24.5%), 6 months to a year (20.4%), and over a year (28.6%).



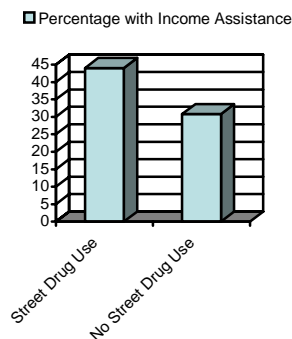
**Figure 2: CHRONIC**

## Social Assistance for the Homeless

- **About half of the participants reported that they did not receive income supplements**

Approximately half of the potential sample responded to the item regarding income assistance. Most of these participants reported that they did not receive income supplements (42, 63.5%). Participants who described shorter periods of unstable housing reported the same level of receipt of income assistance (20, 34.5%) as did the participants who reported longer periods of unstable housing (22, 38.6%).

A substantial proportion of the participants reported that they used street drugs and that they also received income assistance (33, 44.0%). Nevertheless, the association between street drug use and receiving income assistance was not significant (Chi Square = 2.591, df = 1,  $p < 0.107$ ). This relationship is described in Figure INCOMESTREET.

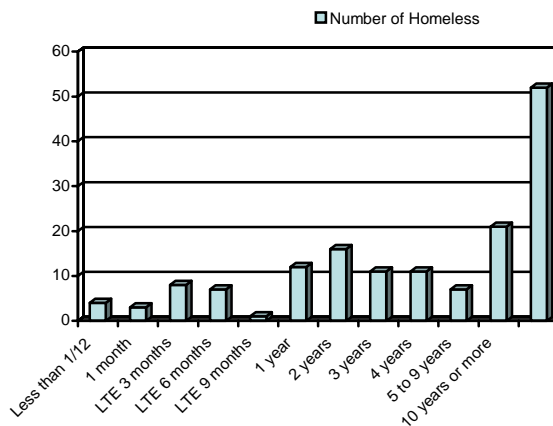


**Figure 3: INCOMESTREET**

Where did the Participants Come From?

- Homelessness is a home-grown problem and “they” are not from some place else
- Participants who had been in Victoria for shorter periods of time had better access to follow up care for their medical problems

The average length of time living in Victoria was 9 years, 4 months (SD = 11.2 months). There was a wide range from less than 2 weeks to 67 years. Participants had stayed in Victoria for approximately the same length of time (Chi Square = 9.482, df = 6,  $p < 0.148$ ). Some of the participants indicated that they had lived in Victoria for over 10 years. This information is summarized in Figure INVICT.



**Figure 4: INVICT**

Of more interest, perhaps, is the relationship between the length of residence in Victoria and the length of homelessness. In the subset of participants reporting both their length of homelessness and the length of their stay in Victoria, the relationship was non-significant (Chi-Square = 34.84, df = 36,  $p < 0.524$ ). It should be noted that there is an obvious overlap between the participants' age and both the length of homelessness and their residence in Victoria. That is, older participants had more opportunity to live in Victoria whether they had shelter or not than younger participants did.

The participants described a wide range of lengths of residency in Victoria (Range = Less than 2 weeks to 67 years). Due to the range in the participants' description of the length of residency in Victoria, the following rubrics were used to

categorize residency in Victoria: Less than 1 year and 1 year or more. These broader categories were used primarily with variables demonstrating non-significant relationships regarding aspects of homelessness.

Participants who reported that they had lived in Victoria for more than 2 years ( $n = 95$ ) were more likely to indicate that they had shelter the evening of the survey (17.4%) than did the participants indicating that they had lived in Victoria for less than 2 years (2, 6.1%). However the length of time living in Victoria was not significantly related to whether the participant reported that they had shelter for the evening of the survey (Chi Square = 7.13,  $df = 6$ ,  $p < .0.305$ ).

There was a significant relationship between the amount of time the participants reported that they had lived in Victoria and the reasons for their homelessness (Chi-Square = 121.646,  $df = 96$ ,  $p < 0.04$ ). This finding is of little utility in that the diverse number of reasons for not having shelter vastly out weighed the number of participants so that every potential contribution to homelessness was quite rare. In addition, one of the alternatives for the item used to assess the cause of lack of shelter was "Can't find a place", which would appear to be redundant with the definition of homelessness.

The length of time spent in Victoria was not related to the report of health problems (Chi Square = 3.73,  $df = 6$ ,  $p 0.713$ ). However, there was a statistically significant tendency for participants who had been in Victoria for shorter periods of time to have better access to follow-up care for their medical problems. For example, more participants who had been in Victoria for less than a year reported that they had follow-up care for their health problems (17, 62.9%) than did participants who had lived in Victoria for a year or more (28, 49.1%). This trend was significant despite the fact that a majority of the participants reported that they had access to help with their medical problems (45, 53.4%).

The consumption of alcohol (Chi Square = 2.726,  $df = 6$ ,  $p < 0.842$ ), street drug use (Chi Square = 3.201,  $df = 6$ ,  $p < 0.783$ ), and the rate of reporting that drugs had caused problems (Chi Square = 7.636,  $df = 6$ ,  $p < .266$ ) was not significantly related to the length of stay in Victoria reported by the participants.

The report of mental illness was not related to the length of residence in Victoria (Chi Square = 1.250,  $df = 6$ ,  $p < 0.974$ ).

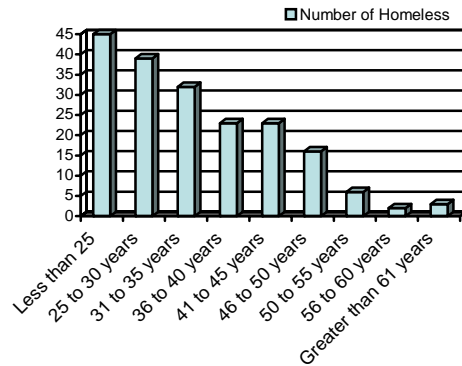
The availability of income assistance was not related to the length of residence in Victoria (Chi Square = 4.324,  $df = 6$ ,  $p < 0.633$ ).

#### How Old were the Participants?

- **Homelessness affects all age groups and is not just a risk for the young**
- **More older participants indicated a longer period of time without shelter**
- **The use of street drugs was more related to younger participants**
- **Age of the participant was not related to the self-report of mental health problems**

- **More than half of younger participants indicated that they had been living without consistent shelter for a year or less whereas only about a third of the old participants indicated a similar length of time without shelter**

The findings indicate that being homeless is not just a risk for the young but it affects all age groups. The following figure AGE, shows the range of ages by frequency.



**Figure 5: AGE**

The average age of participants was 33.4 years old (SD = 10.1). A majority of the participants were male (103, 63.1%) but there was a substantial number of woman who participated in this survey (60, 36.8%). Although the mean age of the sample indicated that a substantial majority of the participants were adults, the range in the participants' ages indicated that homelessness is a problem that affects the very young and the very old (range = 16 to 67 years).

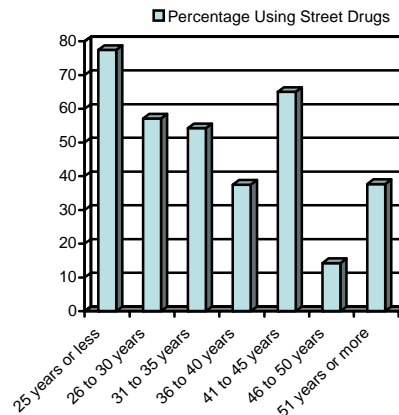
The age of the participant did not play a significant role in determining the reason for being without shelter on the evening of the survey (Chi Square = 109.198, df = 102, p < 0.295). However, the diverse range of age reported by our participants made every possible combination of reasons for homelessness and age very rare.

The age of the participant did not contribute to the length of time being without stable housing (Chi Square = 36.383, df = 36, p < 0.451) nor with the amount of time spent in Victoria (Chi Square = 37.993, df = 36, p < 0.379). The absence of a significant relationship between the age of the participant and the length of time without shelter is consistent with the notion that homelessness affects people of all ages (Chi Square = 24.038, df = 24, p < 0.459).

Despite the lack of a significant overall relationship and the length of time spent without shelter, there were substantial differences among the very young participants (i.e., less than 30 years of age) and very old participants (i.e., more than 46 years of age). That is to say, 61.3% of the younger participants indicated that they had been living without consistent shelter for a year or less whereas only 32.8% of the old participants indicated a similar length of time without shelter.

The report of alcohol-use was not related to the age of the participant (Chi Square = 6.399, df = 6, p < 0.380).

In contrast, the use of street drugs was related to the participants' age (Chi Square = 19.470,  $p < .003$ ). This relationship is summarized in Figure STREETDRUGS. The data in this figure show that participants that were younger than 30 year of age more often reported the use of street drugs (40, 67.8%) than did participants who were 46 years of age or older (5, 22.7%). This finding is, of course, influenced by the limited number of participants responding to the question probing this area (i.e. 62.7% of the potential sample). Although this finding is consistent with the expected effects of age on risk-taking behavior, the failure of many of the participants to respond limited the generalizability of this finding.



**Figure 6: STREETDRUGS**

The age of the participant was not related to the frequency of reporting that drug-use had caused problems in their personal life (Chi Square = 1.956,  $df = 6$ ,  $p < 0.924$ ). It is impossible to determine the role of the participants' defensiveness in this finding.

The age of the participant was not related to the self-report of mental health problems (Chi Square = 6.363,  $df = 6$ ,  $p < 0.384$ ) or the availability of income assistance (Chi Square = 6.864,  $df = 6$ ,  $p < 0.334$ ).

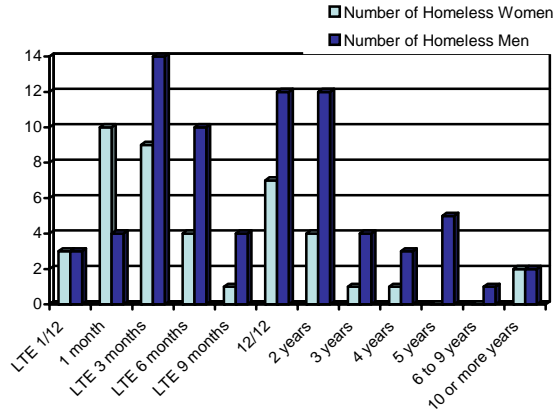
The age of the participant had an irregular association with the report of receiving income assistance. Participants between the ages of 46 and 50 years (2, 14.3%) and between the ages of 16 and 25 (9, 28.1%) reported relatively low rates of receiving income assistance. Participants between the ages of 26 and 30 years (37.9%) and those over the age of 50 (3, 37.5%) reported equivalent rates of income assistance. Participants between the ages of 31 to 44 years of age reported the highest rate of receiving income assistance (27, 46.6%).

#### Is Gender an Issue in Homelessness?

- **Men are chronically hard to house as compared to women**
- **More women are homeless on a short term basis**
- **Most of the male participants were Caucasian and the female participants were First Nations**
- **Gender has a modest relationship with ability to find shelter**
- **Females reported relatively short periods of being without stable housing and men reported more chronic homelessness**

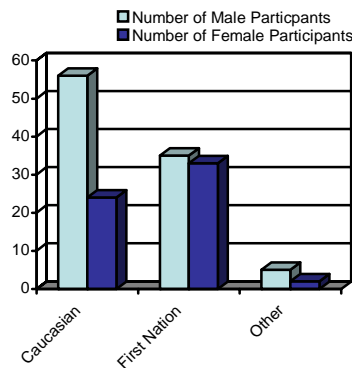
- **Significantly more male participants reported that they used street drugs than did female participants**
- **Female participants reported better access to income assistance than male participants; however, most participants did not report receiving income assistance**

The following figure GENDER illustrates the number of men and women who are homeless as based on the participants in this survey.



**Figure 7: GENDER**

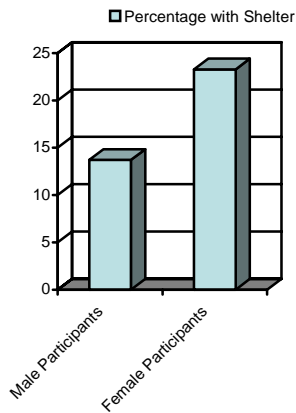
Overall, there were 103 male (63.2%) and 60 (36.8%) female participants in the structured survey. There were more Caucasian male (56, 58.3%) than First Nation male participants (35, 36.5%). In contrast, there were more female First Nation (33, 55.9%) than female Caucasian participants (24, 40.7%). However, this relationship did not reach statistical significance (Chi Square = 5.63, df = 2, p < 0.06). This relationship is illustrated in Figure ETHNIGENDER.



**Figure 8: ETHNIGENDER**

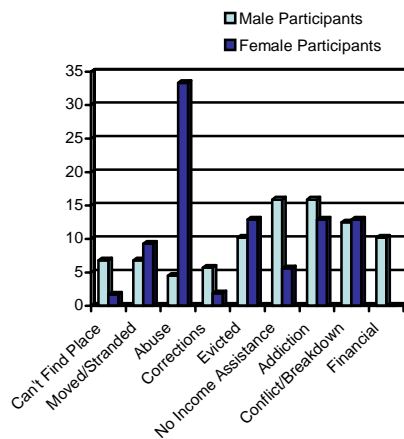
More women had shelter for the evening of the survey (14, 23.3%) than men did (14, 13.7%). However, the difference in rates for male and female participants was not significant (Chi Square = 2.439, df = 1, p < 0.118). This relationship is illustrated in Figure HAVGENDER.





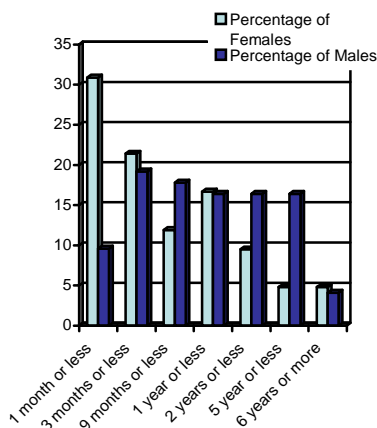
**Figure 9: HAVGENDER**

There was a clear difference in the pattern of reasons for being without shelter between the male and female participants (Chi Square = 39.373, df = 17, p < 0.002). The relationship of gender to reasons for homelessness is illustrated in Figure REASONGENDER. The male participants indicated that they were evicted (9, 10.2%), ineligible for income assistance (14, 15.9%), addicted (14, 15.9%), had conflict with their families (11, 12.5%), or they had financial difficulties (9, 10.2%). In contrast, the female participants reported that they had been abused (18, 33.3%), evicted (7), addicted (7), and had conflict with their families (7, 12.9% respectively).



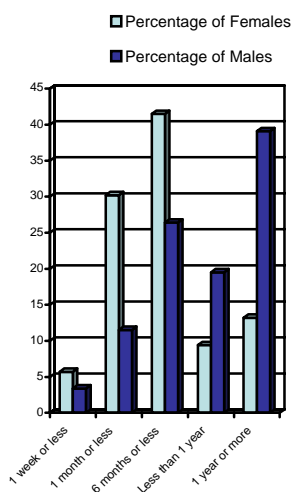
**Figure 10: REASONGENDER**

There was a tendency for gender and length of time without stable housing to be associated (Chi Square = 11.587, df = 6, p < 0.072). The relationship between length of homelessness and gender is illustrated in Figure LASTGENDER. Most of the women (34, 80.9%) had unstable housing for a year or less. In contrast, less than half of the male participants reported longer periods of homelessness (34, 46.6%). Many male participants reported an absence of stable housing for more than 5 years (15, 20.5%) whereas less than half that many female participants reported unstable housing of that duration (4, 9.2%).



**Figure 11: LASTGENDER**

There were significant differences in the length of time male and female participants indicated that they had been staying outside (Chi Square = 18.57, df = 4, p < 0.001). This contrast is illustrated in Figure HOWGENDER. Many more women reported sleeping outside for less than 6 months (41, 77.4%) than did the male participants (36, 41.4%). In contrast, many more male participants reported sleeping outside for a year or more (34, 39.1%) than female participants (7, 13.2%).



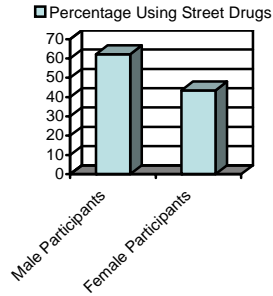
**Figure 12: HOWGENDER**

Gender was unrelated to the presence of health problems (Chi Square = 0.980, df = 1, p < 0.322) or difficulties obtaining follow-up for medical problems (Chi Square = 0.00, df = 1, p < 1.00).

The gender of the participant was unrelated to the report of alcohol use (Chi Square = 0.657, df = 1, p < 0.418). Alcohol use was very common in both male (46, 58.9%) and female participants (28, 51.9%).

In contrast, there was a significant difference in the rate of reported street drug use by male and female participants (Chi Square = 4.593, df = 1, p < 0.032). More male participants reported that they used street drugs (51, 62.2%) than did female

participants (23, 43.4%). This information is summarized in Figure DRUGSGENDER.

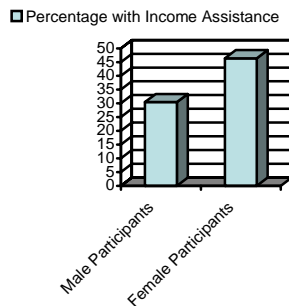


**Figure 13: DRUGSGENDER**

Nevertheless, the number of women reporting that drug use had caused problems for them was very common (21, 48.8%) and very similar to the rate reported by male participants (34, 52.3%). This lack of difference resulted in a non-significant relationship between gender and the reporting that drugs had caused problems (Chi Square = 0.125, df = 1, p < 0.724).

The relationship between gender and mental health problems was not significant (Chi Square = 0.061, df = 1, p < 0.805). That is to say, male and female participants reported similar rates of receiving psychiatric diagnoses (28, 40.5% and 18, 38.3% respectively).

There was a modest tendency for gender to be related to whether the participants reported receiving income assistance (Chi Square = 3.619, df = 1, p < 0.057). More women participants reported receiving income assistance (26, 46.4%) than did male participants (24, 30.4%). This information is summarized in Figure INCOME GENDER.



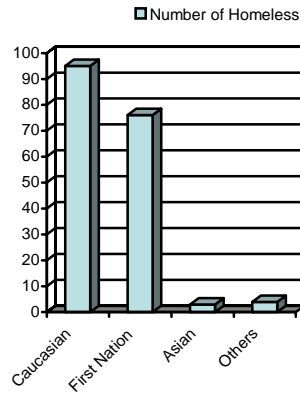
**Figure 14: INCOME GENDER**

Cultural Background of Participants:

- **The data provide little evidence of differences between cultural groups of the homeless; however, on the night of the survey, there were more First Nation individuals reporting that they had shelter that evening**

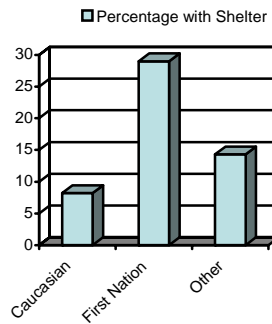
Of the participants willing to describe their cultural identity, 85 (52.1%) endorsed Caucasian as their cultural background; while a further 70 (42.9%) described their cultural heritage as First Nation. A small percentage of the sample indicated diverse cultural backgrounds (4.9%). The cultural

heritage endorsed by the participants is illustrated in Figure ETHNIC.



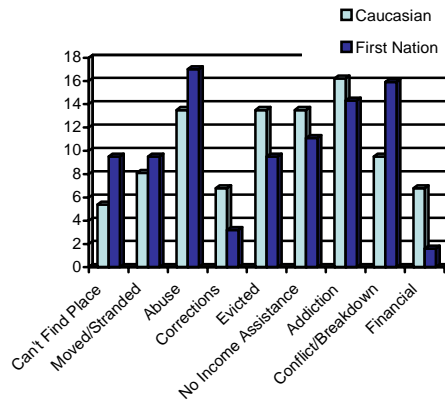
**Figure 15: ETHNIC**

The cultural background of the participants had a significant impact on the rate of having shelter on the evening of the survey (Chi Square = 11.605, df = 2, p < 0.003). This impact is described in Figure ETHNICITY. Using broad categories of cultural identities, First Nation participants were more likely to report that they had a room to stay in on the night of the survey (20, 28.9%) than Caucasian participants (7, 8.2%).



**Figure 16: ETHNICITY**

Although participants reported a diverse set of reasons for their homelessness there was a degree of overlap between the patterns for participants with differing cultural backgrounds (Chi Square = 42.917, df = 34, p < 0.14). The reasons reported by the participants from different cultural backgrounds are illustrated in Figure REASONSETHNIC.



**Figure 17: REASONSETHNIC**

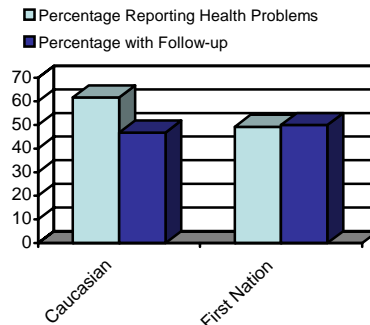
Caucasians most often related their homelessness to being abused (10), evicted (10), ineligible for income assistance (10, 13.5%, respectively) and issues related to addiction (12, 16.7%). In comparison participants with First Nation backgrounds related their lack of shelter to being unable to find a place (6), moving or stranded (6), and being evicted (6, 9.5% respectively), addiction (9, 14.3%), and conflict with family (10, 15.9%).

It should be noted that the reasons reported by the participants for sleeping outside on the night of the survey mixed a variety of causative variables (e.g. Corrections and Addictions) with result driven variables (e.g. "can't find a place").

There was no difference in the reported length of being without stable housing and cultural heritage (Chi Square = 12.339, df = 12, p < 0.419). A majority of the Caucasian participants reported having an unstable housing situation for less than a year (32, 52.4%) as did a majority of the First Nation participants (27, 55.1%).

Cultural identity was not related to the length of time the participants had lived in Victoria (Chi Square = 10.992, df = 12, p < 0.530) nor was the cultural identity of the participant related to the length of time the participant reported that they had been sleeping outside (Chi Square = 5.036, df = 8, p < 0.754). That is to say, the data provided little evidence that participants of different cultural backgrounds are more likely to be sleeping outside. In addition, there is no evidence that participants of different cultural backgrounds moved to Victoria after they had become homeless.

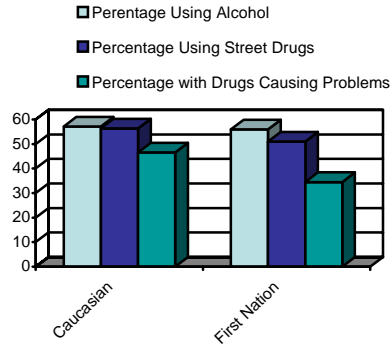
Despite the deplorable differences in health related statistics between First Nation and dominant cultural members of society, there were no overall differences in the rates of reporting health problems among the participants of this survey (Chi Square = 4.209, df = 2, p < 0.122) or their access to follow-up treatment (Chi Square = 3.191, df = 2, p < 0.203). This data is summarized in Figure HELPRO.



**Figure 18: HELPRO**

There were no differences between the rates of alcohol use reported by Caucasians (40, 57.1%) and First Nations participants (33, 56.9%). This led to a non-significant relationship between cultural identity and reported alcohol use (Chi Square = 0.001, df = 2, p < 1.00). The use of street drugs was also unrelated to cultural background (Chi Square = 0.397, df = 2, p < 0.82). This finding should be interpreted in the context of the high rate of participants indicating that their drug use had caused them problems. Over half of the Caucasian (31, 56.4%) and First Nation

(51.0%) participants reported that their drug use had caused them problems. This difference is illustrated in Figure DRUGETHNIC.



**Figure 19: DRUGETHNIC**

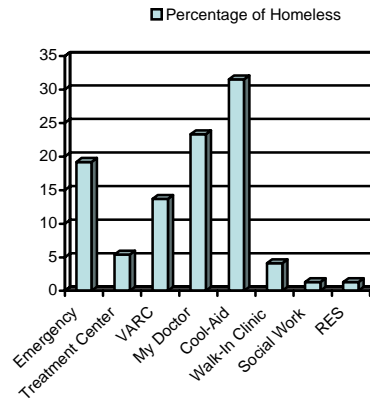
Caucasian participants more often indicated that they had received a psychiatric diagnosis (27, 46.6%) than the First Nation participants (19, 34.5%) did. However, this trend was not significant (Chi Square = 3.639, df = 2, p < 0.162).

Approximately the same number of Caucasian participants (26, 41.9%) and First Nation participants (22, 34.9%) reported that they received income assistance.

#### Presence of Health Problems in the Homeless

- A majority of the participants reported health problems and a substantial proportion reported problems getting follow-up care
- Participants reporting the presence of health problems reported a similar level of difficulties finding follow-up care with increasing lengths of time without stable housing
- The use of street drugs was significantly related to the presence of health problems
- There was a reported strong relationship between health status and drug use when living without shelter
- The use of street drugs was an important determinant of the prevalence of problems in the personal lives of the participants
- Psychiatric diagnoses are approximately twice as common in participants with health problems as they were in participants without health problems

Among the 150 participants who responded to the item regarding health status, a majority of them indicated the presence of health problems (83, 55.3%). In addition, a majority of the participants indicated that they were receiving help managing their health problems (46, 51.1%). The participants reported that they turned to the Cool-Aid Health Center (23, 32.4%), their doctor (16, 22.3%), and the Emergency Unit of the local hospital (12, 16.9%) to manage their health problems. Figure HEALTH shows where the participants received their health care.



**Figure 20: HEALTH**

The participants' age did not have a significant influence on the tendency to report health problems (Chi Square = 3.071, df = 6,  $p < 0.800$ ). Part of this lack of significance could be related to the relatively high rate of reporting health problems by the participants (79, 54.9%). That is to say, the participants who were 41 years or older frequently reported that they had health problems (27, 64.3%) but so did the participants who were 40 or less years of age (52, 50.9%).

There was no difference in the access of younger and older participants to follow-up care for their medical problems (Chi Square = 4.717, df = 6,  $p < 0.581$ ).

The presence of health problems did not influence the rate of not having a place on the evening of the survey (Chi Square = 0.297, df = 1,  $p < 0.586$ ). The rates of homelessness and health problems should be interpreted in the context of the general rate of reporting health problems in the overall sample (83 out of 174, 55.3%).

The lack of a relationship between the reason for losing access to stable housing and the presence of health problems (Chi Square = 14.852, df = 16,  $p < 0.536$ ) was the result of the plethora of alternatives offered to the participants. That is to say, the failure to differentiate among causative variables and the results of homelessness lead to a unique array of alternatives even when analyzing the impact of "yes"/"no" aspects of the participants.

The length of time without stable housing did not have a significant impact on the self-report of health problems (Chi-Square = 9.86, df = 6,  $p < .13$ ). The absence of a significant statistical relationship should be interpreted in the context of the relatively high overall rate of reporting health problems in this sample. That is to say, participants with relatively brief periods without stable housing (e.g. less than 1 year) reported an equivalent level of health problems as participants indicating relatively brief periods without stable housing.

The length of stay in Victoria was unrelated to the report of health problems (Chi Square = 3,841, df = 6,  $p < 0.698$ ).

The relationship between the length of time spent sleeping outdoors and the presence of health problems was non-significant (Chi Square = 5.869, df = 4,  $p < 0.209$ ). That is to say, participants indicating that they had slept outside for less than

6 months reported the same rate of health problems as participants indicating that they had slept outside for 6 months or more.

There was a significant relationship between reporting the presence of health problems and the report of difficulties finding follow-up care (Chi Square = 6.574, df = 6.574, df = 1,  $p < 0.01$ ). It is important to recognize that a substantial proportion of the participants reporting health problems also report problems getting follow-up care (34, 43.6%).

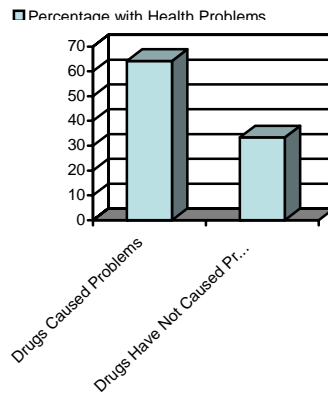
Participants reporting the presence of health problems also reported similar level of difficulties finding follow-up care with increasing lengths of time without stable housing (Chi-Square = 4.16 df = 6,  $p < 0.65$ ). That is to say, the difference between the rate of receiving follow-up care for health problems reported with participants with relatively brief periods of homelessness (22, 61.1%) and those participants with relatively longer periods of homelessness (17, 47.2%) should be interpreted in the context of the overall high rate of reporting difficulties obtaining follow-up care reported by the participants (33, 45.8%).

The presence of health related problems was not predictive of the report of alcohol use (Chi Square = 1.104, df = 1,  $p < 0.293$ ). Participants with health problems reported alcohol use at the same rate (46, 58.9%) as did those participants without histories of health problems (30, 44.7%). There was no difference in the report of difficulties getting follow up treatment between participants reporting that they used alcohol and those that reported that they did not use alcohol (Chi Square = 0.277, df = 1,  $p < 0.598$ ).

In contrast, the use of street drugs was significantly related to the presence of health problems (Chi Square = 4.644, df = 1,  $p < 0.031$ ). That is to say, more participants with health problems also reported that they used street drugs (50, 62.5%) than did participants without health problems (27, 44.3%). Similarly, participants reporting street drug use encountered an equivalent level of difficulties obtaining follow-up care as did participants who did not report that they used street drugs (Chi Square = 0.684, df = 1,  $p < 0.406$ ).

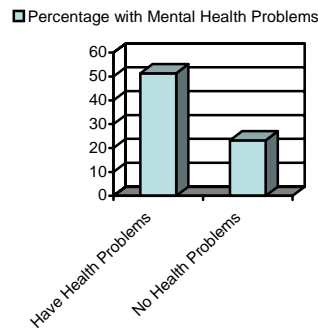
There was a significant relationship between the report of health problems and the participants indicating that their use of drugs had caused problems in their life (Chi-Square = 10.815, df = 1,  $p < 0.001$ ). This relationship is summarized in Figure HELPROUSE. The data in this figure shows that a majority of participants with health problems also reported that their use of drugs had caused problems in their life (42, 64.6%). In contrast, relatively few of the participants without health problems indicated that drug use had impaired their lives (16, 33.3%). Although this study did not differentiate among categories of drug use (e.g., soft, hard, prescription), the data was clear that the participants indicated a strong relationship between health status and drug use when living without shelter.





**Figure 21: HELPROUSE**

The history of health problems was related to the likelihood that the participants had received psychiatric diagnoses (Chi Square = 10.421, df = 1, p < 0.001). This data is summarized in Figure HELPMH. These data show that psychiatric diagnoses were approximately twice as common in participants with health problems (36, 51.4%) as they were in participants without health problems (13, 23.2%).



**Figure 22: HELPMH**

Income assistance was not related to the report of health problems by the participants (Chi Square = 1.678, df = 1, p < 0.195). Part of the difficulties relating income assistance to the presence of health problems was due to the limited ability to assess impairment based on self-reported medical problems. In future surveys, it might be of interest to differentiate between life-threatening health problems (e.g. cardiac conditions), health-maintenance problems (e.g., diabetes), and health management problems (e.g. dermatitis).

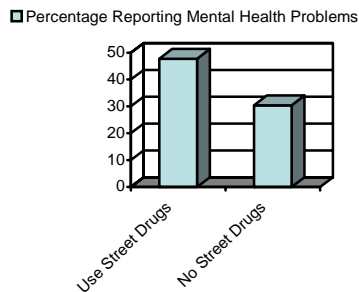
Rate of Mental Illness Relative to Homelessness

- **Up to 40 percent may have a psychiatric diagnosis**
- **Street drug use is significantly related to the presence of psychiatric disorders**

A substantial number of the participants reported that they had been told that they had a mental illness (43, 40.9%). If this percentage were applied to the total sample (n = 225), then there are approximately 92 (or 40 per cent) homeless individuals in the sample that have been given a psychiatric diagnosis.

The rate of participants indicating that they had been given a psychiatric diagnosis did not change with increasing periods of unstable housing (Chi Square = 10.42, df = 6, p < .11). Nevertheless, there was a trend for participants with relatively shorter periods of unstable housing to report more often that they had been given psychiatric diagnoses (22, 62.1%) than those participants reporting longer periods of unstable housing (17, 47.2%).

The use of street drugs was significantly related to the presence of psychiatric disorders (Chi Square = 3.931, df = 1, p < 0.047). That is, nearly half of the participants who reported that they used street drugs also reported that they had been given a psychiatric diagnosis (33, 47.8%) whereas less than a third of the participants who did not indicate that they used street drugs reported that they had been given a psychiatric diagnosis (17, 30.3%). This data is illustrated in Figure STREETMI.



**Figure 23: STREETMI**

Influence of Drug/ Alcohol Related Problems to Homelessness

- **The use of alcohol was strongly related to the report that drug use had caused problems in the participants' personal lives**
- **Participants with relatively brief periods without stable housing reported lower rates of using alcohol than those participants with longer periods without stable housing**
- **The use of street drugs was more common for participants who had slept outside for six months or longer**

The report of alcohol use did not influence the rate of having shelter on the evening of the survey (Chi Square = 0.319, df = 1, p < 0.572). Both participants who reported that they used alcohol (68, 83.9%) and those who reported that they did not use alcohol (55, 87.3%) indicated that they had no shelter that evening at high levels.

The relationship between the report of alcohol use and the reasons for being homeless was not significant (Chi Square = 19.957, df = 15, p < 0.174). Nevertheless, participants reporting alcohol use endorsed addictions as the most frequent reason for their homelessness, followed by conflict with family, eviction, and being unable to find a suitable place. In contrast, very few of the participants indicating that they did not use alcohol related their homelessness to addiction but rather more often cited difficulties finding adequate shelter. However, the diverse number of combinations of reasons once again obscured the nature

of this relationship. Better differentiated alternatives would enhance the understanding of the contribution of alcohol use to the reasons for homelessness.

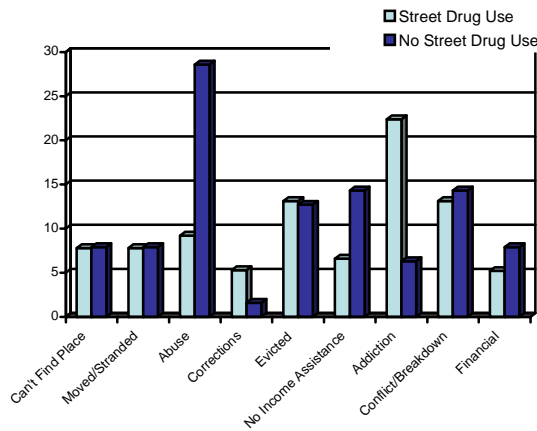
The rate of reporting alcohol use was constant over the periods of homelessness reported by the participants (Chi Square = 4.976, df = 6, p < 0.547). Participants with relatively brief periods without stable housing reported lower rates of using alcohol (25, 43.8%) than participants with longer periods without stable housing (32, 57.1%). This discrepancy should be interpreted in the context of the relatively high overall rate alcohol use reported by the participants (57, 50.1%)

The length of time spent in Victoria was not associated with the tendency to report alcohol use (Chi Square = 2.739, df = 6, p < .841). The use of alcohol was not associated with the amount of time the participants reported sleeping outside (Chi Square = 2.519, df = 4, p < 0.641).

The use of alcohol was not related to whether the participant reported receiving income assistance (Chi Square = 0.008, df = 1, p < 0.927). Participants reporting using alcohol had approximately the same rate of receiving income assistance (28, 37.8%) as the participants indicating that they did not use alcohol (24, 38.1%).

A relatively large number of participants reported that they used street drugs (59, 52.2%). The survey did not distinguish between participants using recreational drugs (e.g., THC), stimulants (e.g., Crystal Meth.), sedatives (Heroin), or prescription medications. With these cautions in mind, 29 of the participants with relatively short periods of homelessness reported that they used a variety of street drugs and 29 of the participants reported that they did not (50.0%, respectively). Similarly, 30 participants with relatively long periods of homelessness reported that they used street drugs (54.4%) and 25 (45.6%) reported that they did not use street drugs.

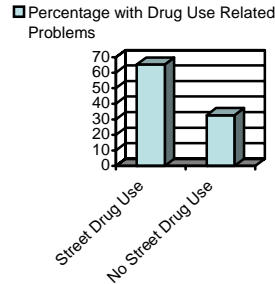
There was a non-significant relationship among the reasons indicated by the participants and the report of street drug use (Chi Square = 20.430, df = 15, p, 0.156). The relationship between street drug use and reasons cited for homelessness is illustrated in figure REASONSTREET. Once again, the failure to distinguish between causative variables and resultant effects of lack of shelter made assessing problematic on the contribution of street drug use to homelessness.



**Figure 24: REASONSTREET**

The use of street drugs was not associated with the period of time participants reported sleeping outside (Chi Square = 4.997, df = 4, p < 0.288). Also, participants reporting that they used street drugs, reported that they had slept outside for 6 months or more (41, 52.6%) at a slightly higher rate than those participants who did not report using street drugs (25, 40.9%).

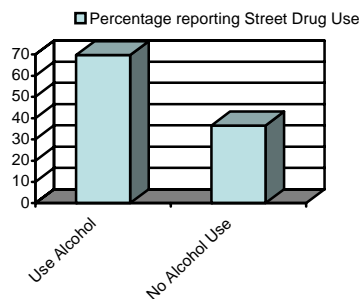
Street drug use serves as a gateway to problem behaviour. The use of street drugs was an important determinant of the prevalence of problems in the personal lives of the participants. Participants who reported that they used street drugs also reported that drug use had caused problems in their personal lives at a higher rate (45, 65.2%) than participants who did not report street drug use (15, 32.6%), see figure USEPROSTREET below.



**Figure 25: USEPROSTREET**

Many of the participants who reported street drug use also indicated that addiction had played a role in their difficulties finding adequate housing (22.4%), followed by eviction (10), and family conflict (10, 13.2%, respectively). In contrast, those participants who did not report street drug use indicated that being unable to find adequate housing (15, 23.8%), ineligibility for income assistance (9), family conflict (9, 14.3% respectively), and evicted (8, 12.7%) were the most frequent reasons cited for not having stable housing.

There was a significant overlap between participants reporting that they used alcohol and the report of street drug use (Chi Square = 13.176, df = 1, p < 0.000). This data is summarized in Figure STREETAL. A majority of participants reporting that they used street drugs also reported that they also used alcohol (53, 69.7%), whereas a majority of participants reporting that they did not use alcohol also reported that they did not use street drugs (40, 66.7%).



**Figure 26: STREETAL**

There was a trend for participants with shorter periods of homelessness to indicate more often that drug-use had caused them problems (24, 52.2%) than those participants reporting longer periods of unstable housing (17, 39.5%). However, that trend was not significant (Chi-Square = 6.10, df = 6,  $p < 0.412$ ) as the prevalence of drug-use reported problems was quite high among all of the participants (41, 46.1%).

The use of alcohol was strongly related to the report that drug use had caused problems in the participants' personal lives (Chi Square = 19.195, df = 1,  $p < 0.000$ ).

#### Finding Shelter for the Evening

Given that having a shelter for the evening was a relatively rare event in this sample ( $n = 9$ , 7.25%), there was a no significant statistical relationship between the length of time of homelessness and whether the participant had adequate shelter for the evening (Chi-Square = 9.68, df = 6,  $p < .139$ ). That is to say, the length of homelessness was of limited utility in estimating whether an individual would be without shelter.

Nor did there appear to be a consistent relationship between the length of homelessness and the reason for not having shelter (Chi-Square = 107.06, df = 96,  $p < .207$ ). Once again, the diverse range of factors leading to homelessness prevented an adequate assessment of the relationship among the stated reasons and the overall length of the participants' homelessness.

#### Relationship between Lack of Housing and Lack of Shelter:

There was a significant association between how long the participant reported being without shelter and the length of time they had been without stable housing (Chi-Square = 118.21, df = 24,  $p < .001$ ). This finding is consistent with a significant increase in the rate of participants reporting that they are without adequate shelter as the length of time of their being without stable housing increases. The concordance between the self-report to these similar probes contributes to the validity of the coding procedure.

#### Limitations

There are some inherent limitations in designs of this nature. The absence of any data with respect to the pre-survey status limits the ability of this study to assess for factors influencing changes in the needs in this sample of homeless individuals. In addition, the lack of a control group prevents any evaluation of the differences between this sample and the general population. As such, this research represents a single case study design, with all the attendant threats to the internal validity that characterize this type of study (Campbell & Stanley, Experimental and Quasi-Experimental Designs for Research, 1963, page 8).

In a related manner, this project involves calculating a large number of statistical tests on a relatively small number of subjects. In areas where strong research effects have been demonstrated, the alpha-level would be divided by the number of comparisons. However, this is an exploratory study where the effects of risk factors are largely unknown. Accordingly, no Bonferroni-like adjustment was made for the number of comparisons.

However, the risk of false-positive efforts should be kept in mind when interpreting data from small samples.

There are also some limitations that are unique to this study. A large number of potential participants volunteered for an in-depth interview (n = 94). Once again, it would be prudent to assume that the results of the relatively large sample completing the structured survey would generalize to the smaller in-depth sample. Moreover, the analysis of the structured data was seen as an important step in preparing to analyze the data from the in-depth sample.

The data does not represent a random-sample of homeless individuals due to the need to honor informed consent. Out of 220 potential participants in this survey, only 175 (79.6%) provided informed consent. The inaccessibility ranged from being partially responsive (14, 6.2%) to outright refusal (10, 4.4%). This figure also included lack of consent due to "empty-nester", failure to respond to knocking, and lack of data (23, 10.2%).

Given the large number of participants in this survey, it is prudent to consider the current data as a robust sample from the population of homeless in the Victoria region. Nevertheless, some caution is warranted with respect to generalizing the current results to this unrepresented portion of the population. That is to say, those clients who were deemed inaccessible might represent a particularly hard-to-house segment of the larger shelterless population. Despite the presence of some unwillingness to provide informed consent, the remaining sample was sufficiently large to allow valid descriptions of factors associated with homelessness. In addition, the participants frequently appended positive remarks and comments to the survey forms.

There were also statistical problems related to the diversity of the participants that made it difficult to capture some of the finer-grain nuances associated with homelessness. As expected, Caucasian (95, 42.6%) and First Nation (76, 33.8%) made up the bulk of the sample's cultural heritage. Subjects who described themselves as having other cultural backgrounds were very infrequent (Black = 1, 0.4%; Asian = 3, 1.3%; Inuit = 1, 0.4%, Mestizo = 1, 0.4%). Similarly, a majority of the participants identified themselves as either male (105, 62.8%) or female (60, 35.9%), some participants were unwilling to share their gender-orientation (11, 6.2%) or were unsure (2, 1.1%). We focused on the 165 participants indicating a male or female gender-orientation. Although these rarer groups were collapsed into a single group, the unique needs of these individual cultural backgrounds should be kept in mind when interpreting the data based on the dominant cultural backgrounds.

Some variables reflected the presence of some relatively rarer combinations of demographic and homelessness variables. For example, homelessness was an issue that involved the very young (minimum age = 16 years) and the very old (maximum age = 67). Although these participants reflected unique interactions between the background of the individual and issues associated with homelessness, the dearth of observations reflecting these combinations limited the type and validity of the statistical analyses available. Accordingly, some variables were categorized into broader rubrics to facilitate the communication of results.

Specifically, the ages of the participants were classified into broad categories for the very young (i.e., 25 years or less) and the very old (51 years or more). It is important to note that

terms 'very young' and 'very old' are relative to the ages demonstrated by the current sample. The five-year intervals used to describe the ages of the other participants was sufficiently sensitive to protect the internal validity of the results. However, if the special needs of the very young (e.g. less than 20) or the very old (e.g. greater than 50) becomes an important topic then additional efforts will be required to gather adequate data bearing on this topic.

The length of time without a home or place was also summarized into relatively broad categories, especially at the extremes (i.e., very brief and very chronic). The intervals were chosen to minimize the differences in the number of observations at each level of homelessness (i. e., 1 month or less = 21; 3 months or less = 25; 9 months or less = 19; 1 year or less = 21; 2 years or less = 17; 3 to 5 years = 16; 6 years or more = 7). Obviously, these broad categories are of little use in differentiating between acute needs for shelter and chronic housing problems. Accordingly, these results should be interpreted in the context of the subtle differences between acute and chronic housing needs.

The length of time spent in Victoria was also summarized into relatively broad categories (i. e., 3 months or less = 14; 4 months to a year = 12; 1 to 2 years = 16; 3 to 5 years = 29; 6 to 9 years = 21; 10 years or more = 51). The attempt at comparing the length of time without stable housing to the length of time in Victoria is, of course, a crude attempt at estimating the effects of migration to Victoria on housing needs. If the issue of the origins of the homeless becomes an issue, additional steps to sharpen our understandings of where the individuals came from will have to be taken.

When variables failed to demonstrate statistically significant results, those variables were re-classified into even broader categories in order to facilitate the description of the influence of these variables.

Some of the participants reported that they had dependent children. Since only some of the participants were asked about the presence of dependent children, it is difficult to interpret the partial results. If this issue is deemed significant, follow-up surveys should have probes with respect to the number of children and how many of them are dependent on the participant.

Two cautions are warranted with respect to the results dealing with the report of street drug use. First, the question probing this area did not differentiate amount and frequency of use. Further, responses to this question did not distinguish between so-called soft drugs, such as marijuana, and street drugs, such as heroin or crack. Finer grained analysis is unlikely to shed additional light on this issue given the restricted amount of information regarding the street drugs.

### Terminology

In analyses involving relative numbers of participants, a Chi-Square test was used to determine the likelihood of obtaining a similar number of observations given the overall rate of occurrence. Thus, observed frequencies that are rare relative to the overall sample are considered statistically significant. These findings indicated by having p-values less than or equal to 0.05. Significant Chi-Squares indicate that, although the results

are extreme or different, they are likely to be found again with repeated sampling. Of course, statistical analysis is not the only way of determining the significance of a particular finding.

It should be noted that statistical analysis only identifies those patterns in the data that were relatively unlikely based on chance. Typically, the p-values less than 0.05 are considered significant in that there is less than 1 chance in 20 that the obtained results were obtained by chance. The lower the p-value the more likely the same pattern of results would be found if the study were completed with another subsample of the population of homeless.

Percentages that do not add up to 100.0 were due to rounding errors.