2018 WINNIPEG
STREET HEALTH SURVEY
FINAL REPORT

-FEBRUARY 2019-

END HOMELESSNESS WINNIPEG

ACKNOWLEDGMENTS

The authors wish to thank the many individuals, agencies and organizations whose participation, insights, time, knowledge and expertise made this project possible.

Firstly, and most importantly, we thank the project participants, who gave of themselves, sharing their stories, insights and time. Thank you also to the many staff at the community agencies and organizations that served as survey sites by welcoming interviewers and supporting participant recruitment. The help and support from the End Homelessness Winnipeg (EHW) team was instrumental in the implementation and completion of this project. We appreciate the work and contribution of the research team members, including interviewers and data entry clerks. We are grateful for all those who provided their input and feedback for this report. Finally, thank you to the project Advisory Committee members and the various Working Group members who worked throughout the project, providing their time, knowledge, expertise and guidance.

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LAYOUT AND DESIGN

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End Homelessness Winnipeg is located on Treaty One Territory, at the crossroads of the Anishinaabe, Métis, Cree, Dakota and Oji-Cree Nations, and on the traditional lands of the Anishinaabe peoples and the homeland of the Metis Nation.

Table of Contents

Executive Summary

The 2018 Winnipeg Street Health Survey was a research study focusing on the health status, housing, and social service needs of individuals experiencing homelessness in Winnipeg. Its main purpose was to provide crucial information to community organizations, agencies, and all levels of government for policy and program development and for system-wide change. The 2018 Street Health Survey Report is essential to the community of Winnipeg and provides important data that is not generally included in government health and census surveys.

The 2018 Street Health Survey project was led by End Homelessness Winnipeg, in partnership with 18 organizations that were represented on the project Advisory Committee. This work builds on the 2011 Winnipeg Street Health Survey, by using similar topics and questions.

After receiving ethical approval from the University of Manitoba Health Research Ethics Board, the study team recruited and surveyed 406 individuals in-person at Winnipeg emergency shelters and community agencies within the homelessness-serving sector. Interviews were conducted from July 10, 2018- October 5, 2018. Data analysis and report writing was completed between October 2018 and February 2019.

Key Findings

The 2018 Winnipeg Street Health survey data, alongside that of previous studies, demonstrate that the fundamental characteristics of the population of individuals experiencing homelessness in Winnipeg have not changed over the past decade: more than 70% of individuals are Indigenous and nearly 50% of participants spent time in foster care/Child and Family Services (CFS). Study participants self-reported high rates of mental health diagnosis, problematic substance use, injuries, chronic diseases, and frequent experiences of physical pain. At the same time, individuals experiencing homelessness are accessing a wide range of health care services and locations in Winnipeg. Most individuals surveyed have a family doctor, and many individuals access care through local clinics, hospitals or community health centres.

Participants reported experiences of disrespect and judgement; limited access to daily needs for good health such as food and sleep; and barriers to the social determinants of health such as housing and income. However, participants also described positive experiences with service providers, programs and community networks where they felt supported with kindness, empathy, understanding, and willingness to help.

This report calls on us to work together to meet the needs of individuals experiencing homelessness in Winnipeg. Partnerships between systems including health, justice, housing and social services are critical to supporting the health and wellbeing of those experiencing or at risk of homelessness. Rather than offering one-size-fits-all services to everyone, an equitable approach is required: one where systems and front-line staff provide supports tailored according to individual needs. Given the significant number of Indigenous individuals experiencing homelessness in Winnipeg, the provision of equitable services and supports, and development of programs and policies using an Indigenous cultural lens, is critical.

Dedication

This report is dedicated in memory of all those who have passed away while experiencing homelessness in Winnipeg

Project Advisory Committee

19 organizations worked in partnership to achieve the project deliverables for the 2018 Winnipeg Street Health Survey by sharing their knowledge and skills, providing advice and expertise on the research process, including ethical and cultural considerations, and by championing the research project in their respective organizations, agencies and the greater community. Each of the following organizations (listed in alphabetical order) was represented on the Project Advisory Committee, which met monthly throughout the duration of the project:

- Canadian Mental Health Association, Manitoba and Winnipeg
- City of Winnipeg
- End Homelessness Winnipeg
- George & Fay Yee Centre for Healthcare Innovation
- Health Sciences Centre
- Here & Now: Winnipeg's Plan to End Youth Homelessness
- Main Street Project
- Ma Mawi Chi Itata Centre
- Manitoba Housing
- Mount Carmel Clinic
- Resource Assistance for Youth (RaY)
- Siloam Mission
- Social Planning Council of Winnipeg
- The Salvation Army
- University of Winnipeg
- Sunshine House
- West Central Women's Resource Centre
- Winnipeg Regional Health Authority
- Youth Agencies Alliance

Advisory Committee Working Groups

Over the course of the project, several Working Groups were developed among the project Advisory Committee membership, providing specific expertise to complete project deliverables:

Methodology Working Group:

- End Homelessness Winnipeg
- Manitoba Housing
- Resource Assistance for Youth (RaY)
- Social Planning Council of Winnipeg
- University of Winnipeg
- Winnipeg Regional Health Authority

Knowledge Translation Working Group:

- End Homelessness Winnipeg
- Social Planning Council of Winnipeg
- West Central Women's Resource Centre
- Winnipeg Regional Health Authority

Analysis Working Group:

- End Homelessness Winnipeg
- University of Winnipeg

Background

The 2018 Winnipeg Street Health Survey was a research study focusing on the health status, housing, and social service needs of individuals experiencing homelessness in Winnipeg. Its main purpose was to provide crucial information to community organizations, agencies, and all levels of government for policy and program development, and for system-wide change.

It was designed to increase understanding of the health issues and health care needs faced by individuals who are experiencing homelessness, and their experiences with, and barriers to accessing health care or other social services. The information gathered provides an in-depth overview of how people experiencing homelessness in Winnipeg interact with health and social service systems.

The Street Health Survey is essential to the community of Winnipeg. The 2018 Street Health Survey builds on findings from the 2011 Winnipeg Street Health Survey, by using similar topics of inquiry and questions. These projects evolved from a recognized lack of comprehensive data on the self-reported health status and health care needs of people who experience homelessness in Winnipeg.

The 2018 Street Health Survey was developed to capture important data that is not generally included in government health and census surveys. Without this essential local information, most community organizations need to rely on anecdotal evidence and data from other communities, which may not reflect the specific needs of individuals and families experiencing homelessness in Winnipeg, to plan programming, work towards system change, and lobby government for policy improvements. Further, all levels of government themselves rely on research data to assess gaps and identify priorities.

The 2018 Street Health Survey project was approved by the University of Manitoba Health Research Ethics Board and was reviewed by the WRHA Research Access and Approval Committee, to ensure WHRA standards regarding privacy and confidentiality were addressed.

This is a high-level report, which provides results on some, but not all, information gathered from the 2018 Winnipeg Street Health Survey.

Additional sub-reports, with more detailed information, will be published in the future.

Methods Synopsis

The 2018 Winnipeg Street Health Survey used a convenience sample to recruit and select participants. Data collection was undertaken using paid interviewers by means of a face-to-face, structured survey, where interviewers recorded participant responses on paper. Interviews generally took between 45 and 75 minutes each. All participants provided written informed consent and were given a $20 cash honorarium to thank them for their participation.

Throughout the report, 'N' = total sample size, and 'n' = number of participants who answered 'yes' or 'no' to the question. 'Missing' includes missing data, system errors, 'don't know' and 'declined to answer' responses. Responses to open-ended questions were summarized by interviewers on paper. To protect the privacy of participants, it is these summarized notes, rather than participants' verbatim statements, that are quoted in this report.

Limitations

The report data is based on information that was self-reported by participants and only captures information from a portion of all individuals who were experiencing homelessness in Winnipeg at the time the survey was conducted. Further, there was limited representation from newcomer and non-binary gender communities among survey participants.

Recruitment

Recruitment for the 2018 Winnipeg Street Health Survey occurred over several months, beginning in July 2018 and ending in early October 2018. Significant time was invested by the research team in connecting with organizations within the homeless-serving sector to ensure participants were drawn from a variety of agencies and locations.

While convenience sampling methods were used, recruitment focused on individuals who were experiencing three main types of homelessness:

1) **Unsheltered**: living in places not intended for human habitation, including in public or private places without consent
2) **Emergency Sheltered**: staying in overnight emergency shelters and family violence shelters
3) **Provisionally Accommodated**: including people living temporarily with others but without guarantee of continued residency or prospects of permanent housing ("couch surfing"), and those living in interim (transitional) housing (*Gaetz et al. 2012*).

For the purposes of this report, unsheltered and emergency sheltered are also referred to as **'absolute'** or **'visible'** homelessness, while provisionally accommodated is also referred to as **'hidden'** homelessness.

Within the three types of homelessness described above, specific sub-populations were recruited, including individuals of Indigenous descent, women, and youth (aged 18-29). The research team recruited participants from nearly 30 different sites (see Table 1).

Table 1: Survey recruitment sites

Recruitment Site	# of Participants	Percentage %
Aboriginal Health and Wellness	48	12.1
Main Street Project	47	11.6
One88 Campus-Eastview Community Church	44	10.9
Siloam Mission	26	6.4
Crossways West Broadway Community Ministry	23	5.7
Union Gospel Mission	22	5.4
Resource Assistance for Youth (RaY)	20	4.9
Ndinawemaaganag Endaawaad Inc. (Ndinawe)	19	4.7
Agape Table	17	4.2
Pam Am Place	16	4.0
Andrews Street Family Centre, Oak Table (Augustine Church), Elizabeth Fry Society, Thrive, WE 24 Youth Safe Space, Welcome Place, Willow Place*	15	3.7
Sage House	13	3.2
West Central Women's Resource Centre	13	3.2
Nine Circles	11	2.7
North Point Douglas Women's Centre	11	2.7
The Salvation Army	10	2.5
John Howard Society	9	2.2
Ma Mawi Wi Chi Itata Centre	9	2.2
Ka Ni Kanichihk	7	1.7
Eagle Urban Transition Centre	6	1.5
St. Matthews Community Ministry	6	1.5
Sunshine House	6	1.5
Wii Chiiwaakanak Learning Centre	5	1.2

n = 405; Missing = 1
*sites where less than 5 participants were recruited

Eligibility criteria for participation in the study required that participants were at least 18 years of age and met criteria for unsheltered and/or emergency sheltered, or provisionally accommodated on the night prior to study enrolment. Table 2 provides the list of potential housing/homelessness options that met or did not meet study criteria.

Table 2: Study eligibility criteria for housing/homelessness

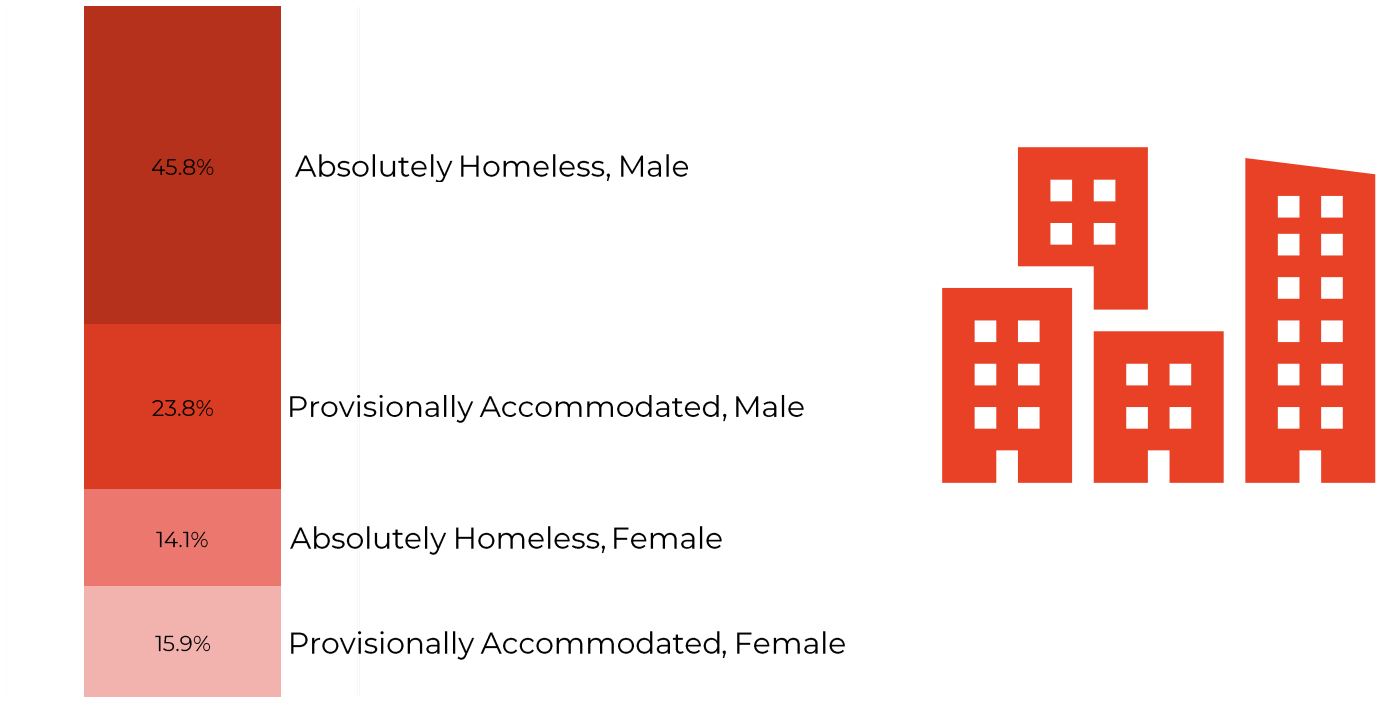
ELIGIBLE		ELIGIBLE			NOT ELIGIBLE
Absolute Homelessness		Provisionally Accommodated			Permanently Housed
Emergency Sheltered	Unsheltered	Transitional housing	Temporary Housing	Institutional Housing	
Emergency shelter or domestic violence shelter	Car or other vehicle	Transitional housing	Stayed with a friend (cannot stay permanently)	Residential addiction treatment program	Own apartment or house
Overnight Youth Safe Space	Abandoned building		Stayed with a family member (cannot stay permanently)	Hospital	Rooming house
	Place of business (e.g. all-night laundromat, restaurant, etc.)		Hotel or motel	Jail (remand or prison)	Stayed with a friend (can stay permanently)
	Anywhere outside (e.g. streets, parks, bus stop, tent, etc.)		Drug/Work/Trap Houses	Hotel or boarding home funded by First Nation & Inuit Health Branch	Stayed with a family member (can stay permanently)
				Detox Unit	

Those who were eligible according to the study criteria were enrolled after providing written informed consent. Individuals who did not meet the criteria were informed that, based on the response they gave to interviewers, they were outside of the target group for this survey and were thanked for their time.

Homelessness Status Pre-enrolment

Most study participants (60.8%) indicated they had experienced absolute homelessness on the night prior to being enrolled in the study, while 39.2% said they were provisionally accommodated. Approximately one-half of those surveyed (45.8%) were males experiencing absolute homelessness, while 23.8% were males who were provisionally accommodated. 14.1% of those surveyed were females experiencing absolute homelessness and 15.9% were provisionally accommodated females (Figure 1).

Figure 1: Accommodation type on the night prior to study enrolment



n = 398 Missing = 8
*Gender Diverse: Absolute Homelessness = <1%, Provisionally Accommodated = 0%

Study Participants: Characteristics

A total of 406 interviews were completed with Winnipeg community members aged 18 years and older. Table 3 highlights key characteristics of study participants. Additional details (such as prior month's income, self-reported mental health diagnoses and hospital emergency room visits) are provided in other sections of this report.

The demographic and other characteristics shown in Table 3 provide a snapshot of the realities of those experiencing homelessness at the time of study enrolment. 71.4% of study participants identified as Indigenous (see Figure 2). Almost half (47.5%) had spent time in the care of Child and Family Services (see Figure 3) during their lifetime. 65% indicated they had been diagnosed with a mental illness, while 57.7% said they had received care from a hospital emergency department in the past year. More than two-thirds (68.0%) were parents. Almost one quarter (24%) were youth (aged 18-29), and close to half (44.7%) were between the age of 30-50, while the average age of participants was 42 years old. 27.2% of participants indicated they had been incarcerated in the past year, spending an average of 59 days in jail or remand.

Gender was identified through an open-ended question ('What gender do you identify with?'). Most participants identified as male (69%), while 30% identified as female, and less than one percent (0.5%) identified as gender diverse (e.g. non-binary, Trans, etc.). Most participants reported their sexual orientation as straight/heterosexual (85.5%), while 14.5% reported as LGBTQI2S+.

Table 3: Characteristics of participants

Characteristic	Percentage %
Identity	
Indigenous	71.4
• First Nations (Status)	50.8
• First Nations (Non-Status)	5.0
• Métis	14.0
• Inuit	1.6
Non-Indigenous	28.6
Age Group (years) (Mean Age = 42)	
18-29	24.1
30-50	44.7
51-64	29.1
65+	2.0
Spent time in care of CFS	47.5
Turned 18 while in CFS care	30.2
Prior Month Income (CDN)	
Less than $200/month	24.4
Mental Health Diagnosis (self-reported)	64.8
Received Care from Hospital Emergency Department in Past Year (self-reported)	57.7
Parental Status (Have Children)	68.0
Gender Identity	
Male	69.3
Female	30.2
Gender Diverse (e.g. Non-binary, Trans, etc.)	0.5
Sexual Orientation	
Heterosexual/Straight	85.5
LGBTQI2S+	14.5
Country of Origin	
Canada	96.1
Other	3.9
Education	
Grade 8 or lower	14.6
Some High School	48.0
High school diploma or GED high school equivalent	21.1
Some college/university, but no degree	8.8
Completed vocational school, college, or university	7.5
Incarcerated in Past Year	27.2
Average (mean) number of days	59.1*

Total Sample N = 406
Standard Deviation (a measure of the amount of variability in the data) = 92.8

Figure 2: Percentage % of Indigenous vs. Non-Indigenous participants

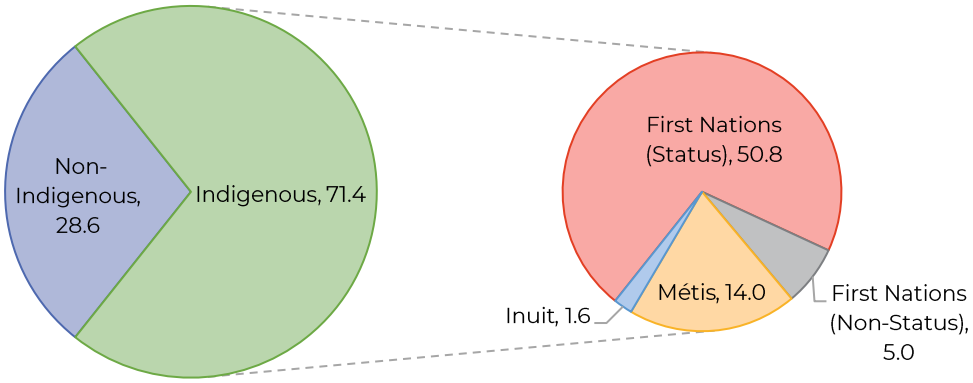
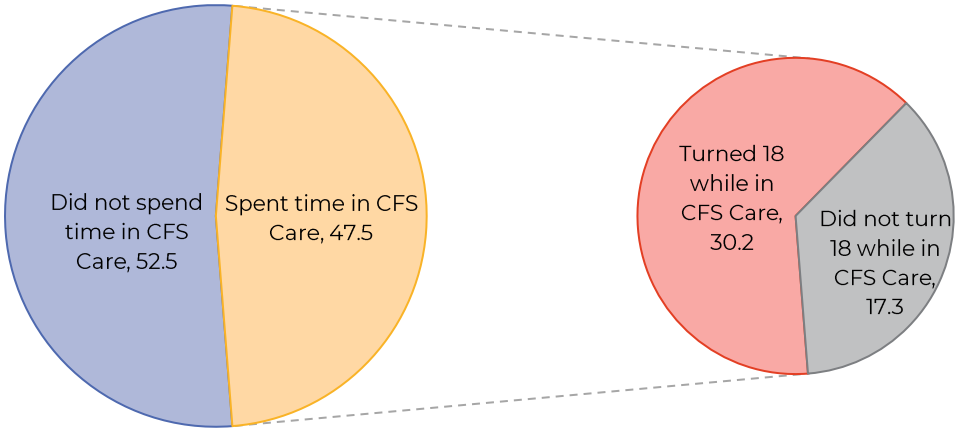


Figure 3: Percentage % of participants who spent time in CFS care



The characteristics of participants are similar in many ways to those of participants from other surveys conducted within the homeless population in Winnipeg over the past decade. As noted above, most participants in our study (71.4%) identified as being of Indigenous descent. Similarly, other key reports on homelessness in our city cite nearly three-quarters of study participants as being of Indigenous descent: At Home/Chez Soi project (Distasio et al., 2014), Street Census 2015 (Maes Nino et al., 2016), and Street Census 2018 (Brandon et al., 2018). Indigenous people are over-represented among the homeless population throughout Canada, particularly in Western Canada (Belanger et al., 2012). On a national level, it is estimated that one-third of the Indigenous population lives in unstable housing, compared to 18% of the non-Indigenous population.

Additionally, age and gender distributions in the 2018 Winnipeg Street Health Survey are similar to those of previous homelessness studies in Winnipeg (Brandon et al., 2018; Distasio et al., 2014; Gessler et al., 2011; Maes Nino et al. 2016).

Daily Experiences

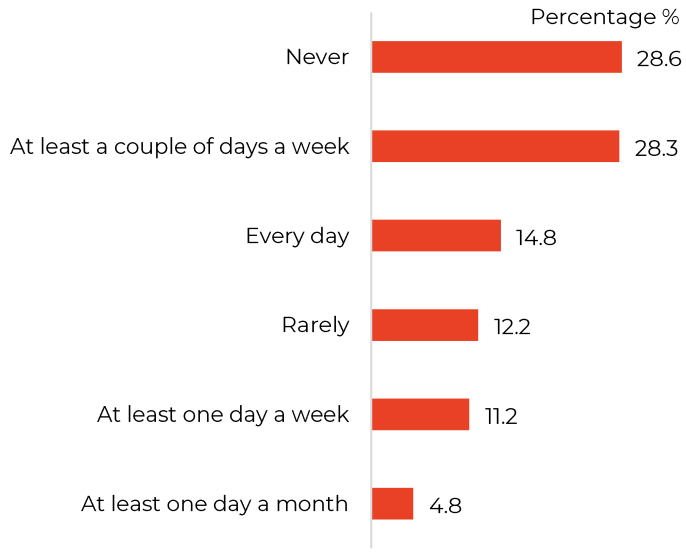
Participants' stories relating to the challenges of trying to survive and stay healthy, while not having a permanent place of their own to live in, clustered on the themes of struggling to meet basic needs such as food, warmth and shelter, and clothing.

"Constantly worrying... Where am I going to sleep? Where am I going to eat?"

Food Security

28.6% of participants indicated they had never been hungry in the past month because of not getting enough food, and 12.2% said they were rarely hungry. On the other hand, 14.8% indicated they were hungry every day, while 28.3% said they felt hungry at least a couple of days a week (Figure 4).

Figure 4: How often in the past month were you hungry because you could not get enough food?

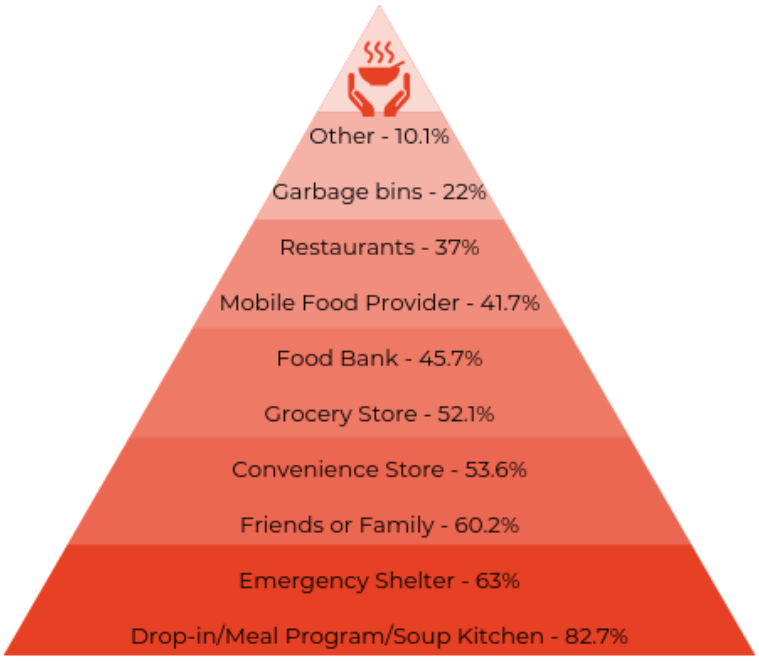


n = 392; Missing = 14

Most study participants accessed food at drop-in centres or meal programs (82.7%).

Eating at an emergency shelter or at friends' or family members' places was also common (63% and 60.2% respectively – see Figure 5).

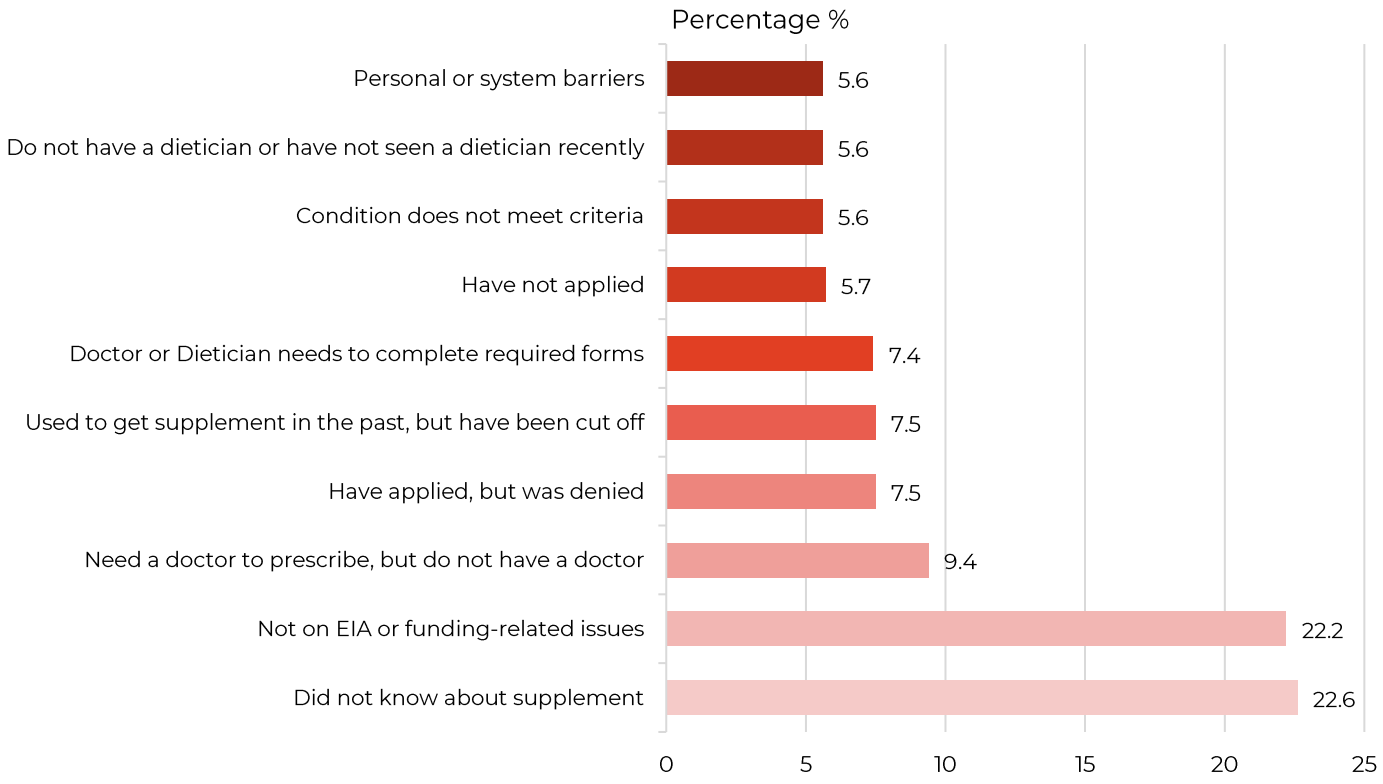
Figure 5: Typical locations accessed for food



Eighty-three participants (21%) indicated they should be following a special diet for health or cultural reasons. Of these, only 22 (28.2%) were receiving the EIA special diet supplement amounts on their EIA payments. When asked why they were not receiving the EIA special diet supplement amounts, the most common responses were that they did not know about the additional EIA financial supplement (22.6%), or that they were not currently on EIA or other funding-related issues (22.2%) (Figure 6).

n = 405; Missing = 1

Figure 6: Why are you not receiving EIA special diet supplement payments?

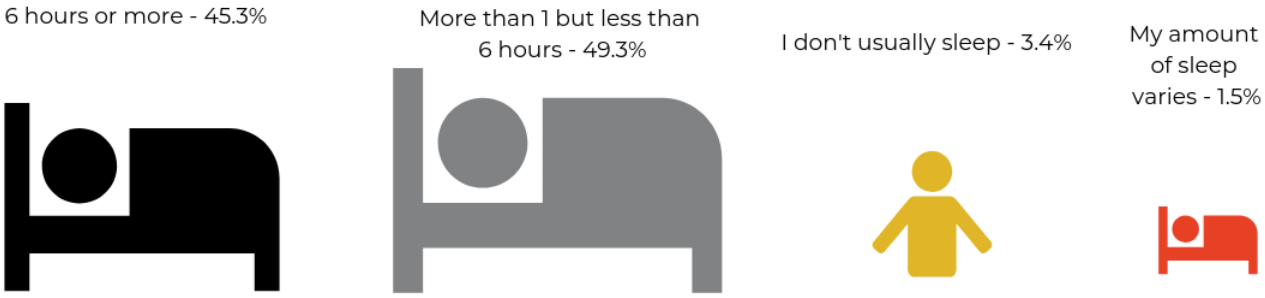


n = 53; Not Relevant or Missing = 353

Sleeping Patterns

Nearly half of participants (49.3%) said they usually got between one and six hours of sleep per day, while 45.3 percent said they usually had six or more hours. A few indicated that they don't usually sleep (3.4%) and a smaller number said their amounts of sleep varied (1.5% - Figure 7). More people got most of their sleep at night (73.1%), versus during the day (26.9% - Figure 8).

Figure 7: Usual number of hours of sleep per night/day

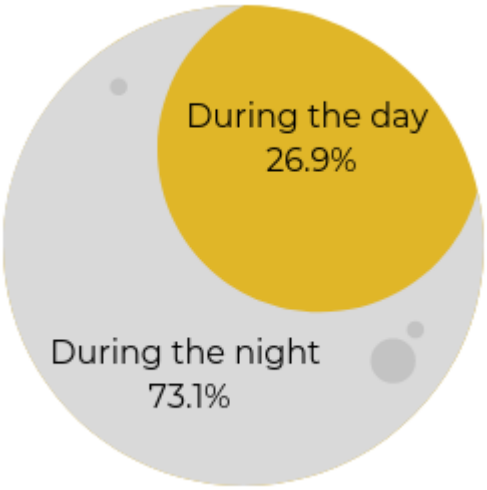


n = 386; Missing = 20

One of the challenges of experiencing homelessness related to sleep that was shared by a participant related to concerns for personal safety:

> "Being cautious and trying to be on guard all the time leads to being awake constantly."

Figure 8: Participants' usual time of sleep (day or night)



For participants who said they got most of their sleep during the day (26.9%), a follow-up question was asked to discover reasons why this was the case for them.

Participants' responses clustered in themes of safety, sleeping conditions, and individual factors. Fears of violence and personal violation were often cited as the reason for sleeping by day, and some participants referred to Winnipeg's experience with missing and murdered Indigenous women as context for these fears. Others noted the increased risk at night of encountering authorities directing individuals to not remain in public spaces.

Night: n = 275; Day: n = 101; n = 376; Missing = 30

Many commented on crowding in shelters, as well as unpleasant and uncomfortable conditions elsewhere, mainly in terms of noise and temperature. Some individuals mentioned working at night or engaging in other activity, including substance use, as the reason for sleeping during the day; boredom and depression were also cited.

"Being homeless is kind of scary because that's the streets of Winnipeg, there's missing women, it's cold, you have no blanket, no pillow, someone could come stab you..."

"I don't sleep well because of all the things going on. We have a buddy system. [I] sleep during the day and friend sleeps at night. [We] watch each other." *-female participant*

The main reasons participants gave for having difficulty sleeping were that other people woke them up (59.7%), their nerves were bad, and they could not relax (56.9%), physical pain, discomfort or other physical needs (55.6%), and because they were sleeping outside or because of the temperature, whether too cold or too hot (54%).

More than half of participants:

- Had experienced absolute homelessness during the month before being surveyed;
- Reported getting less than six hours of sleep per night, and/or
- Reported difficulty sleeping for various reasons

These numbers, along with concerns expressed by participants for their safety while sleeping, suggest that few individuals who are experiencing homelessness have the opportunity for a restful sleep.

Income and Employment

The challenges of experiencing homelessness and daily survival was described by two participants in relation to poverty and access to benefits:

> "When you tell people your story, you're always someone else's problem. They always point you away. You're stuck in this business of poverty. They're perpetrating dependency, not independency."

> "I'm having to fight for every little benefit I can get."

Participants also frequently remarked on the loss of valued roles, such as homemaker, or member of the workforce:

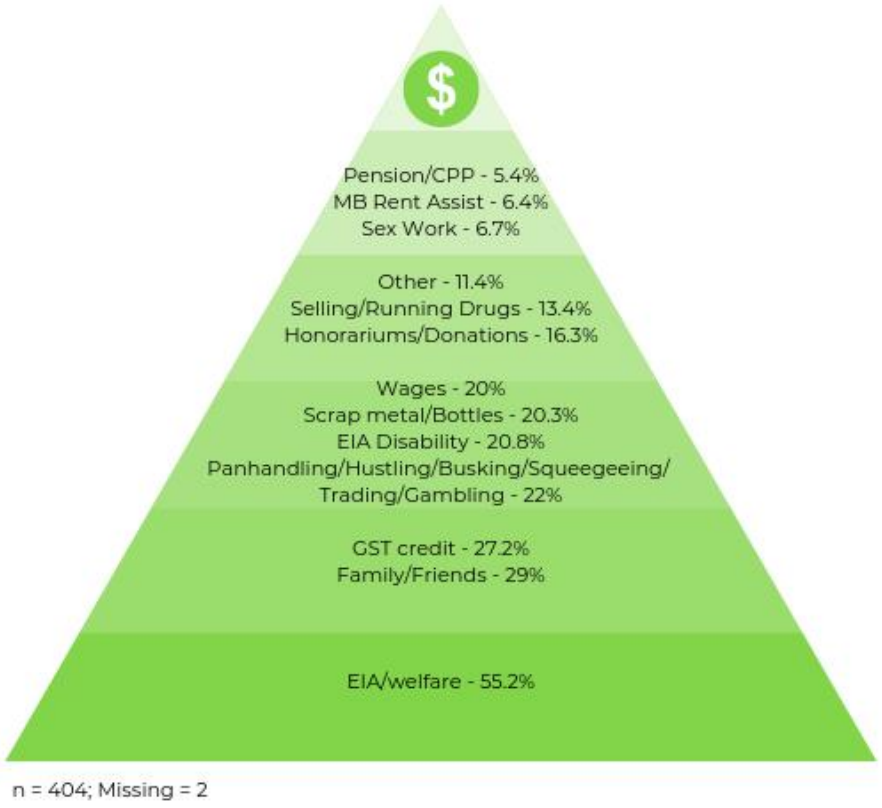
> "Trying to hold a job when you [have no] place to live, no phone: they can't get ahold of you!"

Approximately one quarter of participants (24.7%) reported their past month income as being between $201 and $400, while another 24.4% indicated their income to be less than $200 in the past month. A few participants (6.5%) reported 'no income' (Figure 9).

Figure 9: Approximate total income (CDN) in past month

n = 352; Missing = 54

Figure 10: Most common sources of income in past month



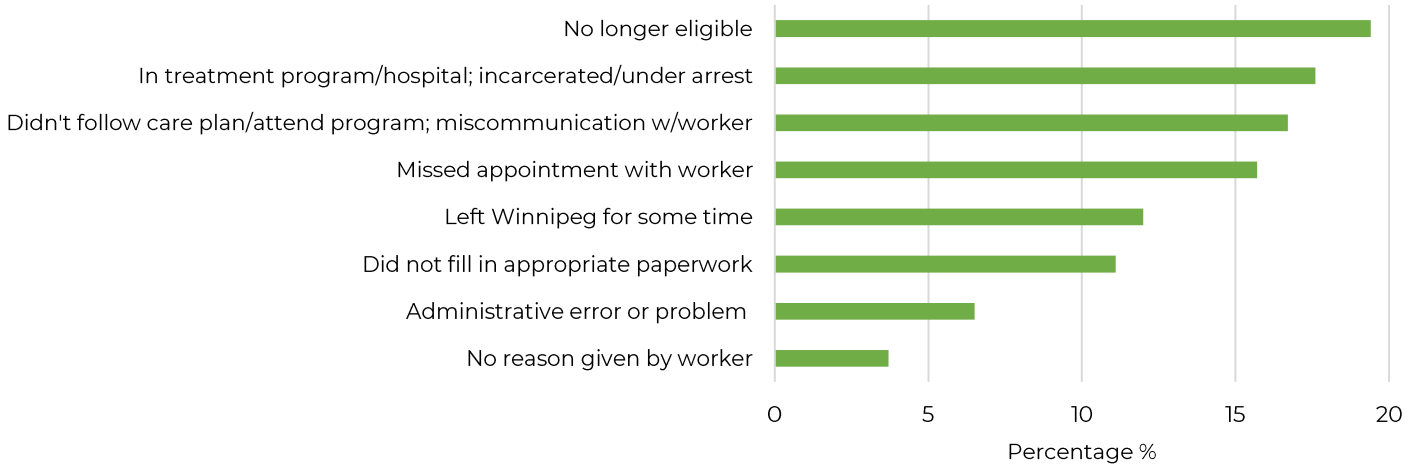
n = 404; Missing = 2

More than half (55.2%) of participants had received provincial welfare/Employment and Income Assistance (EIA) benefits in the past month. Money from friends and family (29%), GST credits (27.2%), panhandling, hustling, busking etc. (22%), EIA Disability (20.8%) collecting and selling scrap metal and bottles (20.3%), and wages (20%), were also common income sources.

In terms of 'other' sources of income (11.4%), 40% came from general casual, temporary labour, and 12 percent from renovations, roofing and landscaping. Construction, arts and music, and culinary work were also noted as 'other' income sources.

While at least half of participants had received provincial welfare/EIA benefits in the past month, 30.4% of participants indicated that their welfare/EIA benefits had been discontinued in the past year without them having any other source of income. The main reasons participants cited for being taken off EIA most recently was that they were no longer eligible (19.4%), followed by going into or being in a treatment program, hospital, jail, or being under an arrest warrant (17.6%).

Figure 11: Reasons for EIA benefits being discontinued in past year



n = 108; Missing = 298

More than half of study participants indicated they had a bank account (56.2%), while the other 43.8% said they did not (n=390; missing = 16). Of those who indicated they did not have a bank account; the most noted reason was a lack of required identification (51.4%). While only 5% of participants indicated they had been refused banking services, more than half of those refusals were due to lack of required identification (Table 4). Further, only half of study participants (50.8%) reported filing their income tax in the past year, while 49.2% indicated they had not.

Table 4: Reasons for not having a bank account and for being refused banking services

Reason	Percentage %
No identification	51.4
No income/money or bank card lost/stolen	12.1
Did not think it was necessary, personal preference, or personal reasons	9.9
Fraud or bank misuse related issues or overdrafts, credit or debt issues	8.9
Have not gotten around to it, or Bank hours/bank was closed	8.3
Was refused services	5.0
Was refused banking services because of:	
• Lack of required identification	2.8
• Overdrafts, credit or debt issues	1.7
• Fraud or bank misuse-related issues	0.5

n = 390; Missing = 16

Homelessness and Housing

Absolute Homelessness

More than half of those interviewed had stayed in unsheltered locations (56.9%), such as a vehicle, abandoned building, place of business, anywhere outside, or at an emergency shelter or domestic violence shelter (56.7%) in the past month (Figure 12).

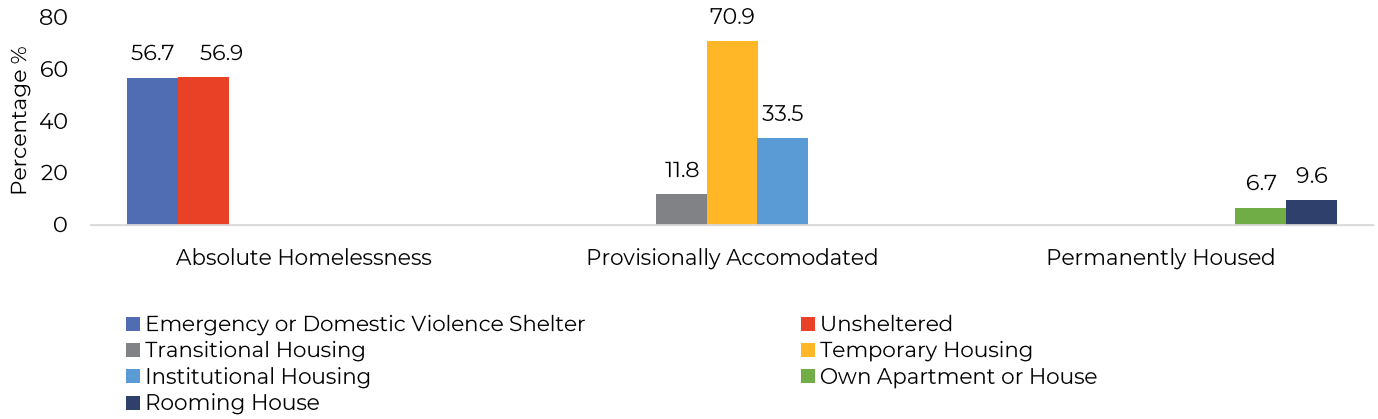
Provisionally Accommodated

Most participants (70.9%) who reported they were in provisional accommodations in the past month had stayed in temporary housing, with friends or family members, in a hotel or motel or in drug, work, or 'trap' houses at some point in the past month. Further, 33.5% had been in institutional housing such as a hospital or a boarding home funded by First Nation and Inuit Health Branch, jail (remand or prison), or addiction treatment or detoxification programs where they stayed overnight or lived temporarily. 11.8% spent time in transitional housing in the past month (Figure 12).

Permanently Housed

Less than 10 percent of participants had been in permanent housing, either in their own house or apartment (6.7%) or a rooming house (9.6%) in the past month (Figure 12).

Figure 12: Homelessness or Housing experiences in the past month (Participants could indicate more than one place)



n = 406; Missing = 0

The reasons for experiences of homelessness are multi-factorial and complex. Comparisons between gender, sexual orientation, Indigenous identity and age groups are presented in Table 5. Housing* and Drug and Alcohol Use (self and/or others') were reported as the two most common reasons by all sub-groups, while health** reasons were reported by approximately half to two-thirds of participants in all sub-groups. Justice involvement was reported as a reason for homelessness by one-third to half of all sub-groups.

Table 5: Top Reasons for experiences of homelessness throughout lifetime (Percentage % - participants could indicate more than one reason)

	Gender		Sexual Orientation		Indigenous Identity		Age Groups			
	Male	Female	LGBTQI 2S+	Hetero-sexual	Indigenous	Not Indigenous	18-29	30-50	51-64	65+
Reason	(n=275)	(n=120)	(n=57)	(n=336)	(n=274)	(n=110)	(n=96)	(n=178)	(n=116)	(n=8)
Housing*	89.1	90.0	94.7	88.4	90.5	85.5	85.4	89.9	94.0	87.5
Drug/Alcohol use (self &/or others)	72.2	73.7	68.4	72.9	77.6	59.6	72.6	76.3	68.7	42.9
Lack of timely & appropriate supports	68.3	75.4	69.1	70.0	69.1	69.2	79.8	65.5	69.9	57.1
Employment or Income	66.2	59.2	50.9	66.4	62.4	69.1	62.5	64.0	65.5	75.0
Health**	61.8	50.0	59.6	58.6	60.9	51.8	52.1	63.5	53.4	62.5
Relationship Challenges	52.2	55.5	52.6	53.0	53.8	49.1	50.0	55.4	54.8	25.0
Justice Involvement	35.2	30.3	35.1	34.0	35.9	26.6	37.9	35.6	25.4	37.5

Males: n = 271-275; Females: n = 114-120; LGBTQ2S+: n = 55-57; Heterosexual: n = 273-336; Indigenous: n = 269-274; Non-Indigenous: n = 107-110; 18-29 years: n = 94-96; 30-50 years: n = 174-178; 51-64 years: n = 113-116; 65+ years: n = 7-8

*Housing (includes being evicted, having to leave due to poor housing conditions, safety reasons, moving to Winnipeg or increased rent which was unaffordable by participant).

**Health (includes getting sick and not being able to work, being hospitalized or going into drug/alcohol treatment and mental illness or traumatic experience).

Participants who were 65 or older reported the longest average time since having a safe and stable place to live (9.5 years), while participants who were younger reported shorter periods since they last had safe and stable housing: 3.5 years for those aged 51-64 and 3.2 years for those between 30-50. Participants of Indigenous descent indicated an average of 3.4 years since having stable, safe housing, while non-Indigenous participants reported 1.9 years on average (Table 6).

Table 6: Last time having a safe, stable place to live (average # of years ago)

	Percentage % of Participants (n)	Average # of Years ago
Gender Identity	95.6	
• Male		3.1
• Female		2.4
• Gender-diverse		0.5
Sexual Orientation	94.1	
• LGBTQ2S+		2.1
• Heterosexual/Straight		2.9
Indigenous/Non-Indigenous	92.1	
• Indigenous		3.4
• Non-Indigenous		1.9
Age Group	95.3	
• 18-29 years		1.5
• 30-50 years		3.2
• 51-64 years		3.5
• 65+ years		9.5
Overall (Standard Deviation = 5.2 years)	97.3	2.9

n = 395; Missing = 11

Participants who were 65+, Indigenous or male reported the greatest average years of total lifetime experiences of homelessness (Table 7).

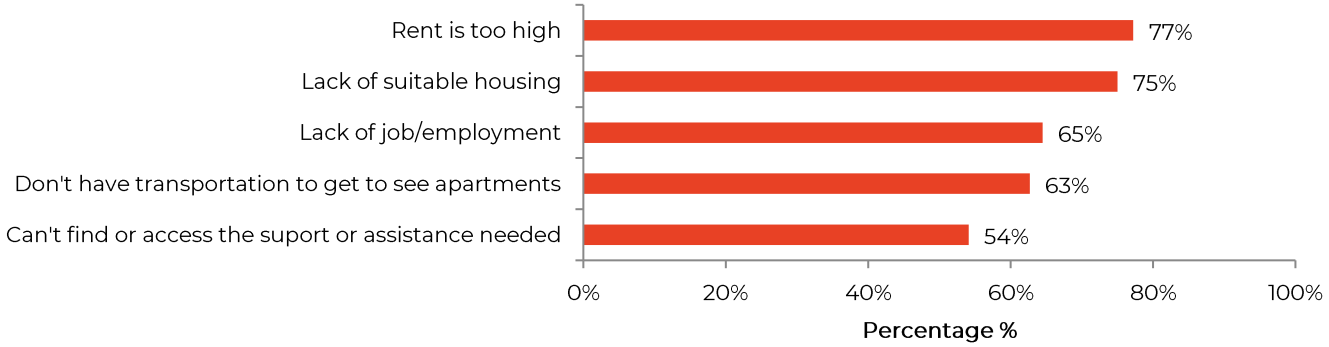
Table 7: Total length of time spent homeless in lifetime (average # of years)

	Percentage % of Participants (n)	Average # of Years
Gender Identity	93.6	
• Male		5.8
• Female		5.9
• Gender-diverse		0.3
Sexual Orientation	92.4	
• LGBTQ2S+		5.5
• Heterosexual/Straight		5.9
Indigenous/Non-Indigenous	90.4	
• Indigenous		6.3
• Non-Indigenous		4.4
Age Group	93.3	
• 18-29 years		3.1
• 30-50 years		6.9
• 51-64 years		6.0
• 65+ years		8.2
Overall (Standard Deviation = 8.0 years)		5.8

n = 387; Missing = 19

In terms of barriers or challenges to finding and maintaining housing, the key barrier reported was that rent is too high (77.2%), while lack of suitable* housing was only slightly lower for 75% of participants. Lack of a job/employment (64.5%), lack of transportation to view housing options (62.7%), and not finding or being able to access the right support at the right time (54.1%) were also identified by more than half of our sample as major barriers (Figure 13).

Figure 13: Top five barriers or challenges to finding and maintaining housing. (Participants could indicate more than one reason)



n= 394; Missing = 12

Negative experiences with landlords and other property personnel were commonly reported. Experiences of disrespect or judgement by landlords were mainly related to participants' source of income (25.8%) or use of alcohol or drugs (24.5%). Participants also reported feeling disrespected by landlords because of their race or ethnic background (21.4%).

Other reasons for feeling disrespected by landlords were related to gender, sexual orientation, appearance, age, or disability. Participants also related examples of landlords misusing power differentials, particularly toward women, through such avenues as inconsistent application of rules, ignoring maintenance conditions and building issues, entering private spaces or violating participants' property, requiring labour without compensation, and exerting inordinate financial pressure. Several people reported verbal abuse as well as actual violence, including sexual violence, at the hands of landlords.

"Landlord was asking questions over the phone:
1. Do you have an income? – Yes, EIA.
2. Are you a visible minority? – Yes, Native.
Then landlord said,
'Oh, I think the apartment is rented.'"

* "Suitable" was determined by the participant, rather than Statistics Canada's definition of "having enough bedrooms for the size and composition of resident households according to National Occupancy Standard requirements."

"He asked where I was currently staying. I said Siloam. His face changed. He called me the next day. I was denied."

"A landlord asked her to go to bed with him and she refused, then was told to get out of there."

Similar to these types of negative experiences with landlords, the main reasons participants reported for experiences of disrespect or judgement by emergency shelter staff were participants' use of alcohol or drugs (27.8%) and their race or ethnic background (22.3%).

Housing First and Centralized Intake

Housing First (HF) is a housing program with wrap around supports that is available in Winnipeg, which focuses on moving individuals who are chronically and episodically homeless from emergency shelters or unsheltered living situations, into permanent housing with supports as quickly as possible.[†]

Few participants (75 individuals or 18.8%) had heard of HF programs in Winnipeg. Participants were also asked about their participation in HF programs. Of the 59 participants who responded to this question, 14 (3.4%) said they were currently part of a HF program, while 45 (11%) said they were not.

Intake into HF programs in Winnipeg is facilitated through the Doorways centralized intake program, located at the Neeginan (Aboriginal Health and Wellness) Centre. 37.2% of participants were aware of the Doorways Intake program, while 247 (60.8%) were not (n=398; Missing = 8).

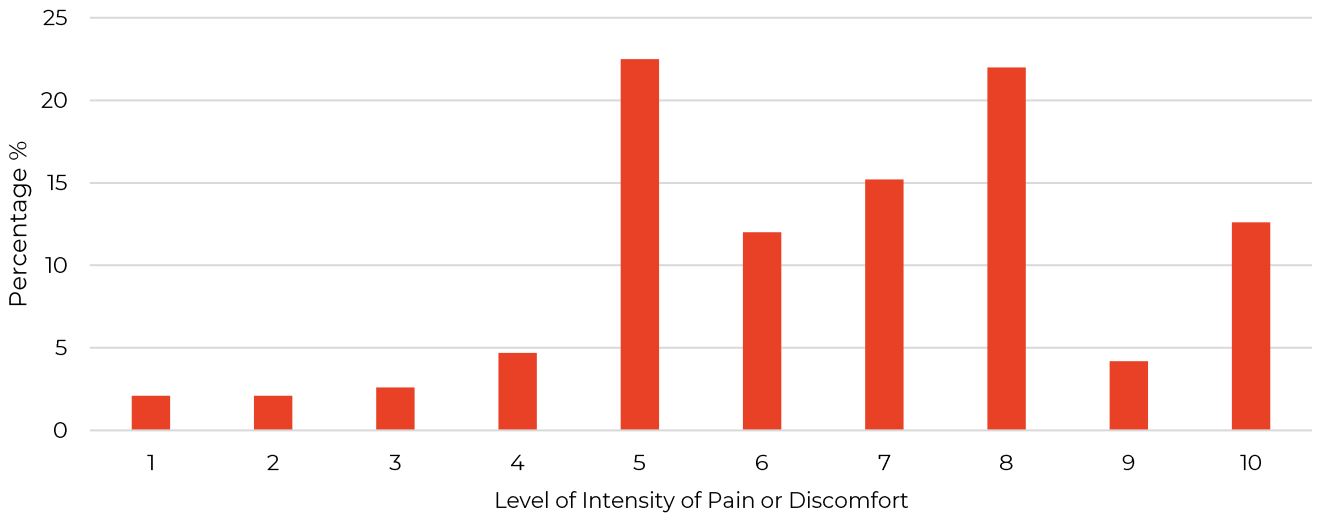
[†] ESDC, https://www.canada.ca/en/employment-social-development/programs/communities/homelessness/housing-first/approach.html

Health

General Health

Several questions relating to general health symptoms were asked. When questioned if participants were usually free of physical pain and discomfort, there were similar numbers of participants who indicated 'yes, free of pain' (47.3%) versus 'no, not free of pain' (52.7%). Those who indicated they were not usually free of pain were subsequently asked to describe the intensity of their pain or discomfort using a scale from 1 to 10, with 1 being 'mild', 5 being 'moderate' and 10 being 'severe'. Participants could select anywhere on the scale. The two most common pain intensity scores were five or moderate (22.5%), and eight or moderately severe (22%) (Figure 14). Most participants selected pain scores between moderate and severe.

Figure 14: Intensity of pain or discomfort

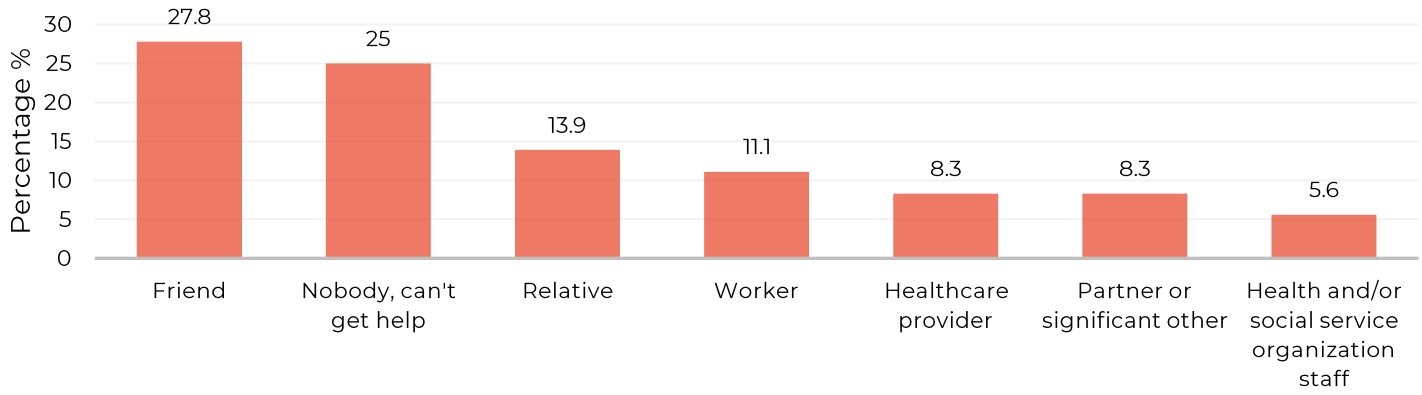


n = 395; Missing = 11

Personal Care

Almost all participants (90.9%) indicated they did not require the help of another person with personal care activities such as eating, foot care, bathing, dressing, or getting around (e.g., walking or using a wheelchair). Of the participants who indicated that they did need another person's help with personal care (8.4%), 27.8% received help from a friend, 25.0% had nobody for help, 13.9% had help from a relative, and 11.1% received help from a worker (Figure 15).

Figure 15: Assistance with Personal Care



n = 36; Missing = 370

Learning Disabilities (self-reported)

24.7% (98) of respondents self-reported that they had been diagnosed as having a learning disability. Of these, Attention Deficit Hyperactivity Disorder (ADHD) was the most indicated learning disability (32.1%), while 19% (16) self-reported a Dyslexia (Reversals) diagnosis. Other learning disabilities faced by participants at lower rates included Fetal Alcohol Spectrum Disorder/Fetal Alcohol Effects (FASD/FAE) (16.7%; 14 participants), learning and memory, difficulty with reading and writing, memory impairment, psychological disorder, traumatic brain injury, autism, and visual-spatial disabilities.

Physical Health (self-reported)

From a list of 34 medical conditions, the 10 most frequently self-reported conditions/diagnoses as experienced by participants are presented in Table 8.

Table 8: 10 Most frequently self-reported medical conditions or diagnoses

Medical Condition (self-reported)	Percentage %
Arthritis, Rheumatism, or Other Joint Problems	51.8
Migraine headaches	37.3
Environmental or seasonal allergies	34.2
Problems walking, lost limb, or another physical handicap	33.9
Hearing problems	24.4
High blood pressure or Hypertension	24.0
Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)	21.0
Asthma	20.4
Eye or vision problems (other than needing glasses)	19.6
Skin disease, like Eczema or Psoriasis	19.0

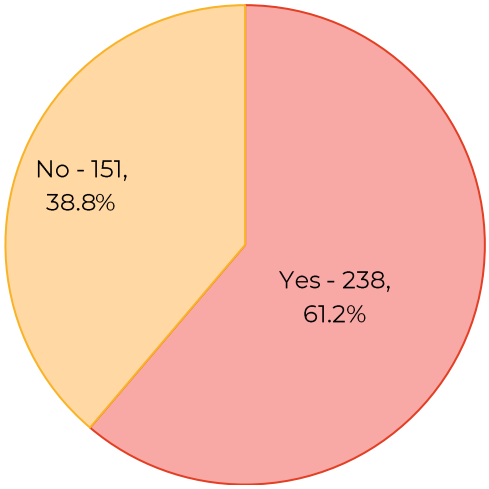
n = 372-402; Missing = 4-34

In addition to the self-reported medical conditions and diagnoses in Table 8, participants self-reported angina (chest pain or discomfort - 15.5%), Hepatitis C (13.6%), FAS/FASD (11.9%) and diabetes (10.4%). The most frequently self-reported medical conditions and diagnoses identified were those with symptoms that can be felt or more easily noticed by participants. More chronic conditions were not self-reported to the same extent. For example, 5.6% and 5.0% of participants reported Cirrhosis or other problems with their liver respectively, while 3.9% self-reported heart disease and 3.1% cancer.

Prescription Medication Requirements and Access

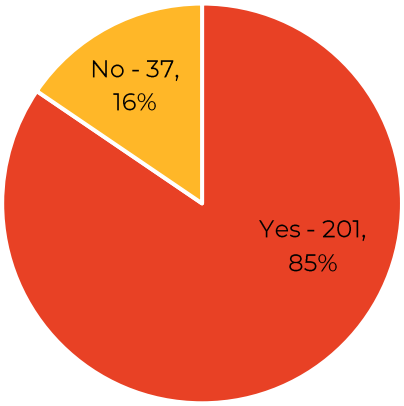
Access to required prescription medication is important for both emergency and general health conditions. Many participants (61.2%) said they were currently supposed to be taking some type of prescription medication (Figure 15).

Figure 15: Are you supposed to be taking any prescribed medication now?



n = 389; Missing = 17

Figure 16: If you were prescribed drugs, were the side effects of the medication explained to you by the medical professional?

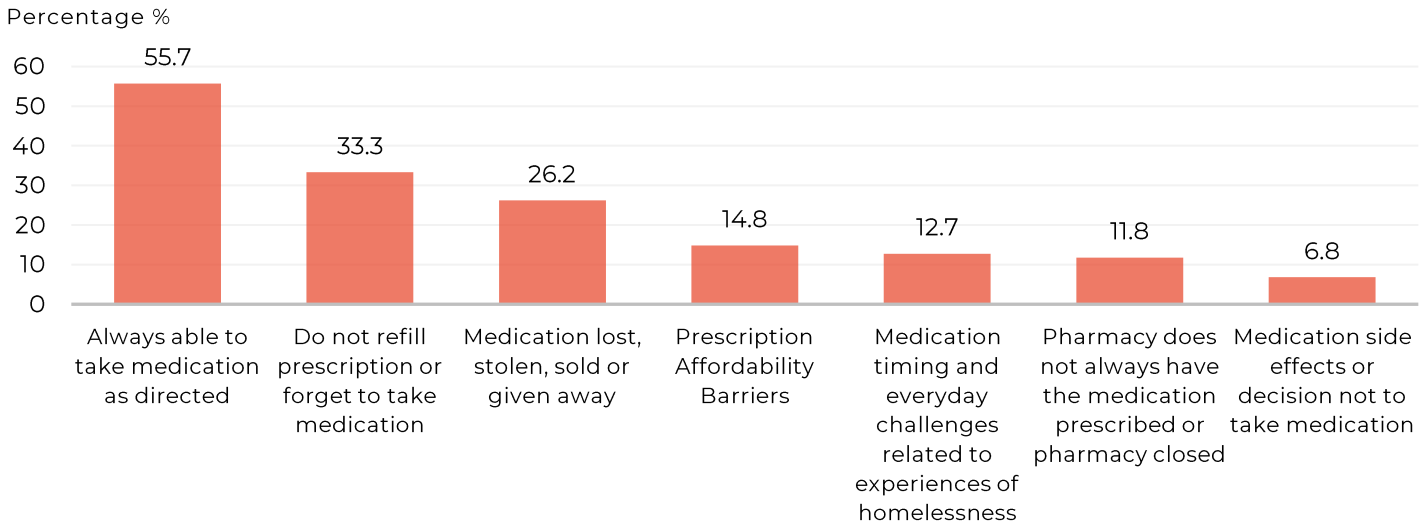


n = 238; Missing = 168

Of the 238 who said they were currently supposed to be taking prescribed medication, the majority (85%) said that their medication side effects had been explained to them by a medical professional (Figure 16).

When asked if they were always able to take medications as directed by a health care professional, more than half (55.7%) said they were always able to do so. Other participants acknowledged barriers to being able to take medications as prescribed. For example, some participants did not refill their prescriptions when needed, or sometimes forgot to take medicine (33.3%). Others (26.2%) lost their medication, or it was stolen, sold or given away (Figure 17).

Figure 17: Are you able to take prescribed medication as directed? (check all that apply)



n = 237; Missing = 169

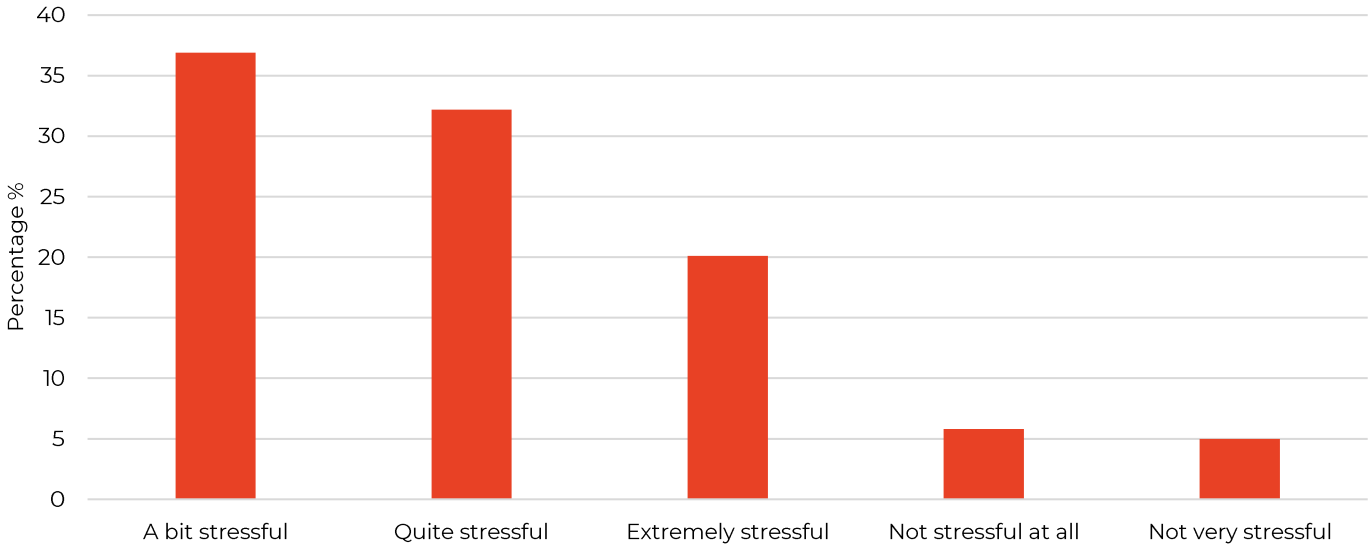
122 participants (30.6%) were not able to obtain a prescription they needed in the past year. The main reasons cited for not being able to get needed prescriptions were the cost of prescription medication or a lack of insurance/health coverage (15%). Lack of identification was cited by 4.6% of participants. Other types of barriers, such as transportation or language were also identified by some participants.

Mental Health & Substance Use (self-reported)

Stress and Social Support Networks

When asked about the amount of stress in their lives most days, 20.1% of participants indicated they were extremely stressed. 32.2% were quite stressed and 36.9% were a bit stressed (Figure 18).

Figure 18: How stressful are most days?



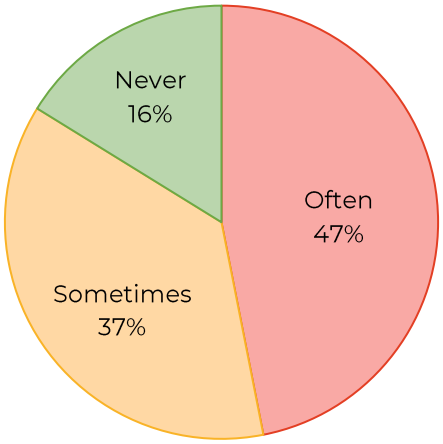
n = 398; Missing = 8

When asked if they ever feel lonely or isolated from other people, 46.9% of participants said they felt that way often and 36.9% said so sometimes (Figure 19). One participant shared what was hardest for them about trying to survive and stay healthy while experiencing homelessness:

> "When you're lonely and miss your mom and your kids; have no one to love or hug you."

If a survey participant was to have an emotional crisis and did not feel they could handle it on their own, 31.8% indicated that they did not know someone who would give them help or counseling.

Figure 19: How often do you feel very lonely or isolated from other people?



n = 390; Missing = 16

A participant's comment on the impact of experiences of homelessness on her/his mental health poignantly captures the interconnections between homelessness, stress and mental health:

> "Your mental health goes to shit, you're tired all the time, you're irritable, depressed, less patient."

Mental Health Conditions (self-reported)

Many participants described helpful features of mental health programs and the positive attributes of the people who staff them, including patience, understanding, advice-giving, maintenance of an ongoing relationship, and willingness to help individuals face difficult issues head-on when needed. Most simply named programs that helped them. Friends, family, and informal supports, including the local community, were another abundantly mentioned theme. Front-line responders were mentioned as well, which is important to note, as they are often in situations where they interact with individuals experiencing mental health issues and can serve as a connecting point between individuals experiencing homelessness and appropriate resources. Traditional healers and spiritual caregivers were also mentioned by participants:

> "Being able to talk to someone who is a neutral party – impartial; they don't pull punches, they tell you."

> "Doctor taught [me] to manage emotions; doctor cares for [me], talks to [me]; advises against risk-taking behaviour."

> "[A traditional healer], one that really knows the language and is really grounded in their culture in a deep and profound way: not just teachings."

Still others talked about working recovery on one's own, many with a sense of pride and self-efficacy, such as "having a strong mind" and "there is not anything outside myself".

Almost three-quarters of participants reported they had experienced serious depression (n=282; 72.1%) or serious anxiety/tension (n=284; 73.2%) in their lifetime. As well, approximately three-quarters of participants said they experienced depression (n=294; 76.6%) or anxiety/tension (n=285;74.6%) in the past year. Further, almost half of the participants (n=196; 49.9%) reported they had seriously thought about hurting themselves or suicide. Of these people, 65.8% (n=129) had these thoughts in the past year. Of the people who had thoughts of self-harm, 66.8% (n=129) had tried to hurt themselves or end their life. Among the people who reported self-harm, about half (50.4%) reported doing this in the past year. A participant made a connection between homelessness and mental health concerns:

> "Suicidal ideation and depression are a huge part of being homeless. People need to understand that."

Participants were asked if they had ever been diagnosed by a doctor or a psychiatrist for a mental health condition. The three most commonly self-reported diagnosed conditions were anxiety disorders (46.4%), mood disorders (39.2%), and substance-related and addictive disorders (38.5%). The two most common types of anxiety disorders were general anxiety (39.7%) and post-traumatic stress disorder (22.3%) and the two most common mood disorders were depression (37.5%) and Bipolar Disorder‡ (15.9%). Another noteworthy finding is that 12% reported they had been diagnosed with a personality disorder; Borderline Personality Disorder was the most commonly self-reported of these (6.7%). While schizophrenia affects around 1% of the general population, 8.4% of those surveyed reported they had a diagnosis of schizophrenia (Table 9).

Table 9: Physician-diagnosed mental health conditions (self-reported)

Diagnoses	# of Participants	Percentage %
Mood Disorders	158	39.2
Anxiety Disorders	187	46.4
Mood and Anxiety Disorders	212	52.6
Personality Disorders	48	11.9
Schizophrenia spectrum and Other Psychotic Disorders	34	8.4
Cognitive Impairment and Neurodevelopmental Disorders	42	10.4
Substance Use Disorders*	155	38.5
Any Mental Health Condition	262	65.0

n = 403; Missing = 3
*Described in the survey question as "addiction to drugs and/or alcohol"

‡ Also known as manic depression or manic-depressive disorder.

Many challenges were reported by participants related to mental health services access and delivery. Access concerns included lack of awareness of available services, administrative barriers such as waitlists and program entry criteria (including identification documents), along with financial barriers such as money for prescription medications. Participants spoke of navigating intersectional system challenges when accessing supports for a mental health disability:

"Don't have enough info supporting that I have a disability to be on disability assistance, and they said that I need to be on disability to have a support worker."

"I don't know, they just denied me. I couldn't get the documents I need."

"Even though I've been diagnosed with PTSD, they won't give me meds until I have a family doctor."

Issues with service delivery included situations where participants did not feel listened to and situations where services or supports did not meet or match participant needs, including being prescribed medication when seeking non-pharmacological interventions:

"I was looking for counselling: they gave me a prescription. Anything to get rid of you as fast as they can. Take a pill. Quick to the pen."

Others shared individual motivations for not accessing mental health care, including working toward recovery on one's own, not following through, or having other priorities.

Substance Use

"Regular drug use" was defined as using non-prescribed substances "3 or more times per week." The top three "hard drug" categories were stimulants (43.8%), opioids (21.9%), and sedatives/tranquilizers (16.0%). The most frequently reported specific "hard drug" types consumed among those surveyed were all classified as stimulants: methamphetamine (meth - 29.3%), cocaine (20.4%), and crack (20.2%).

More than three-quarters of participants (80.7%) smoked cigarettes regularly. Although this survey was conducted before cannabis legalization, 53.9% of participants noted regular use of non-prescribed marijuana and/or medical marijuana. Over the counter medications, such as Tylenol 3s and cough syrup, were regularly used by 13.8% of participants (Table 10).

Table 10: Substances used 3 or more times a week in the past year (does not include prescription drugs being taken as prescribed)

Substance Type	# of Participants	Percentage %
Stimulants	172	43.8
Opioids	86	21.9
Sedatives/Tranquilizers	63	16.0
Hallucinogens (e.g. LSD, PCP, peyote, mescaline, ecstasy, mushrooms)	28	7.2
Solvents and Inhalants (e.g. glue, paint thinner, gas)	8	2.0
Over the counter medication (e.g. cough syrup, Gravol, Sudafed, Tylenol 3s)	54	13.8
Cannabis	212	53.9
Cigarettes and Nicotine products	326	80.7

n = 393; Missing = 13

Alcohol

Participants had similar rates of drinking in the past year (80.9%) as the general population[§]. Participants usually drank 1-2 times per month (33.9%). Heavy drinking, defined as 5 or more drinks on one occasion, was reported within the past year by 81.7% of those responding (n = 302).

Use of non-beverage alcohols, including common domestic products such as mouthwash, hand sanitizer, hairspray, and rubbing alcohol, was reported by 10.2% of participants in the past year, while 6% of participants reported drinking non-beverage alcohol in the past month. 37.5% of participants who reported drinking such products in the past year said they had not consumed any in the past 30 days (Table 11).

[§] 2017 Canadian Tobacco, Alcohol, and Drugs Survey (CTADS).

Table 11: Frequency of Alcohol Consumption

	Percentage %
Drank alcohol in past year (n = 393)	80.9
Frequency of alcohol use in the past month (n = 313)	
• Daily/almost daily	16.3
• 3-4 times a week	13.4
• 1-2 times a week	18.8
• Several times this month	5.8
• 1-2 times this month	33.9
• Never in the last 30 days	11.8
Frequency of heavy drinking in the past year (5 or more drinks in one occasion) (n = 302)	
• More than once a week	20.9
• Once a week	10.9
• About 3 times a month	11.9
• Once a month	14.6
• Less than once a month	23.5
• Never	18.2
Drank non-beverage alcohol (e.g. Listerine, hand sanitizer, hair spray, or rubbing alcohol) in past year (n = 392)	10.2
Frequency of drinking non-beverage alcohol in past month (n = 40)	
• Daily/almost daily	25.0
• 3-4 times a week	5.0
• 1-2 times a week	10.0
• Several times this month	7.5
• 1-2 times this month	15.0
• Never in the last 30 days	37.5

More than half of participants (59.4%) said they would use a clean, safe environment, with nurses or other staff supervising, where drugs could be used (i.e. a safe injection site). Approximately three quarters of participants (74.7%) indicated they would make use of programs to help reduce, control, or make drinking safer (i.e. a managed alcohol program), if this were available in places where they spend time (Table 12).

Table 12: Support for Safe Injection and Managed Alcohol Sites

	Percentage %
Support for safe drug sites (n = 286; Missing = 120)	
• Yes	59.4
• No	40.6
Support for safe drinking sites (n = 273; Missing = 133)	
• Yes	74.7
• No	25.3

Many participants suggested changes or improvements to substance use and addictions treatment services in Winnipeg, mostly centred around themes of improving access or quality and recommendations for broadening the array of services available. Program capacities and the length of time required to remain in a substance use or addictions program were viewed as barriers to access, as were criteria such as needing identification. Opportunities for improvement of programs' quality of service focused mainly on staff attributes such as empathy, knowledge, and lived experience.

One noteworthy finding was the call for more individualised services based on both substance of choice and stage of change. Many individuals criticized some harm reduction or perceived one-size-fits-all approaches: for example, some persons recovering from alcohol dependency sought programming specific to alcohol users, while some persons in recovery from other substance use problems voiced a strong preference not to be exposed to easily available paraphernalia. Several people also voiced the opinion that cannabis, including medical cannabis, can be used safely while recovering from substance use problems involving alcohol or other drugs.

The concept of safe injection or safe drug use sites came up very often during interviews, even when unsolicited. Other suggestions included services for specific populations (e.g. youth, women) and more follow-up and aftercare. Education, especially on the role played by complex trauma in the genesis of substance use disorders and addictions, was appreciated. Participants spoke eloquently about different approaches and the importance of factors such as safe and stable housing in supporting individuals' long-term recovery:

"They need help finding a place to stay. Where do they go after programs? Right back to the street. They don't have services or help to get a place."

Access to Health Services

Identification

69.7% of participants (283) reported that they had a Manitoba health card (i.e. had on their person or would be able to get actual card within 24 hours if needed), while 120 (29.6%) did not. For the participants who indicated they did not have a health card, a follow-up question as to why, provided responses as indicated in Table 13. The main reasons given were that participants' health cards had been lost (52%) or stolen (20.3%).

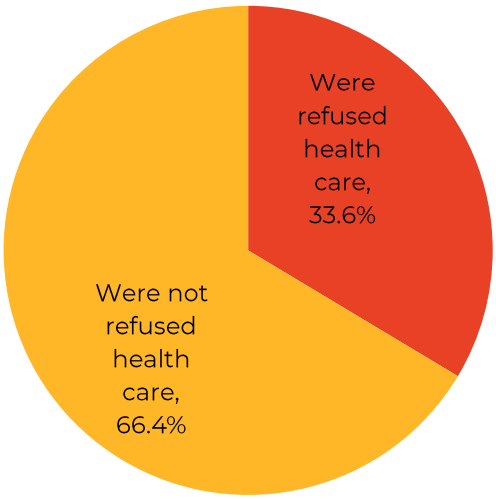
Table 13: Reason for not having a Manitoba health card (participants could select all that apply)

Reason	# of Participants	Percentage %
Lost it	64	52.0
It was stolen	25	20.3
Don't' have required ID/documents to replace it	8	6.5
Have not applied for one	8	6.5
Don't need one	7	5.7
It is damaged and not usable	5	4.1

n = 123; Missing = 283

79 of 119 survey participants (66.4%) self-reported that they were provided health care even though they did not have a Manitoba health card, while 40 (33.6%) self-reported that they were refused health care because they did not have a health card (Figure 20). More than half of those who reported they had been refused health services (57.9%) indicated they had been refused health care at walk-in clinics, while 34.2 percent had this experience at an emergency department or hospital (Table 14).

Figure 20: Self-reported attempts to access health care without a health card



n = 119; Missing = 287

Table 14: Locations where participants self-reported they were refused health care because they did not have a health card (participants could select all that apply)

Location	# of Participants	Percentage %
Walk-in clinic	22	57.9
Emergency department/hospital	13	34.2
Doctor's office	9	23.7
Pharmacy	7	18.4
Other (e.g. dental office, other health facility)	6	15.8
Specialist doctor's office	5	13.2
Community health centre	5	13.2
Lab or x-ray agency	<5	7.9

n = 38; Missing = 368

Participants were also asked what other types of identification they had. 39% indicated they had a birth certificate, while 35.5% selected 'none of the above', suggesting they had no identification at all (Table 15).

Table 15: Other forms of identification

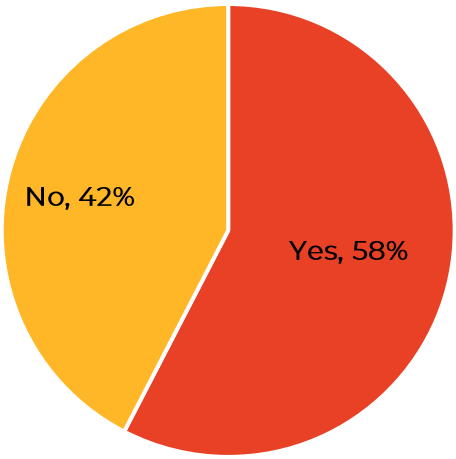
Form of ID	Percentage %
Birth certificate	39.0
'None of the above'	35.5
Provincial photo ID	18.1
Other (e.g. citizenship/permanent resident card, Métis card, passport, expired card, or other card with name on it)	17.1
Status card	16.9
Driver's license	11.4
SIN card	10.4

n = 403; Missing = 3

Source of Care

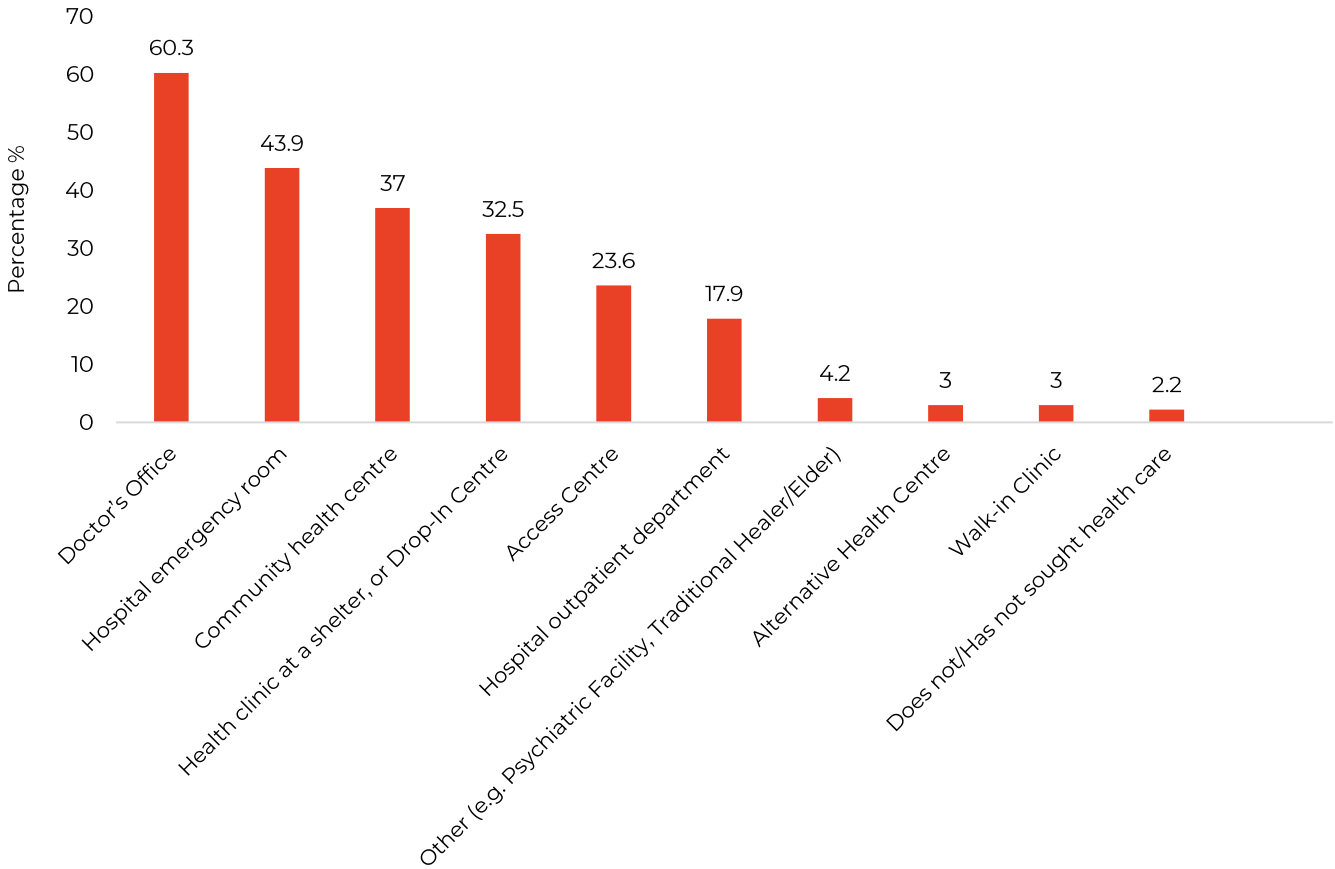
Having a family doctor is an important factor in receiving health care. Approximately half of participants (58%) reported having a family doctor, while 42% did not (Figure 21). The most common place where people said they accessed health care was at a doctor's office (60.3%), followed by a hospital emergency room (43.9%), and community health centres (37%), such as the Health Action Clinics, Women's Health Clinic, Mount Carmel Clinic, Nine Circles, Klinic or Aboriginal Health and Wellness Centre. 32.5% percent of participants said they accessed care at an emergency shelter clinic or drop-in centre. Nine participants (2.2%) reported they either do not or have not accessed health care (Figure 22).

Figure 21: Do you currently have a family doctor?



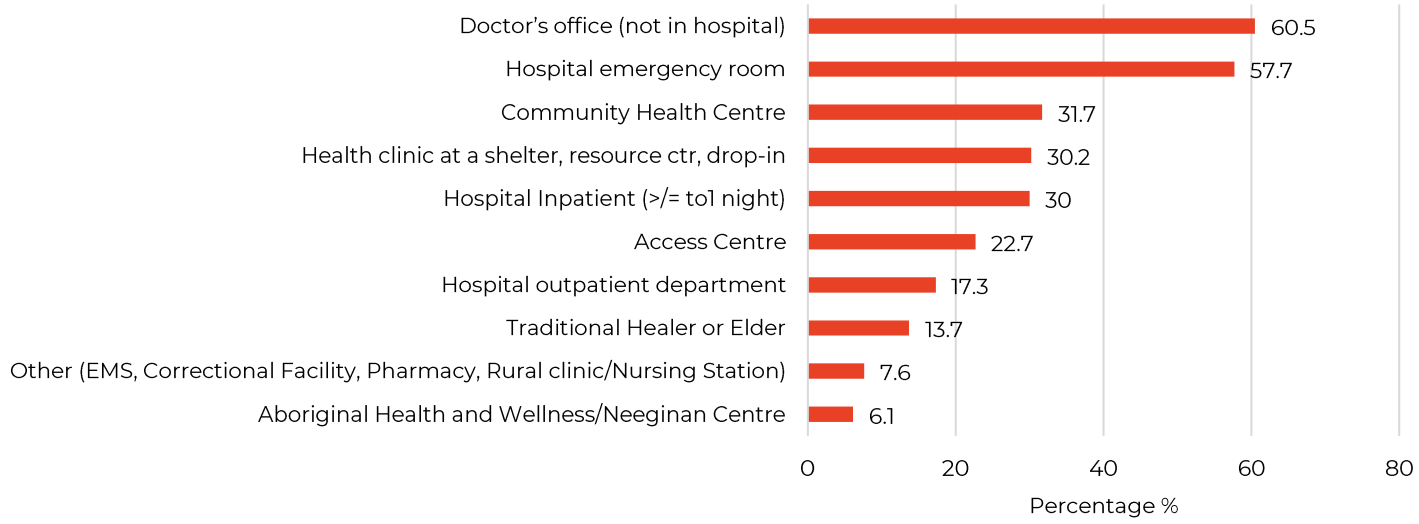
n = 399; Missing = 7

Figure 22: Usual place for accessing health care (participants could select all that apply)



n = 403; Missing =3

Figure 23: Points of health care accessed in past year (participants could select all that apply)



n = 397; Missing = 9

Most people interviewed self-reported that they had received health care in the past year at a doctor's office (60.5%) or a hospital emergency room (57.7%). Other points of care accessed in the past year were community health centres (31.7%), a health clinic at a shelter, a resource or drop-in centre (30.2%), or an overnight stay at a hospital, not including staying overnight in an emergency room (30% - Figure 23).

Of the participants who said they had stayed at least one night in the hospital in the past year (including emergency room stays), 23 (5.7%) said their overnight hospital stays were "scheduled only" (versus a combination of scheduled and emergency stays). For participants who reported their overnight hospital stays as a being scheduled or an emergency stay, 156 of 405 participants, (38.5%) said their hospital stay was an emergency, while 249 (61.5%) did not.

Hospital Emergency Department Experiences

With more than half of participants (57.7%) indicating that one of the main places they accessed health care in the past year was at a hospital emergency department (ED), a look at the reasons why people went to the ED for health care is important. Nearly one quarter (23.3%) went to the ED due to an injury, while 20.7 percent said they visited the ED for a physical problem other than an injury (Table 16).

Other reasons for ED visits were to warm up, sleep or get food (12.2%). Numerous participants shared examples of how hospital staff met their physical needs during a hospital visit. For example, a participant shared that hospital staff "approached me with water and food, asked if I was hungry or wanted something to drink, or brought me a blanket while I was waiting".

Other participants went to the ED for a mental health concern (11.7%) or a prescription refill (9.6%). A small number of participants (7.5%) said they were forced to go to the ED against their will (Table 16).

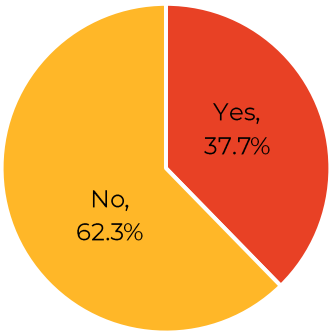
Table 16: Reasons for Emergency Department (ED) visit in past year

Reason	Percentage %
An injury	23.3
A physical problem other than an injury	20.7
Needed a place to get warm, food or a place to sleep	12.2
A mental health concern	11.7
A prescription refill	9.6
Was forced to go against will	7.5
To detox	5.7
A toothache or dental problems	4.4

n = 386; Missing = 20

When asked if they had left the ED at anytime in the past year without being seen by a health care professional, of the 159 participants who answered this question, 60 (37.7%) said 'yes', while 99 (62.3%) said 'no' (Figure 24).

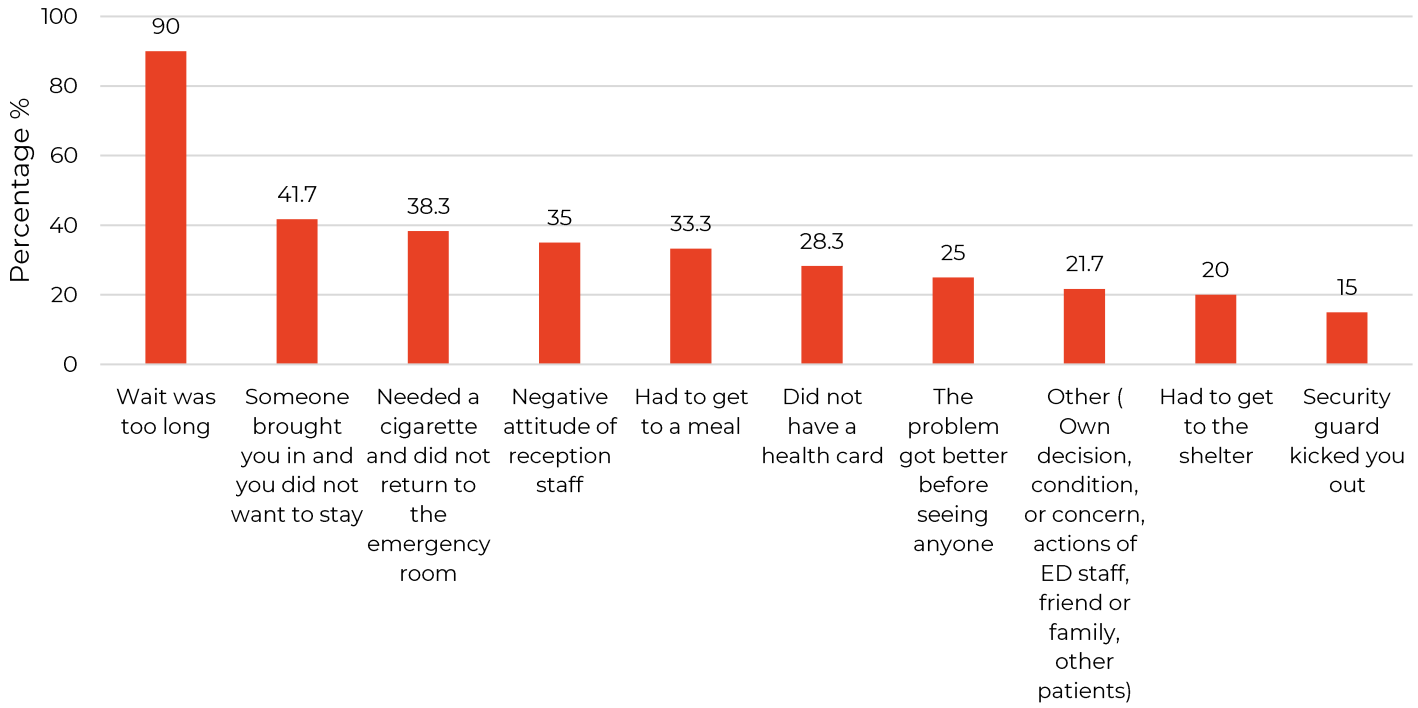
Figure 24: Left ED before being seen by a health care provider in past year



n = 159; Missing 247

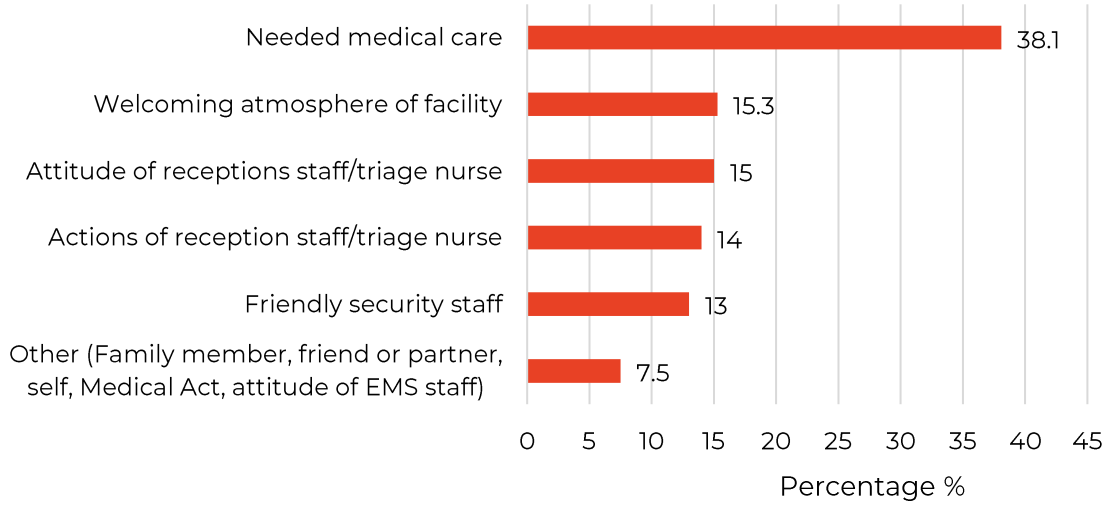
Of the 60 people who indicated they had left the ED before being seen by a health care provider, the most common reason for leaving (90%) was due to long wait times (Figure 25). On the other hand, the need for medical care was selected by 147 of 386 participants (38.1%) as a reason for waiting to be seen by a health care provider (Figure 26). Others acknowledged the welcoming atmosphere (15%), attitude of reception staff/triage nurse (15%), and friendly security staff (15%) as reasons for waiting for care in the ED.

Figure 25: Reasons for leaving ED before being seen (participants could select all that apply)



n = 60; Missing = 346

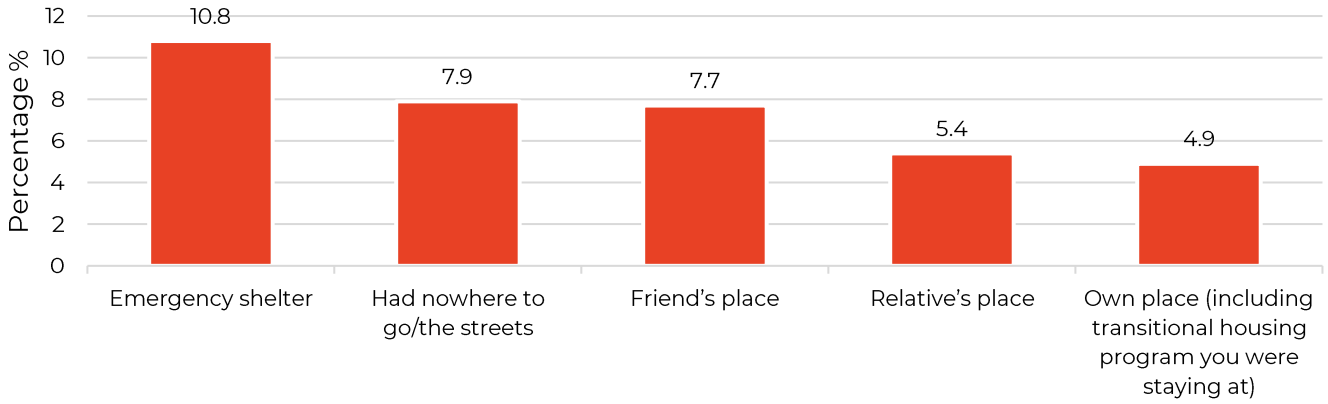
Figure 26: Reasons for waiting to be seen by a doctor or nurse when going to the ED



n = 386; Missing = 20

When participants were asked where they went after leaving the hospital, 42 (10.8%) indicated they went to an emergency shelter, while 31 (7.9%) said they had nowhere to go. 30 (7.7%) stayed at a friend's place and 21 (5.4%) said they stayed with relatives, which are both considered 'provisional accommodation' (Figure 27).

Figure 27: Locations survey respondents went to after leaving the hospital



n = 390; Missing = 16

Injury & Assault

Almost half of the people surveyed (48.2%) reported they had been physically assaulted in the past year. This experience was more common among female (49.1%) participants than male participants (46.7%). Sexual harassment is defined as someone who is bothering you by saying or doing unwanted or unwelcome things of a sexual nature. Almost one-quarter of participants (22.2%) reported being sexually harassed in the past year. A higher percentage of females (43.6%) reported they were sexually harassed than males (12.5%). Survey participants were also asked if they had been sexually assaulted or raped in the past year. There were 28 (7.5%) respondents who indicated this had happened to them; a higher percentage of female participants (16.7%) reported this than male participants (3.1%). Additionally, 12.2% of those surveyed reported they had been hit by a car, bicycle, or transit bus in the past year (Table 17).

Table 17: Experiences of injury and assault in the past year

	# of Participants	Percentage %	Male %	Female %
Been hit by car, bicycle, truck or transit bus	47	12.2	13.8	8.7
Been physically assaulted	185	48.2	46.7	49.1
Been sexually harassed	83	22.2	12.5	43.6
Been sexually assaulted or raped	28	7.5	3.1	16.7

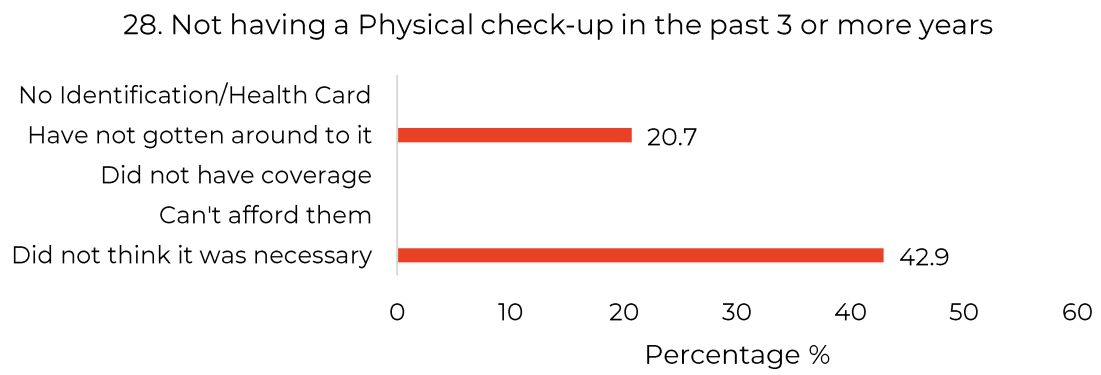
*Due to a small number of people identifying as gender diverse, values are not reported here
n = 372-385; Missing = 21-34

Prevention and Barriers to Regular Care

An important aspect of health, wellbeing and prevention of illness and disease is regular access and visits to various types of health care professionals for vaccinations, check-ups and testing. Approximately half of study participants (207 or 53.1%) reported that they had been offered or had a flu shot in the past year, while 183 (46.9%) had not (n = 390; Missing = 16).

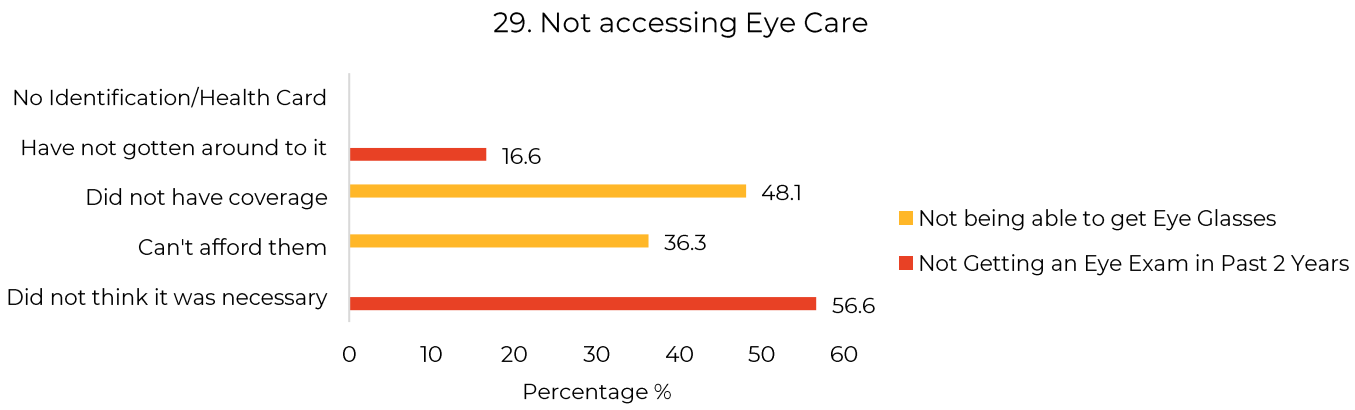
As with the barriers noted above to being able to obtain and/or take prescription medications, numerous barriers were identified by participants to accessing mental health care or getting a regular check-up from a physician, optometrist or dentist. Participants were asked to identify two top reasons why they had not accessed various types of care in the recent past. Unique challenges were noted for barriers to accessing mental health care. For example, 32 of 68 participants (52.9%) identified accessing mental health care or the right type of mental health care (e.g. making appointments, finding a doctor, finding the right doctor etc.) as a barrier, while 17 of 68 (25%) noted anxiety, fear, mental illness and addictions as barriers to accessing mental health care. Not having coverage was the main reason for not getting eyeglasses (48.1%) and for not seeing a dentist in the past three years (28.7%). Numerous participants reported that their reason for not having an eye exam (56.6%), a physical check-up (42.9%), or seeing a dentist (31.5%) regularly in the recent past was because they felt it was not necessary (Figures 28-31).

Figures 28-31: Top reasons for not accessing various types of care

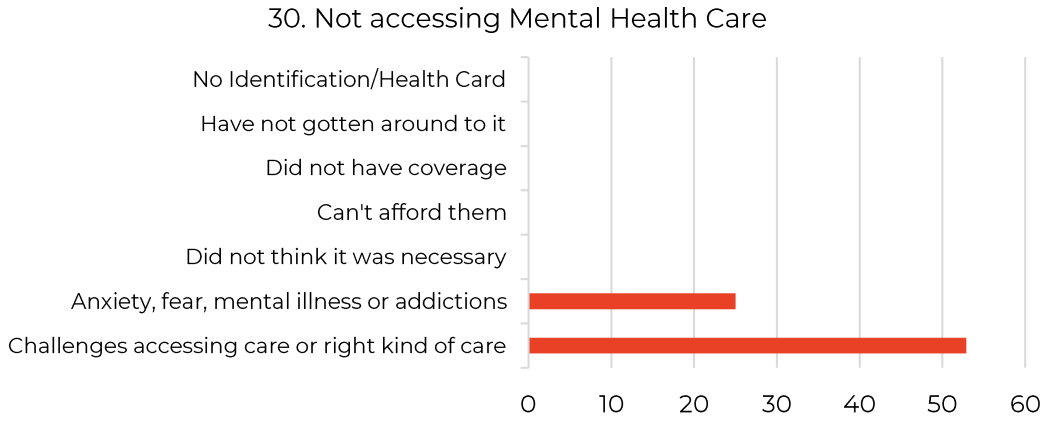


n = 140; Missing = 226

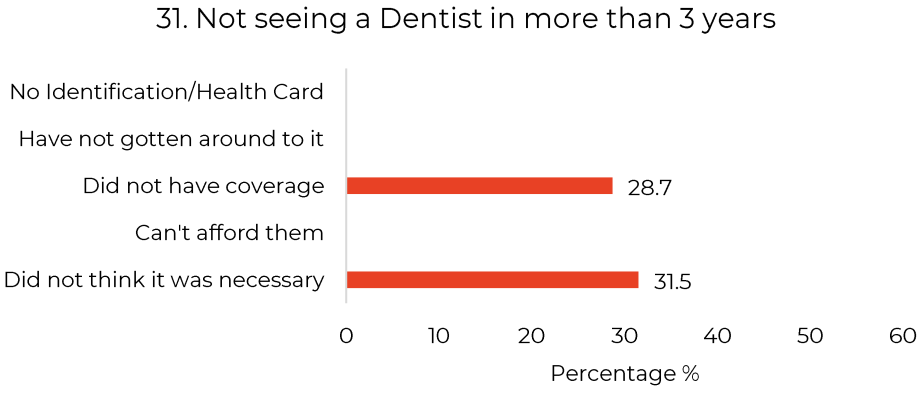
Figures 28-31: Top reasons for not accessing various types of care (cont.)



Eye exam n = 205; Missing = 201; Eyeglasses: n = 135; Missing = 231



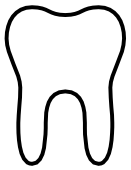
n = 68; Missing = 338



n = 108; Missing = 298

One of the study participants noted that enhanced dental care and support would be helpful for individuals experiencing homelessness:

> "There are no street dentists. Lack of supplies/knowledge. More dentists helping homeless could help the health care system. It would help prevent other problems. Homeless individuals need more supplies and teachings on dental."



Reproductive and Sexual Health

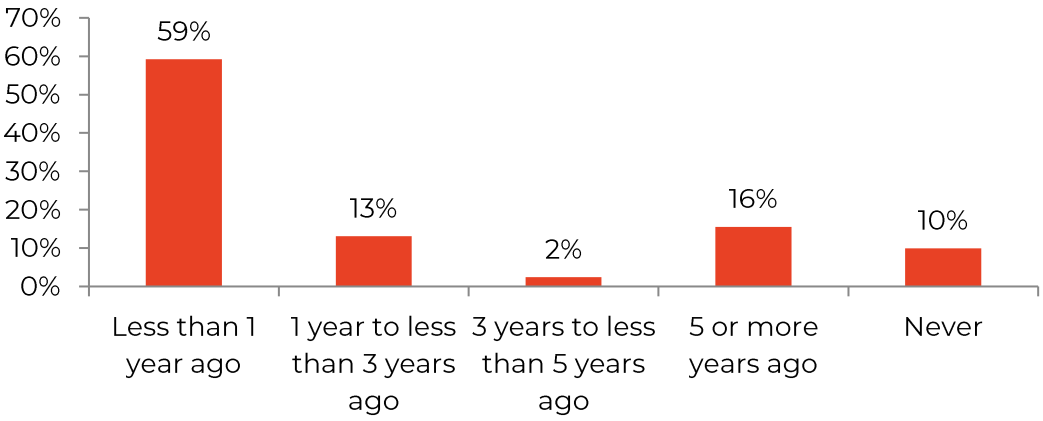
Participants of all genders were asked if, in the past year, they had ever needed birth control or contraception (e.g. condoms) but been unable to obtain it. Of the 387 participants who answered this question, 24 (6.2%) indicated they had been unable to obtain these supplies as required.

Regarding sexual health, participants were asked when the last time was that they were tested for a sexually transmitted infection (STI). More than half of participants (59%) had been tested less than one year ago (Figure 32).

When asked if they had been tested for HIV/AIDS in the past year, 225 (58.9%) of 382 participants said 'yes', while 41.1% said 'no'.

While participants reported they had been tested for STIs and HIV/AIDS, it is unknown whether they went back to receive the results and/or receive treatment if required. Further understanding of sexual and reproductive health among people who experience homelessness is needed.

Figure 32: Most recent time tested for STI



n = 375; Missing = 31

Quality of Care

Nearly all participants (approximately 80% of all study participants) shared an example of a positive experience they had during a health care visit. Participants commented on health care providers' kindness, empathy, non-judgemental stance, and instances of willingness to extend extra care or provide special accommodations.

"They are kind and it's not only about health, it's about how I'm doing on a personal level."

"Health care providers made [me] feel welcome by saying 'Everyone goes through this, you are not alone.'"

"They seemed really compassionate and welcoming. I went in to get stitches, and the doctor reprimanded the students for not giving me enough pain medication and gave me something stronger and apologized for not training them enough to be compassionate enough."

On the other hand, discrimination appeared as a common theme in responses to a question related to feelings of unfair treatment or judgement by a health care provider. Participants felt disrespected because of race or ethnic background, source of income, homeless status, appearance, hygiene, presumed or actual substance use. Other forms of disrespect mentioned included administrative procedures, such as discharge arrangements not being completed; participants not feeling heard or understood; and general discomfort and misunderstandings.

"Just being snapped at for going the wrong way down a hallway. Other people are only asked if they need help, but they assume I'm on alcohol or drugs. I didn't have a drop of anything."

The most common reasons participants reported regarding feelings of disrespect or judgement by health care staff were due to participants feeling the health care provider thought they were drug-seeking (25.4%), participants' use of drugs or alcohol (23.6%), and because participants were experiencing homelessness (23.5%).

Final Reflections

Participants provided numerous suggestions for what would help people experiencing homelessness get the health care they need, which centred on clear notions about the desired qualities of health care service providers:

"More caring people, understanding.
Lack of understanding is triggering."

Numerous critiques related to service access, including administrative and logistical barriers such as obtaining ID or social assistance, were felt to require attention:

"Relax on rules to be able to obtain assistance.
Help people first. Waive requirement for individuals
to have ID to get assistance."

"A unit to help people who don't have ID."

Respondents generated suggestions for increases in existing services, as well as novel ideas for new services and potential actions at the policy level. Other participants' answers, as was noted on other questions as well, revealed a strong sense of personal responsibility:

"A mobile health care clinic."

"More people on the street helping them,
instead of places with help."

"I'd like to see more of a holistic approach which doesn't lead to enabling but leads to independence. And better access to things that lead to a better holistic society."

"Turn the old jail into a hostel.
Take the old cells and turn them into rooms."

To bring the interview to a close and provide opportunity for final thoughts, participants were asked if there was anything else they wished to share about their health or homelessness that didn't come up anywhere else in the survey. Numerous participants took this opportunity to give various perspectives on the causes as well as the effects of homelessness. Identification of causes generated more suggestions for desired services, along with comments on existing services.

“Maybe the reasons why. For me it was abuse at home.
I was kicked out at 16 and not allowed to return.
There was no support from child welfare agencies.”

Several comments related to the need for a variety of types of housing, particularly for families:

"I think there needs to be more transitional housing
and not put people on extensive waiting lists.
Especially for people exiting CFS (aging out)
and moms and kids."

“Not enough shelters where you can take your children.”

“Referrals for housing from welfare.”

“Sucks to be homeless. I wish I could find a home.”

Suggestions were also made regarding the need for improvement to the Employment and Income Assistance (EIA) program:

“Welfare needs to be revamped/readjusted. Increases
in amount of money people get are very necessary.”

“The fact the EIA makes it so difficult for everyone and everybody including [my]self. Put so many hoops in place.”

Finally, participants shared comments about individual attitudes of hope and personal direction:

“Don't give up. Tomorrow is another day. Follow your heart.”

Recommendations and Policy Implications

Based on the 2018 Street Health Survey Results, the authors recommend the following:

Support inclusiveness and apply an Indigenous cultural lens throughout the work, utilizing the knowledge and wisdom of those impacted by homelessness, as we strive to collectively develop and plan programs, practice and policy to implement the following:

1. Enhance **Prevention** measures to address the root causes of homelessness which can lead to and perpetuate poor health outcomes and housing instability.
2. Increase solution-focused infrastructure and Services such as affordable housing, improved discharge planning (hospitals, CFS & incarceration), and specialized substance use, tailoring **Supports** to the specific health, housing and social service needs of Indigenous, youth, women and LGBTQ2S+ community members who are experiencing homelessness
3. Conduct further **Analysis, Research and Evaluation** to identify gaps in current supply, services and supports, and to develop local best practice approaches to address the specific health and housing needs of Indigenous, youth, women and LGBTQ2S+ community members who are experiencing homelessness
4. Utilize a **Systems Integration and Coordinated Access** structure to prevent homelessness and to support individuals on their journeys out of homelessness and into wellness and affordable, adequate, and safe housing.

Next Steps

In the next few years, explore opportunities to provide more in-depth analysis and reporting on the information gathered in the 2018 Winnipeg Street Health Survey to align with current and developing strategies to address homelessness in Winnipeg for specific sub-populations, including youth, women and LGBTQI2S+, and Indigenous community members.

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Appendix: Methods

Participants: Adults who were experiencing Homelessness

Inclusion criteria was defined as being: (1) at least 18 years old; and 2) meeting definition for "absolute homelessness" or "provisional accommodation". See definitions below.

Exclusion criteria included failure to meet inclusion criteria, inability to communicate in English, and inability to provide written consent.

Data Collection and Analysis

Recruitment for the 2018 Winnipeg Street Health Survey (SHS) occurred over several months, beginning in July 2018 and ending in early October 2018. Significant time was spent by the research team connecting with organizations within the homeless-serving sector in Winnipeg to ensure participants were drawn from a variety of agencies and locations in Winnipeg, Manitoba.

Using convenience sampling methodology, a total of 406 individuals met the study criteria. Research Team Interviewers met face-to-face with participants at community agencies and emergency shelters to explain the study, determine eligibility, obtain written participant consent, enrol in the study and complete the survey. Interviews were audio recorded (with participant consent) and generally took between 45 and 75 minutes each. All participants were given a $20 cash honorarium to thank them for their participation.

Data was entered and analyzed using statistical analysis software. Open ended questions were coded manually and analyzed thematically by topic. Open-ended question responses were summarized and are not quoted verbatim in the report.

Definitions

Absolute Homelessness includes two types of homelessness, unsheltered and emergency sheltered, defined as follows:

- **Unsheltered**, and living in places not intended for human habitation, including those living in public places or private places without consent
- **Emergency sheltered**, and staying in overnight emergency shelters and family violence shelters

Provisional Accommodation includes people living temporarily with others but without guarantee of continued residency or prospects of permanent housing ("couch surfing"), and those living in interim (transitional) housing (Gaetz et al. 2012).


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