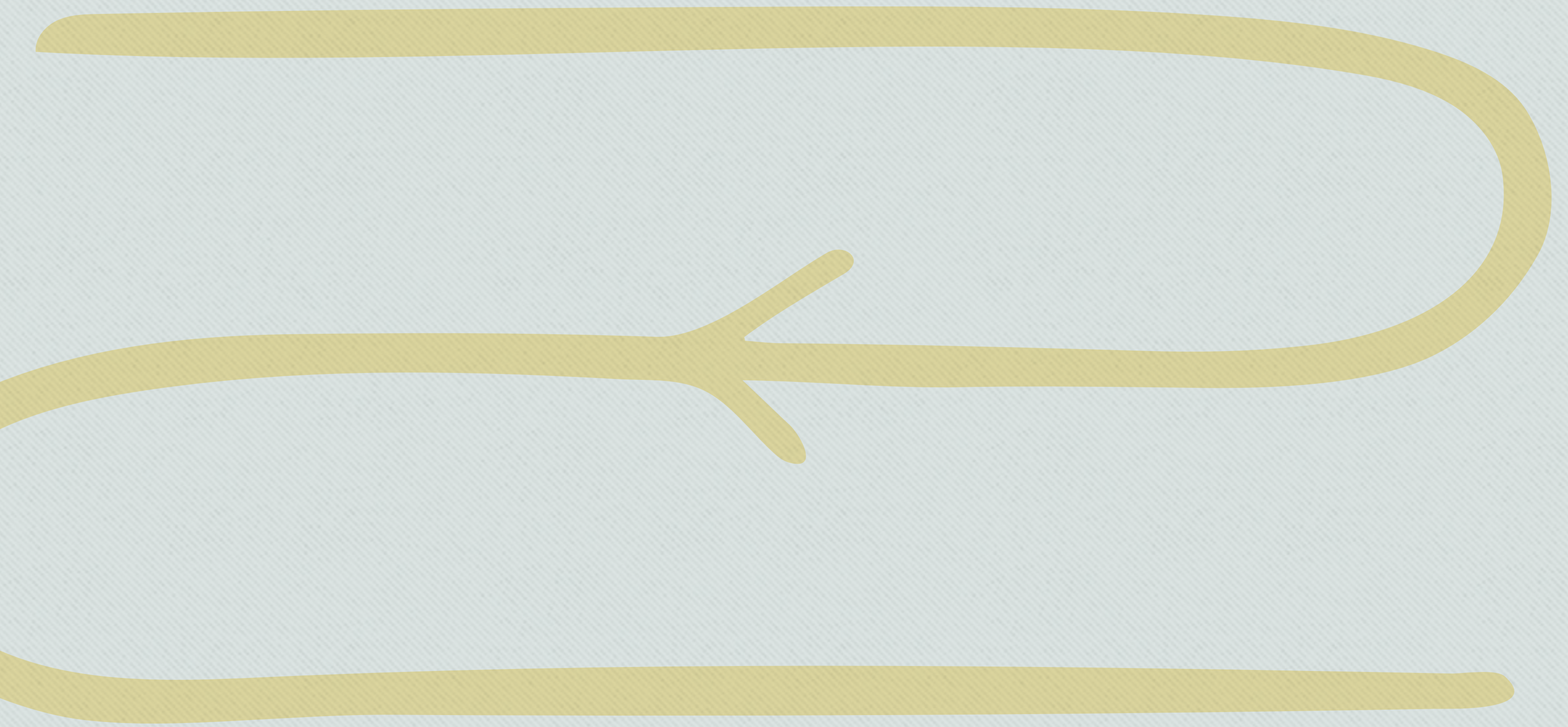
Indigenous Peoples' Experiences of Homelessness:

A Mixed Methods Study in Winnipeg



This study was conducted in Winnipeg, which is on Treaty One Territory, the traditional land of the Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, and the homeland of the Red River Métis. We acknowledge that the water we drink in Winnipeg comes from Shoal Lake First Nation. We also respect the Treaties and acknowledge the past and present harms.

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It should be noted that the organisation names listed above indicate where the Advisory Committee members worked when they participated in the Steering Committee but not necessarily where they work now.

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Dedication

This study is dedicated to First Nations, Métis, and Inuit people experiencing homelessness in Winnipeg.

Citation

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Sarah Brazauskas

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Contents

Acknowledgements 2
Dedication 2
Citation 2
Acronyms 7
List of Tables 8
List of Figures 11
Vocabulary and Terminology 12
Executive summary 13
1. Indigenous Peoples' Experience of Homelessness: A Mixed Methods Study in Winnipeg 19
1.1 Introduction 19
1.2 Research questions 19
1.3 Four-dimensional framework 20
1.4 Methodology for the quantitative study 21
1.4.1 Interpreting the results 22
2. Quantitative results 23
2.1 Demographic information 23
2.2 Identification 26
2.3 Physical dimension 27
2.3.1 Home community 27
2.3.2 Housing and homelessness 30
2.3.2.1 Homelessness status in the month before the survey 30
2.3.2.2 Reasons for experiencing homelessness 31
2.3.2.3 Lifetime length of time experiencing homelessness 34
2.3.2.4 Use of shelters 35
2.3.2.5 Reasons for not staying in a shelter 36
2.3.2.6 Barriers to finding and maintaining housing 37
2.3.2.7 Housing following hospitalisation 40
2.3.3 Incarceration 41
2.3.4 Hygiene 42
2.3.5 Safety and security 44
2.3.6 Food 47
2.3.7 Physical health conditions 48
2.3.7.1 Self-reported conditions over the lifetime 48

Contents continued

2.3.7.2 Self-reported physical and cognitive health conditions experienced in the year prior to the survey ... 48
2.3.7.3 Self-reported current general health conditions ... 50
2.3.8 Health services ... 54
2.3.9 Preventive healthcare ... 62
2.3.10 Accessing services from Indigenous-led organisations ... 66
2.3.11 Income and employment ... 68
2.4 Emotional dimension ... 73
2.4.1 Prior involvement with CFS ... 73
2.4.2 Belonging ... 74
2.4.2.1 Treated unfairly by shelter staff ... 74
2.4.2.2 Treated unfairly by a landlord ... 76
2.4.2.3 Treated unfairly by healthcare staff ... 78
2.4.2.4 Refused service because of lack of identification ... 80
2.5 Mental dimension ... 82
2.5.1 Self-reported health and well-being ... 82
2.5.2 Mental health ... 84
2.5.2.1 Mental health issues in the year prior to the survey ... 84
2.5.2.2 Physician diagnosed mental health conditions ... 85
2.5.2.3 Suicidal ideation and attempts ... 87
2.5.2.4 Mental health care ... 89
2.5.3 Personal health practices and coping methods ... 90
2.5.3.1 Alcohol consumption ... 90
2.5.3.2 Drug use ... 92
2.6 Spiritual dimension ... 93
3. Qualitative study ... 94
3.1 Method ... 94
3.1.1 Participant recruitment ... 94
3.1.2 Interviews ... 96
3.1.3 Data analysis ... 96
3.2 Qualitative results ... 97
3.2.1 Physical dimension ... 97
3.2.1.1 Desired characteristics of a home ... 97
3.2.1.2 Housing type ... 97

Contents continued

3.2.1.3 Belongings ... 98
3.2.1.4 Location ... 98
3.2.1.5 Proximity to amenities ... 98
3.2.1.6 Just having a place ... 98
3.2.1.7 Finding stability in a home ... 99
3.2.2 Spiritual dimension ... 99
3.2.3 Emotional dimension ... 100
3.2.3.1 Sense of belonging ... 100
3.2.3.2 Relationships ... 100
3.2.3.3 Reconnecting with children ... 101
3.2.3.4 Autonomy ... 101
3.2.3.5 Self-fulfilment ... 101
3.2.4 Mental dimension ... 102
3.2.4.1 Coping practices ... 102
3.2.4.2 Mental health and appropriate supports ... 102
3.2.5 Structural factors ... 103
3.2.5.1 Culture ... 103
3.2.5.2 Racism and colonialism ... 104
3.2.5.3 Systems ... 104
3.2.5.3.a Criminal justice system ... 104
3.2.5.3.b Employment and Income Assistance (EIA) ... 105
3.2.5.3.c Child and Family Services (CFS) ... 105
3.2.6 Recommendations heard from participants ... 106
3.2.7 Concept boards ... 107
3.2.7.1 Concept board one ... 109
3.2.7.2 Concept board two ... 111
3.3 Limitations ... 113
4. Discussion ... 114
4.1 Physical dimension ... 114
4.1.1 Homelessness and access to housing ... 114
4.1.2 Built form and housing preferences ... 115
4.1.3 Mobility and location preference ... 115
4.2 Spiritual dimension ... 115
4.3 Emotional dimension ... 116

Contents continued

4.3.1 Discrimination and mistrust....116
4.3.2 Sense of belonging and social exclusion....116
4.4 Mental dimension....117
4.4.1 Substance use and coping mechanisms....117
5. Conclusion....118
5.1 Recommendations....118
References....121
Appendix A: Interview guide....126
Appendix B: Coding scheme....129

Acronyms

Acronym	Meaning
2SLGBTQIA+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, and the plus (other identities not included in the acronym)
CFS	Child and Family Services
CPPD	Canada Pension Plan Disability
EIA	Employment and Income Assistance
GED	General Educational Development
IQR	Interquartile Range
LSD	Lysergic Acid Diethylamide
MB	Manitoba
MLCC	Manitoba Liquor & Lotteries Corporation
MPI	Manitoba Public Insurance
PCP	Phencyclidine
PHAC	Public Health Agency of Canada
PTSD	Post-Traumatic Stress Disorder
SHS	Street Health Survey

List of Tables

Table **Page Number**

Table 1.1: Indigenous identity of the sample. 23
Table 1.2: Demographic characteristics by Indigenous and not Indigenous groups. 24
Table 1.3: Demographic characteristics by Indigenous identity. 25
Table 1.4: Number of children by Indigenous identity. 25
Table 1.5: Type of identification by Indigenous and not Indigenous groups. 26
Table 1.6: Types of identification by Indigenous identity 27
Table 1.7: Home community is a reserve. 28
Table 1.8: Reason for leaving their home community/reserve. 28
Table 1.9: Places respondents stayed when they moved away from their home community/off reserve 28
Table 1.10: Transitions between home community and Winnipeg. 29
Table 1.11: Homelessness status in the month prior to the survey by Indigenous and not Indigenous groups. 30
Table 1.12: Homelessness status in the month prior to the survey by Indigenous identity. 31
Table 1.13: Reasons for homelessness by Indigenous and not Indigenous groups 32
Table 1.14: Reasons for homelessness by Indigenous identity. 33
Table 1.15: Length of time (years) experiencing homelessness over the lifetime by Indigenous identity 34
Table 1.16: Shelter use in the year prior to the survey by Indigenous and not Indigenous groups. 35
Table 1.17: Shelter use in the year prior to the survey by Indigenous identity. 35
Table 1.18: Reasons for not staying in an emergency shelter at the time of the survey by Indigenous and not Indigenous groups 36
Table 1.19: Reasons for not staying in an emergency shelter at the time of the survey by Indigenous identity 37
Table 1.20: Barriers to finding and maintaining housing by Indigenous and not Indigenous groups. 38
Table 1.21: Barriers to finding and maintaining housing by Indigenous identity. 39
Table 1.22: Arrangements made following a hospital stay by Indigenous and not Indigenous groups. 40
Table 1.23: Places people went after being discharged from the hospital by Indigenous and not Indigenous groups. 40
Table 1.24: Places people went after being discharged from the hospital by Indigenous identity. 41
Table 1.25: Spent time incarcerated in the year prior to the survey by Indigenous and not Indigenous groups 41
Table 1.26: Spent time incarcerated in the year prior to the survey by Indigenous identity 41
Table 1.27: Number of days in jail in the year prior to the survey by Indigenous identity 42
Table 1.28: Frequency having trouble accessing hygiene-related services by Indigenous and not Indigenous groups 42
Table 1.29: Frequency having trouble accessing hygiene-related services by Indigenous identity 43
Table 1.30: Issues related to pads or tampons by Indigenous and not Indigenous groups 43
Table 1.31: Injury, accident, and assault by Indigenous and not Indigenous groups. 44
Table 1.32: Statistics describing the number of injury and assault experiences in the year prior to the survey by Indigenous and not Indigenous groups 45
Table 1.33: Injury, accident, and assault by Indigenous identity. 45
Table 1.34: Statistics describing the number of experiences of injury and assault by Indigenous identity 46
Table 1.35: Frequency of being hungry in the last month because could not get enough food by Indigenous and not Indigenous groups. 47
Table 1.36: Frequency of being hungry in the last month because could not get enough food by Indigenous identity. 47
Table 1.37: Experienced a stroke or heart attack (lifetime) by Indigenous and not Indigenous groups. 48
Table 1.38: Experienced a stroke (lifetime) by Indigenous identity. 48
Table 1.39: Medical conditions experienced in the year before the survey by Indigenous and not Indigenous groups. 49
Table 1.40: Medical conditions experienced in the year before the survey by Indigenous identity. 50
Table 1.41: Current health conditions by Indigenous and not Indigenous groups. 51
Table 1.42: Current health conditions by Indigenous identity. 53
Table 1.43: Two main reasons participants do not have a medical professional, or place, that they usually go to when they are sick or need advice about health 55
Table 1.44: Usual sources of healthcare by Indigenous and not Indigenous groups. 57
Table 1.45: Usual sources of healthcare by Indigenous identity. 58
Table 1.46: Sources of healthcare in the year before the survey by Indigenous and not Indigenous groups. 59

List of Tables continued

Table **Page Number**

Table 1.47: Sources of healthcare in the year before the survey by Indigenous identity 60
Table 1.48: Reasons for going to the emergency room in the year before the survey by Indigenous and not Indigenous groups[a] 61
Table 1.49: Reasons for going to the emergency room in the year before the survey by Indigenous identity. 61
Table 1.50: Last time had a physical check-up without having a specific health problem by Indigenous and not Indigenous groups. 62
Table 1.51: Last time had a physical check-up without having a specific health problem by Indigenous identity. 62
Table 1.52: The two main reasons for not having a checkup in the 3 years before the survey by Indigenous and not Indigenous groups 63
Table 1.53: The two main reasons for not having a checkup in the 3 years before the survey by Indigenous identity. ... 64
Table 1.54: Cervical and breast cancer screening by Indigenous and not Indigenous groups. 64
Table 1.55: Challenges accessing birth control or contraception in the year before the survey by Indigenous and not Indigenous groups. 65
Table 1.56: Accessing services from an Indigenous-led organization 66
Table 1.57: Reasons for not accessing services from an Indigenous-led organisation at the time of the survey. 67
Table 1.58: Reasons for not accessing services from an Indigenous-led organization at the time of the survey. 67
Table 1.59: Amount and source of income in the month prior to the survey by Indigenous and not Indigenous groups. 68
Table 1.60: Amount and source of income in the month prior to the survey by Indigenous identity. 69
Table 1.61: Receipt of financial support by Indigenous and not Indigenous groups. 70
Table 1.62: Receipt of financial support by Indigenous identity. 71
Table 1.63: Type of support an EIA worker offered by Indigenous and not Indigenous groups. 71
Table 1.64: Type of support an EIA worker offered by Indigenous identity. 72
Table 1.65: Cheque cashing locations by Indigenous and not Indigenous groups. 72
Table 2.1: Spent time as a child or youth in the care of CFS by Indigenous and not Indigenous groups. 73
Table 2.2: Spent time as a child or youth in the care of CFS by Indigenous identity. 73
Table 2.3: Treated unfairly or disrespected by shelter staff in the year prior to the survey by Indigenous and not Indigenous groups. 74
Table 2.4: Treated unfairly or disrespected by shelter staff in the year prior to the survey by Indigenous identity. 74
Table 2.5: Reasons why participants felt they were treated unfairly or were disrespected by shelter staff by Indigenous and not Indigenous groups. 75
Table 2.6: Reasons why participants felt they were treated unfairly or were disrespected by shelter staff by Indigenous identity. 76
Table 2.7: Treated unfairly or disrespected by a landlord by Indigenous and not Indigenous groups. 76
Table 2.8: Treated unfairly or disrespected by a landlord by Indigenous identity. 76
Table 2.9: Reasons why participants felt they were treated unfairly or were disrespected by a landlord in the year prior to the survey by Indigenous and not Indigenous groups. 77
Table 2.10: Reasons why participants felt they were treated unfairly or were disrespected by a landlord in the year before the survey by Indigenous identity. 78
Table 2.11: Reasons for feeling judged or disrespected by staff in a health care setting in the year prior to the survey by Indigenous and not Indigenous groups. 79
Table 2.12: Reasons for feeling judged or disrespected by staff in a health care setting in the year prior to the survey by Indigenous identity. 80
Table 2.13: Refused service because of lack of identification by Indigenous and not Indigenous groups. 81
Table 2.14: Refused service because of lack of identification by Indigenous identity. 81
Table 3.1: Self-reported general and mental health, and feelings of loneliness and isolation. 82
Table 3.2: Self-reported general and mental health, and feelings of loneliness and isolation by Indigenous and not Indigenous groups 83
Table 3.3: Self-reported general and mental health, and feelings of loneliness and isolation by Indigenous identity. 83

List of Tables continued

Table **Page Number**

Table 3.4: Experiences with mental health issues in the year prior to the survey by Indigenous and not Indigenous groups 84
Table 3.5: Experiences with mental health issues in the year prior to the survey by Indigenous identity. 85
Table 3.6: Physician-diagnosed mental health conditions by Indigenous and not Indigenous groups. 86
Table 3.7: Physician-diagnosed mental health conditions by Indigenous identity. 87
Table 3.8: Suicide ideation and attempts (lifetime and in the year prior to the survey) by Indigenous and not Indigenous groups. 88
Table 3.9: Suicide ideation and attempts (lifetime and in the year prior to the survey) by Indigenous identity 88
Table 3.10: Lack of access to mental health care by Indigenous and not Indigenous groups. 89
Table 3.11: Needed but were unable to get mental health care in the year prior to the survey by Indigenous identity. 90
Table 3.12: Frequency and amount of alcohol consumption by Indigenous and not Indigenous groups. 91
Table 3.13: Frequency and amount of alcohol consumption by Indigenous identity. 91
Table 3.14: Regular drug use in the year before the survey by Indigenous and not Indigenous groups. 92
Table 3.15: Regular drug use in the year prior to the survey by Indigenous identity. 93
Table 4.1: Sample characteristics. 95
Table 4.2: Where participants stayed the night before the interview by gender and Indigenous identity. 96

List of Figures

Figure | **Page Number**

Figure 1.1: Four-dimensional framework....................20
Figure 2.1: Envisioning a two-storey home with a balcony and front deck - drawing shared by an interview participant....................97
Figure 3.1: Themes that emerged from the interviews....................107
Figure 3.2: Concept board one....................110
Figure 3.3: Concept board two....................112

Vocabulary and Terminology

Core housing need: a two-stage indicator that helps to identify households living in dwellings considered unsuitable (not big enough for the household size), inadequate (in need of major repairs), and unaffordable (higher than 30% of the household income before tax).

Dwelling types: different types of houses or buildings with accommodations, including condos, apartments, detached and semi-detached houses, bungalows, and townhouses.

Housing model: forms of housing that may include congregate settings or additional services, such as rooming houses, housing with supports, or co-op housing.

Indigenous peoples: The term refers to the original people of North America and their descendants and includes three recognized groups in Canada: First Nations, Inuit, and Métis.

Indigenous homelessness: is a term coined and defined by Thistle (2017, p.6): "not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews. These include individuals, families, and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages, and identities. Importantly, Indigenous peoples experiencing these kinds of homelessness cannot culturally, spiritually, emotionally, or physically reconnect with their Indigeneity or lost relationships".

Absolute homelessness: includes two types of homelessness, unsheltered, and emergency sheltered.

Unsheltered: is defined as living in places not intended for human habitation, including living in public or private places without consent.

Emergency sheltered: includes staying in overnight emergency shelters and family violence shelters.

Provisional accommodation includes 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).

Executive summary

Research objectives/aims

In 2019, End Homelessness Winnipeg released its 2018 Street Health Survey report, providing an overall picture of homelessness in Winnipeg. The survey had 21 sections on topics such as access and use of healthcare, health conditions and well-being, and experiences interacting with systems, like corrections, Employment and Income Assistance (EIA), and child welfare. The survey also included demographic characteristics. The majority of the survey respondents (71%) identified as Indigenous. This report describes the unique homelessness experiences of First Nations, Métis, and Inuit in Winnipeg.

This report is separated into two large sections: quantitative and qualitative. The quantitative section describes the similarities and differences in experiences between the Indigenous participants and the other participants who responded to the 2018 Street Health Survey. The qualitative section summarises the findings from interviews conducted in 2021 with Indigenous peoples experiencing homelessness. The interview questions asked about the meaning of 'home' and people's housing preferences.

The goal was to gather and present information that could help address homelessness specific to the needs of Indigenous people. The population experiencing homelessness in Winnipeg is not homogenous. Therefore, supports and services must be flexible and tailored to meet the unique needs of those they serve. Organisations and institutions serving Indigenous peoples must be sensitive to the legacy of colonialism and the continued oppression of Indigenous peoples and redress the harms of the past and present. This report aims to assist in addressing this issue by summarising information provided directly by Indigenous peoples experiencing homelessness. We attempted to do this with respect to their personal housing needs and preferences. This report contributes to the literature on urban Indigenous homelessness in Canada.

Literature review

The first step of this project was a review of literature, which attempted to answer the following questions:

(1) What are the reasons for homelessness among Indigenous peoples, and what are their barriers to accessing housing?

(2) What are the health and social conditions of Indigenous peoples experiencing homelessness that impact housing needs?

(3) What are the housing needs and preferences of Indigenous peoples experiencing homelessness?

We scanned Canadian peer-reviewed and grey literature published from 2010 onward. The review informed us of gaps in the literature, which further informed the direction this report's data collection would need to take to advance the conversation.

Answer to Question (1): There is consensus in the literature that housing insecurity is due to a combination of individual and structural factors. However, Indigenous peoples experience unique structural barriers created through past and present racist and discriminatory policies and practices (Adair et al., 2017; Barker et al., 2015; Bingham et al., 2019a; Brandon & Peters, 2014; Schiff & Brunger, 2015; Gaetz et al., 2016; Groening et al., 2019; Hayes, 2016).

Colonialism encapsulates programmes and policies that continue to have grave consequences for Indigenous peoples in Canada such as the Indian Act, the Residential School System, and the 60s Scoop (Brandon & Peters, 2014; Hayes, 2016; Homeward Trust Edmonton, 2015; Native Women's Association of Canada, 2019; Oelke et al., 2016; Pauly et al., 2019; Sinclair, 2016). These policies and practices played a pivotal role in "a deep cultural destabilisation [which] destroyed institutions responsible for the socialisation of Indigenous peoples" (Kidd et al., 2019, p. 164). Colonialism continues today through the child welfare system, the justice system, the healthcare system, and the homelessness and housing sectors (Brandon & Peters, 2014; Pauly et al., 2019). These systems contribute to homelessness and impact how people experience homelessness.

Answer to Question (2): Indigenous peoples experience different pathways into homelessness, resulting in varying health and social conditions. One pathway is poverty. Indigenous peoples in Canada tend to have a lower economic status than the rest of the population. This is due to colonial policies which contribute to fewer educational opportunities (Anderson & Collins, 2014; Homeward Trust Edmonton, 2015), poorer health status (Lavalley et al., 2020), and economic marginalisation due to loss of traditional economies (Anderson & Collins, 2014). Another pathway unique to Indigenous peoples is transitions between their home communities and urban centres, as people search for employment, and health and social services (Harvey, 2016; Homeward Trust Edmonton, 2015). Other pathways into homelessness are overcrowding, fleeing partner violence, incarceration, intergenerational trauma, and mental health and addiction.

Pathways into homelessness also vary by gender. For instance, experiencing and fleeing partner violence, losing social housing due to family breakdown, and apprehension of children by Child and Family Services (CFS) are more common for Indigenous women experiencing homelessness (Bonnycastle et al., 2015; Christensen, 2016; Harvey, 2016). Men are more likely to experience homelessness after moving to an urban centre and after being discharged from treatment or detention centres (Brandon & Peters, 2014; Harvey, 2016).

Answer to Question (3): To prevent and reduce homelessness among Indigenous peoples, strategies must address their unique history, needs, and preferences. Further, racist and discriminatory practices and policies, both historic and novel, need to end. An example accounting for history is the act of delivering services that are trauma-informed, where trauma survivors are supported through personal autonomy and healing (Lavalley et al., 2020). Also, services must be culturally appropriate. Practising one's culture through singing, dancing, storytelling, traditional arts, gathering food, and spiritual practices (Victor et al., 2019), can be healing (Paul et al., 2015); however, no one should be forced to partake. The literature recommends employing Indigenous staff and/or staff with lived experience in organisations serving unhoused individuals (Belanger et al., 2019; Brandon & Peters, 2014; Thistle et al., 2020). Thistle and Smylie (2020) proposed a framework for providing culturally appropriate care to Indigenous peoples. The framework includes four protocols: situating oneself, visiting, hospitality, and treating people as you would treat your relatives.

We identified gaps in the literature. Specifically, the experience of Indigenous women, sexual minorities, and Indigenous youth - who all have unique experiences of homelessness — is missing or lacking in the literature. There is also a dearth of information about on-reserve homelessness experiences.

Four-dimensional framework

With guidance from the Advisory Committee, and a review of theoretical frameworks in the literature (e.g., Indigenous social determinants of health (Christensen, 2016), the Research Team developed a theoretical framework for this project. Our framework consists of four dimensions represented as four quadrants of a circle. The quadrants correspond to the four dimensions of the Medicine Wheel: physical, spiritual, emotional, and mental. We positioned the survey topics within these four dimensions. Doing so revealed the survey was not balanced with respect to the four dimensions; specifically, the survey did not contain any questions addressing the spiritual dimension and asked little about the emotional dimension. The physical dimension pertains to physical wellbeing, access to health services, as well as physical properties individuals require like housing, food, and water. The spiritual dimension is about the beliefs, spiritual practices, and need for environmental connectedness. The emotional dimension is about an individual's relationships with others, self-worth, identity and sense of belonging. The mental dimension pertains to a person's mental health, access to mental health services, personal health practices, and coping mechanisms. The interview questions covered all four dimensions. Systemic and structural factors are identified outside the circle to illustrate their influence on the four dimensions.

Methodology

The quantitative portion of this study utilised data from the 2018 Street Health Survey. The sample of 406 individuals who completed the survey were recruited with the help of several sector organisations in Winnipeg. Participants completed the survey in person at community organisations. To participate, individuals had to be at least 18 years old, and be experiencing "absolute homelessness" or "provisionally accommodated". The survey consisted of 21 sections and covered a wide array of topics, such as income and employment; mental, sexual, physical, and women's health; and experiences with the justice system, child welfare, healthcare, and the housing and homelessness sector. The data were disaggregated by Indigenous identity (Indigenous and not Indigenous) and further disaggregated by Indigenous groups (First Nations, Métis, and Inuit). However, because there were too few Inuit participants, their results could not be presented separately to ensure their anonymity.

The qualitative portion of this study involved semi-structured interviews conducted on the phone in the Winter of 2021. We had intended to meet in person; however, public health restrictions were in place because of the COVID-19 pandemic. The team relied on Indigenous-led sector organisations to recruit participants and arrange the interviews. We set targets based on the demographic profile of the 2018 Street Health Survey sample. A total of 18 participants were interviewed. The questions asked about the meaning of home and about housing needs and preferences. The interviews were audio recorded and transcribed. The transcripts were thematically coded. The codes were organised according to the four-dimensional framework that was developed for this study. The participants were also invited to write and draw anything that came to mind during or after the interviews.

The quantitative and qualitative data were gathered in 2018 and 2021 respectively. To make sense of the findings and determine their relevance, the Research Team consulted with the Advisory Committee in December 2023. The Advisory Committee confirmed that the findings were still relevant.

Limitations/biases

There were limitations to both the quantitative and qualitative components of this study. None of the Research Team members are Indigenous, and one member has experienced hidden homelessness. Unconscious and conscious biases may have influenced all stages of this study.

The interviews for the qualitative component were conducted during the COVID-19 pandemic, three years after the quantitative data was collected. The conversations were held on the phone with aid from community organisations. It was difficult to build rapport with participants on the phone. Hence, it is difficult to tell if they felt awkward or uncomfortable sharing their stories.

The Research Team used quota sampling by setting targets for the characteristics to be represented in the sample. Due to the pandemic and reliance on community organisations to help coordinate, the Team did not meet all our recruitment targets. Three groups were underrepresented: men over the age of 55 years, sexual minorities, and Métis citizens.

Key empirical research findings

We found that Indigenous peoples experiencing homelessness have unique experiences that differ from those who are not Indigenous; however, some experiences are universal. We organised the findings for both the quantitative and qualitative components according to the four-dimensional framework.

Physical dimension

There were several significant differences between the Indigenous participants and the participants who were not Indigenous in the physical dimension. On average, the Indigenous participants experienced homelessness two years longer than those who were not. The difference may be due to systemic and structural barriers that Indigenous peoples face more than other people, such as poverty and insecure employment (Agrawal, 2021). Other researchers have reported that Indigenous peoples tend to experience hidden homelessness more than others, relying on friends and family and/or couch surfing (Alberton et al., 2020; Anderson et al., 2014).

Transitioning between home communities and urban areas was common among the Indigenous participants (Kidd et al., 2019). Approximately 70% of the Indigenous participants in the survey considered their home community a reserve. They left their home community for a variety of reasons, including unfavourable reasons (e.g., overcrowding, avoiding violence), were seeking employment and education opportunities, and were forced to leave. During the interviews, several participants shared they wanted to return to their home community (on reserve or in northern locations like Nunavut).

Preferred location and dwelling type

Some interview participants wanted to stay in urban areas, close to amenities and services, like community centres and grocery stores, and near family and friends. Further, many participants (13 of the 18 interviewed) prefer to live in a detached house with enough bedrooms for family members and others. A mother of several children drew her ideal home, a two-storey house with a veranda (see Figure 2.1). For Indigenous peoples, some studies have recommended flexible-design units with more than three bedrooms to accommodate multi-generational living and others (Brandon & Peters, 2014; Christensen, 2016; Fineblit, 2015; Harvey, 2016; Hayes, 2016). Agrawal et al. (2021) argued that current housing approaches for Indigenous peoples have been unsuccessful because they neglect to account for cultural differences and traditional values.

Spiritual dimension

The survey did not include any questions that addressed the spiritual dimension. Several interview questions attempted to fill the gap. A few participants shared that participating in spiritual and/or traditional practices was important to them. Some wanted easy access to powwows, sweat lodges, and smudging, which would also provide opportunities to socialise. They wanted spiritual objects in their home, like materials for smudging and a Bible. The participants varied regarding the importance of spirituality and participating in spiritual practices. According to Thistle (2017), Indigenous Homelessness involves a series of disconnections, including a disconnect from spiritual relationships.

Emotional dimension

Indigenous participants (65%) were significantly more likely to report being mistreated and/or disrespected by shelter staff than the participants who were not Indigenous (43%). Participants thought they were disrespected because of: (1) their alcohol and/or drug uses (27% of participants; Indigenous, 32%; not Indigenous, 15%); and (2) their race and/or ethnic background (22% of participants; Indigenous, 27%; not Indigenous, 8%). Participants (48%) also felt mistreated by landlords; the two groups had a similar percentage (Indigenous, 50%; not Indigenous, 45%).

Indigenous populations are marginalised and experience systemic discrimination in the healthcare system, housing and shelter services, the housing market, and by employers (Alaazi et al., 2015; Bingham, 2019b; Harvey, 2016; Kitching et al., 2020; Native Women's Association of Canada, 2019; Allan et al., 2015). Due to colonisation and discriminatory policies, Indigenous peoples tend to mistrust government institutions like the child welfare and judicial systems (Cao, 2014; Leckey et al., 2022; Nelson, 2019).

Mothers wanted to reconnect with their children. This was a significant theme that emerged from the interviews. The long-term effects of involvement in the welfare system are grave and perpetuate intergenerational cycles of trauma (Bombay et al., 2020).

Mental dimension

There were only a few significant differences between Indigenous participants and those not Indigenous with respect to self-reported mental health conditions. However, experiences of severe depression, anxiety or tension, and trouble with concentration or remembering were common responses in the 2018 survey. In fact, housing loss or lack of suitable housing can exacerbate mental health conditions, especially for those with previous traumatic experiences (Gabriel et al., 2022).

Regarding gender differences, the literature reports that Indigenous women are at higher risk of experiencing mental health conditions than Indigenous men and twice more likely to be diagnosed with a post-traumatic stress disorder (Bingham et al., 2019b). Factors that contribute to the gender differences include domestic violence (Bingham et al., 2019b; Kirkby & Mettler, 2016), lack of support for women (Bingham et al., 2019b), and involvement with the child welfare system (Alberton et al., 2020).

The survey also asked about substance use. A greater proportion of Indigenous participants (43%) reported consuming alcohol weekly than the participants who were not Indigenous (29%). However, there was no difference between the groups with respect to drug use. Previous research has shown an association between substance use and mental health condition; both are barriers to exiting homelessness (Bingham, 2019; Johnson & Fendrich, 2007). Firestone et al. (2021) shared a couple of best practices for supporting Indigenous individuals experiencing homelessness and who use substances; these include harm reduction approaches that are culturally appropriate.

Conclusion

This report describes the experiences, needs, and housing preferences of First Nations, Inuit, and Métis individuals experiencing homelessness. For many, homelessness is an outcome of colonisation, intergenerational trauma, forced displacement, cultural fragmentation, and systemic racism. This study examines health and social conditions, barriers to housing, and the housing preferences of Indigenous individuals and those who are not Indigenous using data the 2018 Winnipeg Street Health Survey data and 18 interviews completed in 2021.

In many ways, Indigenous and individuals who are not Indigenous experience homelessness differently. Thus, there is a need for personalised and culturally sensitive interventions to address their housing, health, and other needs. Here is a summary of the report recommendations:

1. **Housing providers leading new development projects should retain consultants and architects and scope sites near important amenities. The architects should design flexible housing models that include communal and shared living spaces for larger families and networks, as well as additional indoor/outdoor amenity spaces to provide opportunity for programming, and spiritual and traditional practices.**

2. **Housing practitioners and developers must regularly consult with Indigenous peoples with lived and living homelessness experience to capture difficulties, supports required, and housing preferences.**

3. Housing programmes must provide wraparound supports for those experiencing homelessness with high acuity needs. These programmes should prevent re-traumatization and incorporate strategies like harm reduction, sober living, mental health supports, and gender-based supports.

4. The Housing First model, widely embraced in and outside Canada, focuses on securing permanent housing for individuals experiencing homelessness before following up with necessary and relevant person-centred supports. Adapting this model for Indigenous populations requires recognition of their unique experiences, highlighted by Thistle (2020), which extend beyond the structural component of housing to address disconnection from land, culture, and identity. To effectively adapt the model to the needs of Indigenous peoples, housing providers must collaborate with Indigenous partners, governments, elders, and knowledge keepers to reevaluate the model. Distasio et al. (2019) attempted to Indigenize the Housing First model.

5. The Department of Families, Province of Manitoba should invest in family reunification programmes and counselling for women whose children have been apprehended, as well as consult with women with lived experience and Indigenous governments to determine how best to avert apprehensions.

6. The Department of Families must prepare and support Indigenous youth transitioning out of the CFS system, provide better opportunities to strengthen their life skills (cooking and budgeting), and ensure these youth have access to education, employment, and housing. Furthermore, the Department should fund Indigenous organisations and governments to provide CFS services to their people, and youth in care interested in extending their stay should be allowed to do that at least until age 21.

7. Steps must be taken to eliminate the systemic discrimination Indigenous peoples experience in accessing health, housing, and other services. The provincial government should establish Indigenous advocates to support Indigenous peoples seeking the aforementioned services.

8. An Indigenous-led monitoring group should be established to regularly report the effectiveness and cultural appropriateness of housing policies, support programmes, and housing models to identify any gaps or trends that ensure existing and new housing solutions are appropriate and effective in aiding individuals exiting homelessness.

9. The federal and provincial governments must provide more funding to Eagle Urban Transition Centre and the Winnipeg Friendship Centre to expand settlement services for Indigenous peoples transitioning to Winnipeg.

10. The Province of Manitoba and the City of Winnipeg should regularly evaluate the planning legislation and permit approval process respectively to ensure housing providers are able to deliver with little delays or unnecessary bureaucratic inefficiencies or inconsistencies.

1. Indigenous Peoples' Experience of Homelessness: A Mixed Methods Study in Winnipeg

1.1 Introduction

Indigenous peoples are overrepresented among those experiencing homelessness in urban centres in Canada (Alberton, 2020; Anderson, 2014). Although the Indigenous proportion of the unhoused population varies across the country - 15% in Toronto, 40% in Vancouver, 75% in Winnipeg, approximately 68% in Thunder Bay, and up to 90% in Whitehorse and Yellowknife (Brandon, 2022; Canadian Observatory on Homelessness, n.d.; The District of Thunder Bay Social Services Administration Board, 2022) - the Indigenous population makes up only 5% of the Canadian population (Statistics Canada, 2022). There are multiple pathways into homelessness. However, studies have shown that several factors are unique and more prominent among First Nations, Métis, and Inuit individuals, such as overcrowding, transition to urban centres, migration, residential school experiences, intergenerational trauma, effects of colonialism, poverty, and involvement with the Child Welfare System, and several others (Bonnycastle et al., 2015; Sinclair, 2016; Thistle, 2017).

In 2018, End Homelessness Winnipeg surveyed 406 individuals who were experiencing homelessness. The Street Health Survey (SHS) included questions about housing, health, and social needs (Isaak et al., 2019). Of the 406 survey participants, 71% self-identified as Indigenous. End Homelessness Winnipeg applied and received funding to conduct this study to examine the unique experience of Indigenous peoples more closely. There are two other parallel studies utilising the SHS data; one focused on gender identity and sexual orientation, and the other one is about young adults.

In addition to revisiting the quantitative data, the Research Team conducted interviews with Indigenous individuals experiencing homelessness to gain a better understanding of their unique pathways into homelessness, the meaning of "home", and their housing needs and preferences. Their stories provide End Homelessness Winnipeg with direct experiences and voices from First Nations, Métis, and Inuit experiencing homelessness.

This report is divided into two main sections; (1) the quantitative section reports on findings from the 2018 Street Health Survey (SHS) disaggregated by Indigeneity; and (2) the qualitative section reports the findings from interviews with 18 individuals who were experiencing homelessness and self-identified as First Nations, Métis, or Inuit. Both sections are organised around a four-dimensional framework. The four dimensions are physical, spiritual, emotional, and mental. The process undertaken for developing this framework is discussed in section 1.3. The Discussion (section 4.0) summarises the findings, integrating the results from the two sections, and situates the findings in the literature. The recommendations and conclusions are in section 5.0.

This study was conducted by researchers who are not Indigenous. However, the Advisory Committee included Indigenous peoples who provided feedback and guidance throughout the study. We recognize the colonial nature of research and the use of Western research methods.

1.2 Research questions

This study sought to address the following three research questions:

1. **What are the reasons for homelessness amongst Indigenous peoples, and what are the barriers to accessing housing?**
2. **What are the health and social conditions of Indigenous peoples experiencing homelessness that impact housing needs?**
3. **What are the housing needs and preferences of Indigenous peoples experiencing homelessness?**

The quantitative component addresses the first two research questions while the qualitative component addresses the first and third research questions.

1.3 Four-dimensional framework

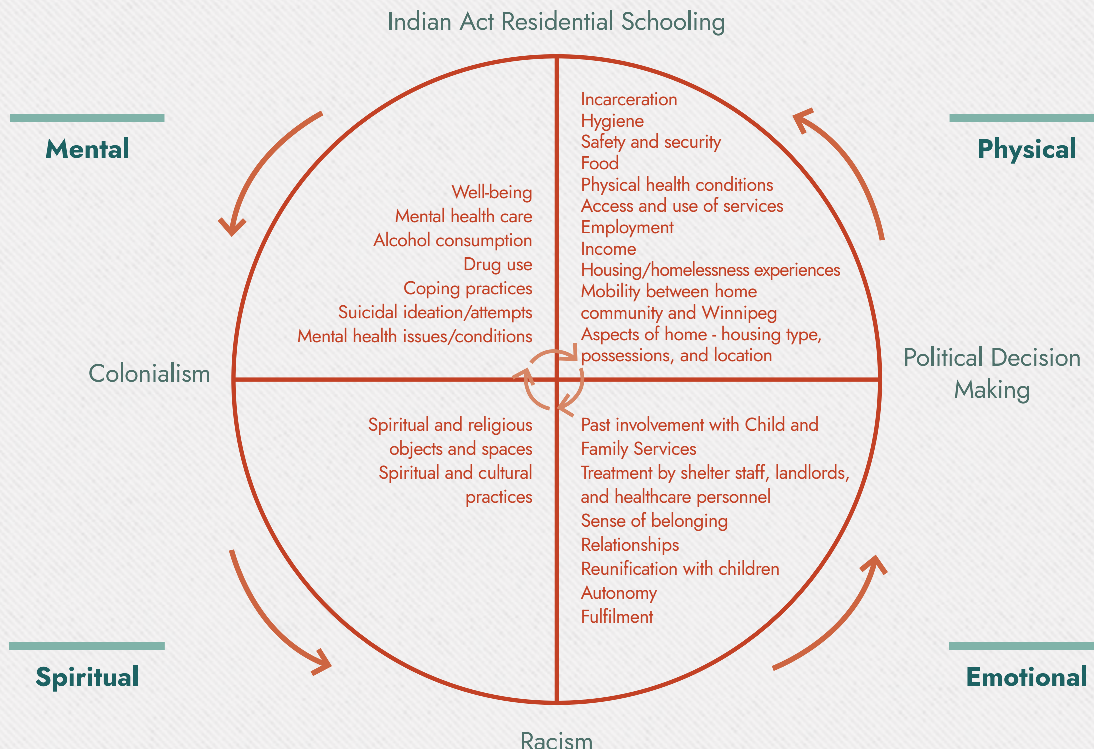
We developed a four-dimensional theoretical framework through an iterative process (see Figure 1.1). The initial version was based on the Public Health Agency of Canada's (PHAC) 2007 *Determinants of Health*. According to Christensen (2016), the social determinants of Indigenous health differ from the standard social determinants of health. Christensen (2016) also stated current housing policy reproduces homelessness as it does not recognize the Indigenous social determinants of health. The social determinants of Indigenous health include relationships with community, land, culture, and self-determination. Therefore, we knew PHAC's framework was insufficient, and thus, we engaged the Advisory Committee to assist us in creating a more appropriate framework.

We presented drafts of the framework to the Advisory Committee and revised it based on their feedback. The process of revising and presenting the framework occurred four times. The final version incorporates the *PHAC's Determinants of Health*, Charlotte Reading and Fred Wien's *Indigenous Determinants of Health*, and feedback from the Advisory Committee.

The framework is divided into four quadrants - physical, spiritual, emotional, and mental - which correspond to the four dimensions of the Medicine Wheel. The physical dimension speaks to the physical wellbeing of individuals (access to health services, personal hygiene, safety and security, etc.), as well as physical properties that an individual may require or seek (housing, food, water, etc.). The spiritual dimension speaks to an individual's spiritual beliefs and practices, purpose, and connectedness with their environment. The emotional dimension speaks to relationships, self-worth, and sense of belonging of an individual. Lastly, the mental dimension pertains to one's mental health and wellbeing, including access to mental health services, personal health practices, and coping mechanisms.

The Advisory Committee recommended the framework be situated within the context of colonialism, racism, the Indian Act, residential schools, and political decision making; these are noted around the circle. The arrows outside the circle are trying to show that inequities are perpetuated by these contexts and influence the determinants of health. The determinants of health were mapped onto the four dimensions and are noted in the four quadrants of the circle. The cycling arrows in the centre of the circle represent how the determinants of health and the four dimensions are interconnected. We organised the quantitative and qualitative findings around the final version of the framework.

Figure 1.1: Four-dimensional framework



*Adapted from Cross, 2007; Public Health Agency of Canada, 2007; Reading & Wien, 2014

1.4 Methodology for the quantitative study

Participants were recruited through convenience sampling. Recruitment began in July 2018 and finished in early October 2018. The research team connected and built relationships with local sector organisations to ensure participants were drawn from various agencies and locations in Winnipeg, Manitoba. A list of the participating agencies is presented below.

The inclusion criteria to participate in the study were: (1) be at least 18 years old; and 2) meet the definition for "absolute homelessness" or "provisional accommodation". Participants were excluded if they did not meet the inclusion criteria, were unable to communicate in English, and/or were unable to provide written consent.

Interviewers met face-to-face with participants at community agencies and emergency shelters to explain the study, determine eligibility, obtain written consent, and complete the survey. The survey contained 21 sections and close to 200 questions. Questions asked about demographic characteristics; income and employment; physical, mental, sexual, and women's health; experiences with/in various systems and sectors (e.g., justice, child welfare, health, homelessness). Also, there was a section specific to Indigenous Peoples' experiences. Most questions were closed-ended, but there were also some open-ended questions.

Participants' responses were recorded on paper copies of the survey, but the interviews were also audio recorded (with participant consent) for reference if needed later. The interviews lasted upwards of 75 minutes. All participants were given a $20 cash honorarium to thank them for their participation (Isaak et al., 2019). Ethics approval for the study was obtained from the University of Manitoba Health Research Ethics Board.

The survey responses were entered into a database and later imported into SPSS statistical software (version 25). The data was cleaned, and duplicate respondents were removed (i.e., several people participated more than once). The final sample included 406 individuals.

The open-ended survey questions were coded manually and analysed thematically. The interviewers did not record the participants' responses verbatim, and thus, the participants' responses included in this report may not be direct quotes. Summaries of the open-ended questions are embedded with the results from the closed-ended questions.

The closed-ended questions chosen for analysis in this report were the ones we identified as gaps in the literature and/or were selected by the project team and the Advisory Committee as variables that may interest local stakeholders and lead to actionable recommendations.

The closed-ended questions were summarised using descriptive statistics. Categorical variables (e.g., gender, presence of a mental illness diagnosis) were summarised using frequencies (N) and percentages (%). Frequencies and percentages based on five or less participants were suppressed to protect confidentiality and ensure anonymity. Continuous variables (e.g., number of children, number of years of homelessness) were summarised using measures of centre (i.e., mean, median) and measures of spread (i.e., standard deviation, interquartile range).

We approached the data first by examining the overall results for the entire sample. Next, we disaggregated the data by Indigenous identity (Indigenous, not Indigenous). We further disaggregated the Indigenous group into First Nations, Métis, and Inuit. However, there were too few Inuit participants to report their results as we needed to ensure their anonymity.

By disaggregating the data, we were able to examine the effects of Indigenous identity on the selected variables, recognizing that individuals who experience homelessness are not a homogenous group. Independent t-tests and Mann-Whitney U-tests were computed to test for statistically significant differences between the Indigenous and not Indigenous groups on the continuous variables. Analysis of Variance or Kruskall-Wallis H-tests were performed to statistically test for differences between the three groups (First Nations, Métis, Not Indigenous) on the continuous variables. A chi-square test was computed to compare groups on the categorical variables.

1.4.1 Interpreting the results

The mean and median are measures of centre; they represent the 'typical' value. The mean, otherwise known as the average, is calculated by summing up the values and dividing by the number of values. The median is the middle value (50th percentile) when data is organised from smallest to largest. The standard deviation and interquartile range are measures of spread. The standard deviation is a value that represents the amount of variability in the data. Essentially, the standard deviation is the average of the differences between each value and the mean. The standard deviation will be small when data are clustered close to the mean. The standard deviation will be larger if the data is spread away from the mean. The interquartile range (IQR) is the difference between the 75th percentile and the 25th percentile (i.e., the middle 50% of the distribution).

When data are symmetrically distributed, the mean and median will be similar. When the data are skewed, the mean and the median differ; extreme values (large or small) 'pull' the mean towards them. When data are symmetrically distributed, the mean and standard deviation are presented. When data are skewed, the median and IQR are presented. The data may be positively skewed distribution or negatively skewed. A positively skewed distribution has a long tail on the right (several large extreme values). A negatively skewed distribution has a long tail on the left (several small extreme values).

Statistical tests produce a *p*-value. A *p*-value is a probability (ranges from 0 to 1) that indicates the likelihood a result would have happened by chance if there was truly no difference. A large p-value ($p > 0.05$) indicates the observed difference in means (or categories) could have easily occurred by chance, and thus, there is no statistical evidence that the groups differ. A small *p*-value ($p \leq 0.05$) indicates the observed difference in means (or categories) is unlikely to have occurred by chance, and thus, there is statistical evidence of a significant difference between the groups.

2. Quantitative results

2.1 Demographic information

In this section, the four groups that are the focus of this report are defined - Indigenous, not Indigenous, First Nations, and Métis. Additionally, this section describes the sample's demographic characteristics overall and by group.

The sample consisted of 406 individuals; 71.4% of whom identified as Indigenous (see Table 1.1). Among the Indigenous participants, 77.9% identified as First Nations, 19.9% identified as Métis, and 2.2% identified as Inuit. Overall, 69.6% of the sample identified as men (see Table 1.2). Although the difference was not statistically significant, the percentage of men participants was lower in the Indigenous group (66.9%) than in the other group (75.7%).

The age distribution of respondents differed significantly between the Indigenous group and the group who did not identify as Indigenous [$\chi_{(2)}^2 = 9.45$, $p = 0.009$]. A higher percentage of Indigenous participants were between the ages of 30 and 54 years (61.5%) compared to participants who were not Indigenous (46.3%), while a lower percentage of Indigenous participants were older than 55 years (15.6%) compared to participants who were not Indigenous (27.8%).

Overall, 68% of the respondents were parents (see Table 1.2). There was a statistically significant relationship between Indigenous identity and parental status [$\chi_{(1)}^2 = 10.81$, p = 0.001]; the difference between these two groups was largely driven by the First Nations group (see Table 1.3). That is, the First Nations participants (77.4%) were significantly more likely to report being parents than the Métis participants (59.3%) and the participants who were not Indigenous (55.1%). Additionally, there were differences between the groups with respect to the number of children they had [$H_{(2)} = 25.8$, $p < 0.001$]. Table 1.4 shows First Nations participants (median = 2, IQR = 3) typically had more children than Métis participants (median = 1, IQR = 3) and the participants who were not Indigenous (median = 1, IQR = 2). No information was collected on the participants' children.

The groups also differed in educational attainment [$\chi_{(2)}^2 = 14.10$, $p = 0.001$]. More than two thirds (68.0%) of the Indigenous participants had not completed high school compared to half (50.0%) of the participants who were not Indigenous. More than one-quarter (25.9%) of participants who were not Indigenous had attended or completed post-secondary schooling, while fewer Indigenous participants (11.9%) had more than a high school education.

Table 1.1: Indigenous identity of the sample.

Identity	*N*	%
Indigenous	274	71.4
First Nations	211	77.9
Métis	54	19.9
Inuit	6	2.2
Not Indigenous	110	28.6

Table 1.2: Demographic characteristics by Indigenous and not Indigenous groups.

Characteristics	Response	Total		Indigenous		Not Indigenous		χ2	*p*-value
		N	%	N	%	N	%		
Age Group[a]	18-29	96	24.1	62	23.0	28	25.9	**9.45**	**0.009**
	30-54	226	56.8	166	61.5	50	46.3		
	55+	76	19.1	42	15.6	30	27.8		
Gender Identity[b]	Male	275	69.6	180	66.9	81	75.7	2.78	0.095
	Female	120	30.4	89	33.1	26	24.3		
Sexual Orientation[c]	Heterosexual/Straight	336	85.5	226	85.0	92	86.0	0.06	0.802
	Sexual Minority	57	14.5	40	15.0	15	14.0		
Parent[d]	Yes	272	68.0	197	72.7	59	55.1	**10.81**	**0.001**
	No	128	32.0	74	27.3	48	44.9		
Educational attainment[e]	[f]Did not complete high school	249	62.6	183	68.0	54	50.0	**14.10**	**0.001**
	Completed high school or GED (General Educational Development) high school equivalent	84	21.1	54	20.1	26	24.1		
	[g]Attended university, college or vocational school	65	16.3	32	11.9	28	25.9		

Note. Groups = Indigenous & Not Indigenous

[a]N = 398 (groups N = 378), [b]N = 395 (groups N = 376), [c]N = 393 (groups N = 373), [d]N = 400 (groups N= 378), [e]N = 398 (groups N = 377).

[f]Did not complete high school = No formal education + Grade 4 or less + Grade 5 to 8 + some high school (no diploma),

[g]Attended university, college, or vocational school = Vocational (business, trade, or technical school) + some college/university but no degree + college/university degree + graduate degree (Master's or PhD).

Bolded values denote statistical significance, $p < 0.05$.

Table 1.3: Demographic characteristics by Indigenous identity.

Characteristic	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Age Group[a]	18-29	45	21.5	14	26.9	28	25.9	**11.10**	**0.026**
	30-54	133	63.6	27	51.9	50	46.3		
	55+	31	14.8	11	21.2	30	27.8		
Gender Identity[b]	Male	135	65.2	40	75.5	81	75.7	4.63	0.099
	Female	72	34.8	13	24.5	26	24.3		
Sexual Orientation[c]	Heterosexual/Straight	174	85.7	44	81.5	92	86.0	0.69	0.710
	Sexual Minority	29	14.3	10	18.5	15	14.0		
Parent[d]	Yes	161	77.4	32	59.3	59	55.1	**18.56**	**0.000**
	No	47	22.6	22	40.7	48	44.9		
Education[e]	[f]Did not complete high school	135	65.5	41	75.9	54	50.0	**15.68**	**0.003**
	Completed high school or GED high school equivalent	44	21.4	9	16.7	26	24.1		
	[g]Attended university, college or vocational school	27	13.1	4	7.4	28	25.9		

Note. [a]*N* = 369, [b]*N* = 367, [c]*N* = 364, [d]*N* = 369, [e]*N* = 386.
[f]Did not complete high school = No formal education + Grade 4 or less + Grade 5 to 8 + some high school (no diploma),
[g]Attended university, college, or vocational school = Vocational (business, trade, or technical school) + some college/university but no degree + college/university degree + graduate degree (Master's or PhD).
Bolded values denote statistical significance, $p < 0.05$.

Table 1.4: Number of children by Indigenous identity.

Group	N	Mean	Standard Deviation	Median	IQR	Minimum	Maximum	95% Confidence Interval
Total	402	2.29	2.52	2.00	3.25	0.00	14.00	2.05, 2.54
Indigenous	273	2.62	2.64	2.00	4.00	0.00	13.00	2.30, 2.93
First Nations	210	2.80	2.61	2.00	3.00	0.00	12.00	2.44, 3.16
Métis	54	2.02	2.71	1.00	3.00	0.00	13.00	1.28, 2.76
Not Indigenous	107	1.48	2.09	1.00	2.00	0.00	14.00	1.08, 1.88

2.2 Identification

Survey respondents were asked what types of identification they had. Over one-third of respondents (35.5%) reported they had no identification, which was consistent across the groups (see Table 1.5). Many respondents (70.2%) had a Manitoba Health Card. Less than half of the respondents had any other types of identification, including a birth certificate (39.0%), a Provincial Photo ID (18.1%), an Indian Status Card (16.9%), or a driver's licence (11.4%). Indigenous respondents (24.0%) were significantly more likely to have an Indian Status Card than respondents who were not Indigenous (0.0%) [$\chi^2_{(1)} = 31.81$, $p < 0.001$] and First Nations respondents (29.3%) were significantly more likely to have this form of ID than respondents who identified as Métis (5.6%) (see Table 1.6). While the percentages of Indigenous (16.2%) and other respondents (20.9%) who had Provincial Photo ID did not differ, Métis respondents (27.8%) were significantly more likely to have this form of ID than First Nations respondents (13.0%). Lastly, respondents who were not Indigenous were significantly more likely to report having a driver's licence and a passport than Indigenous respondents.

Table 1.5: Type of identification by Indigenous and not Indigenous groups.

Types of ID	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Manitoba Health Card	283	70.2	195	72.0	73	66.4	1.17	0.279
Birth Certificate	157	39.0	106	39.1	43	39.1	0.00	0.997
Provincial Photo ID	73	18.1	44	16.2	23	20.9	1.18	0.278
Other[a]	69	17.1	38	14.0	27	24.5	**6.12**	**0.013**
Indian Status Card	68	16.9	65	24.0	0	0.0	**31.81**	**0.000**
Driver's License	46	11.4	24	8.9	21	19.1	**7.87**	**0.005**
Citizenship card / Permanent resident card	11	2.7						
Passport	11	2.7						
Métis Card	7	1.7						
No ID (excludes Health Card)[g]	143	35.5	101	37.3	37	33.6	0.45	0.504

Note. Respondents could select all that apply.

Total *N* = 403 (Indigenous *N* = 271, Not Indigenous *N* = 110), Don't Know *N* = 3.

[a]Other ID includes expired ID (e.g., driver's licence, passport, treaty card), other provincially issued ID (e.g., MPI [Manitoba Public Insurance], MLCC [Manitoba Liquor & Lotteries Corporation]), bank card, social insurance number card, temporary ID.

Since a small number of people had a citizenship/permanent resident card, a Métis card, or a passport, the values are not presented by group to protect people's privacy and ensure anonymity.

Bolded values indicate statistical significance, $p < 0.05$.

Table 1.6: Types of identification by Indigenous identity

Types of ID	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Manitoba Health Card	145	69.4	43	79.6	73	66.4	3.11	0.211
Birth Certificate	79	38.0	22	40.7	43	39.1	0.15	0.929
Provincial Photo ID	27	13.0	15	27.8	23	20.9	7.79	0.020
Othera	27	13.0	8	14.8	27	24.5	7.08	0.029
Indian Status Card	61	29.3	s	s	0	0.0	49.46	0.000
Driver's License	16	7.7	6	11.1	21	19.1	9.16	0.010
No ID (excludes Health Card)[g]	80	38.5	20	37.0	37	33.6	0.72	0.697

Note. Respondents could select all that apply.
First Nation *N* = 208, Métis *N* = 54, Not Indigenous *N* = 110.
[a]Other ID includes expired ID (e.g., driver's licence, passport, treaty card), other provincially issued ID (e.g., MPI, MLCC), bank card, social insurance number card, temporary ID. Since a small number of people had a citizenship/permanent resident card, a Métis card, or a passport, the findings are not presented.
Bolded values indicate statistical significance, $p < 0.05$.
's' means the value was suppressed due to frequencies less than 5.

2.3 Physical dimension

The physical dimension focuses on the physical aspects of Indigenous homelessness and housing, including home communities and transition to Winnipeg, participants' physical health and well-being, and the factors that affect their physical health and well-being, access to services from Indigenous-led organizations, discharges from hospitals into homelessness, hygiene, safety and security, food insecurity, use of healthcare, sources of income, and employment.

2.3.1 Home community

Among the participants who identified as Indigenous (71.4%), 68.9% reported their home community is a reserve; however, this was much more common for the First Nations respondents (84.3%) than the Métis respondents (15.7%) (see Table 1.7). Individuals left their home community for various reasons (see Table 1.8). Just over half of the individuals who left their community (51.8%) cited negative or unfavourable reasons for leaving. These included avoiding substance use and violence, loss of personal relationships, overcrowding, and lack of opportunities. The next most common reason for leaving was to seek out employment or educational opportunities elsewhere (28.7%). A substantial percentage of people (17.6%) left against their will when they were apprehended by or surrendered to the state to attend Residential School or were adopted or put in foster care or in the care of CFS. Some people left their home community to seek out other opportunities (11.9%), such as opportunities for their children and to be close to family, or for health reasons (7.4%).

Table 1.7: Home community is a reserve.

Response	Indigenous		First Nations		Métis		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	182	68.9	172	84.3	8	15.7	92.56	<0.001
No	82	31.1	32	15.7	43	84.3		

Note. Indigenous $N = 264$, First Nations $N = 204$, Métis $N = 51$.
Bold values indicate statistical significance, $p < 0.05$.

Table 1.8: Reason for leaving their home community/reserve.

Reasons for leaving	*N*	%
Push negative factors/unfavourable factors[a]	71	51.8
Employment or educational opportunities	39	28.7
Apprehended/surrendered to state[b]	24	17.6
Other opportunities or personal need factors[c]	16	11.9
Moved away with parent(s)/family	13	9.6
Health treatment for myself, friend, or family member	10	7.4

Note. Only people who identified as Indigenous and indicated home is a reserve answered this question.
$N = 136$; 7 Don't Know/Declined to Answer responses, 128 people were born in Winnipeg or their home was not a reserve, 25+ missing responses.
[a]Push negative/unfavourable factors (to avoid substance use/violence/negative or loss of personal relationships/overcrowding, lack of opportunities, community environment)
[b]Apprehended/surrendered to state (adopted/foster care/CFS/residential school)
[c]Other opportunity or personal need factors (to seek city life/own choice/to be near family)

Table 1.9 shows that when people first left their home community, many moved to a precarious housing situation (54.2%), experienced absolute homelessness (18.3%), or were placed in institutional housing (e.g., group home, foster care, residential school, boarding home) (15.5%). Less than 10% moved into permanent housing.

Table 1.9: Places respondents stayed when they moved away from their home community/off reserve.

Types of housing	*N*	%
Precarious housing	77	54.2
Absolute homelessness	26	18.3
Institutional housing	22	15.5
Permanent housing	14	9.9

Note. $N = 142$; 7 Don't Know/Declined to Answer responses.

Table 1.10: Transitions between home community and Winnipeg.

Variable	Responses	*N*	%
Frequency of returning to home community/ reserve[a]	Never	54	35.3
	Rarely (less than 1x per year)	53	34.6
	Once per year	19	12.4
	Two or more times per year	24	15.7
	For funerals	s	s
Length of time usually stay in home community/ reserve[b]	Less than 1 week	49	48.5
	1 week	18	17.8
	More than 1 week to less than 1 month	17	16.8
	More than 1 month	17	16.8
Lost housing due to mobility between home community/reserve and Winnipeg[c]	Yes	18	17.5
	No	85	82.5

Note. [a]*N* = 153 (excludes individuals who are not Indigenous and those who were born in Winnipeg or whose home community is not a reserve).
[b]*N* = 101 (excludes individuals who are not Indigenous and those who were born in Winnipeg or whose home community is not a reserve and those who do not go back to their home community).
[c]*N* = 103 (excludes individuals who are not Indigenous and those who were born in Winnipeg or whose home community is not a reserve and those who do not go back to their home community).

Of the people who indicated their home is a First Nations community, 35.3% reported they have never returned, 34.6% return less than once per year, 12.5% return once per year, and 15.7% go at least two times per year (see Table 1.10). A few people (2.0%) reported they only go to their home community to attend funerals. When people return to their home community, more than half (51.5%) stay a week or more; in fact, 16.8% reported they stay more than one month. Due to mobility between their home community and Winnipeg, 17.5% reported they had lost housing.[1]

1 The question asked, "Have you ever lost housing because you moved between your home community / reserve and Winnipeg?". There were no follow-up questions asking where they lost their housing.

2.3.2 Housing and homelessness

2.3.2.1 Homelessness status in the month before the survey

In the month prior to the survey, many participants experienced multiple forms of homelessness; 87.2% had experienced absolute homelessness, 81.8% had been provisionally accommodated, and 14.8% had been permanently accommodated (see Table 1.11). These percentages were similar for the Indigenous and not Indigenous groups. While the overall relationship between Indigenous identity (three groups) and being permanently accommodated was almost significant [$\chi_{(2)}^2 = 5.74$, $p = 0.06$], the Métis participants (25.9%) were significantly more likely to be permanently accommodated than the First Nations participants (14.7%) and the participants who were not Indigenous (11.8%) (see Table 1.12).

Table 1.11: Homelessness status in the month prior to the survey by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Absolute Homelessness[a]	Yes	354	87.2	242	88.3	92	83.6	1.52	0.217
	No	52	12.8	32	11.7	18	16.4		
Provisionally Accommodated[b]	Yes	332	81.8	230	83.9	84	76.4	3.02	0.082
	No	74	18.2	44	16.1	26	23.6		
Permanently Accommodated[c]	Yes	60	14.8	44	16.1	13	11.8	1.12	0.291
	No	346	85.2	230	83.9	97	88.2		

Note. Groups = Indigenous + Not Indigenous

[a]*N* = 406 (groups *N* = 384), [b]*N* = 406 (groups *N* = 384), [c]*N* = 406 (groups *N* = 384).

[a]Absolute Homelessness = emergency shelter or domestic violence shelter + car or other vehicle + abandoned building + place of business + outside.

[b]Provisionally Accommodated = transitional housing + hotel or motel or boarding home funded by medical services + hospital + jail + treatment programme where you live/stay overnight + stayed with a friend + stayed with a family member.

[c]Permanently Accommodated = rooming house + own apartment/house.

Table 1.12: Homelessness status in the month prior to the survey by Indigenous identity.

Variable	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Absolute Homelessness[a]	Yes	185	87.7	49	90.7	92	83.6	1.85	0.398
	No	26	12.3	5	9.3	18	16.4		
Provisionally Accommodated[b]	Yes	180	85.3	42	77.8	84	76.4	4.47	0.107
	No	31	14.7	12	22.2	26	23.6		
Permanently Accommodated[c]	Yes	31	14.7	14	25.9	13	11.8	5.74	0.057
	No	180	85.3	40	74.1	97	88.2		

Note. [a]*N* = 375, [b]*N* = 375, [c]*N* = 375.

[a]Absolute Homelessness = emergency shelter or domestic violence shelter + car or other vehicle + abandoned building + place of business + outside.

[b]Provisionally Accommodated = transitional housing + hotel or motel or boarding home funded by medical services + hospital + jail + treatment programme where you live/stay overnight + stayed with a friend + stayed with a family member.

[c]Permanently Accommodated = rooming house + own apartment/house.

2.3.2.2 Reasons for experiencing homelessness

Participants were asked why they experienced homelessness over their lifetime. They were presented with a list of 15 reasons, plus they could identify other reasons. The reasons were grouped into seven categories. Housing-related challenges were identified by 90.5% and 85.5% of participants in the Indigenous and other group, respectively, the highest percentage of any of the reasons (see Table 1.13). If we order the reasons by the percentage who selected the reason from highest to lowest, the orders are different for the two groups. For the Indigenous group, the most common to least common reasons for homelessness are housing-related, substance-use, lack of access to timely and appropriate supports, employment and income, health, relationship challenges, and justice-related. For the group who was not Indigenous, the order of reasons is: housing-related, lack of access to timely and appropriate supports, employment and income, substance use, health, relationship challenges, and justice. The main difference between the two orders is the location of substance use. Substance use was the second most common reason for the Indigenous group, identified by 77.6%, and the fourth most common reason for the other group, identified by 59.6%. The difference in these percentages was statistically significant [$\chi_{(1)}^2 = 12.55$, $p < 0.001$], and was the only statistically significant difference in percentages between the groups of all the reasons.

The order of the reasons for the First Nations and Métis groups were similar, except health was the third most common reason for the Métis group, and the fifth most common reason for the First Nations group (see Table 1.14). Although, justice was the least most common reason for experiencing homelessness identified by all the groups, a significantly higher percentage of people in the First Nations group (39.8%) selected this as a reason compared to the Métis (22.6%) and other (26.6%) groups [$\chi_{(2)}^2 = 8.90$, $p = 0.01$].

Table 1.13: Reasons for homelessness by Indigenous and not Indigenous groups.

Reasons	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Housing-related[a]	Yes	364	89.7	248	90.5	94	85.5	2.06	0.151
	No	42	10.3	26	9.5	16	14.5		
Drug and Alcohol Use[b]	Yes	290	72.1	211	77.6	65	59.6	**12.55**	<0.001
	No	112	27.9	61	22.4	44	40.4		
Lack of Access to Timely and Appropriate Supports[c]	Yes	275	69.6	186	69.1	74	69.2	0.00	0.998
	No	120	30.4	83	30.9	33	30.8		
Employment and Income[d]	Yes	261	64.3	171	62.4	76	69.1	1.53	0.217
	No	145	35.7	103	37.6	34	30.9		
Health[e]	Yes	236	58.1	167	60.9	57	51.8	2.69	0.101 0
	No	170	41.9	107	39.1	53	48.2		
Relationship Challenges[f]	Yes	216	53.5	147	53.8	54	49.1	0.71	0.399
	No	188	46.5	126	46.2	56	50.9		
Justice-Involvement[g]	Yes	134	33.3	98	35.9	29	26.6	3.03	0.082
	No	268	66.7	175	64.1	80	73.4		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 406 (groups *N* = 384), [b]*N* = 402 (groups *N* = 381), [c]*N* = 395 (groups *N* = 376), [d]*N* = 406 (groups *N* = 384), [e]*N* = 406 (groups *N* = 384), [f]*N* = 404 (groups *N* = 386), [g]*N* = 402 (groups *N* = 382).

[a]Housing = eviction + rent increased + moved to Winnipeg + unsafe + poor housing conditions + not suitable + landlord/tenancy issues + lost due to fire, demolition, foreclosure.

[b]Drug and Alcohol Use = use of drugs/alcohol + other people's use of drug/alcohol.

[c]Lack of Timely and Appropriate Supports = could not get the right support at the right time + aged out of care.

[d]Employment and Income = lost job/employment ended + changes in income (e.g., cut off EIA, child tax credit) + lack of income or ID.

[e]Health = got sick and couldn't work + went to a drug or alcohol treatment programme + hospitalised + mental illness or traumatic experience.

[f]Relationship Challenges = relationship breakup + relationship issues + safety issues, violence, abuse

[g]Justice Involvement = sentenced to jail or remand + criminal activity.

Bolded values indicate statistical significance, $p < 0.05$.

Table 1.14: Reasons for homelessness by Indigenous identity.

Reasons	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Housing-related[a]	Yes	193	91.5	48	88.9	94	85.5	2.76	0.252
	No	18	8.5	6	11.1	16	14.5		
Drug and Alcohol Use[b]	Yes	165	78.9	37	68.5	65	59.6	**13.52**	**0.001**
	No	44	21.1	17	31.5	44	40.4		
Lack of Access to Timely and Appropriate Supports[c]	Yes	148	71.5	32	60.4	74	69.2	2.45	0.294
	No	59	28.5	21	39.6	33	30.8		
Employment and Income[d]	Yes	133	63.0	31	57.4	76	69.1	2.34	0.310
	No	78	37.0	23	42.6	34	30.9		
Health[e]	Yes	127	60.2	34	63.0	57	51.8	2.69	0.261
	No	84	39.8	20	37.0	53	48.2		
Relationship Challenges[f]	Yes	120	57.1	25	46.3	54	49.1	3.09	0.213
	No	90	42.9	29	53.7	56	50.9		
Justice-Involvement[g]	Yes	84	39.8	12	22.6	29	26.6	**8.90**	**0.012**
	No	127	60.2	41	77.4	80	73.4		

Note. [a]$N = 375$, [b]$N = 372$, [c]$N = 367$, [d]$N = 375$, [e]$N = 375$, [f]$N = 374$, [g]$N = 373$.

[a]Housing = eviction + rent increased + moved to Winnipeg + unsafe + poor housing conditions + not suitable + landlord/tenancy issues + lost due to fire, demolition, foreclosure.

[b]Drug and Alcohol Use = use of drugs/alcohol + other people's use of drug/alcohol.

[c]Lack of Timely and Appropriate Supports = could not get the right support at the right time + aged out of care

[d]Employment and Income = lost job/employment ended + changes in income (e.g., cut off EIA, child tax credit) + lack of income or ID.

[e]Health = got sick and couldn't work + went to a drug or alcohol treatment programme + hospitalised + mental illness or traumatic experience.

[f]Relationship Challenges = relationship breakup + relationship issues + safety issues, violence, abuse.

[g]Justice Involvement = sentenced to jail or remand + criminal activity.

Bolded values indicate statistical significance, $p < 0.05$.

2.3.2.3 Lifetime length of time experiencing homelessness

The longer someone experiences homelessness, the more likely their health will deteriorate (Gaetz et al., 2014). The median length of time individuals experienced homelessness during their lifetime was three years for both the participants who identified as Indigenous and participants who were not Indigenous (see Table 1.15). This means that 50% of the individuals in both groups had lifetime experiences of homelessness of three years or less, while 50% had experienced homelessness for more than three years. However, the average length of time was almost two years longer for the Indigenous group ($M = 6.28$) than the other group ($M = 4.42$). This means some Indigenous peoples experienced homelessness for many years. Overall, there was a statistically significant difference between the groups in the time spent experiencing homelessness over their lifetime [$z = 2.512$, $p = 0.012$].

The differences in lengths of time of homelessness experience between the First Nations, Métis, and other groups were almost statistically significant [$H_{(2)} = 5.83$, $p = 0.054$]. Again, while the median lengths of time were around three years for all three groups, the average lengths of time for the two Indigenous groups were one to two years longer (First Nations, $M = 6.30$ years; Métis $M = 5.84$ years) than the group who was not Indigenous ($M = 4.42$ years).

Table 1.15: Length of time (years) experiencing homelessness over the lifetime by Indigenous identity.

Group	N	Mean	Standard Deviation	Median	IQR	Minimum	Maximum	95% Confidence Interval
Indigenous	260	6.28	8.21	3.00	7.00	0.02	64.00	5.27 to 7.28
First Nations	203	6.30	8.49	3.00	7.00	0.02	64.00	5.13 to 7.48
Métis	47	5.84	7.50	2.74	7.00	0.06	25.00	3.64 to 8.04
Not Indigenous	107	4.42	6.74	3.00	4.42	0.01	42.00	3.13 to 5.71

Note. IQR = Interquartile Range.

2.3.2.4 Use of shelters

Many participants stayed in a shelter in the year prior to the survey (see Table 1.16). Table 1.17 indicates one in 10 people (10%) stayed in a domestic violence shelter; the group percentages were similar (First Nations, 8.6%; Métis, 11.1%; not Indigenous, 10.0%). Almost three quarters (71.4%) of participants stayed in an emergency shelter; again, the group percentages were similar (First Nations, 70.6%; Métis, 70.4%; not Indigenous, 70.9%). Short shelter stays can be partly attributed to quick transitions into housing, as well as short homelessness experience. Of those who stayed in an emergency shelter in the year prior to the survey, about one quarter (25.3%) stayed longer than six months; this was slightly more (but not significantly) common among the Indigenous respondents (First Nations, 24.2%; Métis, 28.9%) than the group who did not identify as Indigenous (20.8%).

Table 1.16: Shelter use in the year prior to the survey by Indigenous and not Indigenous groups.

Shelter Use	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Domestic Violence Shelter[a]	Yes	40	10.0	23	8.5	11	10.0	0.230	0.631
	No	362	90.0	249	91.5	99	90.0		
Emergency Shelter[b]	Yes	289	71.4	195	71.2	78	70.9	0.00	0.960
	No	116	28.6	79	28.8	32	29.1		
Emergency Shelter for longer than 6 months[c]	Yes	73	25.3	49	25.1	16	20.8	0.57	0.449
	No	215	74.7	146	74.9	61	79.2		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 402 (group *N* = 382), [b]*N* = 405 (groups *N* = 384), [c]*N* = 288 (groups *N* = 272)

Table 1.17: Shelter use in the year prior to the survey by Indigenous identity.

Shelter Use	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Domestic Violence Shelter[a]	Yes	18	8.6	6	11.1	11	10.0	0.39	0.825
	No	191	91.4	48	88.9	99	90.0		
Emergency Shelter[b]	Yes	149	70.6	38	70.4	78	70.9	0.01	0.997
	No	62	29.4	16	29.6	32	29.1		
Emergency Shelter for longer than 6 months[c]	Yes	36	24.2	11	28.9	16	20.8	0.95	0.622
	No	113	75.8	27	71.1	61	79.2		

Note. [a]*N* = 373, [b]*N* = 375, [c]*N* = 264.

2.3.2.5 Reasons for not staying in a shelter

Participants who were not staying in a shelter at the time of the survey (*N* = 255) were asked why this was the case. They could list multiple reasons. The group percentages were similar for each of the reasons (see Tables 1.18 and 1.19). The number one reason was participants had alternative shelter options (overall, 34.5%; Indigenous, 35.9%; not Indigenous, 32.2%), including they had temporary or transitional housing, friends and/or family to stay with, and/or were living on the streets. Shelter facility and operation issues were the number two reason (35.3%) for not staying at a shelter, identified by 33.7% of Indigenous peoples and 39.0% of people who were not Indigenous. These reasons included the shelter was too crowded, had bed bugs, was too noisy, the participants expressed health concerns (e.g., afraid to get sick), and other reasons (i.e., location, hours, cleanliness, comfort). Safety and threat concerns (27.5%) and access issues (17.6%) were also common responses. Access issues included they could not get a bed, they were barred from the shelter, as well as they could not stay there because of their drug or alcohol use, their lack of ID, their criminal history, their partner was not allowed, or they were on the waitlist.

Table 1.18: Reasons for not staying in an emergency shelter at the time of the survey by Indigenous and not Indigenous groups.

Reasons	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
[a]Shelter facility & operations issues	90	35.3	62	33.7	23	39.0	0.55	0.459
[b]Alternative option available	88	34.5	66	35.9	19	32.2	0.26	0.607
[c]Safety & theft concerns	70	27.5	51	27.7	15	25.4	0.12	0.730
[d]Access Issues	45	17.6	35	19.0	9	15.3	0.43	0.513
[e]Concerns with staff or other shelter users' behaviour or influence	34	13.3	25	13.6	6	10.2	0.47	0.494
Stigma or preference not to	10	3.9						
[f]Mental health concerns	9	3.5						
Financial & benefits coverage issues	s	s						

Note. Respondents could select all that apply.
Total *N* = 255 (Indigenous *N* = 184, Not Indigenous *N* = 59).
This question was not relevant to 146 individuals who were staying in an emergency shelter at the time of the survey.
[a]Shelter Facility & Operations Issues = too crowded + bed bugs + too noisy + health reasons (afraid to get sick + others (i.e., location, hours, cleanliness, comfort).
[b]Alternative option available (e.g., temporary/transitional housing, friends, family, streets)
[c]Safety & theft concerns (e.g., feel they are unsafe).
[d]Access Issues = could not get a bed + barred from shelter + others (i.e., drug or alcohol use, lack of ID, criminal history, partner not allowed, on wait list).
[e]Concerns with staff or other shelter users' behaviour or influence (e.g., pressure to use substances).
[f]Mental Health concerns (e.g., anxiety, claustrophobia due to crowding, panic disorder).
Too few to report for Financial & Benefits Coverage Issues, Mental Health concerns, and Stigma or Preference not to.
's' means the value was suppressed due to frequencies less than 5.

Table 1.19: Reasons for not staying in an emergency shelter at the time of the survey by Indigenous identity.

Reasons	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Shelter facility & operations issues[a]	53	34.9	7	25.9	23	39.0	1.39	0.499
Alternative option available[b]	52	34.2	10	37.0	19	32.2	0.199	0.905
Safety & theft concerns[c]	41	27.0	9	33.3	15	25.4	0.608	0.738

Note. First Nations *N* = 152, Métis *N* = 27, Not Indigenous *N* = 59.

[a]Shelter Facility & Operations Issues = too crowded + bed bugs + too noisy + health reasons (afraid to get sick + others (i.e., location, hours, cleanliness, comfort).

[b]Alternative option available (e.g., temporary/transitional housing, friends, family, streets)

[c]Safety & theft concerns (e.g., feel they are unsafe).

Concerns with staff or other shelter users' behaviour or influence (e.g., pressure to use substances).

Due to small frequencies, the results for access issues, and concerns with staff or other shelter users' behaviour or influence could not be reported.

Too few to report for Financial & Benefits Coverage Issues, Mental Health concerns, and Stigma or Preference not to.

2.3.2.6 Barriers to finding and maintaining housing

Participants were presented with a list of potential barriers or challenges to finding and maintaining housing and asked what the biggest ones were. In general, the barriers were either due to not having something positive (e.g., employment, identification, education, skills or training, transportation, assistance, income) or due to having something that may be perceived as negative (e.g., addiction, criminal record, a physical disability or condition, a mental health condition, domestic or family instability). The top five reasons were the cost of housing (77.2%), lack of suitable housing (76.0%), lack of employment (64.5%), lack of transportation to see an apartment (62.7%) and inability to find or access the support or assistance needed (55.3%) (see Table 1.20). There were statistically significant differences between the groups for some of the reasons. Specifically, a significantly higher percentage of the Indigenous group identified the following as barriers compared to the group who was not Indigenous: not having identification (Indigenous, 52.6%; not Indigenous, 38.3%), discrimination by landlords (Indigenous, 49.2%; not Indigenous, 31.8%), not having enough education, skills, or training (Indigenous, 39.0%; not Indigenous, 27.8%), and a physical condition or disability (Indigenous, 23.4%; not Indigenous, 13.9%). When disaggregating the Indigenous group, there were statistically significant relationships with not having identification, discrimination by landlords, and having a physical condition or disability (see Table 1.21). In all cases, the First Nations group had the highest percentage, followed by the Métis group, and then the group that was not Indigenous.

Table 1.20: Barriers to finding and maintaining housing by Indigenous and not Indigenous groups.

Barriers	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Rent is too high[a]	Yes	304	77.2	197	73.8	88	83.0	3.59	0.058
	No	90	22.8	70	26.2	18	17.0		
Lack of suitable housing (including inadequate housing)[b]	Yes	298	76.0	201	75.6	80	74.8	0.03	0.872
	No	94	24.0	65	24.4	27	25.2		
Lack of job/employment[c]	Yes	258	64.5	174	64.2	69	63.9	0.00	0.954
	No	142	35.5	97	35.8	39	36.1		
Don't have transportation to see apartment[d]	Yes	250	62.7	170	63.2	66	60.6	0.23	0.630
	No	149	37.3	99	36.8	43	39.4		
Can't find or access the support or assistance you needed[e]	Yes	214	55.3	144	54.8	57	54.8	0.00	0.992
	No	173	44.7	119	45.2	47	45.2		
You have an addiction[f]	Yes	197	50.0	141	53.0	45	42.1	3.66	0.056
	No	197	50.0	125	47.0	62	57.9		
Don't have identification[g]	Yes	193	48.5	142	52.6	41	38.3	**6.25**	**0.012**
	No	205	51.5	128	47.4	66	61.7		
Discrimination — landlords won't rent to you because of your ethnicity, race, source of income or because you are homeless[h]	Yes	171	44.2	128	49.2	34	31.8	**9.37**	**0.002**
	No	216	55.8	132	50.8	73	68.2		
Don't have enough education, skills, training[i]	Yes	141	35.4	105	39.0	30	27.8	**4.25**	**0.039**
	No	257	64.6	164	61.0	78	72.2		
You have a criminal record — landlords won't rent to you[j]	Yes	120	30.3	86	32.0	29	27.1	0.85	0.355
	No	276	69.7	183	68.0	78	72.9		
Other[k]	Yes	110	29.2	76	30.3	27	25.2	0.93	0.334
	No	267	70.8	175	69.7	80	74.8		
A mental health condition[l]	Yes	92	23.1	62	22.9	25	23.1	0.00	0.955
	No	307	76.9	209	77.1	83	76.9		
Family or domestic instability[m]	Yes	90	22.8	55	20.7	29	26.9	1.68	0.195
	No	304	77.2	211	79.3	79	73.1		
A physical condition or disability[n]	Yes	82	20.6	63	23.4	15	13.9	**4.27**	**0.039**
	No	316	79.4	206	76.6	93	86.1		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 394 (groups *N* = 373), [b]*N* = 392 (groups *N* = 373), [c]*N* = 400 (groups *N* = 379), [d]*N* = 399 (groups *N* = 378), [e]*N* = 387 (groups *N* = 367), [f]*N* = 394 (groups *N* = 373), [g]*N* = 358 (groups *N* = 377), [h]*N* = 387 (groups *N* =367), [i]*N* = 398 (groups *N* = 377), [j]*N* = 396 (groups *N* = 376), [k]*N* = 377 (groups *N* = 358), [l]*N* = 399 (groups *N* = 379), [m]*N* = 394 (groups *N* = 374), [n]*N* = 398 (groups *N* = 377),
[k]Other = Experiences of homelessness + Financial challenges + Landlord/Tenancy Issues (including lack of references) + personal challenges + safety issues/violence/abuse + appearance + your attitude or speaking up for yourself.
Bolded values indicate statistical significance, $p < 0.05$.

Table 1.21: Barriers to finding and maintaining housing by Indigenous identity.

Barriers	Response	First Nations		Métis		Not Indigenous		χ²	*p*-value
		N	%	*N*	%	*N*	%		
Rent is too high[a]	Yes	150	72.5	42	82.4	88	83.0	5.385	0.068
	No	57	27.5	9	17.6	18	17.0		
Lack of suitable housing (including inadequate housing)[b]	Yes	151	73.7	44	83.0	80	74.8	2.013	0.365
	No	54	26.3	9	17.0	27	25.2		
Lack of job/employment[c]	Yes	137	65.9	30	55.6	69	63.9	1.973	0.373
	No	71	34.1	24	44.4	39	36.1		
Don't have transportation to see apartment[d]	Yes	135	65.2	32	60.4	66	60.6	0.872	0.647
	No	72	34.8	21	39.6	43	39.4		
Can't find or access the support or assistance you needed[e]	Yes	110	54.7	29	54.7	57	54.8	0.00	1.00
	No	91	45.3	24	45.3	47	45.2		
You have an addiction[f]	Yes	108	52.9	27	50.9	45	42.1	3.382	0.184
	No	96	47.1	26	49.1	62	57.9		
Don't have identification[g]	Yes	118	56.5	22	41.5	41	38.3	**10.729**	**0.005**
	No	91	43.5	31	58.5	66	61.7		
Discrimination – landlords won't rent to you because of your ethnicity, race, source of income or because you are homeless[h]	Yes	103	51.2	21	42.9	34	31.8	**10.773**	**0.005**
	No	98	48.8	28	57.1	73	68.2		
Don't have enough education, skills, training[i]	Yes	85	41.1	17	32.1	30	27.8	5.833	0.054
	No	122	58.9	36	67.9	78	72.2		
You have a criminal record – landlords won't rent to you[j]	Yes	69	33.3	15	28.3	29	27.1	1.465	0.481
	No	138	66.7	38	71.7	78	72.9		
Other[k]	Yes	60	31.6	12	23.5	27	25.2	2.064	0.356
	No	130	68.4	39	76.5	80	74.8		
A mental health condition[l]	Yes	50	24.0	11	20.4	25	23.1	0.324	0.850
	No	158	76.0	43	79.6	83	76.9		
Family or domestic instability[m]	Yes	42	20.5	9	17.3	29	26.9	2.427	0.297
	No	163	79.5	43	82.7	79	73.1		
A physical condition or disability[n]	Yes	53	25.6	8	15.1	15	13.9	**7.111**	**0.029**
	No	154	74.4	45	84.9	93	86.1		

Note. [a]*N* = 364, [b]*N* = 365, [c]*N* = 370, [d]*N* = 369, [e]*N* = 358, [f]*N* = 364, [g]*N* = 369, [h]*N* = 357, [i]*N* = 368, [j]*N* = 367, [k]*N* = 348, [l]*N* = 370, [m]*N* = 365, [n]*N* = 368.

[k]Other = Experiences of homelessness + Financial challenges + Landlord/Tenancy Issues (including lack of references) + personal challenges + safety issues/violence/abuse + appearance + your attitude or speaking up for yourself.

Bolded values indicate statistical significance, $p < 0.05$.

2.3.2.7 Housing following hospitalisation

Several questions were asked only of participants who had been hospitalised. Following a hospitalisation, arrangements for a place to stay were not made for half of the participants who had been hospitalised (50.3%). In comparison, arrangements were made for 34.0%, and arrangements were not necessary for 15.7% (see Table 1.22). The most common place to stay following a hospitalisation was a private residence (e.g., own place, wfriend, or relative's place) (45.7%), followed by an emergency shelter (27.2%), and the street (17.9%). Table 1.23 indicates that participants who were Indigenous (22.4%) were significantly less likely to stay at an emergency shelter than participants who were not Indigenous (38.9%) [$\chi_{(1)}^2 = 3.85$, $p = 0.05$]. A similar percentage of Indigenous and participants who were not Indigenous stayed at a private residence or were on the street following a hospitalisation. The survey also asked if participants were connected to needed community health supports after discharge. The majority (75.3%) were not connected with supports. There was no statistically significant difference between the Indigenous respondents and those who were not Indigenous in terms of connection with community health supports following a hospitalisation. Also, there was no statistically significant difference between the Indigenous groups regarding where they stayed after being discharged from the hospital (see Table 1.24).

Table 1.22: Arrangements made following a hospital stay by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Place to stay[a]	Yes	52	34.0	37	32.5	12	36.4	0.41	0.815
	No	77	50.3	59	51.8	15	45.5		
	Wasn't necessary	24	15.7	18	15.8	6	18.2		
Connected to community health supports (e.g. homecare or mental health supports)[b]	Yes	37	24.7	25	22.3	10	31.3	1.08	0.299
	No	113	75.3	87	77.7	22	68.8		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 153 (groups *N* = 147), [b]*N* = 150 (groups *N* = 144).
The number of participants who responded "wasn't necessary" was too small to report.
Due to small frequencies, the results for arrangements made following a hospitalisation (i.e., place to stay, connected to community health supports) could not be reported for the three groups.

Table 1.23: Places people went after being discharged from the hospital by Indigenous and not Indigenous groups.

Places	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Private residence	74	45.7	60	51.7	13	36.1	2.683	0.101
Emergency shelter	44	27.2	26	22.4	14	38.9	**3.85**	**0.050**
The street	29	17.9	22	19.0	5	13.9	0.49	0.486

Note. Groups = Indigenous + Not Indigenous.
N = 162 (groups *N* = 152).
Private Residence = Own place + Friend's place + Relative's place.
Treatment/Correctional Facility = Detox + Correctional Facility + Intoxicated Persons Detention Act + Treatment Centre.
Due to small frequencies the results for hotel and treatment/correctional facility could not be reported.
Bolded values indicate statistical significance, $p < 0.05$.

Table 1.24: Places people went after being discharged from the hospital by Indigenous identity.

Places	First Nations		Métis		Not Indigenous		χ²	*p*-value
	N	%	*N*	%	*N*	%		
Private residence[a]	45	51.7	13	48.1	13	36.1	2.50	0.287
Emergency shelter[b]	18	20.7	8	29.6	14	38.9	4.46	0.107

Note. [a]*N* = 152, [b]*N* = 150.

[a]Private Residence = Own place + Friend's place + Relative's place.

Due to small frequencies the results for hotel, treatment/correctional facility, and the street could not be reported.

2.3.3 Incarceration

Overall, 27.7% of the participants were incarcerated in the year prior to the survey (see Table 1.25). Although the percentage of Indigenous participants (29.3%) who were incarcerated was higher than the group who was not Indigenous (22.7%), the difference in percentages was not statistically significant [$\chi_{(1)}{}^2 = 1.70$, $p = 0.19$]. There was also no statistically significant difference in the percentages of First Nations (31.9%), Métis (20.4%), and other participants (22.7%) who were incarcerated [$\chi_{(2)}{}^2 = 4.67$, $p = 0.10$] (see Table 1.26).

The median length of time incarcerated in the year prior to the survey for the Indigenous and other group was 14 days, meaning that 50% of people in both groups spent 14 days or less incarcerated, while 50% spent more than 14 days incarcerated (see Table 1.27). The average number of days incarcerated for both groups was much more than 14 days, because some people in both groups were incarcerated for more than 14 days. Overall, there was not a statistically significant difference between the two groups in the number of days incarcerated [$z = 0.34$, p-value = 0.737]. There was also not a significant difference between the First Nations, Métis, and other groups in the number of days incarcerated [$H_{(2)} = 0.081$, p-value = 0.960]. Again, the median length of time for all three groups was 14 days, but the average number of days was much longer.

Table 1.25: Spent time incarcerated in the year prior to the survey by Indigenous and not Indigenous groups.

Response	Total		Indigenous		Not Indigenous		χ²	*p*-value
	N	%	*N*	%	*N*	%		
Yes	112	27.7	80	29.3	25	22.7	1.70	0.192
No	292	72.3	193	70.7	85	77.3		

Note. Total *N* = 404, Indigenous *N* = 273, Not Indigenous *N* = 110.

Table 1.26: Spent time incarcerated in the year prior to the survey by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ²	*p*-value
	N	%	*N*	%	*N*	%		
Yes	67	31.9	11	20.4	25	22.7	4.67	0.097
No	143	68.1	43	79.6	85	77.3		

Note. First Nations *N* = 210, Métis *N* = 54, Not Indigenous *N* = 110.

Table 1.27: Number of days in jail in the year prior to the survey by Indigenous identity.

Group	*N*	Mean	Standard Deviation	Median	IQR	Minimum	Maximum	95% Confidence Interval
Indigenous	80	66.22	100.04	14.00	87.00	1.00	365.00	43.96 to 88.48
First Nations	67	71.81	106.33	14.00	87.50	1.00	365.00	45.88 to 97.75
Métis	11	37.73	54.99	14.00	59.00	3.00	180.00	0.79 to 74.67
Not Indigenous	25	37.48	56.68	14.00	40.50	1.00	210.00	14.08 to 60.88

2.3.4 Hygiene

A substantial percentage of respondents had trouble, at least sometimes, accessing hygiene-related services, including a bathroom (36.6%), a place to bathe or shower (45.5%), and a place to wash their clothes (58.4%) (see Table 1.28). There were no statistically significant differences in percentages between the Indigenous group and the group who did not identify as Indigenous. However, as shown in Table 1.29, the Métis group was significantly less likely to have trouble accessing a bathroom (20.4%) and finding a place to bathe or shower (24.5%) than the First Nations group (39.4%; 48.6%) and the group who was not Indigenous (38.5%; 49.1%).

Table 1.28: Frequency having trouble accessing hygiene-related services by Indigenous and not Indigenous groups.

Issue	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Finding a bathroom to use[a]	Never / Rarely	249	63.4	175	64.6	67	61.5	0.33	0.569
	Sometimes / Usually / Always	144	36.6	96	35.4	42	38.5		
Finding a place to bathe or shower[b]	Never / Rarely	214	54.5	151	55.9	56	50.9	0.79	0.373
	Sometimes / Usually / Always	179	45.5	119	44.1	54	49.1		
Getting your clothes washed[c]	Never / Rarely	163	41.6	118	43.5	44	40.7	0.25	0.619
	Sometimes / Usually / Always	229	58.4	153	56.5	64	59.3		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 393 (groups *N* = 380), [b]*N* = 393 (groups *N* = 380), [c]*N* = 392 (groups *N* = 379).

Table 1.29: Frequency having trouble accessing hygiene-related services by Indigenous identity.

Issue	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Finding a bathroom to use[a]	Never / Rarely	126	60.6	43	79.6	67	61.5	**7.03**	**0.030**
	Sometimes/ Usually / Always	82	39.4	11	20.4	42	38.5		
Finding a place to bathe or shower[b]	Never / Rarely	107	51.4	40	75.5	56	50.9	**10.76**	**0.005**
	Sometimes/ Usually / Always	101	48.6	13	24.5	54	49.1		
Getting your clothes washed[c]	Never / Rarely	87	41.6	26	49.1	44	40.7	1.13	0.567
	Sometimes/ Usually / Always	122	58.4	27	50.9	64	59.3		

Note. [a]N = 371, [b]N = 371, [c]N = 370.
Bolded values indicate statistical significance, $p < 0.05$.

Individuals who got a period were asked what challenges they experience accessing pads or tampons; individuals could report more than one challenge. The following challenges were identified: shelters only provide one or two at a time (35.4%), pads and tampons are too expensive (32.9%), they have no place to store them (26.6%), and they are not supplied at the drop-in centres (17.7%) (see Table 1.30). There were no statistically significant differences between the groups; this may be due to a lack of statistical power. Due to small frequencies, the results for not having a place to store pads or tampons for the three groups could not be presented.

Table 1.30: Issues related to pads or tampons by Indigenous and not Indigenous groups.

Issue	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Shelter only provides you with one or two at a time	28	35.4	22	37.9	6	33.3	0.13	0.724
Pad/tampons too expensive	26	32.9	18	31.0	8	44.4	1.10	0.295
No place to store pads/ tampons	21	26.6	s		s			
Not supplied at drop in	14	17.7	8	13.8	6	33.3	3.49	0.062

Note. Respondents could select all that apply.
N = 79 (45 individuals who responded "No Periods/Not Applicable" are excluded from the total). Indigenous N = 58, Not Indigenous N = 18 (42 individuals who responded "No Periods/Not Applicable" are excluded from the total; 32 identified as Indigenous and 10 identified as not Indigenous). Individuals who identified as male and individuals who did not answer the question about gender were excluded from all the questions in this section of the survey (i.e., Women's/Female Health). Individuals who identified as "gender diverse" are included.
's' means the value was suppressed due to frequencies less than 5.

2.3.5 Safety and security

Participants were asked about their experiences of being injured and assaulted in the year prior to the survey. Physical assault (48.2%) was the most frequently reported form of injury, followed by sexual harassment (22.2%), being hit by a vehicle (12.2%), and being sexually assaulted or raped (7.5%) (see Table 1.31). Most people who were hit by a vehicle experienced this only once [median = 1, IQR = 1] (see Table 1.32). Of concern, almost half of the respondents (48.2%) indicated they had been physically assaulted; many of whom were assaulted more than once (median = 2, IQR = 2), often by someone they knew (63.8%) or by a stranger (68.7%). Some respondents reported being physically assaulted many times (a maximum of 60).

These experiences of injury and assault did not vary by Indigenous identity. That is, there were no statistically significant differences between the Indigenous and not Indigenous groups or between the First Nations, Métis, and not Indigenous groups (see Tables 1.31 to 1.34).

Table 1.31: Injury, accident, and assault by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Hit by a car, bicycle, truck or transit bus[a]	Yes	47	12.2	32	12.0	14	13.0	0.06	0.803
	No	338	87.8	234	88.0	94	87.0		
Physically assaulted[b]	Yes	185	48.2	124	46.4	54	50.5	0.50	0.481
	No	199	51.8	143	53.6	53	49.5		
Perpetrator of physical assault	Someone they knew*[c]	111	63.8	72	61.5	34	66.7	0.40	0.526
	Stranger[d]	125	68.7	85	69.7	34	64.2	0.52	0.472
Sexually harassed[e]	Yes	83	22.2	56	21.5	23	21.9	0.01	0.939
	No	291	77.8	204	78.5	82	78.1		
Sexually assaulted or raped[f]	Yes	28	7.5	17	6.6	9	8.7	0.49	0.485
	No	344	92.5	242	93.4	95	91.3		

Note. Respondents could select all that apply for the Perpetrator of physical assault question.

Groups = Indigenous + Not Indigenous.

[a]*N* = 385 (groups *N* = 374), [b]*N* = 384 (groups *N* = 374), [c]*N* = 174 (Indigenous *N* = 117, Not Indigenous *N* = 51), [d]*N* = 182 (Indigenous *N* = 122, Not Indigenous *N* = 53), [e]*N* = 374 (groups *N* = 365), [f]*N* = 372 (groups *N* = 363).

*Someone they knew includes acquaintances, family members, and spouse / partner / boyfriend / girlfriend.

Table 1.32: Statistics describing the number of injury and assault experiences in the year prior to the survey by Indigenous and not Indigenous groups.

Source of Injury	Group	*N*	Mean	SD	Median	IQR	Minimum	Maximum	*Z*[a]	*p*-value
Number of times hit by a car, bicycle, truck or transit bus	Total	46	1.46	0.69	1.00	1.00	1.00	3.00		
	Indigenous	32	1.34	0.60	1.00	1.00	1.00	3.00	1.57[a]	0.115
	Not Indigenous	14	1.71	0.83	1.50	1.25	1.00	3.00		
Number of times been physically assaulted	Total	168	4.05	7.73	2.00	2.00	1.00	60.00		
	Indigenous	112	3.94	7.18	2.00	2.00	1.00	60.00	0.67	0.502
	Not Indigenous	51	4.31	9.16	2.00	2.00	1.00	50.00		

Note. [a]Mann-Whitney U test (Z statistic).

Table 1.33: Injury, accident, and assault by Indigenous identity.

Variable	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Hit by a car, bicycle, truck or transit bus[a]	Yes	21	10.3	11	20.8	14	13.0	4.20	0.123
	No	183	89.7	42	79.2	94	87.0		
Physically assaulted[b]	Yes	101	49.0	21	41.2	54	50.5	1.28	0.527
	No	105	51.0	30	58.8	53	49.5		
Perpetrator of physical assault	Someone they knew[*c]	57	60.0	13	68.4	34	66.7	0.90	0.637
	Stranger[d]	68	67.3	16	84.2	34	64.2	2.68	0.262
Sexually harassed[e]	Yes	48	24.2	5	9.4	23	21.9	5.49	0.064
	No	150	75.8	48	90.6	82	78.1		
Sexually assaulted or raped[f]	Yes	11	5.6	s	s	9	8.7	E < 5	
	No	187	94.4	s	s	95	91.3		

Note. [a]*N* = 365, [b]*N* = 364, [c]*N* = 165, [d]*N* = 173, [e]*N* = 356, [f]*N* = 354.

Respondents could select all the apply for Perpetrator of physical assault question.

[a]First Nations *N* = 95, Métis *N* = 19, Not Indigenous *N* = 51, [b]First Nations *N* = 101, Métis *N* = 19, Not Indigenous *N* = 53.

[*a] Someone they knew includes acquaintances, family members, and spouse / partner / boyfriend / girlfriend.

's' means the value was suppressed due to frequencies less than 5.

E < 5 means at least one of the expected counts is less than 5. A condition to performing a chi-square test is the expected values must be 5 or greater; if any are less than 5, the chi-square test should not be performed.

Table 1.34: Statistics describing the number of experiences of injury and assault by Indigenous identity.

Source of Injury	Group	N	Mean	SD	Median	IQR	Minimum	Maximum	Kruskall Wallis H	*p*-value
Number of times hit by a car, bicycle, truck or transit bus	First Nations	22	1.36	0.58	1.00	1.00	1.00	3.00	2.69	0.260
	Métis	10	1.30	0.67	1.00	0.25	1.00	3.00		
	Not Indigenous	14	1.71	0.83	1.50	1.25	1.00	3.00		
Number of times been physically assaulted	First Nations	92	3.74	6.85	2.00	2.00	1.00	60.00	0.63	0.728
	Métis	19	5.00	8.91	2.00	3.00	1.00	40.00		
	Not Indigenous	51	4.31	9.16	2.00	2.00	1.00	50.00		

2.3.6 Food

More than half of the participants (54.3%) experienced hunger at least once a week in the month prior to completing the survey (see Table 1.35). Table 1.36 reveals the First Nations group (61.1%) was significantly more likely to report this than the Métis group (40.4%) and the group who did not identify as Indigenous (48.6%).

Table 1.35: Frequency of being hungry in the last month because could not get enough food by Indigenous and not Indigenous groups.

Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Everyday/ At least a couple of days a week/ At least one day a week	213	54.3	150	55.8	53	48.6	1.59	0.207
At least one day a month/ Rarely/ Never	179	45.7	119	44.2	56	51.4		

Note. Groups = Indigenous + Not Indigenous.
N = 392 (groups *N* = 378).

Table 1.36: Frequency of being hungry in the last month because could not get enough food by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Everyday/ At least a couple of days a week/ At least one day a week	127	61.1	21	40.4	53	48.6	**9.30**	**0.010**
At least one day a month/ Rarely/ Never	81	38.9	31	59.6	56	51.4		

Note. N = 369.
Bolded values indicate statistical significance, $p < 0.05$.

2.3.7 Physical health conditions

Survey participants were asked about medical conditions in three ways — lifetime experiences, conditions in the year prior to the survey, and current conditions. The specific medical conditions asked about in each time frame differed.

2.3.7.1 Self-reported conditions over the lifetime

Overall, 9.6% and 7.5% of participants had a stroke or heart attack, respectively, in their lifetime (see Table 1.37). There were no significant differences between the groups (see Table 1.38).

Table 1.37: Experienced a stroke or heart attack (lifetime) by Indigenous and not Indigenous groups.

Health event	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
A stroke[a]	Yes	38	9.6	28	10.5	9	8.3	0.40	0.527
	No	357	90.4	239	89.5	99	91.7		
A heart attack[b]	Yes	30	7.5	19	7.0	9	8.4	0.22	0.640
	No	368	92.5	252	93.0	98	91.6		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 395 (groups *N* = 375), [b]*N* = 398 (groups *N* = 378).

Table 1.38: Experienced a stroke (lifetime) by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	19	9.3	9	17.0	9	8.3	3.29	0.193
No	186	90.7	44	83.0	99	91.7		

[a]*N* = 366.
Due to small frequencies, the results for lifetime experiences of a heart attack are not presented.

2.3.7.2 Self-reported physical and cognitive health conditions experienced in the year prior to the survey

Participants were asked whether they had experienced any of 10 different medical conditions which were grouped into six categories — seizures (10.9%), bed bug bites (56.0%), skin infections or sores (33.8%), problems with their feet (56.7%), respiratory-related conditions (61.1%), and sexually transmitted infections (17.5%) — in the year prior to the survey (see Table 1.39). The groups only differed on skin infections, sores, or ulcers [$\chi_{(1)}^2 = 7.21$, $p = 0.007$]. Specifically, reporting of skin infections was significantly more common among the group who were not Indigenous (44.0%) than the Indigenous group (29.6%). While the difference in the proportion of individuals who experienced feet problems was not significant between the Indigenous (55.3%) and not Indigenous groups (60.9%) [$\chi_{(1)}^2 = 1.00$, $p = 0.32$], there was a significant difference when comparing the three groups [$\chi_{(2)}^2 = 8.69$, $p = 0.01$] (see Tables 1.39 and 1.40). That is, Métis participants (38.9%) were significantly less likely to report problems with their feet than the First Nations (60.0%) and not Indigenous (60.9%) participants.

Table 1.39: Medical conditions experienced in the year before the survey by Indigenous and not Indigenous groups.

Medical Conditions	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Respiratory-Related Condition[a]	Yes	242	61.1	162	60.4	67	62.0	0.08	0.775
	No	154	38.9	106	39.6	41	38.0		
Problems with your feet[b]	Yes	229	56.7	151	55.3	67	60.9	1.00	0.317
	No	175	43.3	122	44.7	43	39.1		
Bed bug bites[c]	Yes	223	56.0	152	56.9	60	54.5	0.18	0.672
	No	175	44.0	115	43.1	50	45.5		
Skin infection, skin sores or ulcers[d]	Yes	135	33.8	80	29.6	48	44.0	**7.21**	**0.007**
	No	264	66.2	190	70.4	61	56.0		
Sexually Transmitted Infection (does not include HIV/AIDS)[e]	Yes	69	17.5	48	17.8	17	16.2	0.14	0.705
	No	326	82.5	221	82.2	88	83.8		
A seizure[f]	Yes	44	10.9	33	12.1	10	9.2	0.66	0.416
	No	358	89.1	240	87.9	99	90.8		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 396 (groups *N* = 376), [b]*N* = 404 (groups *N* = 383), [c]*N* = 398 (groups *N* = 377), [d]*N* = 399 (groups *N* = 379), [e]*N* = 395 (groups *N* = 374), [f]*N* = 402 (groups *N* = 382).

[a]Respiratory-related Condition = Tuberculosis (active disease, where you are sick) + Pneumonia + Chest infection, cold, cough, bronchitis.

[e]Sexually Transmitted Infection = Chlamydia + Gonorrhea + Syphilis + Other STDs (other than HIV/AIDS).

Bolded values indicate statistical significance, $p < 0.05$.

Table 1.40: Medical conditions experienced in the year before the survey by Indigenous identity.

Medical Conditions	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Respiratory-Related Condition[a]	Yes	126	60.9	29	54.7	67	62.0	0.85	0.652
	No	81	39.1	24	45.3	41	38.0		
Problems with your feet[b]	Yes	126	60.0	21	38.9	67	60.9	**8.69**	**0.013**
	No	84	40.0	33	61.1	43	39.1		
Bed bug bites[c]	Yes	122	59.2	26	50.0	60	54.5	1.69	0.430
	No	84	40.8	26	50.0	50	45.5		
Skin infection, skin sores or ulcers[d]	Yes	60	28.7	19	35.8	48	44.0	**7.55**	**0.023**
	No	149	71.3	34	64.2	61	56.0		
Sexually Transmitted Infection (does not include HIV/AIDS)[e]	Yes	39	18.8	8	15.4	17	16.2	0.51	0.775
	No	169	81.3	44	84.6	88	83.8		
A seizure[f]	Yes	27	12.9	4	7.4	10	9.2	1.82	0.402
	No	183	87.1	50	92.6	99	90.8		

Note. [a]*N* = 368, [b]*N* = 374, [c]*N* = 368, [d]*N* = 371, [e]*N* = 365, [f]*N* = 373.
[a]Respiratory-related Condition = Tuberculosis (active disease, where you are sick) + Pneumonia + Chest infection, cold, cough, bronchitis.
[e]Sexually Transmitted Infection = Chlamydia + Gonorrhea + Syphilis + Other STDs (other than HIV/AIDS).
Bolded values indicate statistical significance, $p < 0.05$.

2.3.7.3 Self-reported current general health conditions

Survey participants were presented with a list of 34 different physical health and cognitive conditions and asked to indicate which, if any, they currently had. Most respondents (89.3%) indicated they had at least one of the 29 physical health conditions and 40.8% indicated they had at least one of the five cognitive conditions (see Table 1.41). The health conditions were grouped into 16 categories based on body systems. There were significant differences between the groups for six categories of health conditions — three of which were more common among Indigenous participants and three were more common among the other participants. A significantly higher percentage of Indigenous participants reported Anaemia, Fetal Alcohol Spectrum/Syndrome Disorder, and Acquired Brain Injury than participants who were not Indigenous. Participants who were not Indigenous (38.4%) were twice as likely to report having a mental, behavioural, or neurodevelopmental disorder (e.g., Autism, Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, Dyslexia) than Indigenous participants (18.3%). Additionally, participants who were not Indigenous were significantly more likely to report diseases of the digestive system (e.g., Cirrhosis (damaged liver), other liver problems, or stomach or intestinal ulcers) as well as skin diseases compared to Indigenous participants. The finding for skin diseases is consistent with the results reported earlier for skin infections, sores, and ulcers. Although significant differences existed among the First Nations, Métis, and not Indigenous groups, there were no consistent patterns for current health conditions (see Table 1.42).

Table 1.41: Current health conditions by Indigenous and not Indigenous groups.

Health Conditions	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Arthritis, rheumatism, joint problems (Diseases of the musculoskeletal system and connective tissue)[a]	Yes	205	51.8	136	50.6	57	52.8	0.15	0.697
	No	191	48.2	133	49.4	51	47.2		
Diseases of the Respiratory system[b]	Yes	173	43.6	120	44.1	42	39.6	0.63	0.428
	No	224	56.4	152	55.9	64	60.4		
Diseases of the Nervous System[c]	Yes	153	38.5	108	40.4	38	34.5	1.14	0.285
	No	244	61.5	159	59.6	72	65.5		
Diseases of the Circulatory System[d]	Yes	138	36.1	96	37.1	34	33.0	0.53	0.468
	No	244	63.9	163	62.9	69	67.0		
Problem walking, lost limb, other physical handicap[e]	Yes	135	33.9	86	32.0	40	36.7	0.78	0.377
	No	263	66.1	183	68.0	69	63.3		
Hearing problems (Diseases of the ear and Mastoid Process)[f]	Yes	96	24.4	58	21.8	32	29.6	2.57	0.109
	No	298	75.6	208	78.2	76	70.4		
Mental, Behavioral, Neurodevelopmental disorders[g]	Yes	90	24.4	46	18.3	38	38.4	**15.82**	**<0.001**
	No	279	75.6	206	81.7	61	61.6		
Eye or vision problems (other than needing glasses) (Diseases of the eye)[h]	Yes	77	19.6	51	19.3	23	21.1	0.15	0.695
	No	315	80.4	213	80.7	86	78.9		
Skin disease, like eczema or psoriasis (Diseases of the skin and subcutaneous tissue)[i]	Yes	76	19.0	41	15.2	31	28.2	**8.60**	**0.003**
	No	323	81.0	229	84.8	79	71.8		
Infectious and Parasitic diseases[j]	Yes	74	19.8	52	20.4	16	16.2	0.82	0.364
	No	300	80.2	203	79.6	83	83.8		
Diseases of the Digestive System[k]	Yes	74	20.0	41	16.5	27	26.5	**4.64**	**0.031**
	No	296	80.0	208	83.5	75	73.5		
Anaemia (Diseases of the Blood)[l]	Yes	54	14.4	44	17.3	9	8.8	**4.10**	**0.043**
	No	321	85.6	211	82.7	93	91.2		
Acquired Brain Injury (Injury, poisoning, and certain other consequences of external causes)[m]	Yes	52	13.8	42	16.3	8	7.8	**4.40**	**0.036**
	No	325	86.2	215	83.7	94	92.2		
Fetal Alcohol Syndrome/Spectrum disorder (Congenital malformations, deformations, and chromosomal abnormalities)[n]	Yes	45	11.9	39	15.6	s	S	**14.22**	**<0.001**
	No	334	88.1	211	84.4	s	S		
Diabetes (Endocrine, Nutritional, and Metabolic diseases)[o]	Yes	39	10.4	30	12.0	7	6.5	2.44	0.119
	No	336	89.6	219	88.0	100	93.5		
Cancer (Neoplasms)[p]	Yes	12	3.1	7	2.7	4	3.8	0.35	0.555
	No	377	96.9	257	97.3	101	96.2		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 396 (groups *N* = 377), [b]*N* = 397 (groups *N* = 378), [c]*N* = 397 (groups *N* = 377), [d]*N* = 382 (groups *N* = 362), [e]*N* = 398 (groups *N* = 378), [f]*N* = 394 (groups *N* = 374), [g]*N* = 369 (groups *N* = 351), [h]*N* = 392 (groups *N* = 373), [i]*N* = 399 (groups *N* = 380), [j]*N* = 374 (groups *N* = 354), [k]*N* =

370 (groups N = 351), [l]N = 375 (groups N = 357), [m]N = 377 (groups N = 359), [n]N = 379 (groups N = 250), [o]N = 375 (groups N = 356), [p]N = 389 (groups N = 369).

[b]Diseases of the Respiratory system = Chronic Bronchitis or emphysema (COPD) + Asthma + Environmental or seasonal allergies.

[c]Diseases of the Nervous System = Epilepsy + Migraine Headaches.

[d]Diseases of the Circulatory System = High blood pressure or hypertension + Heart disease + Angina (chest pain or discomfort) + Congestive heart failure (CHF) + Effects of a stroke including paralysis or speech problems

[g]Mental, Behavioral, Neurodevelopmental disorders = Autism + Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder + Dyslexia.

[j]Infectious and Parasitic diseases = Tuberculosis (inactive infection, i.e. told that you had the TB germ, but it isn't making you sick) + Hepatitis B + Hepatitis C + Hepatitis (don't know type) + HIV+ + AIDS + Herpes + Genital Warts (HPV).

[k]Diseases of the Digestive System = Cirrhosis (e.g. damaged liver) + Other problems with your liver + Stomach or intestinal ulcers.

Due to small frequencies, the results for Fetal Alcohol Syndrome/Spectrum disorder for the not Indigenous group cannot be presented.

Bolded values indicate statistical significance, $p < 0.05$.

's' means the value was suppressed due to frequencies less than 5.

Table 1.42: Current health conditions by Indigenous identity.

Health Conditions	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Arthritis, rheumatism, joint problems (Diseases of the musculoskeletal system and connective tissue)[a]	Yes	111	53.9	20	37.0	57	52.8	5.03	0.081
	No	95	46.1	34	63.0	51	47.2		
Diseases of the Respiratory system[b]	Yes	91	43.3	25	46.3	42	39.6	0.73	0.694
	No	119	56.7	29	53.7	64	60.4		
Diseases of the Nervous System[c]	Yes	82	40.0	22	41.5	38	34.5	1.12	0.571
	No	123	60.0	31	58.5	72	65.5		
Diseases of the Circulatory System[d]	Yes	74	37.0	22	42.3	34	33.0	1.32	0.518
	No	126	63.0	30	57.7	69	67.0		
Problem walking, lost limb, other physical handicap[e]	Yes	71	34.5	14	25.9	40	36.7	1.94	0.379
	No	135	65.5	40	74.1	69	63.3		
Hearing problems (Diseases of the ear and Mastoid Process)[f]	Yes	44	21.5	11	20.8	32	29.6	2.91	0.233
	No	161	78.5	42	79.2	76	70.4		
Mental, Behavioral, Neurodevelopmental disorders[g]	Yes	33	17.1	12	23.5	38	38.4	**16.18**	**<0.001**
	No	160	82.9	39	76.5	61	61.6		
Eye or vision problems (other than needing glasses) (Diseases of the eye)[h]	Yes	41	20.3	9	16.7	23	21.1	0.47	0.791
	No	161	79.7	45	83.3	86	78.9		
Skin disease, like eczema or psoriasis (Diseases of the skin and subcutaneous tissue)[i]	Yes	30	14.5	8	14.8	31	28.2	**9.49**	**0.009**
	No	177	85.5	46	85.2	79	71.8		
Infectious and Parasitic diseases[j]	Yes	45	23.1	7	13.5	16	16.2	3.47	0.176
	No	150	76.9	45	86.5	83	83.8		
Diseases of the Digestive System[k]	Yes	34	18.0	7	13.2	27	26.5	4.70	0.095
	No	155	82.0	46	86.8	75	73.5		
Anaemia (Diseases of the Blood)[l]	Yes	37	18.8	s	s	9	8.8	**7.47**	0.024
	No	160	81.2	s	s	93	91.2		
Acquired Brain Injury (Injury, poisoning, and certain other consequences of external causes)[m]	Yes	34	17.3	6	11.5	8	7.8	5.28	0.071
	No	163	82.7	46	88.5	94	92.2		
Fetal Alcohol Syndrome/Spectrum disorder (Congenital malformations, deformations, and chromosomal abnormalities)[n]	Yes	34	17.8	6	11.5	s	s	**16.84**	**<0.001**
	No	157	82.2	46	88.5	s	s		
Diabetes (Endocrine, Nutritional, and Metabolic diseases)[o]	Yes	25	13.0	5	9.8	7	6.5	3.09	0.214
	No	167	87.0	46	90.2	100	93.5		

Note. [a]*N* = 368, [b]*N* = 370, [c]*N* = 368, [d]*N* = 355, [e]*N* = 369, [f]*N* = 366, [g]*N* = 343, [h]*N* = 365, [i]*N* = 371, [j]*N* = 346, [k]*N* = 344, [l]*N* = 299, [m]*N* = 351, [n]*N* = 243, [o]*N* = 350.
[b]Diseases of the Respiratory system = Chronic Bronchitis or emphysema (COPD) + Asthma + Environmental or seasonal allergies.
[c]Diseases of the Nervous System = Epilepsy + Migraine Headaches.
[d]Diseases of the Circulatory System = High blood pressure or hypertension + Heart disease + Angina (chest pain or discomfort) + Congestive heart failure (CHF) + Effects of a stroke including paralysis or speech problems.
[g]Mental, Behavioral, Neurodevelopmental disorders = Autism + Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder + Dyslexia.
[j]Infectious and Parasitic diseases = Tuberculosis (inactive infection, i.e. told that you had the TB germ, but it isn't making you sick) + Hepatitis B + Hepatitis C + Hepatitis (don't know type) + HIV+ + AIDS + Herpes + Genital Warts (HPV).
[k]Diseases of the Digestive System = Cirrhosis (e.g. damaged liver) + Other problems with your liver + Stomach or intestinal ulcers.
Due to small frequencies, the results for Cancer could not be presented.
Bolded values indicate statistical significance, $p < 0.05$.
's' means the value was suppressed due to frequencies less than 5.

2.3.8 Health services

Less than one-quarter (21.9%) of participants indicated they do not have *one* place to go when sick or in need of health advice; the percentages were similar across the groups (see Table 1.43). Participants who indicated they did not have *one* place to go were asked to identify the *two* main reasons for this (Indigenous, *N* = 54; Not Indigenous, *N* = 29). The most common reason was they do not seek healthcare (47.6%) because they seldom or never get sick, or they do not go to doctors. The next most common reason was access challenges (29.3%) due to not having a health card, not having a telephone number and/or an address, not having access to transportation, the wait time to get an appointment is too long, and/or the clinic hours are inconvenient. Other reasons included: they go to different places (i.e., they do not have one place) (18.3%), they do not have a doctor (15.9%), they have had a negative experience in the past (15.9%), they are too busy addressing their basic needs (13.4%), they move around a lot (13.4%), and they recently moved to Winnipeg (9.8%). Due to small frequencies, the groups could not be compared for most of the reasons.

Table 1.43: Two main reasons participants do not have a medical professional, or place, that they usually go to when they are sick or need advice about health.

Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	N	%		
Doesn't seek out healthcare[a]	39	47.6	23	47.9	13	44.8	0.07	0.792
Challenges with access[b]	24	29.3	15	31.3	9	31.0	0.00	0.984
Goes to different places[c]	15	18.3	5	10.4	9	31.0	**5.17**	**0.023**
Doesn't have a doctor[d]	13	15.9						
Negative experiences in the past	13	15.9						
Moves around a lot[e]	11	13.4						
Too busy finding food, shelter, or other necessities	11	13.4						
Recently moved into the Winnipeg area	8	9.8						

Note. Respondents could select all that apply.
Groups = Indigenous + Not Indigenous.
N = 82 (groups *N* = 77), (Only includes individuals who answered 'no' to having one particular medical professional or place they usually go when they are sick or need medical advice.).
[a]Doesn't seek out healthcare = seldom or never get sick + don't use doctors / treat myself.
[b]Challenges with Access = Don't have a health card + Don't have a telephone number and/or address + Have no transportation + The wait for an appointment is too long + Clinic hours are inconvenient.
[c]Goes to different places = Like to go to different places for different health needs + goes wherever is convenient + goes the Emergency Department.
[d]Doesn't have a doctor = don't know where to go for care + doctor retired + doesn't have a doctor.
[e]Moved around a lot = moved around within Winnipeg and between communities.
Due to small frequencies, the results for doesn't have a doctor, negative experiences in the past, moves around a lot, recently moved into the Winnipeg area, and too busy finding food, shelter, or other necessities could not be reported.
Bolded values indicate statistical significance, $p < 0.05$.

The survey asked two questions about where participants go for healthcare. One question asked about the *usual* source of care and the other question asked about accessing health care in the year prior to the survey. A doctor's office was the most common response for both usual source (60.3%) and source of health care in the year prior to the survey (60.7%); this was the most common source of health care for all the groups (see Tables 1.44 to 1.47). The next most common usual source of health care (43.9%) and source of health care in the year prior to the survey (57.7%) was a hospital emergency department. Indigenous participants (47.6%) were significantly more likely to report a hospital emergency department as their usual source of care than participants who were not Indigenous (35.5%) [$\chi_{(1)}^2 = 4.68$, $p = 0.03$]; however, there were no differences between the groups in visiting a hospital emergency department in the year prior to the survey.

There were no significant differences between the groups on any of the other usual sources of care, except for Access Centres. Overall, 23.6% of respondents reported they usually received care at an Access Centre; the percentage was similar for Indigenous (22.9%) and participants who were not Indigenous (24.5%). However, Métis participants (36.5%) were more significantly likely to use Access Centres than First Nations participants (19.5%). There were no differences between the groups for where they accessed healthcare in the year prior to the survey, except for the Aboriginal Health and Wellness Centre and a traditional healer or Elder. Not surprisingly, these were used by higher percentages of Indigenous participants than participants who were not Indigenous.

Table 1.44: Usual sources of healthcare by Indigenous and not Indigenous groups.

Sources of Healthcare	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	N	%		
Doctor's Office	243	60.3	165	60.9	65	59.1	0.11	0.746
Hospital Emergency Room	177	43.9	129	47.6	39	35.5	**4.68**	**0.030**
Community Health Centre (e.g., Health Action Centre, Women's Health Clinic, Mount Carmel, Nine Circles, Klinic, Aboriginal Health and Wellness)	149	37.0	105	38.7	37	33.6	0.87	0.350
Aboriginal Health and Wellness[a]	15	10.1						
Klinic[a]	12	8.1						
Mount Carmel Clinic[a]	53	35.6						
Nine Circles[a]	18	12.1						
Women's Health Centre[a]	4	2.7						
Health Clinic at a shelter, drop-in (e.g., Siloam, RaY, Main Street Project)	131	32.5	95	35.1	30	27.3	2.15	0.143
Access Centre (e.g., Access Downtown, Access NorWest, Access Transcona)	95	23.6	62	22.9	27	24.5	0.12	0.727
Hospital Outpatient Department	72	17.9	55	20.3	14	12.7	3.02	0.082
Other Sources[a]	24	6.0	17	6.3	6	5.5	0.09	0.761
Walk-in Clinic	12	3.0						
Does Not Seek Care/Has Not Sought Care	9	2.2						
Traditional Healer or Elder	5	1.2						
Psychiatric Facility	5	1.2						

Note. Groups = Indigenous + Not Indigenous.
N = 403 (groups *N* = 381), [a]*N* = 149.
Other Sources = Alternative health centre + Bath House + Chiropractor + Health Links + Meditation + Non-Clinical Community Organization + Pharmacy + Self + Street Connections + Rural Health Clinic or Nursing Station
Due to small frequencies, the results for walk-in clinic, traditional healer or Elder, psychiatric facility, and not seeking health care could not be reported.
Bolded values indicate statistical significance, $p < 0.05$.

Table 1.45: Usual sources of healthcare by Indigenous identity.

Sources of Healthcare	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Doctor's Office	130	61.9	32	61.5	65	59.1	0.25	0.884
Hospital Emergency Room	104	49.5	22	42.3	39	35.5	5.89	0.053
Community Health Centre (e.g., Health Action Centre, Women's Health Clinic, Mount Carmel, Nine Circles, Klinic, Aboriginal Health and Wellness	83	39.5	18	34.6	37	33.6	1.23	0.540
Health Clinic at a shelter, drop-in (e.g., Siloam, RaY, Main Street Project)	75	35.7	20	38.5	30	27.3	2.95	0.229
Access Centre (e.g., Access Downtown, Access NorWest, Access Transcona)	41	19.5	19	36.5	27	24.5	**6.85**	**0.033**
Hospital Outpatient Department	42	20.0	13	25.0	14	12.7	4.19	0.123

Note. $N = 372$.

Due to small frequencies, the results for walk-in clinic, traditional healer or Elder, psychiatric facility, not seeking health care, and other sources could not be reported.

Bolded values indicate statistical significance, $p < 0.05$.

Table 1.46: Sources of healthcare in the year before the survey by Indigenous and not Indigenous groups.

Source of Healthcare	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Doctor's Office[a]	241	60.7	162	60.2	64	58.7	0.07	0.787
Hospital Emergency Room[a]	229	57.7	157	58.4	61	56.0	0.18	0.669
Community Health Centre (e.g., Health Action Centre, Women's Health Clinic, Mount Carmel, Nine Circles, Klinic, Aboriginal Health and Wellness)[b]	127	32.2	82	30.6	38	35.2	0.75	0.388
Doctor or nurse in a shelter, resource centre, drop-in or other programme[c]	120	30.2	78	28.8	37	33.9	0.98	0.322
Hospital where you stayed at least 1 night (not counting the ED)[a]	119	30.0	88	32.6	26	24.1	2.66	0.103
Access Centre (e.g., Access Downtown)[a]	90	22.7	55	20.4	31	28.4	2.82	0.093
Hospital Outpatient Department (e.g., HSC)[d]	69	17.5	46	17.3	19	17.4	0.00	0.974
Traditional Healer or Elder[e]	54	13.7	47	17.5	s	s	10.76	**0.001**
Aboriginal Health and Wellness Centre[f]	24	6.1	22	8.1	s	s	6.85	**0.009**
Other sources[g]	14	4.0						
Alternative Health Centre (e.g., naturopath, Chinese medicine clinic)[h]	6	1.5						

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 397 (Groups *N* = 378), [b]*N* = 394 (Groups *N* = 376), [c]*N* = 398 (Groups *N* = 380), [d]*N* = 394 (Groups *N* = 375), [b]*N* = 395 (Groups *N* = 376), [f]*N* = 396 (Groups *N* = 377), [g]*N* = 353. [h]*N* = 391.

[g]Other Sources = Correctional facility + Emergency Medical Services/Paramedics + Non-Clinical Community Organization + Pharmacy + Rural Health Clinic or Nursing Station + Self + Spiritual Professional.
Due to small frequencies, the results for Psychiatric Health Facility could not be reported.
Due to small frequencies, the results for alternative health centre, psychiatric health facility, and other sources could not be reported.
's' means the value was suppressed due to frequencies less than 5.
Bolded values indicate statistical significance, $p < 0.05$.

Table 1.47: Sources of healthcare in the year before the survey by Indigenous identity.

Source of Healthcare	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Doctor's Office[a]	124	60.2	33	61.1	64	58.7	0.10	0.949
Hospital Emergency Room[a]	122	58.7	31	59.6	61	56.0	0.28	0.870
Community Health Centre (e.g., Health Action Centre, Women's Health Clinic, Mount Carmel, Nine Circles, Klinic, Aboriginal Health and Wellness)[b]	58	28.3	18	33.3	38	35.2	1.72	0.423
Doctor or nurse in a shelter, resource centre, drop-in or other programme[c]	58	27.8	19	35.8	37	33.9	2.05	0.358
Hospital where you stayed at least 1 night (not counting the ED)[d]	68	32.7	18	33.3	26	24.1	2.78	0.249
Access Centre (e.g., Access Downtown)[a]	38	18.4	15	27.8	31	28.4	4.95	0.084
Hospital Outpatient Department (e.g., HSC)[a]	35	17.2	10	18.5	19	17.4	0.06	0.973
Traditional Healer or Elder[c]	36	17.5	9	17.0	*s*	*s*	**10.53**	**0.005**

Note. [a]N = 369, [b]N = 367, [c]N = 371, [d]N = 370.

Other Sources = Correctional facility + Emergency Medical Services/Paramedics + Non-Clinical Community Organization + Pharmacy + Rural Health Clinic or Nursing Station + Self + Spiritual Professional.

Due to small frequencies, the results for Aboriginal Health and Wellness Centre, alternative health centre, psychiatric health facility, and other sources could not be reported.

's' means the value was suppressed due to frequencies less than 5.

Bolded values indicate statistical significance, $p < 0.05$.

One hundred fifty-six (156) participants (38.4%) visited an emergency department for an emergency reason — not for a scheduled appointment (see Table 1.48). More than half of whom went because they had an injury (55.9%) or a physical health problem other than an injury (53.9%). Métis participants (78.3%) were significantly more likely to go to an emergency room for a physical health problem (other than an injury) than First Nations participants (52.5%) and participants who were not Indigenous (45.9%) (see Table 1.49). More than one-quarter of participants went to an emergency department because they had a mental health concern (29.6%) or needed a place to get warm, sleep, or food (29.6%). Other reasons for going to an emergency department were to get a prescription refill (23.7%), were forced to go against their will (19.1%), to detox (14.5%), and had a toothache or dental problem (11.2%). There were no differences between the groups on any of the reasons for visiting an emergency department (except a physical health reason as mentioned above).

Table 1.48: Reasons for going to the emergency room in the year before the survey by Indigenous and not Indigenous groups[a].

Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
An injury	85	55.9	62	59.0	19	51.4	0.66	0.42
A physical problem, other than an injury	82	53.9	61	58.1	17	45.9	1.63	0.20
A mental health concern	45	29.6	27	25.7	14	37.8	1.96	0.16
Needed a place to get warm, food, or a place to sleep	45	29.6	33	31.4	8	21.6	1.28	0.258
A prescription refill	36	23.7	28	26.7	5	13.5	2.65	0.103
You were forced to go against your will	29	19.1	21	20.0	7	18.9	0.02	0.887
To detox	22	14.5	14	13.3	6	16.2	0.19	0.665
A toothache or dental problem	17	11.2						

Note. Groups = Indigenous + Not Indigenous.
N = 152 (groups *N* = 142).
[a]To be included, had to have indicated they spent at least one night in an Emergency Room for an emergency (i.e., not scheduled).
Due to small frequencies, the results for a toothache or dental problem could not be reported.

Table 1.49: Reasons for going to the emergency room in the year before the survey by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
An injury	47	58.8	13	56.5	19	51.4	0.56	0.755
A physical problem, other than an injury	42	52.5	18	78.3	17	45.9	**6.46**	**0.040**
A mental health concern	22	27.5	5	21.7	14	37.8	2.06	0.357
Needed a place to get warm, food, or a place to sleep	27	33.8	6	26.1	8	21.6	1.93	0.380
A prescription refill	19	23.8	8	34.8	5	13.5	3.72	0.155

Note. *N* = 140.
To be included, had to have indicated they spent at least one night in an Emergency Room for an emergency (i.e., not scheduled).
Due to small frequencies, the results for a toothache or dental problem, to detox, and were forced against their will could not be reported.
Bolded values indicate statistical significance, $p < 0.05$.
's' means the value was suppressed due to frequencies less than 5.

2.3.9 Preventive healthcare

Survey participants were asked "When was the last time you had a physical check-up without having a specific health problem (i.e., complete physical). Complete physicals are recommended on an annual basis. Overall, 39.5% of respondents reported they had a physical check-up in the year prior to the survey (see Table 1.50). The Indigenous respondents (43.5%) were significantly more likely to report having had a physical check-up in the year before the survey than respondents who were not Indigenous (29.0%) [$\chi_{(2)}^2$ = 6.29, p = 0.012]. The percentages were similar between First Nations (43.5%) and Métis respondents (39.2%) (see Table 1.51).

Table 1.50: Last time had a physical check-up without having a specific health problem by Indigenous and not Indigenous groups.

Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Less than 1 year ago	145	39.5	110	43.5	29	29.0	6.29	**0.012**
More than 1 year ago[a]	222	60.5	143	56.5	71	71.0		

Note. Groups = Indigenous + Not Indigenous.
N = 367 (groups *N* = 353).
[a]More than 1 year ago includes never had a physical check-up.

Table 1.51: Last time had a physical check-up without having a specific health problem by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Less than 1 years ago	84	43.5	20	39.2	29	29.0	5.87	0.053
More than 1 year ago	109	56.5	31	60.8	71	71.0		

Note. N = 344.
[a]More than 1 year ago includes never had a physical check-up.

Respondents who had not had a physical check-up in the last three years (*N* = 126, 31.0%) and those who did not know if they had a physical check-up in the last three years (*N* = 39, 9.6%) were asked why they had not had a physical check-up. A list of 20 reasons was presented; respondents also had the opportunity to mention other reasons. Respondents were asked to indicate the two main reasons. The reasons were grouped into five categories. Almost half (47.9%) of the respondents indicated they did not think it was necessary to have a check-up (see Table 1.52). The next most frequently reported reasons were lack of access (32.9%) and no time to (30.7%). Lack of access may have been due to not having a health card or a status card, not having a doctor, transportation and/or language barriers, and not knowing where to go. There were several reasons included in "No time to" have a check-up, such as too busy looking after basic needs, long wait time, and inconvenient clinic hours. Some people (15.7%) expressed they were anxious about seeking healthcare because they do not like doctors, they had a negative experience in the past, and/or they were afraid. The reasons for not receiving a physical check-up in the past three years did not vary by Indigenous identity (see Table 1.53).

Table 1.52: The two main reasons for not having a checkup in the 3 years before the survey by Indigenous and not Indigenous groups.

Reasons	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Did not think it was necessary	67	47.9	37	44.0	25	53.2	1.01	0.315
Lack of Access[a]	46	32.9	28	33.3	18	38.3	0.33	0.568
No Time to[b]	43	30.7	27	32.1	14	29.8	0.08	0.780
Anxiety about seeking treatment[c]	22	15.7	10	11.9	9	19.1	1.28	0.259
Caregiving responsibilities prevent me[d]	0	0.0						
Unable to due to Housing, Financial Insecurity, Health Problems	9	6.4						

Note. Respondents could select all that apply.
N = 131 (Indigenous *N* = 84, Not Indigenous *N* = 47).
[a]Lack of Access = Don't have a health card + Don't have status card + Saw doctor but was not offered this care + Don't have a doctor to go to + Can't find a family doctor accepting new patients + Didn't know where to go to get care + Transportation — problems + Language problems.
[b]No Time to = Haven't Gotten around to it + Too busy finding food, shelter, or other necessities + Couldn't get time off work + Inconvenient clinic hours + Waiting time was too long.
[c]Anxiety about seeking treatment = Don't like doctors + Had a negative experience/was treated poorly in the past + Fear (e.g., painful, embarrassing, find something wrong).
[d]Caregiving responsibilities prevent me = Couldn't get childcare + Personal or family responsibilities.

Table 1.53: The two main reasons for not having a checkup in the 3 years before the survey by Indigenous identity.

Reasons	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Did not think it was necessary	25	38.5	11	64.7	25	53.2	4.76	0.093
Lack of Access[a]	20	30.8	6	35.3	18	38.3	0.70	0.705
No Time to[b]	20	30.8	6	35.3	14	29.8	0.18	0.914

Note. Respondents could select all that apply.

First Nations *N* = 65, Métis *N* = 17, Not Indigenous *N* = 47.

[a]Lack of Access = Don't have a health card + Don't have status card + Saw doctor but was not offered this care + Don't have a doctor to go to + Can't find a family doctor accepting new patients + Didn't know where to go to get care + Transportation — problems + Language problems.

[b]No Time to = Haven't Gotten around to it + Too busy finding food, shelter, or other necessities + Couldn't get time off work + Inconvenient clinic hours + Waiting time was too long.

The female-identifying participants were asked questions specific to their health. There were two cancer screening questions. Individuals between the ages of 21 and 69 years were asked when they last had a pap smear. CancerCare Manitoba's guidelines recommend that pap tests be done every three years. Almost three-quarters (72.2%) had a pap test within the past three years, while 27.8% had not (see Table 1.54). The difference between the groups was almost statistically significant [$\chi(1)2 = 3.827$, $p = 0.05$]. Indigenous female-identifying participants (76.3%) were 36% more likely to have received a pap test in the past three years than female-identifying participants who were not Indigenous (56.0%).

Mammograms are recommended for women between the ages of 50 and 74 years. Of the female-identifying individuals in this age range, 54.5% had ever had a mammogram and 45.5% had not. Of the individuals who had ever had a mammogram, approximately half (58.8%) had had one within the last three years (as recommended by CancerCare). Due to small frequencies, the results for having a mammogram by group could not be presented.

Table 1.54: Cervical and breast cancer screening by Indigenous and not Indigenous groups.

Screening Test	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Last Pap Smear[a]	Within the recommended guidelines (in the last 3 years)	78	72.2	61	76.3	14	56.0	3.83	0.050
	Not within the recommended guidelines (more than 3 years ago, including never)	30	27.8	19	23.8	11	44.0		
Ever had a mammogram[b]	Yes	18	54.5						
	Less than 3 years ago	10	58.8						
	3 or more years ago	7	41.2						
	No	15	45.5						

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 108 (groups *N* = 105), [b]*N* = 50.

Individuals who identified as male and individuals who did not answer the question about gender were excluded from all of the questions in this section

in the survey (i.e., Women's/Female Health). Individuals who identified as "gender diverse" are included.
[a]According to CancerCare Manitoba's guidelines, women ages 21 to 69 years should have a pap test every three years (https://www.cancercare.mb.ca/screening/cervix). Total [a]*N* regards individuals who are between the ages of 21 and 69 years.
[b]According to CancerCare Manitoba's guidelines, women ages 50 to 74 years should have mammogram screening every three years (https://www.cancercare.mb.ca/screening/breast). Total [b]*N* regards individuals who are between the ages of 50 and 74.
Due to small frequencies, the results for having a mammogram could not be presented.

Few individuals (6.2%) reported they were unable to access birth control or contraception in the year prior to the survey (see Table 1.55). The percentages were similar for the Indigenous (6.7%) and not Indigenous (4.6%) groups. The two main reasons for not being able to access birth control or contraception were lack of access (52.2%) and lack of information or resources (43.5%). Lacked access included the following responses: location where they are available was closed or was not convenient, and they were denied help. Lacked information or resources included the following responses: did not know where to get them, were too shy or afraid to ask for them, or did not have the money to pay for them.

Table 1.55: Challenges accessing birth control or contraception in the year before the survey by Indigenous and not Indigenous groups.

Challenges	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Unable to get birth control or contraception in the prior to the survey[a]	Yes	24	6.2	18	6.7	5	4.6	0.61	0.43
	No	363	93.8	250	93.3	104	95.4		
Reasons not able to get birth control or contraception[b]	Lacked Access	12	52.2						
	Lacked Information/ Resources	10	43.5						

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 387 (groups *N* = 377), [b]*N* = 22.
Due to small frequencies, the results for reasons not being able to get birth control or contraception could not be reported.

2.3.10 Accessing services from Indigenous-led organisations

Among the Indigenous participants, 51.8% reported they had accessed services from an Indigenous-led organisation in Winnipeg (e.g., Ma Mawi, Ndinawe, Aboriginal Health and Wellness, Eagle Urban Transition Centre)[2](see Table 1.56). Of those who had accessed services from an Indigenous-led organisation, 69.7% were accessing services from one organisation at the time of the survey. The percentages were similar for First Nations (68.8%) and Métis (72.0%) respondents.

Table 1.56: Accessing services from an Indigenous-led organization.

Accessing Services	Response	Total		First Nations		Métis		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Ever accessed services from an Indigenous-led organisation[a]	Yes	144	51.8	111	52.6	25	46.3	0.69	0.408
	No	134	48.2	100	47.4	29	53.7		
Currently accessing services from an Indigenous-led organisation[b]	Yes	99	69.7	75	68.8	18	72.0	0.10	0.755
	No	43	30.3	34	31.2	7	28.0		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 278 (groups *N* = 265), [b]*N* = 142 (groups *N* = 134).

[a]Includes individuals who identified as Indigenous; excludes individuals who did not identify as Indigenous.

[b]Includes individuals who identified as Indigenous and those who have accessed services from an Indigenous-led organisation.

2 Only Indigenous participants were asked "Have you ever access services from Indigenous-led organisations in Winnipeg?". Participants were not asked about accessing services from organisations that were not Indigenous.

If participants were not accessing services from an Indigenous-led organisation, they were asked why. The reasons included the respondents did not want to access them or had not attempted to access them (38.1%), they experienced challenges accessing them (33.0%), they did not feel welcome or comfortable there (9.7%), the services did not meet their needs (5.1%), and the respondents did not follow traditional teachings (5.1%) (see Table 1.57). Access challenges included the following responses: respondents were not familiar with the resources, they did not know how to access the services, they were declined access, they did not have transportation to get to the resources and services, and they lacked identification. Although not statistically significant, Table 1.58 reveals that a higher percentage of Métis respondents reported not wanting or attempting to access Indigenous-led services (55.9%) and a higher percentage of First Nations respondents reported access challenges (38.7%).

Table 1.57: Reasons for not accessing services from an Indigenous-led organisation at the time of the survey.

Reasons for not accessing services	*N*	%
Do not want them/have not attempted to access	67	38.1
Access challenges[a]	58	33.0
Do not feel welcome/comfortable	17	9.7
Does not follow traditional teachings	9	5.1
Services offered do not meet needs	9	5.1

Note. *N* = 160.
Excludes individuals who are not Indigenous and those who are currently accessing services from an Indigenous-led organisation, 17 DK/DA.
[a]Access challenges (e.g., not familiar with resources, don't know how to access, was declined, transportation, ID, safety, substance use).

Table 1.58: Reasons for not accessing services from an Indigenous-led organization at the time of the survey.

Reasons for not accessing services	First Nations		Métis		χ^2	*p*-value
	N	%	*N*	%		
Do not want them/have not attempted to access	46	38.7	19	55.9	3.21	0.073
Access challenges	46	38.7	9	26.5	1.71	0.192

Note. *N* = 153.
Excludes individuals who are not Indigenous and those who are currently accessing services from an Indigenous-led organisation, 17 DK/DA.
[b]Access challenges (e.g., not familiar with resources, don't know how to access, was declined, transportation, ID, safety, substance use).
Due to small frequencies, the results for do not follow traditional teachings, the services do not meet their needs, and they do not feel welcome or comfortable could not be reported.

2.3.11 Income and employment

The Indigenous and not Indigenous groups had different total monthly income distributions (see Table 1.59). A higher percentage of respondents who were not Indigenous (40.2%) earned more than $601 in the month prior to completing the survey, while a higher percentage of Indigenous respondents (44.0%) earned between $201 and $600. For each of the three income categories (i.e., less than $200, between $201 and $600, more than $601), the percentage of Métis respondents fell in between the percentages of First Nations and all other respondents (see Table 1.60).

Survey participants were asked about their sources of income; the responses were grouped into six categories. Government support (65.6%) was the most common source of income, which included federal disability/CPPD, EIA (Disability), EIA (General), EIA (Provincial Rent Assist), and Child Tax Credit. Of the six sources, a higher percentage of Indigenous respondents compared to respondents who were not Indigenous reported each of the different sources of income (5 of 6 sources), except employment-related sources. However, the differences in percentages were statistically significant only for employment-related sources, GST credit, and other sources. Employment-related sources included public insurance/benefits or employee benefits, Workers Compensation, pension, and wages. The relationships between group (First Nations, Métis, and not Indigenous) and sources of income were statistically significant for all sources of income except government support. However, there were no clear patterns (i.e., one group does not consistently have a higher (or lower) percentage than the other groups).

Table 1.59: Amount and source of income in the month prior to the survey by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Total amount of income[a]	Less than $200 (including $0)	109	31.0	72	29.9	34	33.3	**10.62**	**0.005**
	Between $201 and $600	134	38.1	106	44.0	27	26.5		
	More than $601	109	31.0	63	26.1	41	40.2		
Sources of Income[b]	Government Support[c]	250	65.6	176	68.2	66	65.3	0.27	0.602
	Informal Sources[d]	190	49.9	135	52.3	50	49.5	0.23	0.631
	GST Credit	109	28.6	84	32.6	22	21.8	**4.05**	**0.044**
	Employment-Related[e]	106	27.8	66	25.6	38	37.6	**5.12**	**0.024**
	Illegal Activities[f]	86	22.6	67	26.0	18	17.8	2.67	0.103
	Other[g]	68	17.8	55	21.3	11	10.9	**5.26**	**0.022**

Note. Groups = Indigenous + Not Indigenous.
[a]N = 352 (groups N = 343), [b]N = 381 (groups N = 359).
[c]Government Support = Federal Disability/ CPPD + EIA (Disability) + EIA (General) + EIA (Provincial Rent Assist) + Child Tax Credit.
[d]Informal Sources = Retail/Sales + Scrap Metal/Bottles + Panhandling + Friends Family.
[e]Employment-Related = Public insurance/Benefits or Employee benefits + Workers Compensation + Pension + Wages.
[f]Illegal Activities = Sex Work + Theft/Boosting + Selling/Running Drugs.
[g]Other = Alimony/Child Support + Honorarium/Damage deposit return.
Bolded values indicate statistical significance, $p < 0.05$.

Table 1.60: Amount and source of income in the month prior to the survey by Indigenous identity.

Variable	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Total amount of income[a]	Less than $200 (including $0)	56	30.1	15	31.9	34	33.3	**14.92**	**0.005**
	Between $201 and $600	87	46.8	15	31.9	27	26.5		
	More than $601	43	23.1	17	36.2	41	40.2		
Sources of Income[b]	Government Support[c]	136	68.7	32	62.7	66	65.3	0.79	0.673
	Informal Sources[d]	115	58.1	19	37.3	50	49.5	**7.59**	**0.022**
	GST Credit	59	29.8	21	41.2	22	21.8	6.27	0.044
	Employment-Related[e]	46	23.2	16	31.4	38	37.6	**7.02**	**0.030**
	Illegal Activities[f]	58	29.3	9	17.6	18	17.8	**6.22**	0.045
	Other[g]	47	23.7	9	17.6	11	10.9	**7.22**	**0.027**

Note. [a]*N* = 335, [b]*N* = 350.

[c]Government Support = Federal Disability/ CPPD + EIA (Disability) + EIA (General) + EIA (Provincial Rent Assist) + Child Tax Credit.

[d]Informal Sources = Retail/Sales + Scrap Metal/Bottles + Panhandling + Friends Family.

[e]Employment-Related = Public insurance/Benefits or Employee benefits + Workers Compensation + Pension + Wages.

[f]Illegal Activities = Sex Work + Theft/Boosting + Selling/Running Drugs.

[g]Other = Alimony/Child Support + Honorarium/Damage deposit return.

Bolded values indicate statistical significance, $p < 0.05$.

A significantly higher percentage of Indigenous participants (89.0%) reported ever receiving welfare/disability assistance compared to participants who were not Indigenous (79.8%) [$\chi_{(1)}^2 = 5.53$, $p = 0.019$] (see Table 1.61). The groups did not differ on when they last received welfare/disability assistance. Approximately three-quarters of participants (Indigenous, 75.3%; not Indigenous, 72.1%) had received welfare/disability assistance less than one month prior to completing the survey. In the year prior to the survey, 31.9% of the Indigenous respondents (First Nations, 33.0%; Métis, 23.9%) and 28.6% of the respondents who were not Indigenous were cut off welfare without having any other sources of income (see Table 1.62). People were cut off for a variety of reasons, including they were no longer eligible (e.g., left Winnipeg, were incarcerated), they experienced challenges (e.g., missed appointment, miscommunicated with their worker), and other reasons (e.g., did not know why, administrative error). Of the respondents who were not receiving EIA Disability Assistance at the time of the survey, 54.8% of the Indigenous respondents (First Nations, 56.3%; Métis, 52.6%) and 63.6% of respondents who were not Indigenous believed they should be eligible; this difference was not statistically significant.

Individuals who had ever received welfare/disability assistance (EIA) were asked if their EIA worker had offered them support. Seven different types of support were presented to participants. Financial support (47.2%) was the most common type of support offered, followed by bus tickets (28.0%), job search help (25.1%), information about substance treatment programmes (23.9%), housing search help (22.4%), bus passes (18.6%), and information about education programmes (17.7%) (see Table 1.63). These percentages were similar for both groups (see Table 1.64).

Table 1.61: Receipt of financial support by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Ever received welfare/ disability assistance[a]	Yes	338	86.7	242	89.0	87	79.8	**5.53**	**0.019**
	No	52	35.1	30	11.0	22	20.2		
Last time you received welfare/disability assistance[b]	< 1 month ago	249	74.6	180	75.3	62	72.1	0.69	0.875
	1 month to < 1 year ago	35	10.5	26	10.9	9	10.5		
	1 year to < 5 years ago	29	8.7	19	7.9	9	10.5		
	More than 5 years ago	21	6.3	14	5.9	6	7.0		
In the year prior to the survey, was cut off of welfare without having other sources of income[c]	Yes	99	30.5	74	31.9	24	28.6	0.32	0.572
	No	226	69.5	158	68.1	60	71.4		
Reasons for being taken off benefits the most recent time[d]	Eligibility-Related[f]	42	45.7	33	47.8	9	40.9	0.32	0.571
	Participant Challenges[g]	41	44.6	29	42.0	11	50.0	0.43	0.512
	Other[h]	10	10.9						
Believes should be eligible but is not receiving EIA Disability Assistance[e]	Yes	80	58.0	51	54.8	28	63.6	0.95	0.330
	No	58	42.0	42	45.2	16	36.4		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 390 (groups *N* = 381), [b]*N* = 334 (groups *N* = 325), [c]*N* = 325 (groups *N* = 316), [d]*N* = 92 (groups *N* = 91), [e]*N* = 138 (groups *N* = 137).

[f]Eligibility-Related = left Winnipeg + no longer eligible + in programme/incarcerated.

[g]Participant Challenges = did not fill in appropriate paperwork + missed appointment + did not follow care plan/miscommunication with worker

[h]Other = No reason given by worker + administrative error.

There were too few 'other' responses, and consequently the results could not be reported.

Bolded values indicate statistical significance, $p < 0.05$.

Table 1.62: Receipt of financial support by Indigenous identity.

Variable	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Ever received welfare/ disability assistance (not including the past month)[a]	Yes	52	69.3	15	71.4	25	53.2	3.82	0.148
	No	23	30.7	6	28.6	22	46.8		
In the year prior to the survey, was cut off of welfare without having other sources of income[b]	Yes	59	33.0	11	23.9	24	28.6	1.60	0.449
	No	120	67.0	35	76.1	60	71.4		
Believes should be eligible but is not receiving EIA Disability Assistance[c]	Yes	40	56.3	10	52.6	28	63.6	0.88	0.645
	No	31	43.7	9	47.4	16	36.4		

Note. [a]*N* = 143, [b]*N* = 309, [c]*N* = 134.

Eligibility-Related = left Winnipeg + no longer eligible + in programme/incarcerated.

Participant Challenges = did not fill in appropriate paperwork + missed appointment + did not follow care plan/miscommunication with worker.

Other = No reason given by worker + administrative error.

Due to small frequencies, the results for the last time respondents received welfare/disability assistance, and reasons for being taken off benefits could not be reported.

Table 1.63: Type of support an EIA worker offered by Indigenous and not Indigenous groups.

Type of support	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Financial	160	47.2	118	49.8	39	48.1	0.07	0.799
Bus tickets	95	28.0	66	27.8	27	33.3	0.88	0.349
Help with job search	85	25.1	62	26.2	21	25.9	< 0.01	0.967
Information about drug/alcohol treatment programmes	81	23.9	60	25.3	20	24.7	0.01	0.911
Help finding housing	76	22.4	59	24.9	17	21.0	0.51	0.477
Bus passes	63	18.6	45	19.0	18	22.2	0.40	0.528
Information about education programmes	60	17.7	45	19.0	15	18.5	0.01	0.926

Note. Total *N* = 339, Indigenous *N* = 237, Not Indigenous *N* = 81.

Table 1.64: Type of support an EIA worker offered by Indigenous identity.

Type of support	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Financial	92	50.3	18	39.1	39	48.1	1.83	0.401
Bus tickets	47	25.7	16	34.8	27	33.3	2.46	0.292
Help with job search	49	26.8	10	21.7	21	25.9	0.49	0.784
Information about drug/alcohol treatment programmes	52	28.4	7	15.2	20	24.7	3.41	0.182
Help finding housing	43	23.5	13	28.3	17	21.0	0.86	0.650
Bus passes	32	17.5	10	21.7	18	22.2	1.00	0.605
Information about education programmes	38	20.8	5	10.9	15	18.5	2.37	0.306

Note. $N = 310$.

More than half of the respondents (56.2%) reported they had a bank account (Indigenous, 52.8%; First Nations, 50.7%; Métis, 59.3%; not Indigenous, 61.8%). If respondents indicated they did not have a bank account, they were asked where they cash cheques. The most common location was a cash chequing service like Money Mart (55.9%); other less common locations were pawn shops (19.4%), hotels or bars (12.4%), banks or trust companies (8.8%), and stores (8.8%) (see Table 1.65). Due to small frequencies, the results for most cash chequing locations could not be disaggregated by group. For the two locations where it was possible to do this, cash chequing service and pawn shop, there were no statistically significant differences between groups.

Table 1.65: Cheque cashing locations by Indigenous and not Indigenous groups.

Locations	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Cheque cashing service (e.g. Money Mart)	95	55.9	72	60.0	23	63.9	0.18	0.675
Pawn shop	33	19.4	24	20.0	8	22.2	0.8	0.772
Hotel or Bar	21	12.4						
Doesn't receive any cheques	17	9.1						
Bank or trust company	15	8.8						
Store	15	8.8						
Friend/Family member/Partner cashes/ deposits cheques for me	12	7.1						
Trustee (e.g. caseworker)	0	0.00	0	0.0	0	0.0		

Note. Groups = Indigenous + Not Indigenous.

$N = 208$ (groups $N = 127$).

Due to small frequencies, the results for doesn't receive any cheques, bank or trust company, hotel or bar, family/friend/partner deposits cheques for me, and store could not be reported.

2.4 Emotional dimension

The **Emotional Dimension** focuses on experiences that may have positively or negatively affected participants' self-worth and emotional well-being. The first subsection describes the participants' past involvement with CFS. Negative experiences with CFS can disrupt family and community relationships creating a lack of belonging and self-worth. The second subsection focuses on belonging or lack thereof. This section includes negative experiences with staff who work in shelters, landlords, and healthcare professionals. The survey asked participants to identify why they felt they were treated poorly by people in these positions/roles. This section also includes experiences of being refused service for not having identification.

2.4.1 Prior involvement with CFS

CFS is a major pathway into homelessness; overall, 47.5% of respondents spent time as a child or youth in CFS care. However, the statistic does not demonstrate the differences between the experiences of Indigenous participants and participants who were not Indigenous. In fact, Indigenous respondents (55.9%) were two times more likely to have spent time in CFS care than respondents who were not Indigenous (27.5%) (see Table 2.1). This is a statistically significant difference [$\chi_{(1)}^2 = 25.11$, $p < 0.001$]. The percentages of Métis (52.8%) and First Nations (57.2%) respondents who spent time in the care of CFS were similar (see Table 2.2).

More than half of the respondents (58.5%) who spent time in the care of CFS were in care when they turned 18 years old; this percentage was similar for Indigenous respondents (57.3%) and respondents who were not Indigenous (60.0%).

Table 2.1: Spent time as a child or youth in the care of CFS by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
CFS Involvement[a]	Yes	190	47.5	151	55.9	30	27.5	**25.11**	**<0.001**
	No	210	52.5	119	44.1	79	72.5		
Turned 18 while in the Care of CFS[b]	Yes	110	58.5	86	57.3	18	60.0	0.23	0.891
	No	62	33.0	50	33.3	s	s		
	Left Care/Ran Away Before Turning 18	16	8.5	14	9.3	s	s		

Note. Groups = Indigenous + Not Indigenous.
[a]*N*= 400 (groups *N* = 379), [b]*N*= 188 (groups *N* = 180).
[a]CFS Involvement = hotel, foster care, group home.
Bolded values indicate statistical significance, $p < 0.05$.
's' means the value was suppressed due to frequencies less than 5.

Table 2.2: Spent time as a child or youth in the care of CFS by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	119	57.2	28	52.8	30	27.5	**25.88**	0.000
No	89	42.8	25	47.2	79	72.5		

Note. N = 370.
Bolded values indicate statistical significance, $p < 0.05$.
Due to small frequencies, the results for turned 18 while in the care of CFS could not be reported.

2.4.2 Belonging

2.4.2.1 Treated unfairly by shelter staff

Indigenous respondents (57.6%; First Nations, 57.5%; Métis, 64.5%) were significantly more likely to report they were treated unfairly or disrespected by shelter staff in the year prior to the survey than respondents who did not identify as Indigenous (42.5%) [χ(1)2 = 4.69, p = 0.030] (see Tables 2.3 and 2.4).

Table 2.3: Treated unfairly or disrespected by shelter staff in the year prior to the survey by Indigenous and not Indigenous groups.

Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	141	54.2	99	57.6	31	42.5	**4.69**	**0.030**
No	119	45.8	73	42.4	42	57.5		

Note. Groups = Indigenous + Not Indigenous.
N = 260 (groups *N* = 245).
Bolded values indicate statistical significance, $p < 0.05$.

Table 2.4: Treated unfairly or disrespected by shelter staff in the year prior to the survey by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	77	57.5	20	64.5	31	42.5	5.93	0.052
No	57	42.5	11	35.5	42	57.5		

Note. *N* = 238

Participants were presented with a list of reasons why they may have been mistreated or disrespected by shelter staff; they could select more than one response. Overall, the most common reason for feeling disrespected was because of their use of alcohol or drugs (total, 27.2%; Indigenous, 31.8%; not Indigenous, 14.9%), followed by their race or ethnic background (total 22.3%; Indigenous, 27.0%; not Indigenous, 8%), the staff's attitude or lack of understanding (13.7%), their age (11.4%), their physical disability or mental illness (11.2%), their gender identity (10.1%), their hygiene (9.3%), and sexual orientation (7.1%) (see Table 2.5).

For every reason, the percentage for the Indigenous group was greater than the percentage for the group who did not identify as Indigenous. The differences were statistically significant for most of the reasons. Specifically, the Indigenous respondents were significantly more likely to report they were disrespected or treated unfairly by shelter staff because of their age, gender identity, sexual orientation, race or ethnic background, and use of alcohol or drugs than the respondents who were not Indigenous. The percentages for the First Nations and Métis groups were similar for use of alcohol and drugs, and race or ethnic background, but both differed from the group that was not Indigenous (see Table 2.6).

Table 2.5: Reasons why participants felt they were treated unfairly or were disrespected by shelter staff by Indigenous and not Indigenous groups.

Reasons	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Use of alcohol or drugs[a]	Yes	72	27.2	56	31.8	11	14.9	**7.63**	**0.006**
	No	193	72.8	120	68.2	63	85.1		
Race or ethnic background[b]	Yes	59	22.3	47	27.0	6	8.0	11.31	0.001
	No	205	77.14	127	73.0	69	92.0		
Their attitude or lack of understanding[c]	Yes	34	13.7	23	14.1	6	8.3	1.54	0.215
	No	215	86.3	140	85.9	66	91.7		
Age[d]	Yes	30	11.4	23	13.1	s	s	**6.09**	**0.014**
	No	234	88.6	153	86.9	s	s		
Physical disability or mental illness[e]	Yes	30	11.2	19	10.6	7	9.5	0.08	0.783
	No	238	88.8	160	89.4	67	90.5		
Gender identity[f]	Yes	27	10.1	22	12.4	s	s	**4.14**	**0.042**
	No	241	89.9	156	87.6	s	s		
Hygiene[g]	Yes	25	9.3	16	8.9	6	8.1	0.05	0.831
	No	243	90.7	163	91.1	68	91.9		
Sexual orientation[h]	Yes	19	7.1	16	9.0	s	s	**4.97**	**0.026**
	No	248	92.9	161	91.0	s	s		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 265 (groups *N* = 250), [b]*N* = 264 (groups *N* = 249), [c]*N* = 249 (groups *N* = 235), [d]*N* = 264 (groups *N* = 176), [e]*N* = 268 (groups *N* = 253), [f]*N* = 265 (groups *N* = 178), [g]*N* = 268 (groups *N* = 253), [h]*N* = 267 (groups *N* = 177).
s means the value was suppressed because the frequency was < 5.
Bolded values indicate statistical significance, $p < 0.05$.

Table 2.6: Reasons why participants felt they were treated unfairly or were disrespected by shelter staff by Indigenous identity.

Reason	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Use of alcohol or drugs[a]	Yes	45	33.6	11	31.4	11	14.9	8.67	0.013
	No	89	66.4	24	68.6	63	85.1		
Race or ethnic background[b]	Yes	38	28.8	9	25.0	6	8.0	**12.37**	**0.002**
	No	94	71.2	27	75.0	69	92.0		

Note. [a]*N* = 243, [b]*N* = 242.
Due to small frequencies, the results for age, gender identity, sexual orientation, hygiene, physical disability or mental illness, and attitude or lack of understanding, could not be reported.
Bolded values indicate statistical significance, $p < 0.05$.

2.4.2.2 Treated unfairly by a landlord

Almost half (48.0%) of the participants reported they were treated unfairly or were disrespected by a landlord; the percentages were similar for Indigenous respondents (49.6%; First Nations, 51.2%; Métis, 46.2%) and respondents who were not Indigenous (44.8%) (see Tables 2.7 and 2.8).

Table 2.7: Treated unfairly or disrespected by a landlord by Indigenous and not Indigenous groups.

Response	Total		Indigenous		Not Indigenous		χ^2	p-value
	N	%	*N*	%	*N*	%		
Yes	188	48.0	132	49.6	47	44.8	0.71	0.399
No	204	52.0	134	50.4	58	55.2		

Note. Groups = Indigenous + Not Indigenous.
N = 392 (groups *N* = 371).

Table 2.8: Treated unfairly or disrespected by a landlord by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	105	51.2	24	46.2	47	44.8	1.307	0.520
No	100	48.8	28	53.8	58	55.2		

Note. *N* = 371.

Participants were presented with reasons why they may have been treated unfairly or were disrespected by a landlord. Overall, source of income was the number one reason (25.8%), followed by use of alcohol or drugs (21.4%), race or ethnic background (21.4%), age (12.5%), gender identity (7.9%), physical disability (7.1%), and sexual orientation (4.6%) (see Table 2.9). For every reason, the percentage for the Indigenous group was higher than the group who was not Indigenous; however, the difference was only statistically significant for race or ethnic background. There was no clear pattern in the results when examining the First Nations and Métis groups (see Table 2.10). Indigenous respondents (26.1%) were 2.7 times more likely to report they were treated unfairly or disrespected by a landlord because of their race or ethnic background than respondents who were not Indigenous (9.5%) [$\chi_{(1)}^2 = 12.20$, $p < 0.001$].

Table 2.9: Reasons why participants felt they were treated unfairly or were disrespected by a landlord in the year prior to the survey by Indigenous and not Indigenous groups.

Reason	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Your source of income[a]	Yes	102	25.8	71	26.6	26	24.3	0.21	0.648
	No	293	74.2	196	73.4	81	75.7		
Use of alcohol or drugs[b]	Yes	96	24.5	71	26.9	19	17.8	3.46	0.063
	No	296	75.5	193	73.1	88	82.2		
Race or ethnic background[c]	Yes	83	21.4	68	26.1	10	9.5	**12.20**	**0.000**
	No	304	78.6	193	73.9	95	90.5		
Other[d]	Yes	67	17.9						
	No	307	82.1						
Age[e]	Yes	51	12.8	37	13.8	9	8.3	2.11	0.146
	No	347	87.2	232	86.2	99	91.7		
Gender identity[f]	Yes	31	7.9	24	9.0	5	4.7	2.01	0.156
	No	363	92.1	242	91.0	102	95.3		
Physical disability[g]	Yes	28	7.1	21	7.9	5	4.7	1.24	0.266
	No	365	92.9	244	92.1	102	95.3		
Sexual orientation[h]	Yes	18	4.6						
	No	376	95.4						

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 395 (groups *N* = 374), [b]*N* = 392 (groups *N* = 371), [c]*N* = 387 (groups *N* = 366), [d]*N* = 374, [e]*N* = 398 (groups *N* = 377), [f]*N* = 394 (groups *N* = 373), [g]*N* = 393 (groups *N* = 372), [h]*N* = 394.
Due to small frequencies, the results for sexual orientation could not be reported by Indigenous identity.
[h]Other = Difference of beliefs/perspectives (*n* = 2) + financial challenges (*n* = 6) + landlord/tenancy issues (*n* = 5) + mental illness (*n* = 2) + others use of alcohol or drugs (*n* = 3) + personal challenges (*n* = 3) + relationship issues (*n* = 4) + safety issues/violence/abuse (*n* = 3) + their attitude/lack of understanding (*n* = 7) + your attitude or speaking up for yourself (*n* = 2) + criminal history (*n* = 2) + experience of homelessness (*n* = 5) + your friends/kids current or previous behavior (*n* = 10) + appearance (*n* = 6).
Bolded values indicate statistical significance, $p < 0.05$.

Table 2.10: Reasons why participants felt they were treated unfairly or were disrespected by a landlord in the year before the survey by Indigenous identity.

Reason	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Your source of income[a]	Yes	58	28.4	12	22.2	26	24.3	1.16	0.559
	No	146	71.6	42	77.8	81	75.7		
Use of alcohol or drugs[b]	Yes	54	26.7	16	30.2	19	17.8	4.09	0.129
	No	148	73.3	37	69.8	88	82.2		
Race or ethnic background[c]	Yes	58	29.1	10	18.9	10	9.5	**15.82**	**0.000**
	No	141	70.9	43	81.1	95	90.5		
Age[d]	Yes	28	13.6	10	18.5	9	8.3	3.64	0.162
	No	178	86.4	44	81.5	99	91.7		
Gender identity[e]	Yes	19	9.4	6	11.1	5	4.7	2.73	0.256
	No	184	90.6	48	88.9	102	95.3		

Note. [a]*N* = 365, [b]*N* = 362, [c]*N* = 357, [d]*N* = 368, [e]*N* = 364.
Due to small frequencies, the results for sexual orientation and physical disability could not be reported.
Bolded values indicate statistical significance, $p < 0.05$.

2.4.2.3 Treated unfairly by healthcare staff

In the year prior to the survey, some respondents experienced discrimination in healthcare settings. They were asked why they thought they were judged or disrespected by staff. The most common reasons were because they thought the healthcare workers thought they were seeking drugs (25.4%), because of their use of alcohol or drugs (23.6%), because they were homeless (23.5%), and because of their race or ethnic background (18.5%) (see Table 2.11). Less common reasons were because of their age (9.2%), hygiene (6.4%), gender identity (6.0%), and sexual orientation (3.1%).

A significantly higher percentage of Indigenous participants compared to other participants felt disrespected by healthcare staff because of their race or ethnic background (Indigenous, 23.5%; not Indigenous, 5.0%) [$\chi_{(1)}^2 = 16.68$, $p < 0.001$] and because they thought healthcare staff thought they were seeking drugs (Indigenous, 28.3%; not Indigenous, 17.6%) [$\chi_{(1)}^2 = 4.42$, $p = 0.04$]. The two groups did not differ significantly on any of the other reasons. A significantly higher percentage of First Nations respondents (27.0%) compared to the Métis respondents (9.8%) and the respondents who were not Indigenous (5.0%) reported they felt they were disrespected because of their race or ethnic background (see Table 2.12).

Table 2.11: Reasons for feeling judged or disrespected by staff in a health care setting in the year prior to the survey by Indigenous and not Indigenous groups.

Reason	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Healthcare provider thought participant was drug-seeking[a]	Yes	97	25.4	75	28.3	18	17.6	**4.42**	**0.036**
	No	285	74.6	190	71.7	84	82.4		
Use of alcohol or drugs[b]	Yes	91	23.6	66	25.0	22	21.2	0.61	0.436
	No	294	76.4	198	75.0	82	78.8		
Being homeless[c]	Yes	87	23.5	63	24.8	21	21.0	0.57	0.449
	No	283	76.5	191	75.2	79	79.0		
Race or ethnic background[d]	Yes	70	18.5	61	23.5	5	5.0	**16.68**	**< 0.001**
	No	308	81.5	199	76.5	96	95.0		
Age[e]	Yes	35	9.2	25	9.6	6	5.8	1.41	0.235
	No	346	90.8	234	90.4	98	94.2		
Hygiene[f]	Yes	24	6.4	15	5.8	7	6.9	0.13	0.715
	No	352	93.6	242	94.2	95	93.1		
Gender identity[g]	Yes	23	6.0	20	7.6	S	S	4.17	0.41
	No	361	94.0	244	92.4	S	S		
Sexual orientation[h]	Yes	12	3.1						
	No	371	96.9						

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 382 (groups *N* = 367), [b]*N* = 385 (groups *N* = 368), [c]*N* = 370 (groups *N* = 354), [d]*N* = 378 (groups *N* = 361), [e]*N* = 381 (groups *N* = 363), [f]*N* = 376 (groups *N* = 359), [g]*N* = 384 (groups *N* = 264), [h]*N* = 383.

Due to small frequencies, the results for sexual orientation could not be reported.

Bolded values indicate statistical significance, $p < 0.05$.

's' means the value was suppressed due to frequencies less than 5.

Table 2.12: Reasons for feeling judged or disrespected by staff in a health care setting in the year prior to the survey by Indigenous identity.

Reason	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Healthcare provider thought participant was drug-seeking[d]	Yes	64	31.5	11	20.8	18	17.6	**7.68**	**0.021**
	No	139	68.5	42	79.2	84	82.4		
Use of alcohol or drugs[b]	Yes	51	25.2	12	22.6	22	21.2	0.67	0.714
	No	151	74.8	41	77.4	82	78.8		
Being homeless[c]	Yes	46	23.6	15	29.4	21	21.0	1.33	0.516
	No	149	76.4	36	70.6	79	79.0		
Race or ethnic background[a]	Yes	54	27.0	5	9.8	5	5.0	**24.75**	**< 0.001**
	No	146	73.0	46	90.2	96	95.0		

Note. [a]*N* = 352, [b]*N* = 359, [c]*N* = 346, [d]*N* = 358.

Due to small frequencies, the results for age, gender identity, sexual orientation, and hygiene could not be reported.

Bolded values indicate statistical significance, $p < 0.05$.

2.4.2.4 Refused service because of lack of identification

Survey participants were asked if they were ever denied services because they did not have identification. Fifty-eight of the 406 participants (14.4%) reported they always have identification, and hence, they have never been refused service due to a lack of ID. An additional 27.0% indicated they have never been denied service because they did not have ID. Respondents who did not identify as Indigenous (41.1%) were significantly more likely to report they have not been refused service because of not having ID than Indigenous respondents (21.8%) [$\chi^2_{(1)} = 12.26$, $p < 0.001$].

Being refused service because of a lack of ID was quite common. For example, among respondents who tried to access a service without ID, 48.8% reported this occurred at a bank, 30.2% reported this occurred while trying to get housing, 29.4% reported this occurred at a food bank, and 28.8% reported this occurred when trying to get employment (Table 2.13). Although not always significant, Indigenous participants were *always* more likely to report being refused service because they did not have ID than the other respondents. The difference in percentages between the groups *were* statistically significant for being denied service at a food bank, when attempting to get EIA, when attempting to get employment training or education, and when trying to stay at an emergency shelter. Additionally, First Nations respondents were *always* more likely to report they were refused service because they did not have ID than Métis respondents (Table 2.14). The differences between the First Nations and Métis group percentages were statistically significant for being refused service at a bank and a food bank.

Table 2.13: Refused service because of lack of identification by Indigenous and not Indigenous groups.

Service	Total		Indigenous		Not Indigenous		χ²	*p*-value
	N	%	*N*	%	*N*	%		
Banking	168	48.8	119	50.9	35	38.9	3.73	0.053
Housing	104	30.2	77	32.9	21	23.3	2.82	0.093
Food Bank	101	29.4	75	32.1	18	20.0	**4.61**	**0.032**
Employment	99	28.8	72	30.8	20	22.2	2.34	0.126
Welfare/EIA	74	21.5	58	24.8	13	14.4	**4.06**	**0.044**
Employment Training/Education	62	18.0	48	20.5	7	7.8	7.48	0.006
Disability Assistance (EIA)	39	11.3	31	13.2	7	7.8	1.88	0.170
Emergency Shelter	37	10.8	28	12.0	s	s	**4.13**	**0.042**
Never refused service	93	27.0	51	21.8	37	41.1	**12.26**	**< 0.001**

Note. Total N = 344, Indigenous N = 234, Not Indigenous N = 90.
Bolded values indicate statistical significance, $p < 0.05$.
's' means the value was suppressed due to frequencies less than 5.

Table 2.14: Refused service because of lack of identification by Indigenous identity.

Service	First Nations		Métis		Not Indigenous		χ²	*p*-value
	N	%	*N*	%	*N*	%		
Banking	101	55.5	17	38.6	35	38.9	**8.61**	**0.014**
Housing	63	34.6	13	29.5	21	23.3	3.64	0.162
Food Bank	66	36.3	9	20.5	18	20.0	**9.65**	**0.008**
Employment	62	34.1	10	22.7	20	22.2	5.10	0.078
Welfare/EIA	49	26.9	8	18.2	13	14.4	5.91	0.052
Employment Training/Education	43	23.6	6	13.6	7	7.8	**10.96**	0.004
Disability Assistance (EIA)	s	s	s	s	7	7.8	4.60	0.100
Never refused service	33	18.1	13	29.5	37	41.1	**16.70**	**0.000**

Note. First Nation N = 182, Métis N = 44, Not Indigenous N = 90.
Since a small number of people were refused service at an emergency shelter, the findings are not presented.
Bolded values indicate statistical significance, $p < 0.05$.
's' means the value was suppressed due to frequencies less than 5.

2.5 Mental dimension

The **Mental Dimension** includes mental health, coping skills, and self-fulfilment. This section includes three subsections. The self-reported health and well-being subsection includes ratings of general health and mental health as well as frequency of feeling lonely and/or isolated. The mental health subsection covers lifetime experiences of mental health issues, experiences of mental health issues in the year prior to the survey, self-reported physician-diagnosed mental health conditions, suicidal ideation and attempts, and mental health care. The personal health practices and coping methods subsection includes frequency and amount of alcohol consumption and drug use.

2.5.1 Self-reported health and well-being

Survey participants were asked to rate their overall health and their mental health. The most common response for both questions was "good", as reported by 33.4% and 35.0% of respondents respectively for overall health and mental health (see Table 3.1). Slightly less than half of respondents reported their overall health (44.7%) and mental health (44.5%) were fair or poor. There were no significant relationships between Indigenous identity and self-rated general health or mental health; that is, the groups responded similarly to these two questions (see Tables 3.2 and 3.3).

Survey participants were also asked how frequently they feel lonely or isolated from other people. Few participants (16.2%) reported they never feel lonely or isolated; almost half (46.9%) reported they often feel this way. The Indigenous and not Indigenous groups responded similarly to this question.

Table 3.1: Self-reported general and mental health, and feelings of loneliness and isolation.

Variable	Response	*N*	%
General Health[a]	Excellent	32	8.2
	Very good	53	13.6
	Good	130	33.4
	Fair	120	30.8
	Poor	54	13.9
Mental Health[b]	Excellent	43	11.1
	Very good	37	9.5
	Good	136	35.0
	Fair	119	30.6
	Poor	54	13.9
Frequency of feeling lonely or isolated from other people[c]	Often	183	46.9
	Sometimes	144	36.9
	Never	63	16.2

Note. [a]*N*= 389, [b]*N*= 389, [c]*N* = 390.

Table 3.2: Self-reported general and mental health, and feelings of loneliness and isolation by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
General Health[a]	Excellent/Very good/Good	215	55.3	143	54.4	59	56.2	0.10	0.752
	Fair or poor	174	44.7	120	45.6	46	43.8		
Mental Health[b]	Excellent/Very good/Good	216	55.5	147	55.9	58	54.2	0.09	0.767
	Fair or poor	173	44.5	116	44.1	49	45.8		
Frequency of feeling lonely or isolated from other people[c]	Often	183	46.9	122	46.2	51	47.2	0.13	0.939
	Sometimes	144	36.9	99	37.5	41	38.0		
	Never	63	16.2	43	16.3	16	14.8		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 389 (groups *N*= 368), [b]*N* = 389 (groups *N* = 370), [c]*N* = 390 (groups *N* = 372).

Table 3.3: Self-reported general and mental health, and feelings of loneliness and isolation by Indigenous identity.

Variable	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
General Health[a]	Excellent/Very good/Good	109	54.0	29	56.2	59	56.2	0.14	0.933
	Fair or poor	93	46.0	24	45.3	46	43.8		
Mental Health[b]	Excellent/Very good/Good	110	54.5	32	61.5	58	54.2	0.93	0.629
	Fair or poor	92	45.5	20	38.5	49	45.8		
Frequency of feeling lonely or isolated from other people[c]	Often	99	49.0	21	40.4	51	47.2	1.54	0.820
	Sometimes	70	34.7	22	42.3	41	38.0		
	Never	33	16.3	9	17.3	16	14.8		

Note. [a]*N*= 360, [b]*N*= 361, [c]*N*= 362.

2.5.2 Mental health

The survey asked questions about mental health conditions in several ways: lifetime experiences, experiences in the year prior to the survey, and self-reported physician-diagnosed mental health conditions. There were few statistically significant differences (at the 5% level of significance) between the groups. In general, the group who did not identify as Indigenous had higher percentages compared to the Indigenous groups. When group percentages did not differ significantly, the group percentages were similar to the overall percentage. In general, for lifetime experiences and experiences in the year prior to the survey of mental health issues, the percentages for the Métis group were higher than the First Nations group; however, there was not a clear pattern for physician-diagnosed mental health conditions.

2.5.2.1 Mental health issues in the year prior to the survey

Many participants experienced mental health issues in the year prior to completing the survey, including depression (76.6%), anxiety or tension (74.6%), and trouble understanding, concentrating, or remembering (63.2%) (see Table 3.4). The group who did not identify as Indigenous had a significantly higher percentage (85.4%) who reported anxiety than the Indigenous group (69.8%) [$\chi_{(1)}^2 = 9.40$, $p = 0.002$]. The two Indigenous groups had similar percentages for those who reported anxiety or tension in the year prior to the survey (First Nations, 68.8% and Métis, 70.6%; see Table 3.5). The groups did not differ significantly on the other three mental health issues.

Table 3.4: Experiences with mental health issues in the year prior to the survey by Indigenous and not Indigenous groups.

Mental Health Issue	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Depression[a]	Yes	294	76.6	197	74.9	85	81.7	1.95	0.162
	No	90	23.4	66	25.1	19	18.3		
Anxiety or tension[b]	Yes	285	74.6	183	69.8	88	85.4	**9.40**	**0.002**
	No	97	25.4	79	30.2	15	14.6		
Trouble understanding, concentrating, or remembering[c]	Yes	242	63.2	167	63.7	67	64.4	0.02	0.902
	No	141	36.8	95	36.3	37	35.6		
Hallucinations (heard voices or seen things that you could not control or that others could not hear or see)[d]	Yes	103	27.1	66	25.3	32	31.4	1.38	0.240
	No	277	72.9	195	74.7	70	68.6		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 384 (groups *N* = 376), [b]*N* = 382 (groups *N* = 365), [c]*N* = 383 (groups *N* = 366), [d]*N* = 380 (groups *N* = 363)

Bolded values indicate statistical significance, $p < 0.05$.

Table 3.5: Experiences with mental health issues in the year prior to the survey by Indigenous identity.

Mental Health Issue	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Depression[a]	Yes	152	74.5	39	78.0	85	81.7	2.06	0.357
	No	52	25.5	11	22.0	19	18.3		
Anxiety or tension[b]	Yes	139	68.8	36	70.6	88	85.4	**10.10**	**0.006**
	No	63	31.2	15	29.4	15	14.6		
Trouble understanding, concentrating, or remembering[c]	Yes	132	65.0	28	56.0	67	64.4	1.46	0.483
	No	71	35.0	22	44.0	37	35.6		
Hallucinations (heard voices or seen things that you could not control or that others could not hear or see)[d]	Yes	49	24.3	14	28.0	32	31.4	1.79	0.409
	No	153	75.7	36	72.0	70	68.6		

Note. [a]*N* = 358, [b]*N* = 356, [c]*N* = 357, [d]*N* = 354.
Bolded values indicate statistical significance, $p < 0.05$.

2.5.2.2 Physician diagnosed mental health conditions

Nearly two-thirds of all respondents (64.8%) reported having a physician-diagnosed mental health condition. The most common conditions were anxiety disorders (46.4%) (see Table 3.6). Anxiety disorders included anxiety, Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder, Panic Disorder, and phobias. Mood disorders (39.2%) were the next most common condition, followed by substance use disorders (38.5%), personality disorders (11.9%), and schizophrenia (8.4%). A notable percentage (10.4%) reported they had been diagnosed with cognitive impairment.

The difference in percentages of having a physician-diagnosed anxiety disorder between the Indigenous group (43.5%) and the other group (54.5%) bordered on statistical significance [$\chi_{(1)}^2 = 3.81$, $p = 0.051$]. Table 3.7 shows the percentage reporting an anxiety disorder from the First Nations group (46.4%) was statistically similar to the group that was not Indigenous (54.5%), while the Métis group differed statistically from other two groups (28.3%) [$\chi_{(2)}^2 = 9.92$, $p = 0.007$]. There were no statistically significant differences between the groups for any of the other physician-diagnosed mental health conditions.

Table 3.6: Physician-diagnosed mental health conditions by Indigenous and not Indigenous groups.

Mental Health Condition	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
A Mental Health Diagnosis[a]	Yes	261	64.8	173	63.8	77	70.0	1.32	0.251
	No	142	35.2	98	36.2	33	30.0		
Anxiety Disorders[b]	Yes	187	46.4	118	43.5	60	54.5	3.81	0.051
	No	216	53.6	153	56.5	50	45.5		
Mood Disorders[c]	Yes	158	39.2	104	38.4	48	43.6	0.90	0.342
	No	245	60.8	167	61.6	62	56.4		
Addiction[d]	Yes	155	38.5	105	38.7	42	38.2	0.01	0.918
	No	248	61.5	166	61.3	68	61.8		
Personality Disorder[e]	Yes	48	11.9	29	10.7	17	15.5	1.67	0.197
	No	355	88.1	242	89.3	93	84.5		
Cognitive Impairment[f]	Yes	42	10.4	28	10.3	12	10.9	0.03	0.868
	No	361	89.6	243	89.7	98	89.1		
Schizophrenia[g]	Yes	34	8.4	23	8.5	10	9.1	0.04	0.849
	No	369	91.6	248	91.5	100	90.9		

Note. Groups = Indigenous + Not Indigenous.

[a]*N* = 403 (groups [a]*N* = 381), [b]*N* = 403 (groups [b]*N* = 381), [c]*N* = 403 (groups [c]*N* = 381), [d]*N* = 403 (groups [d]*N* = 381), [e]*N* = 403 (groups [e]*N* = 381), [f]*N* = 403 (groups [f]*N* = 381), [g]*N* = 403 (groups [g]*N* = 381).

[b]Anxiety Disorders = Anxiety + Post-Traumatic Stress Disorder (PTSD) + Obsessive Compulsive Disorder + Panic Disorder + Phobia.

[c]Mood Disorders = Depression + Manic Depression + Bipolar Disorder.

[e]Personality Disorders = Multiple Personality Disorder + Borderline Personality Disorder.

Table 3.7: Physician-diagnosed mental health conditions by Indigenous identity.

Mental Health Condition	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
A Mental Health Diagnosis[a]	Yes	135	64.6	30	56.6	77	70.0	2.87	0.238
	No	74	35.4	23	43.4	33	30.0		
Anxiety Disorders[b]	Yes	97	46.4	15	28.3	60	54.5	**9.92**	**0.007**
	No	112	53.6	38	71.7	50	45.5		
Mood Disorders[c]	Yes	82	39.2	17	32.1	48	43.6	2.02	0.365
	No	127	60.8	36	67.9	62	56.4		
Addiction[d]	Yes	83	39.7	19	35.8	42	38.2	0.28	0.87
	No	126	60.3	34	64.2	68	61.8		
Personality Disorder[e]	Yes	22	10.5	6	11.3	17	15.5	1.68	0.431
	No	187	89.5	47	88.7	93	84.5		
Cognitive Impairment[f]	Yes	24	11.5	s	s	12	10.9	1.56	0.459
	No	185	88.5	s	s	98	89.1		

Note. [a]*N* = 372, [b]*N* = 372, [c]*N* = 372, [d]*N* = 372, [e]*N* = 372, [f]*N* = 319.

[b]Anxiety Disorders = Anxiety + Post-Traumatic Stress Disorder (PTSD) + Obsessive Compulsive Disorder + Panic Disorder + Phobia.

[c]Mood Disorders = Depression + Manic Depression + Bipolar Disorder.

[e]Personality Disorders = Multiple Personality Disorder + Borderline Personality Disorder.

Due to small frequencies, the results for schizophrenia could not be reported.

s means the value was suppressed because the frequency was < 5.

Bolded values indicate statistical significance, $p < 0.05$.

2.5.2.3 Suicidal ideation and attempts

Half of all respondents (49.9%) reported ever having thoughts about hurting or killing themselves (see Table 3.8). The respondents not identifying as Indigenous (61.0%) were significantly more likely to report suicidal ideation than the Indigenous respondents (45.8%) [$\chi_{(1)}^2 = 6.99$, $p = 0.008$]. Reported lifetime suicidal ideation was more common among the Métis respondents (51.9%) than the First Nations respondents (44.0%); though, this difference was not significant (see Table 3.9).

Among those who reported ever experiencing suicidal ideation, around two-thirds reported experiencing suicidal ideation in the year prior to completing the survey (Métis, 64.3%; First Nations, 69.2%; not Indigenous, 61.9%) and/or had ever tried to hurt or kill themselves (Métis, 57.1%; First Nations, 65.9%; not Indigenous, 69.2%). Among those who had ever tried to hurt or kill themselves, around half reported attempting this in the year prior to the survey (Métis, 55.6%; First Nations, 54.0%; not Indigenous, 43.6%).

Table 3.8: Suicide ideation and attempts by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Suicidal ideation (Lifetime)[a]	Yes	196	49.9	124	45.8	64	61.0	**6.99**	**0.008**
	No	197	50.1	147	54.2	41	39.0		
Suicidal ideation in the year prior to the survey[b]	Yes	129	65.8	78	63.4	45	69.2	0.64	0.425
	No	67	34.2	45	36.6	20	30.8		
Suicide attempt (Lifetime)[c]	Yes	129	66.8	84	68.9	39	61.9	0.90	0.343
	No	64	33.2	38	31.1	24	38.1		
Suicide attempt in the year prior to the survey[d]	Yes	65	50.4	44	52.4	17	43.6	0.82	0.364
	No	64	49.6	40	47.6	22	56.4		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 393 (groups *N* = 376), [b]*N* = 196 (groups *N* = 188), [c]*N* = 193 (groups *N* = 185), [d]*N* = 129 (groups *N* = 123).
Bolded values indicate statistical significance, $p < 0.05$.

Table 3.9: Suicide ideation and attempts by Indigenous identity.

Variable	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Suicidal ideation (Lifetime)[a]	Yes	92	44.0	28	51.9	64	61.0	8.10	0.017
	No	117	56.0	26	48.1	41	39.0		
Suicidal ideation in the year prior to the survey[b]	Yes	60	65.9	16	57.1	45	69.2	1.27	0.529
	No	31	34.1	12	42.9	20	30.8		
Suicide attempt (Lifetime)[c]	Yes	63	69.2	18	64.3	39	61.9	0.93	0.628
	No	28	30.8	10	35.7	24	38.1		
Suicide attempt in the year prior to the survey[d]	Yes	34	54.0	10	55.6	17	43.6	1.23	0.541
	No	29	46.0	8	44.4	22	56.4		

Note. [a]*N* = 368, [b]*N* = 184, [c]*N* = 182, [d]*N* = 120.
Bolded values indicate statistical significance, $p < 0.05$.

2.5.2.4 Mental health care

Almost 20% of participants reported they needed mental health care in the year prior to the survey but were unable to get help; the percentages were similar for Indigenous respondents (19.4%) and those who did not identify as Indigenous (18.7%) (see Table 3.10).

Participants were asked to name the two main reasons why they were not able to access mental health care. The number one reason was because they lacked access (78.3%), followed by they were anxious about seeking treatment (32.4%), and they did not have time to access care (17.6%). Lack of access to mental health care was due to not having a health card, seeing a doctor but not being offered this care, not having a doctor to go to, not able to get a specialist referral, not knowing where to go for care, transportation issues, and/or not having health care coverage. Individuals were anxious because they did not like doctors, they had a negative experience or were treated poorly in the past, were fearful (e.g., painful, embarrassing, find something wrong), and/or were concerned about their personal safety. There were no differences between the groups for reasons for not accessing mental health care (see Tables 3.10 and 3.11)

Table 3.10: Lack of access to mental health care by Indigenous and not Indigenous groups.

Variable	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Needed but unable to get mental health care in the year prior to the survey[a]	Yes	77	19.8	52	19.4	20	18.7	0.03	0.875
	No	312	80.2	216	80.6	87	81.3		
Two main reasons for not accessing mental health care	Lack of Access[b]	54	78.3	40	85.1	12	66.7	2.77	0.096
	Anxiety about seeking treatment[c]	22	32.4	12	26.1	8	44.4	2.03	0.154
	No Time to[d]	12	17.6						
	Did not think it was necessary	s	s						
	Caregiving responsibilities prevent me[e]	s	s						
	Unable to due to housing or health problems[f]	s	s						

Note. Respondents could select two that apply for the reasons for not accessing mental health case question.
Groups = Indigenous + Not Indigenous.
[a]*N* = 389 (groups *N* = 375), [b]*N* = 69 (Indigenous *N* = 47, Not Indigenous *N* = 18), [c]*N* = 68 (Indigenous *N* = 46, Not Indigenous *N* = 18), [d]*N* = 68.
[b]Lack of Access = Don't have a health card + Saw doctor but was not offered this care + Don't have a doctor to go to + Can't get a specialist referral + Didn't know where to go to get care + Transportation — problems + Language problems + Don't have coverage + Weather/environmental issues.
[c]Anxiety about seeking treatment = Don't like doctors + Had a negative experience/was treated poorly in the past + Fear (e.g., painful, embarrassing, find something wrong) + Personal safety or interpersonal reasons.
[d]No Time to = Haven't Gotten around to it + Too busy finding food, shelter, or other necessities + Couldn't get time off work + Inconvenient clinic hours + Waiting time was too long.
[e]Caregiving responsibilities prevent me = Couldn't get child care + Personal or family responsibilities.
[f]Unable to due to Housing/Health Problems = Health problems prevent me from going + Current lifestyle or living situation
s means the value was suppressed because the frequency was < 5.

Table 3.11: Needed but were unable to get mental health care in the year prior to the survey by Indigenous identity.

Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
	N	%	*N*	%	*N*	%		
Yes	40	19.3	11	20.8	20	18.7	0.10	0.953
No	167	80.7	42	79.2	87	81.3		

Note. N = 367. Due to small frequencies, the results for the two main reasons for not accessing mental health care could not be reported.

2.5.3 Personal health practices and coping methods

2.5.3.1 Alcohol consumption

Survey participants were asked both how often they consume alcohol and how much alcohol they consume. In the month prior to the survey, slightly more than one-quarter of respondents (28.5%) indicated they did not consume alcohol, while almost one-third (32.1%) consumed alcohol one to four times, and 39.4% consumed alcohol at least once a week (up to once a day) (see Table 3.12). There was a statistically significant relationship between Indigenous identity and frequency of alcohol consumption [$\chi_{(2)}{}^2 = 6.73$, $p = 0.035$]. Alcohol consumption reported "at least weekly (up to daily)" was 47% higher among Indigenous respondents (43.1%) than respondents who were not Indigenous (29.4%). However, Table 3.13 indicates that frequency of alcohol consumption did not differ statistically when Indigenous identity was disaggregated (i.e., First Nations and Métis groups).

The amount of alcohol consumed on one occasion is reported here is based on Statistics Canada's categories. Slightly more than half of respondents (52.9%) reported heavy drinking (i.e., consumed at least five drinks on one occasion at least once a month). There was a statistically significant relationship between the amount of alcohol consumed and Indigenous identity [$\chi_{(1)}{}^2 = 6.75$, $p = 0.009$]. A higher percentage of individuals in the Indigenous group reported heavy drinking (51.4%) than individuals in the other group (36.4%). The difference in the percentages of reported heaving drinking between First Nations respondents (51.8%) and Métis respondents (46.0%) was not significant.

Table 3.12: Frequency and amount of alcohol consumption by Indigenous and not Indigenous groups.

Alcohol Consumption	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Frequency of drinking in the past month[a]	At least once a week (up to daily)	152	39.4	115	43.1	32	29.4	**6.73**	**0.035**
	1 to 3 or 4 times last month	124	32.1	83	31.1	38	34.9		
	Never in the past 30 days	110	28.5	69	25.8	39	35.8		
Amount of alcohol consumption in the year prior to the survey[b]	Heavy drinking	198	52.9	132	51.4	39	36.5	**6.75**	**0.009**
	Not heavy drinking	176	47.1	125	48.6	68	63.6		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 386 (groups *N* = 376), [b]*N* = 374 (groups *N* = 364).
Statistics Canada defines heavy drinking as men who report having five or more drinks or women who reported having four or more drinks, on one occasion, at least once a month in the year prior to the survey. (https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009611).
The SHS survey asked, "How often, in the year prior to the survey, have you had 5 or more drinks on one occasion?" Heavy drinking is defined here as "once month/about 3 times a month/once a week/more than once a week".

Table 3.13: Frequency and amount of alcohol consumption by Indigenous identity.

Alcohol Consumption	Response	First Nations		Métis		Not Indigenous		χ^2	p-value
		N	%	*N*	%	*N*	%		
Frequency of drinking in the past month[a]	At least once a week (up to daily)	91	44.6	20	37.0	32	29.4	7.95	0.093
	1 to 3 or 4 times last month	59	28.9	20	37.0	38	34.9		
	Never in the past 30 days	54	26.5	14	25.9	39	35.8		
Amount of alcohol consumption in the year prior to the survey[b]	Heavy drinking	103	51.8	23	46.0	39	36.4	**6.56**	**0.038**
	Not heavy drinking	96	48.2	27	54.0	68	63.6		

Note. [a]*N* = 367, [b]*N* = 356.
Statistics Canada defines heavy drinking as men who report having five or more drinks or women who reported having four or more drinks, on one occasion, at least once a month in the year prior to the survey. (https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009611).
The SHS survey asked, "How often, in the year prior to the survey, have you had 5 or more drinks on one occasion?" Heavy drinking is defined here as "once month/about 3 times a month/once a week/more than once a week".
Bolded values indicate statistical significance, $p < 0.05$.

2.5.3.2 Drug use

Survey participants were provided with a list of 19 different drugs and asked if they used any of them regularly in the year before the survey. They also had the opportunity to identify other drugs not part of the list. Regular use was defined as three or more times a week. Cigarettes were the most reported drug used — 80.7% (see Table 3.14). Cannabis use was reported by more than half of respondents (53.9%). Stimulants, which include cocaine, crack, amphetamines, and methamphetamines, was the next most reported (43.8%) class of drugs. Opiate use was reported by 21.9% of respondents, followed by use of sedatives (16.0%), use of over-the-counter medication not taken as prescribed (13.8%), and hallucinogens (7.2%).

There were no statistically significant differences in the percentages of reported use of any of the drugs between the Indigenous and not Indigenous groups. There were also no differences in the percentages of reported use of any of the drugs between First Nations and Métis respondents, except for hallucinogens (see Table 3.15). A higher percentage of Métis respondents (14.8%) reported using hallucinogens than First Nations respondents (5.3%). Hallucinogens include Lysergic Acid Diethylamide (LSD), Phencyclidine (PCP), peyote, mescaline, ecstasy, and mushrooms.

Table 3.14: Regular drug use in the year before the survey by Indigenous and not Indigenous groups.

Drug	Response	Total		Indigenous		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Cigarettes[a]	Yes	326	80.7	223	81.7	95	86.4	1.22	0.270
	No	78	19.3	50	18.3	15	13.6		
Cannabis[b]	Yes	212	53.9	152	55.7	55	50.5	0.86	0.355
	No	181	46.1	121	44.3	54	49.5		
Stimulants[c]	Yes	172	43.8	121	44.3	47	43.1	0.05	0.831
	No	221	56.2	152	55.7	62	56.8		
Methamphetamines[d]	Yes	115	29.3	76	27.8	37	34.3	1.53	0.216
	No	277	70.7	197	72.2	71	65.7		
Opiates[e]	Yes	86	21.9	64	23.4	21	19.3	0.79	0.375
	No	307	78.1	209	76.6	88	80.7		
Sedatives[f]	Yes	63	16.0	46	16.8	16	14.7	0.27	0.603
	No	330	84.0	227	83.2	93	85.3		
Over-the-counter medication (not taken as prescribed)[g]	Yes	54	13.8	43	15.9	11	10.1	2.13	0.145
	No	337	86.2	228	84.1	98	89.9		
Hallucinogens[h]	Yes	28	7.2	19	7.1	9	8.3	0.18	0.671
	No	360	92.8	250	92.9	99	91.7		
Inhalants[i]	Yes	8	2.0	7	2.6	s	s	1.02	0.313
	No	383	98.0	265	97.4	s	s		

Note. Groups = Indigenous + Not Indigenous.
[a]*N* = 404 (groups *N* = 383), [b]*N* = 393 (groups *N* = 382), [c]*N* = 393 (groups *N* = 382), [d]*N* = 392 (groups *N* = 381), [e]*N* = 393 (groups *N* = 382), [f]*N* = 393 (groups *N* = 382), [g]*N* = 391 (groups *N* = 380), [h]*N* = 388 (groups *N* = 377), [i]*N* = 391 (groups *N* = 272).
[b]Cannabis = Marijuana (includes medical marijuana not taken as prescribed).
[c]Stimulants = Cocaine, Crack, Amphetamines, Methamphetamines.
[e]Opiates = Heroin, Methadone, Morphine, Oxycontin, Fentanyl, Other Opiates (Percocet, Demerol, Talwin, Dilaudid)
[f]Sedatives = downers (e.g., Barbiturates), hypnotics, tranquillisers, Special K, GHB.
[h]Hallucinogens = LSD, PCP, peyote, mescaline, ecstasy, mushrooms.
[g]Over-the-counter medication = cough syrup, Gravol, Sudafed, Tylenol.
[i]Inhalants = solvents (e.g., glue, paint thinner, gas, aerosol sprays).
'*s*' means the values were suppressed due to small frequencies (less than 5).

Table 3.15: Regular drug use in the year prior to the survey by Indigenous identity.

Drug	Response	First Nations		Métis		Not Indigenous		χ^2	*p*-value
		N	%	*N*	%	*N*	%		
Cigarettes[a]	Yes	170	81.0	47	87.0	95	86.4	2.13	0.346
	No	40	19.0	7	13.0	15	13.6		
Cannabis[b]	Yes	115	54.8	31	57.4	55	50.5	0.85	0.654
	No	95	45.2	23	42.6	54	49.5		
Stimulants[c]	Yes	91	43.3	26	48.1	47	43.1	0.45	0.799
	No	119	56.7	28	51.9	62	56.8		
Methamphetamines[d]	Yes	58	27.6	16	29.6	37	34.3	1.50	0.472
	No	152	72.4	38	70.4	71	65.7		
Opiates[e]	Yes	47	22.4	16	29.6	21	19.3	2.23	0.328
	No	163	77.6	38	70.4	88	80.7		
Sedatives[f]	Yes	38	18.1	5	9.3	16	14.7	2.67	0.263
	No	172	81.9	49	90.7	93	85.3		
Over-the-counter medication (not taken as prescribed)[g]	Yes	35	16.8	8	14.8	11	10.1	2.61	0.271
	No	173	83.2	46	85.2	98	89.9		
Hallucinogens[h]	Yes	11	5.3	8	14.8	9	8.3	E < 5	
	No	195	94.7	46	85.2	99	91.7		

Note. [a]N =374, [b]*N* = 373, [c]*N* = 373, [d]*N* = 372, [e]*N* = 373,[f]*N* = 373, [g]*N* = 371, [h]*N* = 368.
[b]Cannabis = Marijuana (includes medical marijuana not taken as prescribed).
[c]Stimulants = Cocaine, Crack, Amphetamines, Methamphetamines.
[e]Opiates = Heroin, Methadone, Morphine, Oxycontin, Fentanyl, Other Opiates (Percocet, Demerol, Talwin, Dilaudid)
[f]Sedatives = downers (e.g., Barbiturates), hypnotics, tranquillisers, Special K, GHB.
[g]Over-the-counter medication = cough syrup, Gravol, Sudafed, Tylenol.
[h]Hallucinogens = LSD, PCP, peyote, mescaline, ecstasy, mushrooms.
Inhalants = solvents (e.g., glue, paint thinner, gas, aerosol sprays).
Inhalants could not be reported due to the small number of individuals (i.e., less than 5) who reported using inhalants in each of the groups.
E < 5 means that the expected value is less than 5. It is not appropriate to perform a chi-square test if E < 5.

2.6 Spiritual dimension

The Spiritual Dimension includes religious and spiritual beliefs and practices. Spirituality gives people a sense of connectedness and life purpose. Community and spirituality connect people to their roots, help them understand who they are and what they want to do in life, and give them hope. None of the survey questions aligned with the spiritual dimension.

3. Qualitative study

The qualitative research findings are presented here. The qualitative component of this study aimed to understand the perspectives and experiences of Indigenous peoples who had experienced homelessness in Winnipeg. Indigenous peoples are overrepresented in homelessness in Winnipeg. In the 2018 Street Health Survey, 71% of participants identified as Indigenous, which included First Nations, Inuit, and/or Métis. It is imperative to understand their needs and experiences to address homelessness among this population in a good way.

Eighteen Indigenous individuals who were experiencing or had previously experienced homelessness were recruited. The recruitment plan is detailed in the methods section below. We learned that there are different housing preferences, and external and personal factors play a large role. For instance, an individual with children may prefer to live in a two-story house in a neighbourhood with amenities nearby, whereas a single male in his early twenties may prefer a one-bedroom apartment where he could have friends over. Participants also shared how current housing options do not meet the needs of Indigenous peoples in Winnipeg. Several solutions were suggested, such as consulting those in need of housing when designing housing options.

The qualitative component of this report is divided into five sections. The first section describes the methods. The characteristics of the participants are presented in section 2. The findings are presented in section 3 and are organised according to the four dimensions: physical, spiritual, emotional, and mental. The fourth section describes the structural factors that affect the participants' lives, including culture and systems (e.g., justice and child protection), and presents their own recommendations. The discussion section summarises the key themes and offers recommendations. In the conclusion section, we share our reflections on the research.

3.1 Method

3.1.1 Participant recruitment

We sought to recruit individuals who identified as Indigenous and were or had experienced homelessness in Winnipeg. Recruiting participants was challenging because of the COVID-19 pandemic and the public health restrictions. At the time, in-person contact was strongly discouraged. Therefore, we requested the assistance of community organisations to help recruit participants. We decided to interview over the phone, relying on the community organisations to facilitate this.

We developed a strategy to recruit a diverse group of participants. We aimed to recruit between 20-25 individuals with characteristics (i.e., age, gender, Indigenous identity, sexual orientation) reflective of characteristics of the participants of the 2018 SHS. We also sought to ensure various groups were represented. We identified several community organisations that could help with recruitment. We chose organisations we had a relationship with. The organisations that agreed to assist were Just a Warm Sleep (1justcity), Manitoba Inuit Association, North End Women's Centre, Shawenim Abinoojii, and Sscope. We met with a representative from each organisation and provided them with instructions.

In total, the community organisations were able to recruit 18 people between February and April 2021. Table 4.1 shows the distribution of the characteristics we aimed for and the distribution of the characteristics of the sample. Note that the distribution of characteristics was not met in all groups, particularly individuals who are: Métis, over 50 years old, men, non-binary and/or part of a sexual minority. However, considering there were only 18 people in the sample, the underrepresentation would have only equated to a handful of individuals.

Table 4.1: Sample characteristics.

Characteristic	Identity	Target Percentage	Number of Participants	Percent of Participants
Indigenous Identity	First Nations	83	15	83
	Métis	15	1	6
	Inuit	2	2	11
Age (in years)	18-29	25	6	33
	30-49	45	9	50
	50+	30	3	17
Gender	Non-binary	3	0	0
	Women	32	12	67
	Men	65	6	33
Sexual orientation	2SLGBTQIA+	15	2	11

Note. N = 18.

The staff representative gave each participant a package before their interview. The following materials were in each package:

- A copy of the consent form
- A COVID-19 information sheet
- Several pieces of paper and coloured and regular pencils
- A bag of snacks and two bus tickets
- A $40.00 (Canadian) gift card as an honorarium

After all the interviews had been conducted at an organisation, someone from the Research Team picked up the extra materials and the participants' drawings.

The staff person arranged for participants to be in a comfortable space for the interview, helped them connect to the conference line, and provided them with supports if they became upset or distressed during or after the interview.

The interviews began with screening questions to ensure participants met the criteria to participate. The screening questions asked where they slept the night before, their age, and whether they identified as Indigenous. Table 4.1 above shows the participants' age distribution and Indigenous identity. Table 4.2 below shows where participants stayed the night before the survey.

Table 4.2: Where participants stayed the night before the interview by gender and Indigenous identity.

Location	Gender		Indigenous Identity		
	Men	Women	First Nations	Métis	Inuit
An emergency shelter or domestic violence shelter[a]	4	4	8		
Transitional housing[b]	1	5	3	1	2
Stayed with a friend[c]		1	1		
Stayed with a family member[d]	1	1	2		
Own apartment/house[e]		1	1		

Note. [a]N = 16, [b]N = 12,[c]N = 2, [d]N = 4, [e]N = 2.

Next, we obtained verbal consent to participate and audio record the interviews. We promised participants' anonymity and that we would keep the recordings in a secure location with access limited to the research team. Participants could withdraw from the study at any point, including after the interview. They could also refuse to answer questions.

3.1.2 Interviews

Following receipt of consent, participants were provided coloured and regular pencils and paper so they could draw or write. This provided participants with an alternative way to document their thoughts during and after the interview. Participants were invited to sketch their ideal living accommodation. They were invited to share their drawings with the Research Team.

We used a semi-structured interview format to ensure the interviews would be consistent, while also allowing participants to elaborate on their responses. The interview guide is in Appendix A. There was a pilot phase prior to launching the study. In this phase, the interview guide was "tested" with three people who had lived experience of homelessness to determine if the guide was well-organised, suitable, and easy to understand.

Each interviews took 20 minutes to over an hour, depending on how much participants shared. A few participants took breaks during their interview. The staff representative was nearby in case participants needed support. A staff person was present for two of the interviews to provide support.

3.1.3 Data analysis

The interviews were audio recorded and transcribed verbatim by a transcriptionist. The recordings and transcriptions were anonymized by assigning unique codes to the participants.

We used a thematic analysis method and developed a coding scheme to analyse the transcripts. The coding scheme was based on the 4-dimensional framework: physical, spiritual, emotional, and mental dimensions. We also added a code called structural. The structural code encapsulated external factors that impact Indigenous peoples experiencing homelessness (e.g., colonialism, racism). These five codes were broken down into sub-codes (see the coding scheme in Appendix B) to capture related topics within each code.

Several limitations and biases to the methods and analyses adopted for the qualitative results were identified and can be reviewed in Section 3.3.

3.2 Qualitative results

This section presents the findings from the interviews that relate to the 4-dimensional framework. The first dimension is physical, which explores the participants' housing preferences, like dwelling size, location, and proximity to amenities, as well as the sense of security that a home provides. The second dimension is spiritual. Participants shared their desires to own objects and live near groups and facilities that host spiritual events. Thirdly, the emotional dimension highlights the importance of relationships, sense of belonging, and autonomy of participants. Lastly, the mental dimension describes the coping mechanisms that participants used while experiencing homelessness, as well as how their mental health impacted finding a home.

Upon reviewing the data collected that did not quite fit within the four dimensions, the Research Team included an additional section titled "Structural and Participant's Recommendations". The structural piece comprises anything that participants shared related to culture, colonialism and racism, as well as government systems (eg., child family services, criminal justice, employment, income assistance).

3.2.1 Physical dimension

3.2.1.1 Desired characteristics of a home

Participants were asked what their ideal home would look like. The respondents described the size of the home, the belongings they would like to have, and the location.

3.2.1.2 Housing type

There was a range of preferred housing types. Three participants, two of whom were youth, expressed interest in living in an apartment. One participant said, **"I want a tall apartment, with a balcony, on the top floor"**. The other youth, who is Inuit, spoke about different housing for different family compositions:

> **"I find that for the person that's single, they'd need an apartment and a person that has children should have a house setting. Like a real house setting with three bedrooms and a kitchen and a living room — a full house for a family. A clean apartment for the ones that are single."**

In contrast, thirteen respondents indicated they preferred a house over an apartment as houses have more space to accommodate family members and allow for greater privacy.

One respondent shared they would prefer to have **"a two bedroom [house]. This way if I ever had visitors, I'd have a room for them to sleep in, for relatives from out of town or something."** Another participant said she wants more privacy with **"no neighbours so close, side by side. Just a place with no thin walls."** She shared that it was something she had not had in a few years.

Other participants preferred a two-storey home over a bungalow. The number of bedrooms is important, particularly for the mothers who wanted between two and five bedrooms for their family. However, a First Nations male wanted:

> **"Just a one-bedroom. It's just me and my wife. And [if I] get my kids back [I'd] upgrade it to two to three bedrooms, when the kids come home. For now, it would probably be a one bedroom or a bachelor or something. It wouldn't matter. It doesn't have to be fancy or anything. I don't care."**

A mother of several children drew a two-storey home with a deck on the front (see Figure 2.1). This was the only drawing from the study.

Having a yard was important to some participants. One participant wanted **"A nice cosy home, [with] a garden in the front"**. An Inuit woman in her 20s joked that a big yard would be too much work but **"If it's a small yard, I don't mind. It would be great. A place for children to play outside at least and watch over them."**

Figure 2.1. Envisioning a two-storey home with a balcony and front deck - drawing shared by an interview participant

3.2.1.3 Belongings

A few participants spoke about the things they would like in their home. A First Nations man shared that "pictures of my family, of my parents, my mum, things like that, have them on the wall" would be important and would make it feel like home. A male youth in his early 20s wished for "a radio, TV, internet. I have my phone, so I don't really need a TV. I don't like paying for internet twice." Another participant wanted the cost of utilities included in the rent as it can be expensive. For example, the participant desired a place:

> "Where the heat is included, where the utilities are included because sometimes when you pay rent somewhere, the utilities aren't included, like hydro. So, I'd like to stay in a house where they're included, all under one bill, with the rent, for example. Where the rent will cover everything, like the utilities, the hydro."

3.2.1.4 Location

Participants differed in where they preferred their home be located. Several expressed their home community was the ideal place to live, not Winnipeg. A First Nations male shared:

> "Home is...I don't feel comfortable in Winnipeg. Home is Churchill to me. That's where I'm originally from. I like to go and spend time with my brother. That's where I was born and raised. The city life is not very great."

Similarly, a female participant shared, "As a Manitoba Inuit who's been here since 1984, my community in Nunavut is my real home." On the contrary, some participants indicated a preference to live on the outskirts of Winnipeg where there are opportunities to have a yard and more space.

Most participants who wished to stay in Winnipeg, preferred to live in central neighbourhoods, such as the North End and near downtown. These areas were familiar to participants and are where their family and friends live. A female youth shared she would "rather live downtown or somewhere near the downtown, the Exchange, Osborne [Village]". Another participant elaborated on why they preferred being near downtown. They said, "Somewhere not far from the downtown [because] this way it's not far for everything, let's say the local library. The library would be close by, and the stores are close by."

However, a few participants preferred not to live in central areas because they wanted to avoid something (e.g., negative memories, certain lifestyle) or were drawn to something (e.g., space to have a yard). One participant shared:

> "Ya, Central and West Side I grew up in, but I don't [go] there. I stopped hanging around with my old friends, and I don't want to be in that lifestyle anymore. I'm sick of that lifestyle. I'd like to live in somewhere like St. Vital, somewhere far, you know what I mean? Not in the areas where I used to go."

3.2.1.5 Proximity to amenities

Respondents who preferred to live in a central area wanted to be within walking distance of amenities, such as schools, libraries, shopping centres, convenience stores, and bus routes. A male youth wanted to live close to Pan Am Boxing in the Exchange District to remain active. An Inuit woman enjoys living on Langside in West Broadway, as she often visits the corner grocery store down the street. A mother of several children wanted to live "where there's a recreation centre nearby... Like a drop-in centre, where the kids can go, with a hockey rink and stuff that they do for families, for the children, the kids." She also shared "The last neighbourhood I lived in was Concordia but that was way out and there's no recreation centre around there. I really didn't get into looking into one around that area."

3.2.1.6 Just having a place

Several participants did not care where they lived or in what type of structure. They just wanted a place to call home. This idea is illustrated in the following quote:

> "I don't think it would really matter to me as long as I have a roof over my head and food in my fridge and just a place for me and my kids to sleep. That's all that would matter to me. Whether it'd be a house or an apartment, it wouldn't really matter to me. So long as we're safe and warm."

Another participant stated, "I wouldn't be picky on the area as long as it's a home. Anywhere in the city would be fine by me." A female in her 30s elaborated, "We're not going to say 'I want a five-bedroom house with bay windows, all the highest-end stuff from Leons' and 'it's gotta be leather' – no. We used to live in teepees on the land. We're not materialistic people."

3.2.1.7 Finding stability in a home

Another theme that emerged was housing stability. Thirteen participants desired a sense of security and comfort, a critical component often lacking when experiencing homelessness. Several participants shared an ideal home is a place that is safe and stable over a long period of time. That is, an ideal home is a place where "you have a roof over your head, and you don't have to worry about things like holes in your home. You have somewhere safe to stay. Somewhere to stay for the night and the next few nights." One participant said a home is "Where I feel safe [...] where I'm OK with being every day, not just for now."

A First Nations woman shared her story:

> "I've been on the streets, I've slept in abandoned cars, I've slept on benches, I've slept in stairwells, I've slept in places you wouldn't think anybody would be able to sleep. It's survival mode. You do what you can when you can. [...] But everybody deserves a chance to be happy and to feel safe."

Participants also spoke about the need for physical comfort and safety. A woman in her 20s spoke about wanting a place where she and her belongings would be safe. She said:

> "Am I going to wake-up and my stuff's going to be gone?' Or 'Am I even going to be able to sleep?' Somewhere where I can let my guard down and I don't have to worry about things that I would have to worry about if I was on the street."

Many respondents described home as a place where they felt comfortable. A Métis youth shared that a home is "Somewhere to relax, feel safe. For me, I'd like to create a peaceful atmosphere." Having a home would contribute to the participants' emotional and mental well-being, enabling them to address their personal needs without worrying about the dangers on the street or needing to find a place to sleep.

3.2.2 Spiritual dimension

Participants were asked if they wanted something in their home or nearby to fulfil their spiritual needs or if it would help them connect to their home. They provided examples of spiritual objects and spaces, such as materials for smudging, sweat lodges, and spaces for cultural gatherings.

Three participants spoke about practising their Christian faith. An older First Nations male said,

> "Yes, I'd like to have a holy Bible, and I'd like to leave it open. I watch those things in the morning, sometimes those spiritual talk shows."

Another male participant said, "Christians, or Christianity or whatever. That's what I was growing up. In my family was (sic) Christians. I believe in Jesus and God and that, but I don't believe in that Indian culture stuff. I'm not into that kind of stuff."

Some participants wanted somewhere to smudge. One participant said they would "smudge every day, [it's] something [I] plan to bring into [my] home. Take it with [me]," wherever they lived if given the opportunity.

An Inuit woman said she would not "mind going to sweat lodges and stuff" near her home, despite it not being part of her culture because she appreciates these cultural practices.

Several individuals wanted to live near where spiritual services and events are held. A First Nations woman shared there was a church in the neighbourhood where she grew up:

> "There were churches around and that would be important to me. I'm going to push my way to get my kids back but that's the regular thing for me that would expose my children to every week at Sunday School. A church would be important for me to be around if I ever get a place."

A First Nations man wanted more opportunities to smudge and to attend powwows:

> "I like watching [...] when they dance. I like watching their outfits, their colourful outfits [...] Maybe once a month they could have a monthly powwow or something, or a small gathering. There must be a whole lotta dancing, like 2 or 3 dancers and some drummers playing some music, like that. Once a month or something."

Participating in spiritual practices contributes to emotional well-being and provides opportunities to socialise with others in the community.

3.2.3 Emotional dimension

This section describes the things that contribute to emotional well-being, namely belonging, relationships, and autonomy.

3.2.3.1 Sense of belonging

A sense of belonging was important. Several participants wanted to be close to their neighbours, family, and friends. Participants described home as a place where you decide who you allow in, when you visit with others, and how you engage with the community.

A First Nations man spoke about a men's group he used to attend and wanted to live close to one. He said, **"It was kind of like a family setting, like a brotherhood. Whenever somebody would be going through something, they would always have a brother there"**. A woman shared she wanted to live where there is "A community centre close by (inaudible) because that's where you get to meet everybody in your community."

Several participants wanted a support system with friends and family. A youth shared he wanted **"a cribbage table, good roommates, I guess, or a family"** and be able to do what he likes.

Participants spoke about creating memories and having a place that reminds them of who they are. For example, a Métis woman said she wanted a home that is: **"Somewhere I could create memories. Good memories. I remember how it was when I was a kid and how it was growing up with my mom and just familiarity."**

3.2.3.2 Relationships

Most participants spoke about how a home would help foster and strengthen their relationships with family, friends, and partners. For instance, when asked what home means, one woman replied, **"Family, security, happiness, love."**

It was apparent that relationships with loved ones were often strained when individuals experienced homelessness. Participants interacted with loved ones less and sometimes lost contact with them, which took an emotional toll. A First Nations man shared:

> **"Ya. I'd like to stay in contact with some of my family if I could. It's good to have someone to talk to. Sometimes there's no one to talk to. Then you just go and do anything you want 'cause you got no one to talk to. Like before when my mum was alive, my mum would always tell me things like 'Don't drink.' She'd always try to be a positive influence. After my mum died, now I've no one to say those kinds of things to me. Like 'Don't go drinking,' things like that."**

An Inuit woman explained she prefers to live in a small town, so it is easier to see and

> **"Get together with Inuit people or family. It would be nice to have family or friends visiting, like Inuit, or other Inuit people. But I hardly ever see them anyways 'cause we live in a big city now and we're not in a small, little community like Wilco. It would be nice to have people dropping in and visit and spend some time with them. Not just for entertainment but to actually be a family. Togetherness. It's hard enough being down here and not seeing our family."**

A First Nations man longed to be reunited with his children. He said:

> **"I'd like to go down to York Landing where my son and daughter is. My daughter is a qualified carpenter; my son is a qualified heavy equipment operator. Spend some time with them and watch them grow up a bit and my grandchildren, get to know them a little better. And go back to Churchill."**

3.2.3.3 Reconnecting with children

Several women desired to be reunited with their children, who were in the care of CFS or with family members. Some explained that having a home would allow them to care for and provide for their children and re-establish their role as a parent. Living in precarious housing without a steady income contributed to their children being taken into CFS care. A First Nations mother shared, with anguish, her wish of **"Matching me and my kids, have everything. Start over."**

Another mother said:

> **"I wish I was in a home where I would just see my kids again [...] I'm going to be working on trying to gain my children back but as long as I have a home for us, and they have their bedrooms where they can have their privacy when they need it."**

A mother in her 20s shared, **"I would want a home where I would have my children with me and where we wouldn't have to worry about food or nothing like that. Just us three."** It was evident the mothers were profoundly impacted from being separated from their children.

3.2.3.4 Autonomy

Most participants wanted autonomy to make their own decisions. A First Nations woman remarked, **"I've never really had that, right? Had my own space to do what I want, and come and go, you know what I mean? I've always had to live by other people's rules and everything."** A Métis woman commented she would not let certain people know where she lived or let them into her home. She said, **"not the way that things have been happening with my family, so not really. If I were to get my own place, I really wouldn't let anybody know where I stay. Just very close relatives I could trust."** Participants had mostly lived in congregate settings and wanted a place where they would have the freedom to choose who to have in their space.

3.2.3.5 Self-fulfilment

A man who often visited an emergency shelter shared having a home would allow him to have a new routine and explore new interests. He said:

> **"If I had my own place, I'd start going to casual [work] again every morning and use an alarm clock. Get up at 5 or 6 [am] because you have to be at the office by 6 [am]. After that, get home, end of day. Maybe in the evening have spare time, work on some ideas. I got some ideas about inventions so maybe I just sit around and buy a scribbler and draw, work on my ideas. You can't really do that here because I don't really have my own place here."**

A First Nations man shared a time when he lived in a First Nations community in Manitoba. He said:

> **"The people there showed me a lot of love, and they helped me get rid of my anger. They showed me how to get rid of my anger. I started carving, started painting, all kinds of weird shit. My wife, she was so happy to go door-to-door. She got me jobs, I couldn't stop. Some people had so many holes in the roof. [...] I felt like I was doing something right. What I'm trying to say is that was like being at home. Having my own place, and the people around me aren't worried about themselves. When we get together, we all look after each other."**

Overall, a home would provide refuge and give participants opportunities to focus on their interests.

3.2.4 Mental dimension

This section describes participants' coping practices, their mental health challenges, and the need to have mental health supports nearby.

3.2.4.1 Coping practices

Seven participants shared they have used or currently use alcohol or drugs to cope. We asked them what they need at a personal level to be able to maintain housing. A woman in her 40s stated, **"My drinking. I need to stop drinking. I need to go to treatment to live that life. To have that house back, my kids."** Another woman also referred to drinking. She said, **"That's the one thing I've got to change in order to take that step to get myself a place."**

Several individuals explained that substance use can lead to homelessness, but experiencing homelessness may also contribute to using substance(s) as a coping mechanism. A 22-year-old bisexual woman spoke about the paradox she found herself in when looking for housing while using substances:

> **"When I was on the streets, I was known as an addict. No one really wanted to help me. 'Oh, you've got a substance problem. You're not going to be able to maintain a house. You've got to get this in order, go to detox,' all this stuff. But I was an addict because I was homeless. I had to use drugs to stay awake, to not be hungry all the time. I didn't know where I was going to sleep. I didn't know the next time I was going to eat."**

Using substance(s) can be a barrier to finding a home. A 22-year-old woman shared that landlords are reluctant to provide housing to individuals who are using substances as they believe they will need additional support. She recommended that new housing have programmes staffed by addiction specialists and psychologists to support individuals who are dealing with substance use. An Inuit woman recommended having reoccurring community meetings for individuals trying to overcome an addiction. She recollected a time when she was part of a **"community of recovering addicts that all wanted to do better. That was a really good thing."** Another Inuit woman wanted support workers close by in case she was having a bad day. She said, **"My workers would be right downstairs to me, and I'll either have a suite on the second or third floor."**

3.2.4.2 Mental health and appropriate supports

Participants talked about their mental health and how it was a barrier to finding a permanent home. A First Nations man observed there was an increasing number of individuals living with mental health challenges. He said, **"What I've been experiencing at some places, especially Main Street Project, are more mental health cases."** One participated connected homelessness with mental health. They said, **"homelessness really causes [more] mental health [troubles]; people on the street need help from [more] psychiatrists, nurses, doctors, and mental health workers."**

A 37-year-old Inuit woman spoke about how experiencing homelessness impacted her mental health. She said:

> **"When I was homeless, I was mentally ill, and the streets are very, very traumatising [...] when someone from homelessness is getting a home, they'll experience flashbacks. That's what I go through. Sometimes I go through flashbacks, and when I'm in a car, if I am there, I can remember what happened to me when I was homeless. Honestly, it's a very, very scary feeling, being homeless."**

The trauma continued after she was housed. For a while, she did not trust her support workers. She said:

> **"At first, I didn't really trust my workers because I thought they were against me. I thought they were provoking me, doing stuff to me that I didn't want but really, it was something going on in me (inaudible). It was just a phase. Now I'm totally trusting my psychiatrist now and my workers."**

She spoke about the importance of having adequate long-term support. She said,

> **"it takes time to heal 'cause when you want to heal from that, you have to have all this support to reach out to help you, to stay on your meds to have the right kind of meds and have comfort and compassion that they all need for that."**

Other people also wanted mental health support close to home. A mother of six agreed that a proper support system would be necessary for mothers to find a home. She needed someone:

> "...to come work with my kids because I was getting stressed out, being alone with them. I mean raising them on my own, no help from their dad. To have a support system that can help me to get on my feet, to help me have a routine for our family structure, family thing for me to do with myself and my kids. Well for my kids and for myself."

Having a community to rely on was important for several people and their mental health. A mother, who is Inuit, described how she used to participate in gatherings, which helped her feel connected. She said:

> "It's good to see other Inuit people go to these drop-in centres. At least we eat our traditional food together. When they opened the [Inuit] centre just off Sargent [Avenue], at least we started having gatherings and eating together. Good to communicate with each other."

Some participants thought they would benefit from living in a congregate setting so they could help each other. Some thought that having sustained mental health support post-homelessness would be important, particularly to help them deal with their trauma. Mental health support is crucial for individuals experiencing and exiting homelessness.

3.2.5 Structural factors

The findings presented in the section pertain to structural factors that impact Indigenous peoples, including culture, racism, colonialism, and systems of oppression. We attempt to explain how positive factors, like culture, and negative factors, like discrimination and systemic injustices, impact Indigenous peoples in Winnipeg, particularly as it relates to access to safe, affordable, and appropriate housing.

3.2.5.1 Culture

The participants were from diverse backgrounds and cultures. However, as one participant noted, there are

> "...different points of view from different people. We may say different things, but we all have the same goal in mind, when it comes to the way that we want to live our lives. For me, personally, I'd much rather return to tradition and the medicines, the 'Red Road' because it's simpler, and it's not as structured, and it's more relaxing. I think it would be more comfortable."

Participants mentioned several cultural practices relevant to home. For example, an Inuit participant described what she would like in her kitchen. She said:

> "I would like a spot where I could have my own food, like my caribou, my muktuk, which is whale meat. Just a little spot when I'm getting Inuit food, a spot where I could just have my Inuit food. You know how Inuit eat raw meat, right? Well, eventually, in the future, if I ever get my home food, I'd make a spot right in my place to have that."

An Inuit woman expressed appreciation for First Nations cultural practices. She explained that Inuk cultural practices are different in Winnipeg than they are in Nunavut. She longed for these practices, but they are not available in Winnipeg, and therefore, it is difficult for her to feel at home here. She said:

> "The Indigenous peoples have so much more strength and belief in honour and stuff. They're very talented and different that Inuit people. There's a lot of Indigenous peoples that I know that are very much into their traditions. They believe in powwow and stuff like this, and it helps them. It helps people. It gives them strength and honour and pride. I envy them. I love my traditions but it's very different down here than compared to Nunavut. I only know the men go hunting, the women do the labour for the sewing and skinning the top or whatever, right? We do all that, but nowadays, it's the women who butcher the whole caribou. The men go hunting, and the women do the butchering."

3.2.5.2 Racism and colonialism

Four of the respondents shared that many Indigenous peoples who are without a home perpetually experience racism - from the government, from people on the streets, and from support workers (who some) feel refuse service. A man spoke about how individuals experiencing homelessness face racism regularly: **"A lot of people that are homeless have a lot to say. They're hurting. They're hurt inside. It has to do with everything around us...Everyday living and who we are as Native people."**

When asked what governments need to do with regards to housing for Indigenous peoples, many participants felt they first need to be heard. Participants said they feel ignored not only by governments, but also by the public. A First Nations mother felt governments and others lack empathy for the concerns and challenges that Indigenous peoples face. She said:

> **"They don't take us seriously. They think we're joking around, but if you were an Indigenous person living on Main Street who was homeless and hadn't eaten in three or four days and hadn't showered in a week and didn't have anywhere to sleep, would you be willing to talk to somebody from St. Vital that has a job, that's in a car at a red light, when you're currently calling 'home' a bus shack? Would you be willing to talk to the person in the car, you're sitting in front of? No, I don't think so. Because it's two different sides of the spectrum. It comes down to barriers and stuff like that..."**

As this participant expressed, they feel the public does not understand or is indifferent to the experiences of Indigenous peoples experiencing homelessness and does not feel taken seriously when encountering them in public.

3.2.5.3 Systems

3.2.5.3.a Criminal justice system

Government systems treat individuals who are Indigenous and experiencing homelessness unfairly. These systems contribute to the cycle of homelessness. For instance, three participants spoke about how the justice system impacts Indigenous peoples more harshly. This system includes the police, the courts, and jails and prisons. An Inuit woman stated:

> **"The criminal justice system is so racist towards homeless people. They're so hard on them. They were hard on me. I was in the criminal justice system too because I used to shoplift. I would shoplift to survive and sometimes to support my addictions."**

There is a lack of support for individuals when they are released from prison. One participant spoke about recidivism or reoffending. They said:

> **"But most of these people that come out of jail are gonna go back to what they do. Doesn't matter how long they stayed in there, all healthy when they come out. They're gonna go back to what they do."**

3.2.5.3.b Employment and Income Assistance (EIA)

Another challenge mentioned during the interviews was EIA. An Inuit woman in her 60s shared how finding an affordable apartment in Winnipeg is difficult with the high cost of rent and inadequate financial support. She now stays with her daughter. She said:

> **"For people like me, that are on EIA, it's near impossible to find a decent place, an affordable home. It's impossible to even look at the Renters Guide these days because they go over $800+. Ya, that would be nice, but you know what? Poor people on EIA, I said. They're just looking at rooming houses. That's all we can afford [...] regardless of how much the rent is, it would be nice for them to come up with the whole rent instead of me having to pay the difference. That's my food money that's paying for the difference. And then there's a damage deposit on top of that."**

A First Nations man expressed frustration with the welfare system and how the government stops EIA payments, resulting in individuals having difficulty paying rent. He said:

> **"I kinda think it's with the welfare too. The welfare system, is why so many people are homeless. They just want to cut everybody off welfare. They give people a hard time, and they cut them off too early, and that's why people are homeless, 'cause of welfare."**

EIA is a disincentive to finding employment as support decreases when one becomes employed. A young woman was hesitant to pursue her professional goals because her EIA amount will be reduced when she becomes employed, and she would have difficulty making ends meet. She said:

> **"Finish school, get a job. But the whole thing with getting a job is I won't be able to maintain my apartment. Because if I work, E.I.A. will cut me off, and then my rent won't be paid, and I'll have to pay full rent. It's like a never-ending story."**

3.2.5.3.b Child and Family Services (CFS)

CFS was mentioned numerous times. As discussed in the *Emotional* section, CFS has had and continues to have a negative impact on the participants' lives. For example, a young man explained his relationship with his birth family when he aged out of care. He said:

> **"Everyone I met in my life, like my family, I just met after I aged-out of CFS. I don't really know them, and I feel like a stranger, but they still accept me. But some of them haven't. They've disowned me and stuff. So home is where I make it."**

Participants shared that CFS created a disconnection from their culture and their family. Most participants had either been in the care of CFS themselves or their children were. When asked what an ideal home would be, a First Nations youth replied, **"I don't know. Growing up, I grew up in CFS group homes and stuff, so that's pretty much the structure that I know."** The youth moved around a lot and never had a stable home.

As also discussed in the *Relationship* section, CFS impacts parents whose children are apprehended. A mother shared her biggest desire is:

> **"My kids. That's all I need. They've only been gone for two years, and I raised my children. My daughter was ten when they took her. After, everything was the beginning of a long fight. I want to get a home for my children. [...] I don't want to be homeless anymore".**

It would be tough to get her children back, without a home and stable income. CFS involvement has long-lasting repercussions and is a pathway into homelessness, particularly for Indigenous peoples who are disproportionately involved with CFS.

3.2.6 Recommendations heard from participants

Some participants were asked what they want governments or policymakers to know about providing housing for Indigenous persons. Several participants thought that policymakers should experience what it is like to be without a home. A First Nations man said they **"need to take a good tour inside those organisations and spend a good week or two. They could find out the truth."** A First Nations woman recommended that government officials:

> **"Get more people out on the street asking questions, doing surveys, reaching out to people, asking them what they need. Not just assuming they need this and this and this when they don't. You don't know anybody unless you've walked a mile in their moccasins. I never judge a book by its cover."**

Many participants believed government officials are unaware of what is needed on the streets as they do not take the time to ask and listen to what people endure. An Inuit woman described people's ignorance and lack of compassion. She said:

> **"I just wish the government and the community could stop being so hard on homeless people because it's not their fault, right? Ya, they do drugs sometimes. Ya, they drink but it's not their fault. They need to be nicer and more gentle and nicer to homeless people so that homeless people know they can reach out without getting hurt."**

She explained that the lack of compassion leads to distrust and fear among individuals experiencing homelessness. She said, **"they're scared of the government because of doing drugs, drinking or whatever."** She recommended that government officials and service providers be gentler and more empathetic towards individuals experiencing homelessness.

A First Nations woman explained how Indigenous peoples are discriminated against and disregarded. She said:

> **"I would tell the government they should take Aboriginal people into consideration and be treated just as any other people because that's where most Aboriginal people become homeless because they're not taken seriously into consideration because they're just looked down at, as alcoholics and drunks and they should look at it and in different ways."**

Evidently, many felt governments do not understand how their policies and regulations cause harm. For instance, a bisexual First Nations man felt abandoned when he aged out CFS care. He had to find employment and discover who he was without any support, as he was no longer close to his birth family. This man attributed the large proportion of Indigenous youth experiencing homelessness to the lack of transition support. He recommended raising the age for exit. He said:

> **"Being able to sign yourself out when you're 18 shouldn't be an option. That's just a magic number. You're still, you're just 18 — it's a special day. Because I have friends — they're 18, no, they're like 24 — and they're still living at their parents', and they don't have to worry about anything like that. CFS kids and everyone have to."**

Participants provided recommendations directed to policymakers and sector workers. The recommendations were: (1) acknowledge and resolve the systemic issues (i.e., justice, EIA, and CFS) that disproportionately impact Indigenous peoples and contribute to pathways into homelessness, and (2) speak with and listen to people experiencing homelessness to learn what their needs and preferences are. This recommendation was well-expressed by a First Nations woman. She said:

> **"There's a lot of barriers between people and the outside world. We need to unify the way we think, and we need to support one another in our cultural aspects of life, going back to our ancestral ways and the stories and the teachings and everything that goes along with our traditions. We need to learn how to communicate with each other, first and foremost. To understand where other people are coming from, you need to sit and listen to them."**

3.2.7 Concept boards

As part of the arts-based research method for the qualitative component, End Homelessness Winnipeg enlisted the services of Brook McIlroy.

Brook McIlroy is an architecture, landscape architecture, urban design and planning firm based in Toronto with offices in Winnipeg and Thunder Bay. The firm has received many national accolades, such as awards from the Canadian Association of Landscape Architects and Canadian Institute of Planners. As mentioned on their website, their clients span from a wide variety of municipalities; Indigenous communities and organizations; education institutions, including primary and post-secondary, and public and private development and investment organizations.

Initially, the firm was retained to create renderings of housing models and designs depicting what participants shared during the interviews. However, participants focused on relationships, adequate support, stability, and safety, not housing models or designs. Consequently, the Research Team reconsidered and requested Brook McIlroy's expertise in drafting conceptual drawings that represented what participants shared.

The boards were set to be printed and shared with individuals with lived experience to determine if their preferences were captured accurately during consultations. The drawings were also going to be used to stimulate further discussions. Unfortunately, due to the public health restrictions related to the COVID-19 pandemic and lack of time and resources, additional consultations with people with lived experiences were not possible.-However, the concept boards could be used this way in the future.

The Research Team identified themes from the interviews and created an "interview snapshot" bubble chart (see Figure 3.1). We created a bubble chart for each interview question: (1) what does the word 'home' mean to you? (2) I wish to live in a home where... , and (3) what are your preferred features in a home and location for a home? The size of the bubble reflects the frequency of the theme, that is, larger bubbles represent more prevalent themes. We shared the bubble charts with Brook McIlroy to provide them with direction in creating the concept boards.

Figure 3.1: Themes that emerged from the interviews

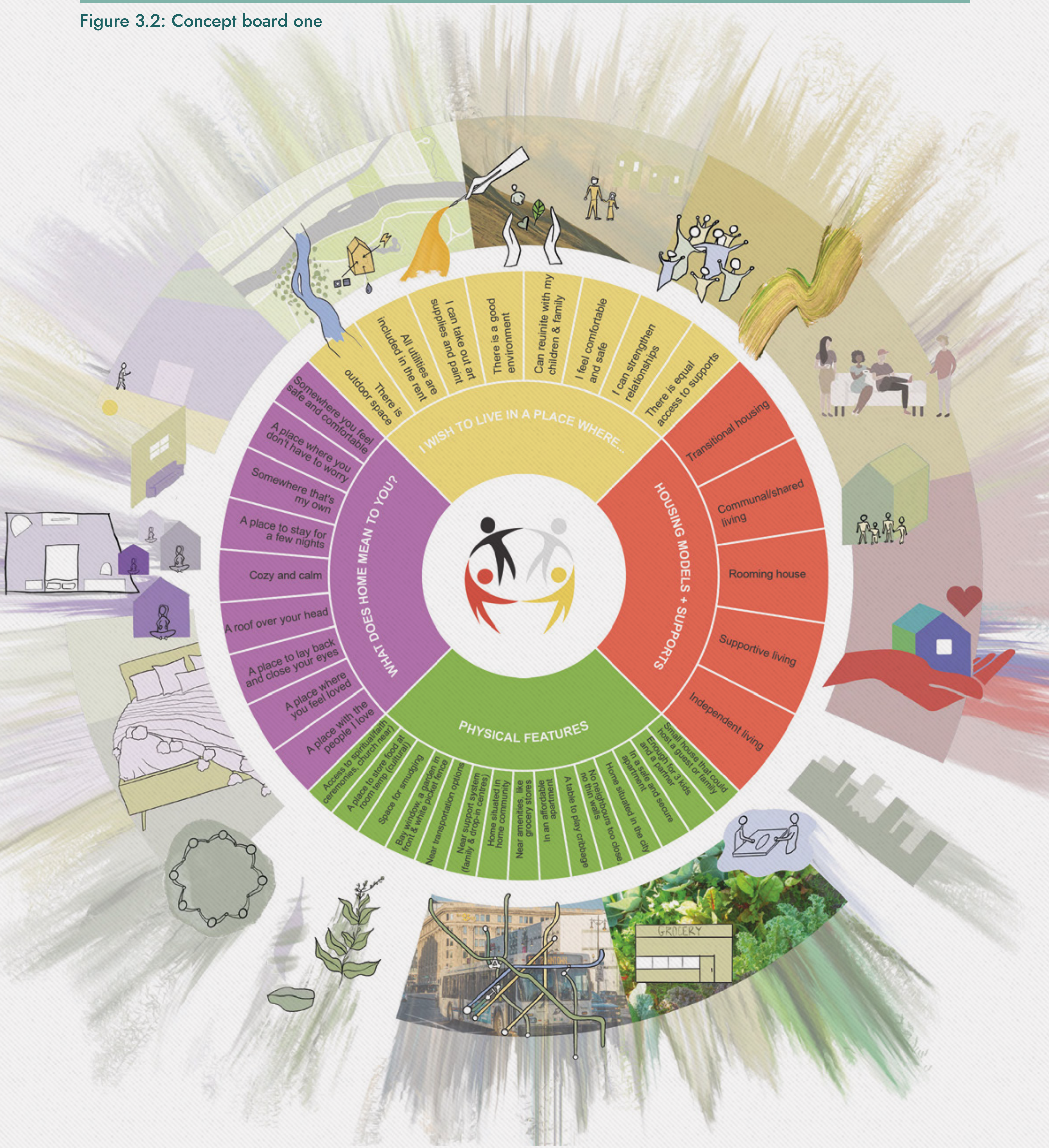
Figure 3.1: Themes that emerged from the interviews continued

3.2.7.1 Concept board one

The first concept board is an overview of the participants' responses (see Figure 3.2). Near the centre of the diagram are the two lines of questioning as well as the physical features and preferred housing models shared by participants. Moving outwards are participants' responses. The outermost layer consists of images representing the responses.

Common themes emerge for the board such as nature, medicines (for smudging), and a sense of care (depicted by the open hands near the top centre). Interconnectedness is also a prominent theme, with the four figures at the centre holding hands, the images of gatherings, the family and children, and the transit lines crossing and connecting with one another. This concept board represents the participants' desires, values, and preferences.

Figure 3.2: Concept board one



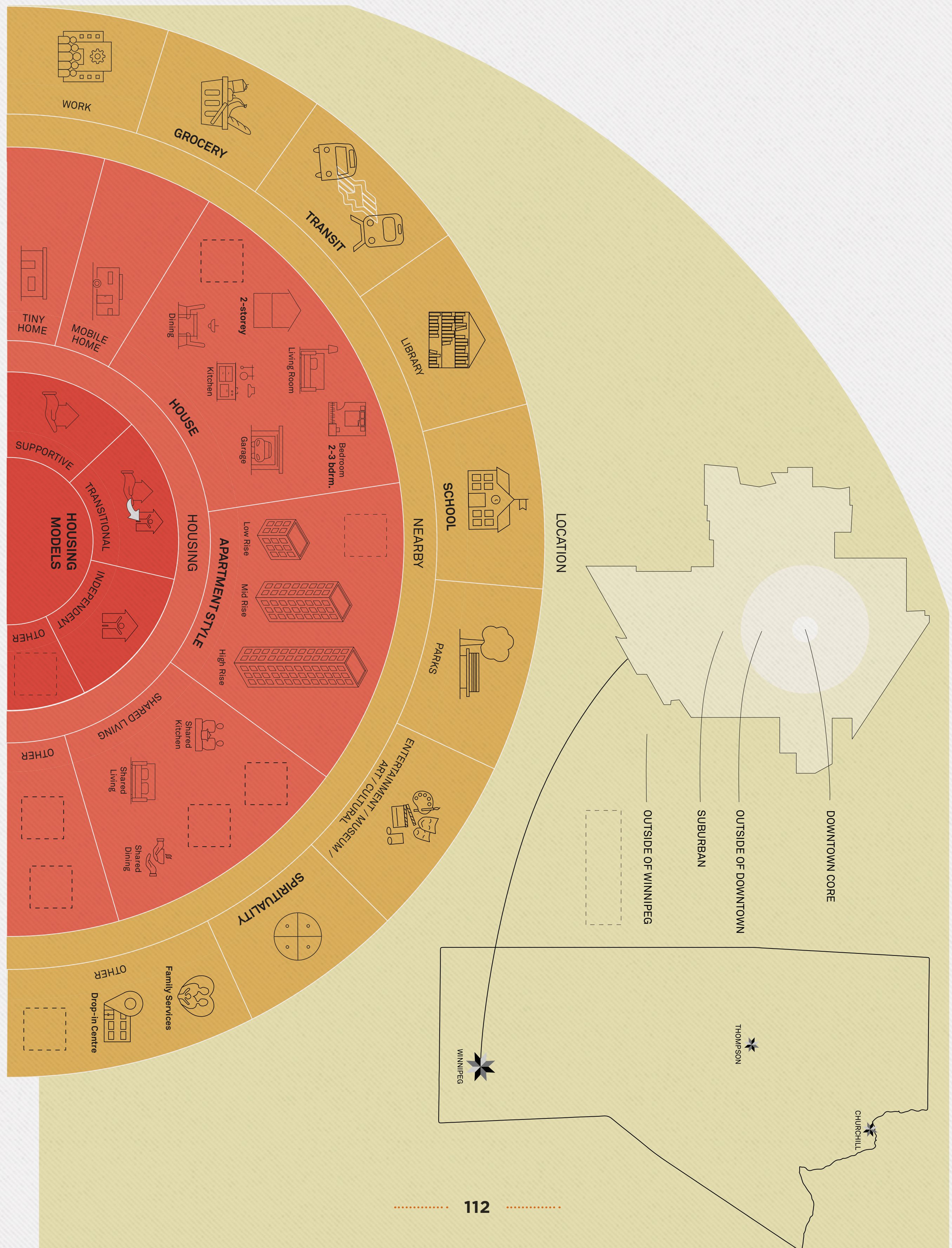
3.2.7.2 Concept board two

The second concept board represents the participants' preferred physical features of a home. At the centre are housing models - independent, transitional, supportive, and other (see Figure 3.3). The next layer illustrates types of dwellings and housing arrangements, such as a mobile home, a detached home, an apartment, and congregate living. The outer layer contains amenities that were important for participants to have nearby.

The outer portion shows where participants wish to reside in Manitoba. The majority preferred to live in and around Winnipeg, either in the downtown core because they were familiar with the area or in the suburbs. As seen on the map, a few participants preferred to live in their home communities, such as Thompson and Churchill.

Overall, the concept board visualises the wide variety of housing preferences. It shows that not one model, dwelling, living arrangement, or location is preferred. It illustrates people's diverse needs, such as spaces for spiritual practices, proximity to amenities, and type of living arrangements (i.e., alone or with others).

Figure 3.3: Concept board two



3.3 Limitations

There were limitations to both the quantitative and qualitative components of this study. None of the members of the Research Team are Indigenous and only one has lived experience with hidden homelessness. We are limited by our personal biases and worldviews, which shaped every aspect of this study (from the questions asked to the interpretation and presentation of the findings).

We relied on community organisations to assist with recruiting participants for both the qualitative and quantitative components of the study. Our survey sample and interview participants may not be representative of the populations experiencing homelessness as we used convenience sampling techniques.

For the qualitative component, we attempted to reach individuals with diverse backgrounds. Notwithstanding the small sample of 18 interview participants, three groups were underrepresented: men over 55 years of age, members of the 2SLGBTQIA+ community, and Métis citizens. To address this gap, the Research Team planned to hold three community engagement sessions with individuals from these identity groups. These community engagement sessions would have involved the Research Team presenting the qualitative findings and inviting feedback from participants on the extent to which the results reflected their own lived/living experience. However, the community consultations were planned during the COVID-19 pandemic, and we could not hold them due to the public health restrictions. We could not hold them after the restrictions were lifted because of budget and timeline constraints. Future research should fill the gaps by specifically including the three underrepresented groups.

The interview process was affected by the COVID-19 pandemic. Community organisations were responsible for coordinating the interviews. The staff were working under precarious and stressful circumstances. Because the interviews had to be done over the phone, it was difficult to build rapport with the participants. The participants may have felt awkward, uncomfortable, and less willing to share their thoughts and experiences than they would have been if the interviews were conducted in-person. For example, one participant started the interview by expressing confusion as they thought the staff person at the organisation was going to interview them.

In many sections of this report, the data is disaggregated by Indigenous identity. The Indigenous group was further disaggregated into First Nations and Métis groups. There were not enough Inuit participants in the survey sample to present the results for this group (due to protecting people's anonymity). However, the Inuit participants were included as part of the Indigenous group. Also, there were Inuit participants in the qualitative study.

People self-identified as Indigenous. The Research Team consulted with the Advisory Circle about how to ask about Indigeneity. There were Métis representatives on the Advisory Committee, so there were Métis voices at the table throughout the research process. However, after the data collection process was completed, the Manitoba Métis Federation expressed concerns about how Métis citizenship was determined as they preferred defining it by possession of a Métis citizenship card. The Research Team and Advisory Circle agreed it was important to honour those who self-identified as Métis by including their responses in this report. In the future, we will work more closely with the Manitoba Métis Federation to determine how best to address this concern.

4. Discussion

One takeaway from this study is that there is no single housing model that will meet everyone's needs. Another takeaway is that some experiences are universal to people experiencing homelessness while others are unique to Indigenous peoples. Thus, housing solutions must account for Indigenous peoples' history, current-day realities, needs, and preferences. Indigenous homelessness is more than a lack of a physical structure; it includes cultural and spiritual homelessness (Christensen, 2016; Kidd et al., 2019). Colonial policies and practices, like residential schools, the 1960s Scoop, and the CFS system, disrupt(ed) Indigenous families by separating children from their families and displacing them from their lands (Christensen, 2016). Many interview participants believe that current housing solutions are not working for them and that their needs and preferences are not being considered. The current best practice housing model is Housing First; however, it is founded on Western conceptions of home, which may not resonate or be appropriate for Indigenous individuals (Alaazi et al., 2015).

The summary below compares this study's key quantitative and qualitative findings with literature on Indigenous homelessness. The discussion is organised according to the four-dimensional framework.

4.1 Physical dimension

4.1.1 Homelessness and access to housing

According to the survey, there were some significant differences between Indigenous participants and participants who were not Indigenous in terms of barriers to finding and maintaining housing. Indigenous peoples were being denied housing because of a lack of identification, lack of formal education and training, having a physical condition or disability, as well as discrimination from landlords. Other studies have reported discrimination by landlords as a barrier to maintaining housing for Indigenous peoples (Anderson et al., 2014; Belanger et al., 2013; Brandon & Peters, 2014).

According to Anderson et al. (2014), another housing barrier for Indigenous peoples can be conflicts between the expectations of housing providers and differing cultural practices and make-up of households for Indigenous peoples. An example of this would be an obligation to accommodate extended family and have more people in a unit than what is 'expected'. This action can be perceived as overcrowding and may result in an eviction. Indigenous peoples face unique structural barriers. The housing barriers stem directly from colonialism, such as displacement from lands, and assimilation policies like the residential school system and the 60s Scoop (Homeward Trust Fund, 2015; Anderson et al., 2014).

Over their lifetime, the "typical" person in the sample had experienced homelessness for three years; however, there were some people who experienced homelessness for either much shorter or much longer lengths of time. There were some people in the Indigenous group, in particular, who experienced homelessness for many years, resulting in the Indigenous group having a nearly two years longer average length of time experiencing homelessness (6.28 years) than the other participants (4.42 years). The average number of years experiencing homelessness was 6.30 years for the First Nations groups and 5.84 years for the Métis group. Differences between groups in lengths of time experiencing homelessness may be due to different barriers Indigenous peoples experience that others experience to a lesser extent, such as poverty and insecure employment (Agrawal, 2021).

Researchers have documented Indigenous individuals experiencing homelessness frequent shelters less often than individuals who are not Indigenous (Lindstrom, 2020; Brandon, 2022). However, Indigenous peoples experience hidden homelessness (i.e., couch surfing, residing with friends/relatives when transitioning from their home community to the city) more often than other people (Alberton et al., 2020; Anderson et al., 2014). The higher rate of hidden homelessness among First Nations people may reflect the strong relational nature of their culture and value systems (Lindstrom, 2020).

4.1.2 Built form and housing preferences

The participants of the qualitative research preferred different housing types that were reflective of their differing needs and the circumstances of their lives. A majority preferred a detached house; this was because of the number of bedrooms for visiting family members, and the space to host friends and have gatherings. This finding is consistent with the literature: Indigenous peoples may prefer housing that can accommodate multi-generational living arrangements and space to host visitors, including friends who do not have a home (Brandon & Peters, 2014; Christensen, 2016; Harvey, 2016; Hayes, 2016). Several studies recommended housing construction with at least three bedroom units, which can be modified to adapt to changing family structures (Brandon & Peters, 2014; Fineblit, 2015; Hayes, 2016). Social housing and similar initiatives may not always be the most suitable in housing Indigenous peoples because they ignore the importance of culture and values of Indigenous peoples (Agrawal et al., 2021).

4.1.3 Mobility and location preference

Nearly 70% of the Indigenous participants (in the quantitative component) shared that their home community is a reserve. This was more common among the First Nations participants than the Métis participants. Many people left their home community for unfavourable reasons (e.g., avoiding substance us and/or, violence, loss of relationships, overcrowding, and lack opportunities). Other reasons for leaving were seeking employment and educational opportunities elsewhere, leaving against their will, leaving for other opportunities for their children and family, as well as for greater access to healthcare. Other studies identified factors, like access to healthcare, social services, education, and employment, as reasons why individuals relocate to urban centres (Harvey, 2016; Brandon & Peters, 2014; Christensen, 2016; Schiff et al., 2016). Kidd et al. (2019) attributed the transition to urban centres to the disruption of traditional ways of life through forced relocation to reserves and denial of Indigenous rights to land.

During the interviews, several participants shared they want to move back to their home communities (e.g., Nunavut, Churchill) to reconnect with family and to be where they grew up. Researchers have described a cyclical pattern, where Indigenous peoples move back and forth between their home community and urban centres throughout their lives (Bonnycastle et al., 2015; Harvey, 2016; Thistle, 2017).

Other interview participants preferred to live in central Winnipeg, in areas they were familiar with, were near family and friends, and were close to amenities and services, such as grocery stores, schools, and recreational and drop-in centres (for their children). Several studies recommended that housing specifically for Indigenous peoples should be located close to the services they need and safe locations (Fineblit, 2015; Hayes, 2016).

4.2 Spiritual dimension

During the interviews, participants were asked if participating in spiritual and/or traditional practices is important to them. Several wanted to have access to smudging and participate in powwows. Some participants desired to have objects at home that would allow them to practise their spirituality, like the materials for smudging or a Bible. Note that the 2018 Street Health Survey did not include questions about spirituality.

Thistle's (2017) definition of Indigenous homelessness references 12 distinct dimensions, including one called spiritual disconnection homelessness. According to Thistle (2017), homelessness is more than a lack of a physical structure. It is a series of disconnections from physical, social, emotional, cultural, and spiritual relationships because of "the colonisation of Indigenous bodies, minds, and lands" (Thistle, 2017, p.7). In her research, Christensen (2013) spoke with a social worker in the Northwest Territories who described her own experience of spiritual homelessness as a "powerful dis-belonging in her home community" after having been taken into the residential school system as a child and not returned to her community until she was 18. She had to relearn her language, and at the time of the study, she still felt a sense of homelessness and disconnection from her community (Christensen, 2013).

In the case of the interview participants, many did not explicitly state they felt disconnected from their home community. However, in terms of spiritual beliefs, a few shared they practise Christianity and do not identify with Indigenous beliefs.

4.3 Emotional dimension

4.3.1 Discrimination and mistrust

The quantitative study found that Indigenous participants were significantly more likely to report being mistreated by shelter staff than the other participants. The Indigenous participants were significantly more likely to report their age, gender, sexual orientation, race and/or ethnicity, and use of alcohol or drugs as reasons for being mistreated. Participants also felt disrespected by healthcare staff. Indigenous participants were significantly more likely to think they were disrespected by healthcare staff because of their race and/or ethnicity, and because healthcare staff assumed they were seeking drugs. Indigenous populations continually experience discrimination and marginalisation (Barker et al., 2015; Christensen et al., 2017; Kauppi et al., 2015; Oelke et al., 2016) from multiple sectors, including the healthcare system (Kitching et al., 2020), housing and shelter services (Native Women's Association of Canada, 2019; Alaazi et al., 2015), and employers (Alaazi et al., 2015; Harvey, 2016).

Discrimination experienced in the healthcare system may dissuade Indigenous peoples from seeking healthcare altogether (Allan & Smylie, 2015; Bingham, 2019a; Kitching et al., 2020). For instance, the Browne et al.'s (2011) study featured an interview with a First Nations man who sought medication for chronic pain. He dreaded running low and requesting a refill, as he sensed his healthcare provider viewed him as someone 'who is abusing it'. The man's discomfort, paired with his concern of being judged when showing his status card, and the provider knowing he does not have to pay for the medication, feel stigmatising to him (Browne et al., 2011).

The mistrust felt by Indigenous peoples extends to the police and the justice system (Cao, 2014), the child welfare system (Leckey et al., 2022), and other government institutions (Nelson, 2019).

4.3.2 Sense of belonging and social exclusion

In the qualitative study, a sense of belonging and relationships emerged as prevalent themes. Several participants shared their desire to be near family and friends and participate in community activities. A First Nations man wanted to live near a men's group to be in a "family setting, like a brotherhood" and have a support system. Browne (2011) stated that inner city areas are particularly concerning for those who identify as Indigenous in regard to experiencing social exclusion, racism and discrimination. Social exclusion occurs when a person is refused the same opportunities to participate in different aspects of life, such as social, economic, cultural or political (Browne et al., 2011).

Social isolation may also be experienced by individuals transitioning to the city from a rural community. Housing in urban centres tends to be more isolating than housing in rural settings (Anderson et al., 2014). Indigenous individuals may also feel cultural isolation due to their minority status in urban areas and distance from culturally relevant services (Anderson et al., 2014; Bingham et al., 2019a; Thistle & Smylie, 2020).

Another prominent theme that emerged from the interviews was the need for participants (particularly mothers) to be reunited with their children and to care for them. The majority shared that their primary reason for wanting a physical place to call home would be to have their family together and be able to provide for them. Indigenous children are overrepresented in the child welfare system due to factors like racism and systemic biases, poverty and poor housing conditions (Alberton et al., 2020; Leckey et al., 2022; Sinclair, 2016), discriminatory practices by some service providers, and a lack of legal representation (Leckey et al., 2022). The child welfare system perpetuates the legacy of colonialism (Alberton et al., 2020). It is founded on the colonial notion of family, not the Indigenous conception of family (Leckey et al., 2022). The impacts of the child welfare system result in "negative intergenerational cycles of individual, familial, and community adversity and distress" (Bombay et al., 2020). Further, losing custody of a child to foster care negatively impacts mothers' mental health. Several studies have found high rates of depression, substance use, physician visits, medication prescriptions (Kenny, 2018), and suicide (Ridgen, 2023) among mothers whose children have been apprehended.

4.4 Mental dimension

Mental health and addictions are common health concerns among populations experiencing homelessness (Milaney, 2020). The survey data did not show a significant difference between individuals who are Indigenous and not Indigenous in regard to self-reported mental health conditions. A large proportion of the sample reported lifetime experiences of severe depression, severe anxiety or tension, and trouble concentrating or remembering. A significantly higher percent of individuals who were not Indigenous had an anxiety disorder (54.5%) compared to the Indigenous group, especially compared to the Métis group (28.3%). Further, the respondents who were not Indigenous were significantly more likely to report suicidal ideation (61.0%) than the Indigenous respondents (45.8%).

Researchers report that housing loss has a profound impact on mental health (Bingham et al., 2019a; Gabriel et al., 2022), and exacerbates existing mental health conditions, especially for those who experienced earlier traumatic events (Gabriel et al., 2022). According to the Bingham et al. (2019b) study, Indigenous women who experience homelessness are more likely to experience mental health conditions than Indigenous men, are two times more likely to be diagnosed with post-traumatic stress disorder, and are four times more likely to be at risk of suicide than Indigenous men. The factors that contribute to the gender differences are domestic and interpersonal violence (Bingham et al., 2019b; Kirkby & Mettler, 2016), lack of culturally appropriate support for women (Bingham et al., 2019b), and child apprehension (Alberton et al., 2020).

4.4.1 Substance use and coping mechanisms

The survey asked about substance use. A higher proportion of the Indigenous respondents (43.1%) reported consuming alcohol 'at least weekly' than the respondents who were not Indigenous (29.4%). There were no significant differences between the Indigenous participants and all other participants with respect to drug use. This finding is contrary to other studies, such as Belanger et al.'s (2013) study, which found that substance use was more common among Indigenous individuals experiencing homelessness.

Studies show that a dependence on substances puts individuals experiencing homelessness at an increased risk of mental health conditions. It also serves as a barrier to exiting homelessness, as some programmes and services require people to be clean (Johnson & Fendrich, 2007). An interview participant had these experiences.

Johnson and Fendrich (2007) explained that the experience of homelessness may reinforce an individual's use of substances as they may use it as a coping mechanism, to overcome the stress of living on the streets, and to self-medicate for other underlying conditions. Several studies describe best practices for supporting Indigenous individuals experiencing homelessness who use substances and have mental health conditions. These include harm reduction approaches that are culturally appropriate (Firestone et al., 2021).

5. Conclusion

This section concludes the report. First Nations, Inuit, and Métis people experiencing homelessness have unique experiences, needs, and housing preferences compared to those who are not Indigenous. Indigenous peoples are impacted by colonisation, intergenerational trauma, forced displacement, cultural and spiritual fragmentation, and systemic racism. The objectives of this report were to examine the unique health and social conditions of Indigenous peoples experiencing homelessness, to identify the barriers they face in accessing housing, and to determine their housing preferences and needs. To achieve the study's objectives, we used the 2018 Winnipeg Street Health Survey data and conducted 18 qualitative interviews in 2021. We organised the results around the four-dimensional framework — a derivative of the medicine wheel — with the guidance of the Advisory Committee. We identified differences and similarities in the homelessness experiences of Indigenous participants and those who were not Indigenous and among the three Indigenous groups. The qualitative interviews reinforced the idea that homelessness is a unique and highly individualised experience, and thus, interventions should be personalised and culturally sensitive. It is crucial to tailor services to effectively address the diverse needs of individuals experiencing homelessness to give them the best chance at successfully securing safe, sustainable, and secure housing.

A home is more than just a physical space. For Indigenous peoples, a home includes a connection with others, their home communities, and their physical environment. As Thistle (2017) explained, Indigenous peoples view a home through a composite lens of Indigenous worldviews. According to Christensen (2016), housing policies perpetuate homelessness among Indigenous individuals as they fail to account for the social determinants of Indigenous health. Therefore, housing that meets the needs of Indigenous peoples should be reviewed through the lens of cultural safety and go beyond addressing the physical needs of a home. Housing programmes should address spiritual homelessness by connecting people to the land, their culture, and their family.

Below are recommendations formulated from the results of this study. They provide ways to address homelessness specific to Indigenous peoples.

5.1 Recommendations

1. Housing developers should site housing developments in proximity to important amenities, such as grocery stores, community centres, transit hubs, meeting spaces for cultural and spiritual events, and other supporting elements that Indigenous groups may identify; as well as deliver flexible housing models to accommodate the diverse needs and preferences of Indigenous individuals and families. These flexible housing models may include communal and shared living spaces, as well as amenity spaces like outdoor patios and indoor gathering spaces. These would be more appropriate for multi-generational and larger family arrangements and provide opportunity for communal spaces within the building to practise spiritual and traditional activities and ceremonies.

2. Indigenous peoples' housing needs may change over time. Therefore, housing developers and providers should regularly consult with Indigenous peoples with lived/living homelessness experiences to develop and implement housing models and supports that best meet their needs. These engagements must be culturally sensitive and appropriate. Individuals should be properly compensated for their time. These discussions would increase the understanding of funders, developers, and service providers of the experiences and housing needs of Indigenous peoples. They would also help determine areas in the sector that require immediate attention and provide valuable recommendations that will inform where new Indigenous housing should be located in the urban areas, as well as define what amenities are important, which services are missing and should be provided nearby, and advise on any changes to their needs that will affect future housing development.

3. More housing programmes with wraparound supports should be provided for Indigenous peoples experiencing homelessness. These supports must be managed by Indigenous groups, lived experts, and/or by individuals who are culturally competent. These programmes must adopt a trauma-informed approach that acknowledges and reacts to the historical and colonial trauma, as well as personal traumas. The trauma-informed approach must prevent re-traumatization and be integrated into

the organisational-level of housing programmes (e.g., offer an array of supports, recognize and address the cultural dimension of existing traumas Indigenous persons experience, resist proselytization), as well as at the individual-level within the programme (e.g., staff receive cultural and trauma-informed training, create safe spaces, are aware and able to anticipate things that may trigger trauma to eliminate or mitigate its effects). Lived experts should inform how these programs are designed, implemented, managed, and evaluated.

These programmes should also adopt harm reduction strategies and encourage sober living, which could be done by providing appropriate counselling and medical treatment to individuals, providing a safe space and sterile needles for injection, dispersing opioid testing kits, and ensuring adequate access to naloxone in the case of emergencies. Additionally, gender-based and mental health supports should be available to aid with conditions that may have been present prior to, exacerbated during, or caused by the experiences of homelessness (e.g., distress, lack of security, trauma, disconnection). These supports should vary to ensure that different needs are met, such as those who have experienced gender-based violence and violence based on sexual orientation, as well as those who have been forcibly separated from their children.

4. In principle, the Housing First model prioritises finding permanent housing followed by adequate and person-centred wraparound supports for individuals experiencing homelessness. Housing First has been adopted by many organizations across Canada and beyond. To adapt this model for Indigenous peoples, funders and housing providers must understand the differences between the experiences of Indigenous peoples and those who are not. As emphasised in this study and in Thistle's definition of Indigenous homelessness (2017), experiencing homelessness as an Indigenous person is more than a lack of structure and is better described through Indigenous worldviews, which includes isolation from their relationship to the land, place, family, cultures, languages, and identities among others. Housing providers and developers must collaborate with Indigenous partners, including Indigenous governments and leadership, knowledge keepers, and elders, to reevaluate how the model can be adapted to meet the needs of Indigenous groups. This framework was developed into a guide by Distasio et. al (2019) in their report titled, "Localised Approaches to Ending Homelessness: Indigenizing Housing First". Distasio et. al (2019, p.65) recommended that "Indigenizing" Housing First takes more than simply following a guide to being "deeply connected to each First Nations, Métis, or Inuit community and its leaders, whose knowledge and wisdom bring forward histories and future paths."

5. A substantial proportion of the Indigenous women participants in this study lost contact with their children through apprehension. The Department of Families, Province of Manitoba should invest in family reunification programmes and counselling for women, as well as consult with Indigenous women with lived experience and other partners such as Indigenous governments to identify how best to prevent apprehensions.

6. Many of the Indigenous participants in this study were in the care of CFS as children. The Department of Families must prepare and support youth transitioning out of care through programming and services, such as opportunities to learn and strengthen life skills (e.g., cooking, budgeting), as well as ensuring access to education, employment, and housing. Transitional housing programmes in Winnipeg intended for Indigenous youth in or exiting care, such as Shawenim Abinoojii Incorporation's Memengwaa Programme and Ka Ni Kanichihk's Manitoba Youth Transitional Employment Assistance and Mentorship, should be scaled up. In addition, the Department of Families must ensure all youth interested in Agreements with Young Adults, that is, extension of care, get it at least until 21 years, as well as support more Indigenous organisations in taking over the responsibility of CFS for their own people.

7. Given the relationship between educational attainment and homelessness, the six school divisions in Winnipeg, in collaboration with Indigenous partners, must improve high school attendance and graduation rates for Indigenous youth. The rates can be improved by hiring and retaining Indigenous teachers and support staff who can provide more culturally appropriate mentorship (Winnipeg Indigenous Executive Circle, 2022). According to the Winnipeg Indigenous Executive Circle, an additional 1,500 Indigenous teachers are needed in Winnipeg to match the proportion of Indigenous students — 19.1%

(Woelk, 2024). In addition, an equity office should be established in the Department of Education and Early Childhood Learning (Province of Manitoba) and school divisions to address equity issues for Indigenous students (Winnipeg Indigenous Executive Circle, 2022).

8. Steps must be taken to eliminate systemic discrimination Indigenous peoples experience in healthcare, housing and shelter services, and employment settings. These steps should include: evaluating and adjusting policies from an Indigenous lens, providing continuous training for staff, establishing safe and accessible channels for reporting incidents of racism, and ensuring organisations are held responsible for addressing racism through regular performance reviews or through disciplinary actions if they are not complaint. The provincial government should establish Indigenous advocates to support Indigenous peoples seeking the aforementioned services.

9. End Homelessness Winnipeg along with Indigenous partners, including Indigenous governments and organisations, should establish an Indigenous-led monitoring group to regularly evaluate and report on the effectiveness and cultural appropriateness of housing, support programmes, and housing models. The findings of this group should be shared with the housing and homelessness sector to ensure transparency and dissemination of up-to-date information.

10. The federal and provincial governments should support Indigenous organisations such as Eagle Urban Transition Services and the Winnipeg Friendship Centre to expand settlement services to Indigenous peoples transitioning to Winnipeg for education, health, employment, housing, identification, etc.

11. Many affordable housing projects struggle to meet timelines due to unnecessary delays in land use applications and permit approvals, significantly hindering the supply or willingness to develop affordable housing (Osei-Yeboah et al., 2024). Funding for low-income housing development often outlines timelines to meet project milestones, and developers can lose significant capital funding if development is delayed. Sector partners should support End Homelessness Winnipeg's efforts to advocate for the City of Winnipeg to evaluate the permit process for low-income housing and make efforts to reduce unnecessary delays in the land use application and permit approval process, which are typically due to bureaucratic inefficiencies or inconsistencies (e.g., delays in departmental approvals and inconsistent advice between pre-application review and formal development application review process). The advocacy could also be directed towards the Province of Manitoba to implement statutory timelines for development approvals relating to low-income housing and provide more flexibility for municipalities to set structures to ensure permit approval processes are transparent, client-focused, and reasonably expedited. This can include proposing further amendments to the City of Winnipeg Charter and Planning Act to set further failure to achieve targets relevant legislation - see the Province of Ontario's Bills 109 and 185).

12. Another obstacle to low-income housing development in Winnipeg is the limited access to affordable land that is "shovel-ready" and able to be used for residential development (Osei-Yeboah et al., 2024). Sector partners should support End Homelessness Winnipeg to lobby the City of Winnipeg to develop an accessible land bank of City-owned land. This land must be reasonably priced, and all deficiencies on the land (e.g., insufficient water servicing) should be addressed by public funding. One of the reasons why Helsinki, Finland has been very successful in reducing and preventing homelessness is the easy access to land for low-income housing development — the Helsinki government owns 70% of the city's land (for more information about how the Helsinki government has reduced homelessness significantly, see Henley, 2019).

The recommendations aim to address the multiple causes of Indigenous homelessness and provide a foundation for the development of targeted and culturally sensitive interventions. Indigenous communities must lead the decision-making processes to ensure the relevance and success of these recommendations.

References

Adair, C. E., Streiner, D. L., Barnhart, R., Kopp, B., Veldhuizen, S., Patterson, M., Aubry, T., Lavoie, J., Sareen, J., LeBlanc, S.R., & Goering, P. (2017). Outcome trajectories among homeless individuals with mental disorders in a multisite randomised controlled trial of Housing First. *Canadian Journal of Psychiatry*, *62*(1), 30–39. https://doi.org/10.1177/0706743716645302.

Agrawal, S. K. & Zoe, C. (2021). Housing and homelessness in Indigenous communities of Canada's North. *Housing Policy Debate*, 1–31. https://doi.org/10.1080/10511482.2021.1881986.

Alaazi, D.A., Masuda, J. R., Evans, J., & Distasio, J. (2015). Therapeutic landscapes of home: Exploring Indigenous peoples' experiences of a Housing First Intervention in Winnipeg. *Social Science & Medicine, 147*, 30–37. https://doi.org/10.1016/j.socscimed.2015.10.057.

Alberton, A.M., Angell, B.G., Gorey, K.M., & Grenier, S. (2020). Homelessness among Indigenous peoples in Canada: The impacts of child welfare involvement and educational achievement. *Children and Youth Services Review*, *111*. https://doi.org/10.1016/j.childyouth.2020.104846.

Alliance to End Homelessness Ottawa (2024, January 16). *Ending homelessness is possible: Lessons from Finland*. https://www.youtube.com/watch?v=noQvBWdNsjw&t=3s.

Allan, B. & Sakamoto, I. (2014). Chapter three. Helpers, not helpless: Honouring the strength, wisdom and vision of Aboriginal women experiencing homelessness or marginal housing. In M. Guergis-Younger, R. McNeil, & S. Hwang (Eds.), *Homelessness and health in Canada* (pp. 57-85). University of Ottawa Press.

Allan, B. & Smylie, J. (2015). *First peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Toronto*. The Wellesley Institute.

Anderson, J. T. & Collins, D. (2014). Prevalence and causes of urban homelessness among Indigenous peoples: A three-country scoping review. *Housing Studies*, *29*(7), 959–976. https://doi.org/10.1080/02673037.2014.923091.

Barker, B., Alfred, G. T., Fleming, K., Nguyen, P., Wood, E., Kerr, T., & DeBeck, K. (2015). Aboriginal street-involved youth experience elevated risk of incarceration. *Public Health, 129*(12):1662-8. https://doi: 10.1016/j.puhe.2015.08.003.

Barker, B., Kerr, T., Alfred, G.T., Fortin, M., Nguyen, P., Wood, E., & DeBeck, K. (2014). High prevalence of exposure to the child welfare system among street-involved youth in a Canadian setting: Implications for policy and practice. *BMC Public Health*, *14*(197).

Belanger, Y. D. & Awosoga, O. (2013). Homelessness, urban Aboriginal people, and the need for a national enumeration. *Aboriginal Policy Studies*, *2*(2), p.4-33. https://doi.org/10.5663/aps.v2i2.19006.

Belanger, Y., Dekruyf, K. A., Moncrieff, A., & Kazakoff, T. (2019). *The urban Indigenous housing experience of NIMBY-ism in Calgary, Alberta*. Calgary.

Bingham, B., Moniruzzaman, A., Patterson, M., Distasio, J., Sareen, J., O'Neil, J., & Somers, J. M. (2019a). Indigenous and non-Indigenous people experiencing homelessness and mental illness in two Canadian cities: A retrospective analysis and implications for culturally informed action. *BMJ Open*, *9*(4). https://doi.org/10.1136/bmjopen-2018-024748.

Bingham, B., Moniruzzaman, A., Patterson, M., Sareen, J., Distasio, J., O'Neil, J., & Somers, J. M. (2019b). Gender differences among Indigenous Canadians experiencing homelessness and mental illness. *BMC Psychology*, *7*(57).

Bombay, A., McQuaid, R.J., Young, J., Sinha, V., Currie, V., Anisman, H., & Matheson, A. (2020). Familial attendance at Indian residential school and subsequent involvement in the child welfare system among Indigenous adults born during the Sixties Scoop era. *First Peoples Child and Family Review*, *15*(1), 62–79.

Bonnycastle, M., Simpkins, M., & Siddle, A. (2015). The inclusion of Aboriginal voice in co-constructing "home": Aboriginal homelessness in a Northern semi-urban community in Manitoba. In E. J. Peters & J. Christensen (Eds.), *Indigenous homelessness, perspectives from Canada, Australia, and New Zealand*. University of Manitoba Press.

Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for Indigenous North Americans and Australians. *Social Science & Medicine*, *41*(11), 1487–1498. https://doi.org/10.1016/0277-9536(95)00055-C.

Brandon, J. (2022). *The Winnipeg street census 2022: Final report.* End Homelessness Winnipeg and Social Planning Council of Winnipeg. https://endhomelessnesswinnipeg.ca/wp-content/uploads/2022-Winnipeg-Street-Census-Final-Report.pdf.

Brandon, J. & Peters, E. (2014). *Moving to the city: Housing and Aboriginal migration to Winnipeg*. Canadian Centre for Policy Alternatives.

Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2011). Access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative Health Research*, *21*(3), 333–348. https://doi.org/10.1177/1049732310385824.

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research*, *16*(544). https://doi.org/10.1186/s12913-016-1707-9.

Canadian Observatory on Homelessness. (n.d.). *Indigenous Peoples*. https://www.homelesshub.ca/about-homelessness/population-specific/indigenous-peoples.

Cao, L. (2014). Aboriginal people and confidence in the police. *Canadian Journal of Criminology and Criminal Justice*, *56*(5), 499–525. https://doi.org/10.1353/ccj.2014.0042.

Christensen, J. (2013). 'Our home, our way of life': Spiritual homelessness and the sociocultural dimensions of Indigenous homelessness in the Northwest Territories, Canada. *Social & Cultural Geography*, *14*(7), 804–828. https://doi.org/10.1080/14649365.2013.822089.

Christensen, J. (2016). Indigenous housing and health in the Canadian North: Revisiting cultural safety. *Health & Place, 40*, 83–90. https://doi.org/10.1016/j.healthplace.2016.05.003.

Christensen, J., Arnfjord, S., Carraher, S., & Hedwig, T. (2017). Homelessness across Alaska, the Canadian North and Greenland: A review of the literature on a developing social phenomenon in the Circumpolar North. *Journal of The Arctic Institute of North America*, *70*(4), 343–445.

Cross, T. L. (2007, September 20). *Through Indigenous eyes: Rethinking theory and practice*. Paper presented at the 2007 Conference of the Secretariat of National Aboriginal and Islander Child Care in Adelaide, Australia. https://www.snaicc.org.au/wp-content/uploads/2015/12/02242.pdf.

Distasio, J., Zell, S., McCullough, S., & Edel, B. (2019). *Localized approaches to ending homelessness: Indigenizing Housing First*. Institute of Urban Studies.

Fineblit, E. (2015). *Indigenizing housing: A guide to providing culturally-appropriate housing for Aboriginal communities in British Columbia*. Aboriginal Housing Management Association.

Firestone, M., Syrette, J., Brant, T., Laing, M., & Teekens, S. (2021). Findings from a process evaluation of an Indigenous holistic housing support and mental health case management program in downtown Toronto. *International Journal of Indigenous Health*, *16*(2), 139–150.

Gabriel, M., Mirza, S., & Stewart, S. (2022). Exploring mental health and holistic healing through the life stories of Indigenous youth who have experienced homelessness. *International Journal of Environmental Research Public Health*, *19*(20).

Gaetz, S., Dej, E., Richter, T., & Redman, M. (2016). *The state of homelessness in Canada 2016*. Canadian Observatory on Homelessness Press.

Gaetz, S., Gulliver, T. & Richter, T. (2014). *The state of homelessness in Canada: 2014*. The Homeless Hub Press.

Groening, A., Bonnycastle, C., Bonnycastle, M., Nixon, K., & Hughes, J. (2019). Housing needs of Indigenous women leaving intimate partner violence in Northern communities. Winnipeg. *Canadian Centre for Policy Alternatives*.

Harvey, M.-F. (2016). *Homelessness: Portrait of homelessness in First Nations communities in Quebec*. First Nations of Quebec and Labrador Health and Social Services Commission.

Hayes, J. (2016). *Guidelines for culturally-relevant urban Aboriginal housing: Promoting wellness through key components of project form, design, and development*. City of Vancouver.

Henley, J. (2019, June 03). *'It's a miracle': Helsinki's radical solution to homelessness*. The Guardian. https://www.theguardian.com/cities/2019/jun/03/its-a-miracle-helsinkis-radical-solution-to-homelessness.

Homeward Trust Edmonton. (2015). *Towards a deeper understanding of the Indigenous experience of urban homelessness*. Homeward Trust Edmonton. http://www.bluequills.ca/wpcontent/uploads/2017/03/BQ-Homeward-Trust-Report-Final.pdf.

Isaak, C., Hinds, A., Steur, T., Nelson, G., & Campos-Ordonez, P. (2019). *2018 Winnipeg Street Health Survey: Final Report*. End Homelessness Winnipeg.

Johnson, T.P. & Fendrich, M. (2007). Homelessness and drug use - Evidence from a community sample. *American Journal of Preventive Medicine*, *32*(6), S211—S218.

Kauppi, C., Forchuk, C., Montgomery, P., Edwards, B., Davie, S., & Rudnick, A. (2015). Migration, homelessness, and health among psychiatric survivors in Northern and Southern Ontario. The *International Journal of Interdisciplinary Social Sciences*, *9*(1), 1—14. https://doi.org/10.18848/1833-1882/CGP/v09/53550.

Kenny, K. S. (2018). Mental health harm to mothers when a child is taken by child protective services: Health equity considerations. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *63*(5), 304-307. https://doi.org/10.1177/0706743717748885.

Kidd, S. A., Thistle, J., Beaulieu, T., O'Grady, B., & Gaetz, S. (2019). A national study of Indigenous youth homelessness in Canada. *Public Health*, *176*, 163—171. https://doi.org/10.1016/j.puhe.2018.06.012.

Kirkby, C. & Mettler, K. (2016). Woman first: An analysis of a trauma-informed, women-centred, harm reduction housing model for women with complex substance use and mental health issues. In N. Nichols & C. Doberstein (Eds.), *Systems planning for targeted groups* (pp. 114—131). Canadian Observatory on Homelessness.

Kitching, G.T., Firestone, M., Schei, B., Wolfe, S., Bourgeois, C., O'Campo, P., Rotondi, M., Nisenbaum, R., Maddox, R., & Smylie, J. (2020). Unmet health needs and discrimination by healthcare providers among an Indigenous population in Toronto, Canada. *Canadian Journal of Public Health*, *111*(1), 40—49. https://doi.org/10.17269/s41997-019-00242-z.

Lavalley, J., Kastor, S., Tourangeau, M., Goodman, A., & Kerr, T. (2020). You just have to have other models, our DNA is different: The experiences of Indigenous people who use illicit drugs and/or alcohol accessing substance use treatment. *Harm Reduction Journal*, *17*(1), 1—10. https://doi.org/10.1186/s12954-020-00366-3.

Leckey, R., Schmieder-Gropen, R., Nnebe, C., & Clouthier, M. (2022). Indigenous parents and child welfare: Mistrust, epistemic injustice, and training. *Social and Legal Studies*, *31*(4), 559—579. https://doi.org/10.1177/09646639211041476.

Legislative Assembly of Ontario. (2022). *Bill 109: An Act to amend the various statutes with respect to housing, development and various other matters*. Legislative Assembly of Ontario. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2022/2022-04/b109ra_e.pdf.

Legislative Assembly of Ontario. *Bill 185: Cutting red tape to build more homes Act, 2024*. Legislative Assembly of Ontario. https://www.ola.org/en/legislative-business/bills/parliament-43/session-1/bill-185.

Lindstrom, G. (2020). Framing the research in critical context. In G., Lindstrom, S., Pomeroy, N., Falvo, & J. Bruhn (Eds.). *Understanding the flow of urban Indigenous homelessness: Examining the movement between Treaty 7 First Nations and Calgary's homeless-serving system of care*. Calgary Homeless Foundation. https://www.calgaryhomeless.com/wp- content/uploads/2021/08/Understanding-Flow_Final_print_2020_07_21.pdf.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, *365*(9464), 1099–1104. https://doi.org/10.1016/S0140-6736(05)71146-6.

Mcneil, R., Guirguis-Younger, M., Dilley, L.B., Turnbull, J., & Hwang, S. W. (2013). Learning to account for the social determinants of health affecting homeless persons. *Medical Education*, *47*(5), 485–494. https://doi.org/10.1111/MEDU.12132.

Milaney, K., Williams, N., Lockerbie, S. L., Dutton, D. J., & Hyshka, E. (2020). Recognizing and responding to women experiencing homelessness with gendered and trauma-informed care. *BMC Public Health, 20*(1), 397–397. https://doi.org/10.1186/s12889-020-8353-1.

Native Women's Association of Canada. (2019). *Indigenous housing: Policy and engagement final report to Indigenous services*. Native Women's Association of Canada. https://nwac.ca/assets-knowledge-centre/Indigenous-Housing-Policy-and-Engagement-%E2%80%93-Final-Report-to-Indigenous-Services-Canada.pdf.

Nelson, R. (2019). Beyond dependency: Economic development, capacity building, and generational sustainability for Indigenous people in Canada. *SAGE Open*, *9*(3).

Oelke, N. D., Thurston, W. E., & Turner, D. (2016). Aboriginal homelessness: A framework for best practice in the context of structural violence. *International Indigenous Policy Journal, 7*(2). https://doi.org/10.18584/iipj.2016.7.2.5.

Osei-Yeboah, E, Whitford, J., Hunt, J., Quigley, J., Bisson, S., & Bramadat, J. (2024). *First Nations housing and homelessness in Winnipeg*. End Homelessness Winnipeg (forthcoming).

Paul, J., Clarkson, A. F., Christian, W. M., Pearce, M. E., Jongbloed, K. A., Caron, N. R., Teegee, M.P., Moniruzzaman, A., Schecter, M.T., & Spittal, P. M. (2015). The cedar project: Negative health outcomes associated with involvement in the child welfare system among young Indigenous people who use injection and non-injection drugs in two Canadian cities. *Canadian Journal of Public Health*, *106*(5), e265–e270. https://doi.org/10.17269/CJPH.106.5026.

Pauly, B., Brown, M., Evans, J., Gray, E., Schiff, R., Ivsins, A., Krysowaty, B., Vallance, K., & Stockwell, T. (2019). "There is a place": Impacts of managed alcohol programs for people experiencing severe alcohol dependence and homelessness. *Harm Reduction Journal*, *16*(1), 1–14. https://doi.org/10.1186/s12954-019-0332-4.

Public Health Agency of Canada. (2007). Determinants of health: What makes Canadians healthy or unhealthy? http://www.phacaspc.gc.ca/phsp/phdd/determinants/#determinants.

Reading, C.L. & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health*. Public Health Agency National Collaborating Centre for Aboriginal Health. http://www.nccah-ccnsa.ca/docs/social%20determinates/nccah-loppie-wien_report.pdf.

Ridgen, M. (2023, February 17). An Indigenous mother took her life after child welfare took her kids. What can be done? Global News. https://globalnews.ca/news/9474610/manitoba-child-welfare-mother-remembered/.

Schiff, J.W., Schiff, R., & Turner, A. (2016). Rural homelessness in Western Canada: Lessons learned from diverse communities. *Social Inclusion, 4*(4), 73–85. https://doi.org/10.17645/si.v4i4.633.

Schiff, R. & Brunger, F. (2015). Northern housing networks: Building collaborative efforts to address housing and homelessness in remote Canadian Aboriginal communities in the context of rapid economic change. *Journal of Rural & Community Development*, *10*(1), 1–18.

Sinclair, R. (2016). The Indigenous child removal system in Canada: An examination of legal decision making and racial bias. *First Peoples Child & Family Review*, *11*(2), 8–18.

Sinha, V., Trocmé, N., Fallon, B., & MacLaurin, B. (2013). Understanding the investigation-stage overrepresentation of First Nations children in the child welfare system: An analysis of the First Nations component of the Canadian Incidence Study of Reported Child Abuse and Neglect 2008. *Child Abuse & Neglect*, *37*(10), 821–831. https://doi.org/10.1016/j.chiabu.2012.11.010.

Stafford, A., & Wood, L. (2017). Tackling health disparities for people who are homeless? Start with social determinants. *International Journal of Environmental Research and Public Health, 14*(12), 1535. https://doi.org/10.3390/IJERPH14121535.

Statistics Canada. (2022, September). Indigenous population continues to grow and is much younger than the non-Indigenous population, although the pace of growth has slowed. *The Daily*. https://www150.statcan.gc.ca/n1/en/daily-quotidien/220921/dq220921a-eng.pdf?st=hs8Y6jUV.

The District of Thunder Bay Social Services Administration Board. (2022). *2021 Point in Time Count of people experiencing homelessness in the District of Thunder Bay*. The District of Thunder Bay Social Services Administration Board.

Thistle, J. A. (2017). Reframing the discussion: An Indigenous definition of homelessness. *Canadian Observatory on Homelessness*. https://www.homelesshub.ca/sites/default/files/attachments/COHIndigenousHomelessnessDefinition.pdf.

Thistle, J.A. & Smylie, J. (2020). Pekiwewin (coming home): Advancing good relations with Indigenous people experiencing homelessness. *Canadian Medical Association Journal*, *192*(10), E257–E259. https://doi.org/10.1503/cmaj.200199.

Victor, J., Shouting, M., DeGroot, C., Vonkeman, L., Brave Rock, M., & Hunt, R. (2019). I'taamohkanoohsin (everyone comes together): (Re)connecting Indigenous people experiencing homelessness and addiction to their Blackfoot ways of knowing. *International Journal of Indigenous Health*, *14*(1), 42–59. https://doi.org/10.32799/ijih.v14i1.31939.

Winnipeg Indigenous Executive Circle (2022). *2021 state of equity in education report*. Winnipeg Indigenous Executive Circle.

Woelk, D. (2024, February 13). Representation is critical, experts say in bid for more Indigenous teachers. *Global News*.

Appendix A: Interview guide

Street Health Survey Indigenous Sub-Report Qualitative

INTERVIEW GUIDE
INDIVIDUAL INTERVIEW

Introduction

[Complete informed consent & Demographic Form]

This interview is a chance for you to share your thoughts on the housing needs and preferences of Indigenous people who are or have experienced homelessness in Winnipeg. All of this will help us to better understand what types of homes, housing and supports are best for Indigenous people who have or are experiencing homelessness.

Take the time you need. For most people it takes about 60-90 minutes, but how much time we take to do the interview is up to you. We can take a break if you wish.

You are also invited to use art or creativity during this interview to share your thoughts and ideas during the interview, to add to what you are sharing. For example, drawing, sketching, photos (photos can not include other people), poetry, other writing, music etc. Drawing supplies and paper will be provided, and you can also take time during the interview to do this, just let me know.

Your responses are confidential, and you may decline to answer any question if you wish – just say "skip".

Do you have any questions before we get started?

I am going to start the recorder now – is that still okay with you?

Meaning of Home

1) Please tell us about what home means to you. This can be anything that comes to mind. (you can write down some words or draw your ideas if you wish.

   PROMPTS: What do you think of when you hear the word 'home'?

   - The House - physical structure, design, building materials, décor/art/plants, ventilation for smudging.
   - The Home – social and psychological environment of the house (e.g., safe, secure, healthy, clean, belonging, family/kin/company/companion/partner, stable, affordable, warm/inviting, pet friendly,)
   - The Neighbourhood – the immediate physical area around the house and home (e.g., sense of belonging and community connectedness, able to have a garden and grow own food, close to nature vs downtown)
   - The Community – the shared, community aspects and important services in a neighborhood (e.g., proximity to healthcare/doctors/hospitals/clinics, EIA/mental health/case workers, friends/family, recreation, transit/transportation, away from gangs/violence/drugs/crime)
   - Other – anything else?

Version 3.0 JAN 2021

Appendix A: Interview guide continued

Street Health Survey Indigenous Sub-Report Qualitative

Housing Preferences for Indigenous people

1) If you were to think of the best home for you, how would you finish this sentence? I wish to live in a home where...

2) Please tell me/us about the type of living space and home that would honour who you are as an Indigenous person?

PROMPTS [*should be used to generate qualitative responses vs. yes/no*]:

- Stand-alone house; Apartment
- Close to family/with family/partner/friends, community, services, resources
- Where? Which part of Winnipeg? Somewhere outside Winnipeg?
- How big? How many bedrooms/other types of rooms?
- Accessibility? No stairs, main floor etc.
- Cost/affordable
- Stable (eviction prevention safety net)
- With supports attached/on-site?

3) Thinking about a home, what are the things you would like to have around you in your home?

PROMPTS:

Spiritually: What would help you to feel spiritually/your spirit connected to your home? E.g. medicines, Creator, smudging, dancing

Physically: What would help you to feel physically/your body connected to your home? e.g. water, food, housing, safety, and security

Emotionally: What would help you to feel emotionally connected to your home? For example, positive self-image, positive self esteem, self love, positive environment and belonging

Cognitively/Mindfully: What would help you to feel cognitively connected to your home? E.g. teachings from elders, cultural knowledge, full realization of own potential and community potential

- PROMPTS: What is needed to make these things happen? What changes might need to be done to make that place to be a home for you?

Housing Types needed for Indigenous people

4) What would be an ideal home, a place to live, look like to you?
   - Where would you prefer to live?
   - Who, if anyone, would you want to live with?
     - What changes might be needed to make a place feel like a home for you?

Version 3.0 JAN 2021

Appendix A: Interview guide continued

Street Health Survey Indigenous Sub-Report Qualitative

5) What types of housing have you heard of or know of that worked or could work well for other Indigenous people who are living in Winnipeg who currently do not have a place to call home?

   - PROMPTS:
     - place where y can stay temporarily until you get back on their feet;
     - place where there are people to support them and they can stay for as long as they want;
     - their own place, [temporary/interim housing, transitional housing, supportive housing, permanent housing]
   - PROMPTS: what kinds of housing are needed, e.g. apartments, row housing, small tiny homes, large homes, community living, other?
   - PROMPTS: Housing specifically for,
     - women, men, youth, families, 2SLGBTQ+
     - First Nations, Metis, Inuit
     - People coming out of corrections, hospital, CFS, etc.
     - Specific needs e.g. mental health, substance use, disabilities (cognitive, physical, mobility), physical health

6) Thanks for the examples of types of homes and housing you have shared as being important. Why do you think these types of housing are needed?

Ending the Interview

We are almost finished,

7) What would you share with workers, community, and government/policy makers about housing needs for Indigenous people in Winnipeg?

8) Do you have any other ideas, thoughts, or anything you want to share about what we have talked about today?

9) Do you have any questions of me/us?

Thank you very much for sharing today, this will be helpful for us to do our work and to help Indigenous people with finding homes.

Version 3.0 JAN 2021

Appendix B: Coding scheme

Code	Definition	Sub-Code	Definition
Physical	Needs related to the physical environment, services, and health/ well-being. These needs are characterized by descriptions of physical aspects of a home, proximity to desired services, and affordability.	Food	Characterized by statements regarding stable access to affordable food.
		Water	Characterized by statements regarding stable access to clean water.
		Housing	Characterized by statements regarding stable access to housing that meets basic physical form needs including but not limited to nearby amenities, neighbourhood preference, number of bedrooms, and so on.
		Safety & Security	Characterized by statements regarding feelings of safety afforded by having a home, particularly one in an area deemed as being safe.
		Physical Well-Being	Characterized by statements regarding improved physical health and well-being as a result of having a home.
		Physical Supports/ Services	Characterized by statements regarding access to health care services, income & employment services, and food, water, and personal hygiene services, and freedom from discrimination relating to homelessness when acquiring these services.
		Income & Employment	Characterized by statements regarding opportunities for stable employment and income, including access to advancing education in an effort to attain employment.
		Personal Hygiene	Characterized by statements regarding stable access to running water, including showers, toilets, and laundering services, in addition to access to hygiene supplies.
Emotional	Needs related to interpersonal connections and positive emotionality. These needs are characterized by indications of self-esteem, emphasis on stability in relationships, and connection.	Belonging	Characterized by statements regarding feelings of loneliness that can be alleviated by having a home at which others may visit/stay, and the desire to have a sense of home and belonging. In addition, freedom from discrimination.
		Relationship	Characterized by statements regarding improving the quality of or reconnection of relationships in addition to emphasizing the desire to have interpersonal connections.
		Self-Worth	Characterized by statements of improved self-esteem and value in society as a result of having a home.
		Emotional Well-Being	Characterized by statements of improved emotional well-being, including happiness and freedom from negative emotions.
		Emotional Supports/ Services	Characterized by having access to emotional supports/ services, including but not limited to having someone to talk to about their feelings and to rely on in times of need.

Spiritual	Needs related to engagement with ones' spiritual beliefs. These needs are characterized by specific spiritual practices and proximity/availability of services.	Spirituality/Belief	Characterized by statements regarding a desire to engage with/explore ones' spiritual beliefs, including participating in events and access to services/knowledge keepers/elders.
		Life Purpose	Characterized by statements regarding finding a purpose in life, similar to the concept of self-actualization.
		Connectedness	Characterized by statements regarding connecting to the world/environment in the spiritual sense.
		Spiritual Supports/Services	Characterized by having access to the appropriate spiritual ceremonies, services, advice, and so on, that one deems important to them.
Mental	Needs related to mental well-being, involvement in ones' community, and mental health services/ supports. These needs are characterized by access to mental health supports, ability to meet goals as a result of having stable housing, and active engagement in supporting one's community.	Self-Fulfillment	Characterized by statements regarding achieving ones' goals.
		Community	Characterized by statements of ones' place within a community and how they view that place as being integral of the functioning of that community.
		Role	Characterized by statements of ones' contributions to their community, family, friends, and society at large. As well, ones' own role in their own successes, accomplishments, and decision making; autonomy.
		Identity	Characterized by statements regarding an understanding of ones' values, ambitions, skills/talents, and other such attributes.
		Service	Characterized by statements regarding how one can contribute to society or their community, particularly as it relates to their identity as an Indigenous person.
		Self-Worth	Characterized by statements of improved self-esteem and value in society as a result of having a home.
		Mental Health	Characterized by statements regarding ones' mental health status, including by not limited to professional diagnoses and self-diagnosed conditions.
		Personal Health & Coping Practices	Characterized by statements regarding ones' coping skills, particularly as it relates to substance use.
		Mental Supports/ Services	Characterized by having access to mental health related supports, including counselling, addictions support, and so on.
Structural Elements	Elements that influence the physical, mental, emotional, and spiritual aspects of this model. These elements transcend anyone category and have implications in all aspects.	Indian Act & Residential Schooling	Characterized by statements regarding personal or familial experience with Residential Schooling and implications of the Indian Act.
		Political Decision Making	Characterized by statements regarding past, present, or future policies and those who have created them. In addition, recommendations for how political decision makers should improve their policies and decision-making processes.
		Racism & Colonialism	Characterized by statements regarding experienced racism and discrimination, and the implications such experiences have had.
		Culture	Characterized by statements regarding cultural practices and the desire to learn more about or participate in them. In addition, the implications of not having access to such culturally relevant practices.

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