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STUDY

Summary Report
2004

The Edmonton Joint Planning Committee on Housing

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Background

The 2003 Edmonton Homeless study was carried out between June and December 2003. The study, which built upon prior homelessness research carried out in Calgary during 2002, had **five goals**:

Figure 1: Goals of the 2003 Edmonton Study

1. **To obtain a profile on the characteristics of homeless people in Edmonton;**
2. **To map the current homelessness system and to identify how individuals and families move through the system and identify gaps in the system from the perspective of homeless people and those at risk of becoming homeless;**
3. **To identify intervention strategies, policies and programs that will remediate the problems of homelessness;**
4. **To develop a profile of the population at risk of becoming homeless, by identifying the factors that may precipitate homelessness; and**
5. **To identify prevention strategies, policies and programs that will assist those at risk of becoming homeless.**

Vista Evaluation and Research Services Inc. was contracted to carry out the study and analysis. The core research team worked with members of the Edmonton community in all phases of the research. Community partnership was critical to structure a randomized and stratified survey sample, design and gather quantitative information, and complete in-depth interviews to gather qualitative information.

The level of collaboration and the solution-focused approach of the Edmonton community was remarkable throughout this project. The community wholeheartedly took on the task of advising the research team on a myriad of issues, from debating the merits of stratified sampling and the various definitions of homelessness to providing advice on the best locations and times to locate individuals who were at risk of becoming homeless, and identifying appropriate individuals to be trained as surveyors.

The definitions of homelessness, as well as the sample sizes, were determined in advance. The survey sample size was to be a minimum of 330 (100 Sheltered, 100 Shelterless, 130 At-Risk), with a minimum of 70 of these individuals also completing in-depth interviews. The definitions of homelessness to be used were in keeping with those used in the Edmonton Homelessness Plan 2000 – 2003, and were as follows:

Figure 2: Definitions of Homelessness used in the 2003 Edmonton Study

1. **Shelterless**: Have no residence at all and are living on the streets or in parklands;

2. **Sheltered**: Are living anywhere not intended to be, or suitable as, a permanent residence, including emergency and transitional shelters and locations with one or more of the following characteristics:
    a. Lack of protection from elements/weather;
    b. Lack of safe water;
    c. Lack of washroom facilities;
    d. Unsafe;
    e. No security of tenure;
    f. Rental cost exceeds ability to pay;
    g. Lack of space; and
    h. Location that makes work, school, or health care inaccessible;

3. **At risk:** Have accommodation intended to be permanent**,** but may lose their residence due to:
    a. Being discharged from an institution or facility with nowhere to go; or
    b. Loss of income support.

KEY FINDINGS

We have attempted to identify the most critical findings for the Edmonton community and distil them into an executive summary.

It is also important to understand that the Shelterless sub-group corresponds to the Parklands population. Substantial numbers of homeless persons who were Sheltered at the time of the survey also use the Parklands on a sporadic basis, as do many of those who were At-Risk. However, these two groups use the Parklands far less frequently than the Shelterless homeless do. The results based on the Shelterless homeless that are presented in this report should therefore be understood as descriptive of Edmonton's Parklands homeless population.

1. Most of Edmonton's Homeless population considers Edmonton their home

More than 60% of the three homeless or At-Risk groups came from locations in Alberta. An additional 20% came from Saskatchewan and Manitoba. This pattern is consistent across all three groups within the study – the only exception being a slightly increased proportion with Alberta origins in the At-Risk group (66%). The great majority of Edmonton's homeless population considers Edmonton "home". The lack of housing and employment, combined with high rates of addiction on some reserves and settlements in Northern Alberta and Saskatchewan, are important contributing factors to the growth of Edmonton's homeless population.

2. Causes of homelessness

The methods used in the 2003 Edmonton Homelessness Study cannot establish causality absolutely. Survey and interview methods can only speak to possible causes of homelessness as identified by the respondents. However, memories are fallible or too painful to recall for strangers, and lives are complicated and difficult to summarize in a one-hour survey. Participants were asked directly about what caused their homelessness, and the life experiences told by respondents to the interviewers had consistent themes that were very similar to those found in other studies. When taken together, the evidence regarding what causes homelessness, although not conclusive in the same sense as a randomized control experiment might be, points clearly to the problems that must be addressed if the goal is to prevent homelessness or to ease the problems of homelessness.

Health problems and poverty are the primary causes of homelessness identified by the EHS participants. In many instances, though not all, "health problem" included substance abuse and its health consequences. The homeless in Edmonton rely heavily on emergency rooms and on EMS services for healthcare treatment. EMS is used as primary transportation to health care and as a mental health service, particularly by the Shelterless group. Hospital in-patient stays are also frequent in this population, and can be lengthy. There is an urgent need for increased health care capacity located in the community and accompanied by outreach capabilities to meet the physical and mental health care needs of the Shelterless homeless in particular.

Poverty is also a major cause of homelessness in Edmonton, but it is not a simple issue. For instance, many of the survey and interview participants indicated that they came from impoverished backgrounds that resulted in early home and school leaving and frequent family moves. Further, significant numbers of the Sheltered and Shelterless indicated that the reason they did not have their own homes now was either lack of money or money-related problems, such as needing a damage deposit, a first month's rent, a steady job to afford

rents, or funds for basics such as food, clothing and furniture. In most cases, poverty is a reflection of the high current addiction rates across groups (67% Sheltered, 86% Shelterless, 52% At-Risk, 66% overall), and of the unstable employment that so often accompanies addiction in combination with social policy that sets minimum wage to low to permit stable housing. However, the Edmonton homeless also typically have low levels of education and employability skills that make them even less likely to find sustainable work or earn a living wage. These individuals cannot rely on government financial support programs such as SFI and AISH, since **current rates for these programs and for minimum wage are set too low to sustain independent living in a city such as Edmonton**. In any event, most would be unable to obtain such financial assistance, since they have no fixed address.

These causes of homelessness are complex and are not amenable to "quick fix" solutions. Evidence gathered over multiple studies in Alberta provides strong evidence that the primary individual-level mechanisms of homelessness are:

1. Loss of developmental assets due to childhood context;
2. Loss of resilience due to repeated trauma and lack of social support; and,
3. Loss of "stake in conformity" and accompanying aspirations.

It is often difficult to translate these statements into an understanding of the challenges homeless and At-Risk people have faced in their past and now face in their current lives. We have therefore inserted a few short vignettes to put a personal face on the experiences of the 340 homeless and At-Risk people we spoke to over the course of the study. In some cases, details have been modified to protect the privacy of the respondents. However, each represents themes that we heard consistently throughout the study. For instance, Sophia is a very typical example of a person whose path to housing instability was set from a very early age by the presence in her childhood of many of the risk factors identified in the model of homelessness provided in an adjunct report on the qualitative data from the study

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Sophia is a middle aged Métis woman who described her early years as very good. Then her mother died, and her father moved the 5 children away from their close-knit community and into a series of small towns. Her father was an alcoholic who sexually abused the girls and "treated children like slaves". Sophia and her sister kept running away until they were finally put into separate foster homes. Sophia was not able to connect with any of her foster parents, although she says they were good people. She began drinking, dropped out of school before completing junior high school, had a baby when she was 16 and has had a long history of alcoholism, addictions treatment, and

abusive relationships which were so physically violent that she is now permanently disabled. She was staying with a friend at the time of the interview, but the relationship is breaking down. She did not know where she would go next.

Many of the Shelterless, Sheltered, and At-Risk individuals we spoke to started life in difficult circumstances. For example, 66% of women and 35% of men who participated in the in-depth interview reported the death of a parent before their 18th birthday. Parental addictions were frequent (80% of women and 48% of men interviewed reported parental addictions), as were high levels of domestic violence, abuse and neglect during childhood. The family of origin issues were often combined with negative life events[1] such as job loss, domestic violence in adulthood, health crises, and other trauma. When an individual had a particularly difficult childhood, they tended to be less resilient to negative life events, simply because they had few supports to fall back on and lacked normal developmental strengths such as problem-solving capacity and self-management skills. **These already disadvantaged individuals then encountered a variety of social conditions that added to the likelihood of their becoming or remaining homeless.** Most important among these conditions were:

1. Street conditions (e.g. lack of transportation, lack of reliable phone service, sleep deprivation, health consequences of homelessness);
2. Social policy barriers to being housed (e.g. low SFI and AISH rates and eligibility barriers, minimum wage inadequate to support housing);
3. Housing conditions (e.g. lack of available, affordable housing, lack of emergency shelter space, lack of supported housing); and
4. Gaps in the system of available help/services (e.g. basic needs for food and shelter and medical or mental health care not met, services not offered in an accessible way).

3. Housing preferences

There is clearly a preference in all homeless groups for basic, independent housing with financial and other supports, both in the short term and in the long term. There were also many comments about the necessity to ensure that housing was located away from the downtown core and close to transportation, and that it be alcohol and drug-free. Ideally, it would include assistance with obtaining basic furniture, covering utility costs, a telephone, and support for basic needs such as food. These needs seem to suggest that the housing must be very specialized. However, in the case of long-term and long-term transitional housing, it could probably best be located as a designated number of units in new or existing developments with a mixed population, rather than as a population-specific development (i.e. using a dispersed model). An exception

would be the development of aggregated therapeutic communities, particularly for dual diagnosis populations.

4. Shelter use

Some homeless individuals avoid shelters for fear of the clientele, unwillingness to accept shelter rules such as exclusion of drugs and alcohol, and, importantly, lack of safe storage for personal belongings. However, **most would use shelters, particularly in bad weather, if increased capacity were provided.**

The survey and interview respondents in all three groups consistently indicated that the current shelters in Edmonton do not provide sufficient secure storage for homeless people to leave their possessions safely. Benchmark programs that have designed appropriate **storage for homeless people's belongings** are in place in other cities, and should be consulted to inform Edmonton's options. If Edmonton decides to build additional shelter capacity, there are a number of important design characteristics to be considered. It may be preferable, for example, to move in the direction of the "therapeutic community" model rather than the dormitory model. This approach offers multiple services on-site and provides a stable, structured environment for the several months that are likely to be required for meaningful stabilization and successful housing. If the therapeutic community approach were used, the shelters could enhance their transitional role rather than acting exclusively as an emergency resource, and might be better suited to the specific characteristics of Edmonton's homeless population (e.g., high rates of addictions and mental illness, high rates of hunger and lack of sleep) and to co-location of associated services.

5. Income sources

When the three study groups are combined, the most frequent sources of income are borrowing, GST rebates, and collecting bottles and cans. About one in three of the At-Risk group receives SFI, in comparison to about one in five of the Sheltered and Shelterless participants. This variance is explained in part by SFI policy around eligibility, but there are clearly individuals receiving AISH or SFI while living rough.

The Sheltered group reports the highest proportion of employed participants, at about 18% (cf. Shelterless at 12.4% and At-Risk at 15.3%). Overall, however, **the employment rates in Edmonton's homeless and At-Risk population are very low, suggesting that barriers to employment are substantial.** A small number of the homeless have monthly incomes that, if addictions were absent, could support housing.

Mark is a middle aged Aboriginal man currently living with his partner in the Parklands. Both of his parents were alcoholic; his mother died

from cirrhosis while Mark was quite young, and his father is in a nursing home due to an alcohol-induced illness. Although Mark came from a large family, he has lost three siblings to violent deaths, three more to serious mental illness, and is not in touch with any family members now. He is actively addicted to drugs and alcohol, as is his partner, and they avoid the shelters and services because they do not want to be bound by shelter rules. When it rains too much or is too cold, he and his partner sometimes move into a heated parkade or into a laundry room they know of. His partner is on AISH but she rarely sees any of it, as it is usually taken by her family (whose address they use to obtain the AISH) before she can spend it.

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6. Barriers to maintaining stable housing

The three most frequently mentioned barriers/needs are health problems (95.9%), transportation problems (46.2%), and substance abuse (39.7%). However, the differences on this variable across sub-groups are sufficient to affect planning. More of the Shelterless and At-Risk groups report health barriers, and the Sheltered population has a somewhat lower rate of substance abuse. The At-Risk group reports relatively fewer basic need concerns (lack of food, sleep), and more job market concerns and concerns about work experience deficits. **The overall picture suggests that the Sheltered and Shelterless groups have greater basic need deficits (food, sleep, shelter) while the At-Risk have more instrumental needs (education, work experience).**

7. Incarceration

About two-thirds of the Sheltered homeless and the At-Risk group have criminal records, in comparison to the Shelterless group's 82.5%.

Sentences of less than 30 days account for about 45% of all offences reported, suggesting that a large proportion of offences are relatively minor.

The most frequently reported type of offence is theft, at about one-third of each group. Assault, and alcohol or drug related offences are the next most frequent offence categories for the study group as a whole. The information on activities undertaken to survive also supports a finding of a high rate of criminal behavior in the Edmonton homeless population, since about 30% report stealing and selling

drugs as survival necessities. The fact that these rates are lowest in the Sheltered homeless suggests that stable housing and increased shelter capacity may have a beneficial effect on criminal activity. The probability is that a combination of stable, supported housing and addiction treatment would be most effective.

8. Health issues

There are clearly large components of Edmonton's homeless population that experience daily deprivation of basic needs for food and for a safe place, protected from the weather, to sleep. Edmonton's limited number of shelter beds and apparently insufficient capacity to feed the homeless are very serious concerns that should be addressed on an emergency basis.

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a. **Physical health and disability**. 43% of the overall sample reported good or very good health in the last month, but about **22% reported bad or very bad health**. The Shelterless group has the lowest levels on this variable, with fewer participants reporting good to very good health and more reporting bad to very bad health in the last month ($p<.000$). Their greater disability level is apparent in the extent to which they report experiencing severe to extreme effects of disability on their day to day lives (37.1% of the Shelterless vs. 22.5% of the Sheltered and 20% of the At-Risk group), and in the higher number of days they were unable to carry out their usual activities. The At-Risk group also had a significantly higher disability level than the Sheltered group ($p<.001$).

b. **Mental health**. Estimates of the proportion of the study participants who had a mental health problem varied widely depending on which approach to identification was taken. The in-depth interview approach provides a higher estimate than the survey approach - **a 59.2% overall prevalence, excluding addictions, (56.9% of men and 72.2% of women interviewed**), and is probably the most accurate prevalence estimate. A large proportion of those with mental illness were found in the Parklands population, and, in the absence of enhanced capacity for outreach-focused mental health intervention, these individuals are likely to continue living outdoors.

c. **Overall health**. **About two-thirds of each of the three study groups reports having a physical or mental health condition requiring treatment**. The Shelterless group had the highest ER use in the previous year, at 64.9% (cf. 54% of Sheltered and 41% of At-Risk). These rates are

certainly in excess of the general population average and may indicate that many of the homeless use emergency services as their primary health resource. They also often use EMS to get to the ER (63% of Sheltered, 62% of Shelterless, and 42% of At-Risk).

Dental care and provision of eyeglasses are also important health measures that need to be addressed. Only half of those who need glasses have them, and half of those in each of the homeless groups, as well as 40% of the At-Risk group, have current, untreated dental problems.

d. **Addictions**. **There is a very high prevalence of current and past addictions across all groups of the Edmonton Homeless population**. Two-thirds of those with past or current problems have sought treatment, but relatively few appear to have benefited by it. There are a number of possible reasons for the apparent lack of success of addictions treatment programs. Unfortunately, we do not have sufficient information to determine whether the problem is attributable to failure to enter or complete treatment, to a lack of transitional housing and support for those leaving completed treatment, to limited knowledge about what works for this population, or to other possible factors.

   Edmonton can begin to address one important cause of chronic homelessness by increasing its supply of supported transitional housing for those leaving completed addiction treatment. Making housing affordable is not likely to be a sufficient solution for the homeless who require supported housing, regardless of whether it is achieved through subsidies or through new construction of non-market housing. Affordable housing is only one piece of the solution to homelessness, albeit a critical one.

Having a current addiction clearly impacts a person's ability to remain healthy, employed and housed. Helping homeless individuals in Edmonton who have a current addiction will require a combination of effective addictions treatment and post-treatment supports. Increased capacity to (a) treat those with dual diagnosis (mental illness and addictions), (b) match individuals to programs, (c) provide supported, affordable housing during and after treatment, (d) assist with personal changes that support employability, (e) address education deficits, (f) improve levels of financial support through SFI/AISH and minimum wage increases, (g) provide treatment for physical and mental health problems and, (h) provide long term follow-up services are all essential components of the solutions to homelessness.

9. Parklands

While there are some significant differences between the parklands homeless group and the Sheltered and At-Risk groups – primarily in greater severity of health problems, rates of addiction, and criminal behavior – these can be explained by the fact of being Shelterless, and by the different composition of the Sheltered group, which includes a larger proportion of female participants.

The information gathered during the study suggests that the Parklands population is very similar to the "Shelterless" group, although the Parklands group does have a number of special needs.

If the City of Edmonton is to reduce the number of people staying overnight in the Parklands, it is likely that more emergency shelters will have to be built to accommodate them, that mobile health and mental health services will need to be made available, and that a drug and alcohol addiction treatment court program (recommended below) is put into place. These changes will be a good beginning, but should not be expected to solve the problem quickly or entirely. It will take time for any changes to be felt. For long-term change to occur, the prevention measures that would stem the flow of people into homelessness must also be implemented. The problems are complex and the solutions are similarly complex.

RECOMMENDATIONS

Each recommendation provided below is preceded by a statement of the study evidence and context that supports it.

1. The makeup of Edmonton's homeless population is strongly influenced by Edmonton's position as the northernmost population center in Canada and as a transportation hub. Edmonton's homeless population includes a disproportionate number of Aboriginal people, most of whom consider Edmonton home and have lived here for many years. Those who have migrated to Edmonton from northern Alberta reserves and settlements have often left behind intractable problems with lack of employment, lack of adequate housing, and high levels of substance abuse. They often arrive in Edmonton already disadvantaged by pre-existing health problems and without a plan for housing. Federal government studies, such as the Statistical Profile on the Health of First Nations in Canada (2003) have repeatedly confirmed that First Nations people experience a disproportionate burden of infectious

disease, dental problems, inadequate shelter, suicide risk, and infant mortality. When homelessness or risk of homelessness is added to these burdens, the load may easily become too overwhelming for individuals to address without appropriate supports. As a result of all of these factors combined, there are often extreme gaps between the quality of life of Edmonton's Aboriginal people and its overall population.

The current federal/provincial Urban Aboriginal Strategy provides a leveraging opportunity to begin to address Aboriginal quality of life issues in Edmonton, and to identify other funding sources that could be used to enhance culturally competent services for this population. Provision of transitional housing for youth and families arriving in Edmonton from reserves and settlements is also important as a homelessness prevention measure.

<u>Recommendation 1</u>: Reduce the gaps in quality of life between Edmonton's urban Aboriginal population and the mainstream population.

2. The rates of current addiction problems are very high in all three homeless groups included in the study. Problems of addiction are identified by three quarters of the participants as being important causes of their homelessness. Addictions are closely associated with health problems, unemployment, and unstable tenancy. Few of the participants who have sought treatment for their addictions report having succeeded in overcoming the addiction, and many have never sought treatment. The provision of effective addictions treatment and incentives to enter treatment are essential components of the plan to assist people out of homelessness. Supports for treatment effectiveness, such as the provision of supported transitional housing to those leaving a treatment facility, are also critical. Intervention in the problem of addiction requires a coordinated community response (CCR) to be effective. Current best practice in this area is the provision of specialized drug courts. Drug treatment courts work to ensure that addicts enter treatment, and maximize the likelihood of effective treatment by implementing intensive, community-based supervision and support. For a drug court to be effective, partnerships must be formed among police, probation services, addiction treatment services, Crown prosecutors and other related services to form a unified and coordinated community response to the problem. Results should be evaluated as part of the process for the first 3 years of such a program. The drug court must offer wrap-around, outreach based assistance that addresses the need for supported housing, accesses physical and mental health treatment, and connects individuals to other appropriate resources such as training or employment opportunities.

<u>Recommendation 2</u>: Implement a drug and alcohol addiction treatment court, **similar to those currently in place in Vancouver and Toronto, but modified to fit the Edmonton context (e.g. inclusion of culturally competent services for Aboriginal persons, outreach capacity to reach the Shelterless homeless).**

3. The research data clearly show that there are significant problems, particularly for the Shelterless homeless, in obtaining enough to eat. Sleep deficits, lack of dental care or eyeglasses, and other health problems are also serious problems. Only half of those who need glasses have them, and half of those in each of the homeless groups, and 40% of the At-Risk group, have current, untreated dental problems.

   <u>Recommendation 3a</u>: There are large groups in the homeless population (particularly the Shelterless) whose basic needs for food, sleep, shelter, and safety are not being met. The City should add supported emergency shelter beds and plan to use these facilities strategically and flexibly to provide short-term emergency housing and care and to connect to short and long term transitional housing. A review of existing services for providing meals to the Shelterless and At-Risk groups in particular is also required to identify options for improving nutritional status in these groups.

   <u>Recommendation 3b</u>: Either build on existing clinics or develop a centrally located clinic that can address dental care and eyeglass needs of the homeless and those living in poverty.

4. A number of barriers to the use of Edmonton's emergency shelters were identified. The most frequently described barrier for the two homeless groups was concern about the lack of safe/secure storage for personal goods at the shelters. This issue is of particular importance for achieving a reduction in the numbers of homeless who sleep in the city parklands. For the At-Risk group, the most frequent barrier was finding that the shelters were full, which again argues for increased shelter capacity (see recommendation 3a above).

   <u>Recommendation 4</u>: Increase capacity for storage of personal possessions at shelters or in purpose-built facilities.

5. Overnight shelters fill an immediate need and are an essential part of the response to homelessness. However, they are not intended to provide the stable housing or the array of support services that are necessary to assist individuals who want to find and keep work. Such persons need a permanent address to put on application forms, to receive and make telephone calls, and to use as a base to find and keep employment. Supported housing for persons with mental illnesses and/or addictions is also a high priority need. In

the absence of support, these individuals are unlikely to succeed in remaining housed.

<u>Recommendation 5</u>: Expand Edmonton's stock of non-market housing of all types, and especially of long-term transitional housing for specialized populations (mentally ill, hard-to-house, dual diagnosis).

6. Poverty is a primary barrier to maintaining stable housing. Currently, Alberta's minimum wage levels, as well as SFI and AISH levels are too low to allow recipients to afford market housing. The most frequently identified causes for not having housing were health problems/disability that prevent employment, and the lack of money for damage deposits, setup costs and rent.

<u>Recommendation 6a</u>: Adopt a living wage policy for all companies contracted by it to deliver goods or services, as well as for its own employees and for those who work in NGOs funded by the City of Edmonton.

<u>Recommendation 6b</u>: Lobby the provincial government to set an appropriate minimum wage for employees and adjust current levels of SFI and AISH to support independent living.

7. The rate of emergency service use and the high levels of use of EMS suggest that these services are often acting as primary health and mental health care resources for the homeless. Homeless participants report encountering significant barriers to accessing services for mental and physical health conditions, and generally have insufficient funds for public transportation to get to service locations. Both the location of health services and the pattern of service provision (i.e. office-based practice that requires the client to come to appointments) should be reviewed with the intention of making services more accessible and enhancing outreach capability.

<u>Recommendation 7</u>: Offer a "one-stop" approach to accessing health and other services, **with active outreach components wherever possible to improve access and reduce financial barriers.**

8. Since many homeless persons do not have resources to enable them to access existing services (e.g. telephone, money for transportation, knowledge of services, health status) there is a need to coordinate currently available services and advocate for homeless individuals to obtain equitable access to appropriate programs. Outreach teams that connect the homeless to services should be community based, inter-disciplinary, inter-agency, and modeled on an assertive outreach or assertive community treatment (ACT) or the Community Extension Team approaches that provide the benchmark standards in this area. The teams pull elements of the system together to support their clients, and work primarily in the community, rather than in office-based practice. Interventions of this type are well researched and have

been repeatedly shown to be more effective than other service-delivery models for working with complex problems, as well as providing significant cost savings.

<u>Recommendation 8</u>: Develop community outreach teams for connecting homeless persons to services.

9. Transportation problems are frequently identified in the study results as barriers to employment, health care, and access to services. At a minimum, bus passes should be provided to people who have or are actively seeking employment, to those with chronic health problems, and to those who are caring for dependent children – the latter to ensure access to the child's school or daycare as well as health care access.

   <u>Recommendation 9</u>: Provide short-term subsidized monthly transit passes to employed homeless people and to those who have chronic health problems or are accompanied by children.

10. Unlike the Shelterless and Sheltered groups, most of the "At-Risk" population currently has access to a telephone to make and receive calls. However, affordable rental properties are scarce and the process of attempting to locate them may be too onerous for individuals who are already coping with multiple problems. Further, eviction is a constant pattern in the lives of many homeless persons and interventions that mediate disputes between them and their landlords can be useful in preventing homelessness.

    Some of the resources necessary to enable an effective housing crisis line would be:

    a. A current list of approved[2] affordable housing units including location, restrictions;
    b. Funding to cover damage deposits, first month's rent, moving, and the basics of living (clothing, including clothing for work, furniture, food, money for basic expenses), through subsidy, a rent bank program or SFI/AISH;
    c. Strong connections to government and non-governmental sources of funding such as SFI, AISH;
    d. Knowledge of community programs such as addictions treatment, domestic violence assistance, ways to upgrade education or obtain supported employment;
    e. Strong connections to utility companies (telephone, gas, water, cable) in order to resolve disputes which prevent individuals from having these services;

[2] There would have to be some mechanism for ensuring that the housing units being recommended by the crisis line met standards for safety and human habitation.

f. Access to legal aid to assist in resolving legal issues such as obtaining WCB payments, replacing lost or stolen identification, resolving child custody issues;
g. Connection to all transitional shelters and subsidized housing units, and
h. An eviction-prevention service.

In short, the primary goal of the housing crisis line would be to remove whatever barriers were in the way of keeping individuals or families housed.

An additional benefit of an integrated housing crisis and eviction prevention service is that such a service, if program evaluation were built into the process from the beginning, would be able to quickly identify where there are barriers or lack of resources in the system of help. The information could be reviewed quarterly to maintain a current understanding of these needs and to determine the impact of any changes made in the system to prevent homelessness.

If such a housing crisis line is established, it will be critical that an appropriate data collection system be established concurrently. The research team recommends the Canadian Outcomes Research institute as an inexpensive and flexible solution to this need. The Canadian Outcomes Research Institute is a non-profit organization funded by a 25-year grant. Its explicit goal is to assist non-profit organizations to collect outcome information.

The key goal of the crisis housing line would be to pull together all of the available resources in Edmonton to assist those who are at risk or couch surfing to either keep their own place or find suitable, long term housing. The crisis line itself can be staffed by volunteers provided that sufficient training and interactive computer supports are provided.

<u>Recommendation 10:</u> Current housing crisis lines in the city should be reviewed to ensure that they are offering an integrated and accessible service. The crisis line should operate extended hours and be linked to the current Edmonton Support Network.

11. Our long-term goal is to prevent homelessness. Given the study evidence that suggests that homelessness arises from a complex array of immediate and long-range social and individual causes, its prevention calls for significant change in social conditions and for supports to individuals whose environments place them at-risk, particularly the poor.

The analysis of the survey questions, in combination with the in-depth interviews, shows a consistent pattern for homelessness causation across all homeless and at-risk groups (see qualitative data report). The pattern is characterized by the victimization of the homeless person, beginning in early childhood, in ways that ultimately disadvantage them as participants in mainstream culture (e.g. disrupted education, absence of social supports, exposure to abuse and neglect, early addictions, chronic health problems, early school leaving). These individual-level problems are created and exacerbated by social policies and conditions that further disadvantage the poor (e.g. low minimum wage rates, lack of non-market housing, service and entitlement access barriers). If we are to prevent homelessness in the longer term, changes in social policy and practice, and the provision of supports and individual interventions must be focused on child development. The following are only some of the many possible interventions and advocacy initiatives that should be considered and tested.

Recommendation 11: Begin with early intervention and intensive investment in early childhood development through the public and private school systems. The school system is the most likely place to identify family of origin risk factors, including parental addictions, child abuse and neglect, frequent moves that leave the child without significant relationships or friendships (support network), death of a parent or other close family member, marital relationship breakdown, domestic violence, incarceration of a parent, or serious health problems within the family. Children who are experiencing academic problems or are at risk for leaving school early should be identified as early as possible and intensively assisted.

Recommendation 12: Provide strong supports to schools for the early identification of and intervention with at-risk children and families. Teachers, volunteers and school administration cannot be expected to take on responsibility for supporting At-Risk children in addition to their already overwhelming responsibilities. Once a child or family has been identified as potentially At-Risk, **additional** supports must be made available to assist that family or child. **Benchmark programs for such interventions are widely available.**

Recommendation 13: Address the problem of childhood poverty. Poverty alone is a powerful predictor of a range of negative outcomes for children and their families, including homelessness. Families that fall below the poverty line (or locally determined living wage) should receive sufficient financial assistance to ensure that they have the essentials of life and that their children can participate fully in normal childhood opportunities and activities.

Recommendation 14: Ensure that all children have access to developmental daycare with appropriate subsidies provided when necessary. These programs address a number of concerns, such as ensuring that children have a clean, safe, and stable place to learn, enough to eat, a safe place to catch up on sleep, strong social connections, educational opportunities and access to other assistance, such as medical care or assessment of learning or behavioral problems. Developmental daycare can include parallel programming for parents to address their needs for addictions treatment, upgrading education, and supported employment.

Systematic prevention programs are likely to provide better outcomes in the long term than crisis oriented interventions can, and should be supported as a long-term strategy aimed at reducing the growth rate of homelessness.

Recommendation 15: Implement a province-wide child development initiative to support recommendations 10 through 13 above. An organized initiative could provide the leadership at all levels of government and within the community to support the implementation of the prevention plan.

Proposed Further Research

A number of research initiatives are needed to support Edmonton's work towards reducing its homeless population in the short term and preventing homelessness in the longer term. These initiatives include at least the following items.

Recommendation 16: Conduct a "State of the Science" Review on homelessness. This initiative is based on the assertion by Begin et al (1999) that the underlying problems and potential solutions for homelessness may vary considerably based in part on characteristics such as gender, age and ethnicity. It also reflects the need for improved communication among service providers to ensure that best practices are developed, evaluated and disseminated.

Recommendation 17: Carry out additional analysis on the dataset collected in the 2003 study. Subgroups of interest could be examined further. This analysis will help to better distinguish the characteristics and needs of each group, including points of intersections between groups.

Recommendation 18: Consider obtaining an increased sample from the institutional At-Risk group, using the same survey but working to the timeframes of the institutions and obtaining approval for the process from upper management to avoid last-minute delays or cancellations. This approach may take longer, and would probably require research ethics board review, but would

provide a sufficient sample size to build understanding of the contribution of institutional discharge to the problems of homelessness in Edmonton.

Recommendation 19: Complete a more detailed analysis of data from the AISH and SFI recipients in the study sample to identify any systematic differences between them and homeless and At-Risk people who were not receiving these supports.

Recommendation 20: Explore the hypothesis that recent work experience (resulting in a temporary but steady income flow from EI) and having an accessible social support network may be the critical resources that discriminate between the At-Risk group and the homeless groups.

Recommendation 21: A thorough review of the effectiveness of Alberta's drug and alcohol addiction programs is needed, as is a state of the science review on this issue. The former would allow us to compare our success rates against those of benchmark programs, and the latter would provide the necessary evidence to support the implementation of benchmarks.

Recommendation 22: Empirically examine the issue of the criminalization of poverty in the homeless population. Research should be focused on understanding the problem and identifying possible solutions, such as the proposed drug and alcohol treatment court proposed in recommendation #2 of this summary.