Women and Homelessness in Canada

A brief review of the literature

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Women in Homelessness
A briefing report

This briefing report was prepared in anticipation of the expansion of the OBM-McGill research partnership to include the women's services offered by the Old Brewery Mission. The OBM-McGill research partnership merges the analytical expertise from a third-party, academic institution to the homelessness expertise of a service-driven, not-for-profit organization in order to build research capacity, better understand the homeless population served and improve on service models offered.

In this report, we aim to address several topics. First, we will discuss the opportunities related to the expansion of research at the OBM. This should help to situate the document in terms of the work done at the Old Brewery Mission. Next, we will present a background on the scale and scope of homelessness in Canada including a brief summary of possible reasons for homeless episodes. A discussion of why people become homeless helps to situate this complex problem in social, political and individual contexts for a better understanding of how these factors interact to generate and maintain vulnerabilities.

The paper then moves on to present a summary of both qualitative and quantitative research on homeless women in Canada[1] with information from journal articles, books, and governmental/academic policy papers and reports. Though many research projects have a tendency to group together male and female populations, there is plenty of evidence to suggest that homeless men and women have different health needs, vulnerabilities, come into homelessness from different contexts, and have different social experiences once they become homeless. As Belknap states in her 2006 book, *The Invisible Woman: Gender, Crime, and Justice*, "inequalities between the sexes can differentially affect male and female experiences and behaviors" (Belknap, 2006, p.4). For these reasons, we felt a literature review focusing exclusively on research about homeless women was necessary.

Past studies about homeless women have largely focused on subgroups of the homeless population including youth, substance users, sex workers, and the mentally ill (Gaetz, 2004). Because of this, the research section is broken down into several sub-sections including income, shelter and housing, violence, incarceration and the law, mental health, substance use, physical health, the Lesbian, Gay, Bisexual and Transsexual (LGBT) community, sex work and survival sex, immigration, and indigenous peoples. These topics were chosen based on prevalence in the literature. The aim is to give a brief overview of what has been done before so we do not replicate research.

We then review some of the ethical considerations in conducting research with the population of homeless women. Finally, this report concludes with a discussion about research gaps that the OBM-McGill partnership may be able to address, limitations of this briefing note, and potential policy conclusions that can be drawn from existing information.

Opportunities for conducting research at the PMP

In the process of expanding the existing OBM-McGill partnership, we can apply lessons learned from the Webster research project to ensure a smooth transition[2]. Expectations for timeline and workload should be laid out clearly. The limitations of research should also be delineated. For example, the ability to find causal links between social services and a particular research project is extremely

[1] While there is no doubt that international research is important, this briefing report uses Canadian sources and examples wherever possible. This more narrow scope helps to maximize the generalizability of results to the population served by the Old Brewery Mission (OBM).

[2] For more information on the OBM-McGill partnership, please see the Homeless Hub Chapter.

limited. We lack the capacity to control for all possible influences. Also, our ability to follow a representative cohort of individuals in the community is limited. We must therefore rely largely on retrospective administrative information, which prohibits causal inference, therefore interpretation must be careful. That being said, useful information can be found by examining the associations between a variety of factors and the homeless experience.

Computerized databases like the Homeless Individuals and Families Information System (HIFIS) used by the OBM enable community institutions to learn more about the specific needs of the particular homeless population that they serve. This is especially true for the Old Brewery Mission, which runs the largest women's shelter in Canada and maintains a sizeable administrative database. A well-developed and maintained database can produce research that takes into account complex community-level interactions between psychosocial factors, institutional rules and regulations, and social context. These detailed community-level research projects allow organizations to: 1) Plan ahead by reading trends in the population that may lead to changes in service requirements, 2) Make the most of a resource-limited environment by identifying top priorities, 3) Learn about the population to develop preventive services to end chronic and episodic homelessness, and 4) Justify funding requests using solid numbers specific to the organization. This can increase the likelihood of successfully funded evidence-based projects.

Engaging in novel research with the PMP using the HIFIS database will also enable the OBM to contribute to the research landscape. Many studies do little more than compare groups of women to men. Others focus solely on women in specific needs groups (i.e. single mothers, injection drug users, sex workers, youth, etc.). Furthermore, the vast majority of these studies are set in jurisdictions outside of Quebec. This significant research gap makes it difficult to develop service models appropriate to the specific needs of the Quebec homeless community. While there is research on homelessness from other Canadian jurisdictions, most notably Vancouver, Ottawa, and Toronto, their findings may not be generalizable to a Quebec population. For example, many social services used by the homeless including welfare and social housing developments come under the jurisdiction of the provinces and each province offers a different basket of services (FPT Directors of Income Support, 2010; D. of F. Government of Canada, 2000). Factoring in job availability, climate and cultural differences, the experience of homelessness between provinces is likely to vary widely (Gaetz, Donaldson, Richter, & Gulliver, 2013).

Conducting novel studies at the PMP offers an opportunity to engage in positive and rigorous research that solely examines the needs of women at the Old Brewery Mission to maximize its relevance to internal policy. Furthermore, it will contribute important information to the homelessness research landscape.

Background

How Many People are Homelessness in Canada?

In 1999, several Canadian mayors declared homelessness to be a national emergency (Miloon, 2009). Despite public calls-to-action and scholarly reports, the situation has not improved. In his 2007 report, *Homelessness in a growth economy: Canada's 21st century paradox*, Laid proclaimed that we are in the midst of a homeless crisis unseen since the days of the Great Depression (Laird, 2007, p. 6). Unfortunately, there are few reliable counts of homeless people in Canada, a situation that has solicited criticism from the UN (Miloon, 2009). Sources disagree on an exact number. In 2012, the Wellesley Institute estimated that between 150,000 and 300,000 Canadians are visibly homeless in a given year (Wellesley Institute, 2012). Other sources estimate that the number is closer to 200,000 visible homeless (Gaetz, Gulliver, & Richter, 2014; Segaert, 2012). Statistics on the number of individuals who are hidden "homeless" are even less reliable. Depending on the source, Canada might be host to anywhere between 500,000 and 900,000 people who are hidden homeless.

In Montreal, homelessness is a growing phenomenon and seems to have spilled over to neighborhoods outside of the city center, which opens up a whole new set of challenges for service provision (Santé Montréal, n.d.). An up-to-date point-in-time count of homeless persons in the Montreal area is due to be released in June 2015 ("FAQ," 2015).

Why do People Become Homelessness in Canada?

Several reasons have been cited to explain growing homelessness and repeat episodes of homelessness. Some are related to larger societal and organizational problems, other reasons pertain to individual-level issues. Anucha (2005) has criticized homeless researchers for exploring homelessness based on either individual factors (the result of individual choices or circumstance) or structural factors (the results of the distribution of resources within society) when both perspectives must be examined in tandem to better understand the phenomenon (Anucha, 2005).

Structural determinants of homelessness include low wage/ inadequate welfare payments, unaffordable housing , high unemployment rate, changing job market, unsafe living conditions and difficulty in accessing healthcare services (Booth BM et al., 2002; "Briefing Note: Poverty and Homelessness in Canada," 2013; Fitzpatrick, LaGory, & Ritchey, 1999; Forchuck, Brown, Schofeld, & Jensen, 2008; Gaetz et al., 2013, 2014; Hartman, 2000; The Conference Board of Canada, n.d.; Trypuc & Robinson, 2009). Many scholars blame the rise of homelessness on the closure of psychiatric institutions without a subsequent scale-up of community support programs (Bachrach, 1992; Booth BM et al., 2002; S. W. Hwang, 2001; Trypuc & Robinson, 2009). Others point to the rising cost of real estate and rental prices without proportionate increases in wages, salaries and welfare payments (Collins, 2010; WHEN-Canada & CERA, 2008). Welfare incomes continue to fall well below any measure of poverty used in Canada ("Briefing Note: Poverty and Homelessness in Canada," 2013). In Quebec in particular, the poverty rate according to the Market Basket Measure (MBM)[3] has increased steadily over the last 10 years (Government de Quebec, 2014, p. 70). Still others point to the steady decline in affordable housing spending for Canada's poorest residents (Gaetz, 2010; Gaetz et al. 2014; Londerville & Steele, 2014; "Summative Evaluation of the National Homelessness Initiative," 2008). Approximately 1.7 million Canadians have trouble affording their housing (Laird, 2007). Further, many formally homeless people can only afford inadequate housing options, which does not encourage stability (Anucha, Smylie, & Mitchell, 2007) and may result in frequent returns to the homeless shelter. Other concrete barriers to housing stability among working adults have also been identified. These include, among other factors, lack of access to replacement identification, banking, and a mailing address as well as lack of access to stable, permanent employment (Jones, Shier, & Graham, 2013).

Despite mounting evidence that structural issues contribute significantly to homelessness, the reputation of homelessness as a mainly individual issue persists. According to Shier et. al (2011) "…public perceptions of people who are homeless or of the use of shelter-based support services are rooted in common cultural stereotypes, informed by ideological notions of individualism and traditional welfarism" (Shier, Jones, & Graham, 2011). These societal attitudes play a role in access to much needed resources to help women leave homelessness as many service models are "created and maintained on the basis of sociocultural perceptions and beliefs about deserving and undeserving service users" (Shier et al., 2011). This individualist viewpoint blames those who are homeless for "laziness" and failing to "pull themselves up by their bootstraps" (Kyle, 2005; Pleace, 1998). The image of a homeless individual as a dirty person with mental health and addiction problems continues to dominate media and political discourse. While this view is widely rejected by researchers and activists alike, its pervasiveness in culture continues (Reid, Berman, & Forchuk,

[3] The Market Basket Measure is a measure of low income developed by human resources and skills development Canada. It is based on the cost of a specified basket of goods and services representing a modest, basic, standard of living (housing, food, clothing, transportation and some other basic expenses).

2005). Some common individual reasons for homelessness cited in research include mental health problems, substance use, lack of employment, criminal history, poor education, inadequate skills for functioning in everyday life, and social isolation from friends, family and the community (Booth BM et al., 2002; Hartman, 2000). Personal safety is also an important factor. Homelessness is privy to its own particular set of stresses and dangers. The "survival mode" phenomenon is common among people who are homeless. It may limit a person's ability to be comfortable alone, feel safe, and feel well-being (Calgary Homeless Foundation, 2012). A person can only begin to stabilize and plan for the future when they feel secure physically, emotionally, and financially.

Vulnerability is the result of social environment, methods of intervention, and personal implications. As such, there is a real need to identify the underlying societal, community-level and personal factors contributing to cyclic vulnerability in order to develop appropriate preventative interventions and policies (Shier et al., 2011).

Research on Homeless women in Canada

The majority of homeless individuals in Canada are men[4] (Segaert, 2012) therefore the majority of homeless services available in Canada are male-centric despite evidence that women are more vulnerable than men in several key areas including poverty, racialization and violent victimization. However, research on homeless and precariously housed women is lacking, due in part to the male-centric nature of homeless services (Bukowski & Buetow, 2011; Huey & Berndt, 2008).

In a 2012 point-in-time survey of women residing in Canadian shelters, 74% said they sought shelter services because of abuse. Over a third of respondents were unable to find affordable housing. One in four cited mental health problems. One in five stated that short-term housing problems or drug/alcohol problems contributed to their shelter admission. One in ten said housing emergencies contributed to their seeking shelter services (S. C. Government of Canada, 2014). A brief overview of these as well as several other contributing factors can be found below.

Income

Compared to men, women are more likely to experience poverty (Williams, 2010). Further, the earning gap between men and women actually increased between 2007 and 2008 (Williams, 2010). A lower earning potential decreases the likelihood of being able to escape poverty and achieve financial independence. The situation is even worse for women with dependent children. A report published by the Library of Parliament in 2009 stated that there is no community where it is possible to support a family on a single full-time minimum wage income (Echenberg, 2009). Single female parents are significantly poorer than all other household types in Canada (Williams, 2010). The risk of poverty increases when gender is combined with compounding factors. For example, two in three women with a disability or a chronic health problem live below the poverty line (Chouinard, 1999).

The relationship between gender, economics and family formation is complex. Family relationships can be a source of practical support, including food, shelter and money, however, they can also pose a barrier to access to services or they can be a source of abuse and control (Loates & Walsh, 2010). For women, leaving a relationship can result in extreme financial hardship. For example, after divorce, Canadian women experience a 40% decrease in financial wellbeing on average and almost a three-fold increase in poverty rates (Finnie, 1993).

Shelter and Housing

[4] Males: 73.6%, Females: 26.2%

The availability and affordability of housing is an important consideration when examining homelessness (Sedky, Lambert, & McBain, 2011). Canada is the only G8 country that does not have a national strategy to address homelessness and access to housing (Hwang, 2010). However, the federal government's Housing Partnership Strategy (HPS) has outlined some priority areas including: adopting a housing first model, improving employment opportunities, and encouraging private/public partnerships.

In the mid-1990s, the federal government passed on the financial and administrative responsibilities of social housing to the provinces, ("Canadian Housing Observer 2011. Chapter 9: The Evolution of Social Housing in Canada," 2011) many of which, in turn, passed the financial responsibility on to the municipalities despite the assertion from affordable housing advocates that "municipal governments in Canada have a limited tax base and generally cannot support income distributive programs such as social housing." (Shapcott, 2005, p. 2) This resulted in a serious decline in the availability of social housing units. In Montreal, Some 22,000 households would like to move into affordable housing[5] provided by the Office Municipal d'Habitation de Montréal, but only 2,000 units become available each year. The wait-time can range from several months to several years (OMHM, 2011).

In 2012, the House of Commons unanimously passed a motion stating that "the government should keep with Canada's obligation to respect, protect and fulfill the right to housing under the UN International Covenant on Economic, Social and Cultural Rights" (Valeriote, 2013). In response to this motion, Bill C-400, the Secure, Adequate, Accessible and Affordable Housing Act, was introduced to require the government to work in conjunction with the Canada Mortgage and Housing Corporation, not-for-profits, private sector housing partners and civil society organizations to establish a national housing strategy. The bill was defeated in 2013 (Morin, 2013).

The lack of affordable housing options means that people must often find shelter in the traditional housing market, with community-level, non-governmental housing programs, and in the shelter system. Further, rushing from homelessness to housing may not be the best solution for all individuals who experience homelessness.

The traditional housing market is largely unaffordable to those living on social assistance. For example, a single adult can receive between $600 and $750 per month in Quebec (Government of Québec, 2015). The average price of a 1-bedroom apartment in Montreal is estimated to be 550-570$ (CMHC, 2014). This leaves little room for other daily necessities including food, and electricity. Discrimination in the renting market is also an issue. Women who have been homeless may not have a stable renting record, or may lack appropriate references for the landlord to contact. This issue hinges on the demands of the market-based renting system (Shier et al., 2011).

Community-level, non-governmental institutions have increasingly offered housing options though 'transitional housing' models or though a 'housing first' models. Eligibility criteria for housing and supportive services available to residents differ depending on the institution. Wait times vary depending on funding and housing availability. Very few of these projects (beyond the At Home/Chez-Soi program) have been formally studied in the Montreal region.

In general, women will exhaust alternative options before entering the shelter system, even when it is disadvantageous. Precariously housed women often report being financially exploited by the friends or acquaintances they stay with. Many report being pressured to provide drugs/alcohol or to perform sexual favors in exchange for impermanent accommodation (Dickson-Gomez J et al., 2009). One study found that homeless women will often present at a shelter after exhausting their family and friends support network, thus arriving to the shelter system feeling isolated, depressed and

[5] In this context, affordable housing is defined as lodging supplemented by the government so that tenants pay 25% of their household income in rent.

disappointed (Hudson et. al, 2010).

There is huge political pressure to move people through the shelter system quickly and place them in housing. However, this may not be in the best interests of all shelter users. Paradis et. al. discuss the problems with rushing to place people in housing:

> *Respondents were usually happier in their own homes than they had been in the shelter, but reestablishing housing in the community did not represent an unambiguously "happy ending" for most of them. Many were still facing the conditions that had caused them to become homeless in the first place: deep poverty; lack of childcare and employment; lack of permanent status in Canada; violence from partners and ex-partners; discrimination from landlords and employers; and housing that was unaffordable, unstable, and in poor condition*. (Paradis, Novac, Sarty, & Hulchanski, 2008, p. 2)

Violence

"It seems that when women are assertive, violence against them is on the rise."
-Wellesley Institute, Ontario Prevention Clearinghouse, and Ontario Women's Health Network. Count Us In! Inclusion and Homeless Women in Downtown East Toronto.

Considerable research is focused on the correlation between violence and homeless women. Homeless women are often victims of violence including assault and sexual abuse (Duff, Deering, Gibson, Tyndall, & Shannon, 2011; Evans & Forsyth, 2004; Gaetz, 2010; Paradis, Mosher, & Homeless Hub, 2014; Wenzel SL, Koegel P, & Gelberg L, 2000). For example, a Toronto study found that 37% of the homeless women surveyed had been abused in the past year (Khandor & Mason, 2007). A US study performed in 2006 reported that over 20% of the homeless women they interviewed had been physically or sexually abused 6 months prior to their interview with the research team compared to just 9% of housed women in low-income settings (Wenzel, Tucker, Hambarsoomian, & Elliott, 2006). Another found that nearly 20% of homeless women had been abused within the 30 days prior to the interview (Wenzel SL et al., 2000). Lazarus et al. argue that "… subordination to existing policies combined with pervasive messaging about individual-level harm reduction strategies work to reproduce risk and normalize violence" (Lazarus, Chettiar, Deering, Nabess, & Shannon, 2011). The high proportion of women who return to abusive conditions (Dobash & Dobash, 1992; Metraux & Culhane, 1999) and the small portion of maltreatment victims who report their experience(s) demonstrate the effects of this normalization.

Sexual, physical, or emotional childhood abuse is also a commonly examined risk factor in studies of homeless women and children (Jasinski, 2010). Several comprehensive systematic literature reviews have been published on this subject alone (ex. Greenan (2004), National Center on Family Homelessness (2004), and Wenzel, Leake, and Gelberg (2001)). Family history of violence is an all too common narrative among homeless young women and children (Echenberg & Jensen, 2009; Huey, Fthenos, & Hryniewicz, 2013; Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Novac, 2002). Victimization in childhood has been linked to violence in adulthood through several factors including low self-esteem, the association of violence with love or attention, seeking out abusive relationships, being unable to identify the warning signs of abusive relationships, being unable to maintain positive relationships, depression, and substance abuse (Jasinski, 2010). A history of physical or sexual abuse in childhood increases the risk of sexual victimization, assault, and mugging in adulthood (Arata, 2002; Hudson et al., 2010; Simons & Whitbeck, 1991; Tischler, Rademeyer, & Vostanis, 2007). Further, a recent systematic review and meta-analysis found that childhood sexual and physical abuse is strongly associated with depression and anxiety in adulthood (Lindert et al., 2012) both of, which are positively associated with physical assault (Hudson et al., 2010).

A large proportion of women cite abusive partners as the main reason for becoming homeless (Tischler et al., 2007). However, the absence of alternative safe housing options may result in repeated returns to the abusive partner (Metraux & Culhane, 1999; OAITH, 1998). Further, as a

consequence of the high levels of victimization on the street, women may be faced with sexual abuse and other forms of violence no matter where they turn (Bourgois, Prince, & Moss, 2004; Gaetz et al., 2013).

Incarceration and the law

Poverty is one of the main contributors to incarceration among women in Canada. The majority of women are incarcerated for economic-related crimes, usually fraud or theft under $5000 (Pollock, 2008). Violence against women is also associated with incarceration. Approximately 80% of female federal prisoners reported physical abuse[6] and over half reported sexual abuse prior to incarceration (Canadian Human Rights Commission., 2004).

Importantly, the rate of recidivism among female federal prisoners is only about 20% compared to nearly 60% of male federal prisoners. Approximately 1-2% of women return to federal prison as a result of new crimes and less than half a percent return as a result of violent acts (Canadian Center for Justice Statistics, 2008).

Combined with the personal, social and economic factors leading to incarceration, many people who have been through the prison system end up homeless after their release. About 30% of individuals incarcerated individuals in Canada have no home to go to upon their release. In addition, most provinces allow landlords to discriminate against individuals with a criminal history (Canada Mortgage and Housing Corporation, 2007). Arrest history has been associated with a longer duration of homelessness and recurrent homelessness (Caton et al., 2005; McQuistion, Gorroochurn, Hsu, & Caton, 2014). Mental health, substance use and incarceration can work in concert to increase a person's risk of homelessness. Offenders with a dual diagnosis of mental illness and substance use are especially vulnerable to becoming homeless after release from detention compared to those who are not substance abusers (Hartwell, 2004).

Studies examining homeless persons perceptions of police seem to indicate that the police are seen as agents of control rather than protection. Individuals that were interviewed cited excessive ticketing for minor offences, searches, verbal harassment and confiscation of goods (Novac, Hemer, Paradis, & Kellen, 2006).

Mental Health

Estimates of prevalence of mental illness among the homeless population vary widely. This is particularly muddy because it is unclear whether severe mental illness is a precursor to homelessness or whether homelessness exacerbates existing conditions or even creates them (Chambers et al., 2013; Echenberg, 2009; Frankish CJ, Hwang SW, & Quantz D, 2005). We may never know the true proportion because many mental illnesses go undiagnosed, especially among the homeless population (Munn-Rivard, 2014). Studies generally estimate that between 20% and 50% of homeless women in an urban setting have been diagnosed with a mental illness (Herrman et al., 2004; Khandor & Mason, 2007). This discrepancy may be a result of misclassification of individuals For example, the stress related to poverty and the struggle to survive in harsh conditions may make people appear to be more mentally unstable than they actually are. (Liebow, 1993, p.xiii)

Regardless as to the actual proportion of people with mental illness, it is widely accepted that mental health problems are more prevalent among homeless women compared to almost every other comparison group (E L Bassuk, Perloff, & Garcia Coll, 1998; E. L Bassuk, 1996; Weinreb, Goldberg, & Perloff, 1998). This is unsurprising considering the prevalence of violent experiences of homeless

[6] This climbs to 90% for Aboriginal women.

women combined with inadequate social support and a stressful environment that often discourages the healing process. One study estimates that between 51% and 98% of public mental health clients have traumatic histories (Mueser KT et al., 1998). Those who have ever been homeless report more strained relationships with family and less satisfaction in family relationships (Sanders, 1999). It has also been suggested that the lack of social support among low-income women serves to reduce the ability to cope in the face of stressors (Ellen L. Bassuk, Mickelson, Bissell, & Perloff, 2002). Homelessness itself also affects overall mental wellbeing. Many women have reported their self-esteem and behaviors have been affected by internalized negative discourse (Shier et al., 2011).

Many studies have found that women have different mental health needs than men, and have different experiences with the mental health service system. For example, a longitudinal Quebec study spanning 5 years of data found that 21% of homeless women were hospitalized for a mental health condition. This longitudinal study also found that women were more likely to seek treatment for physical and mental health conditions compared to men and were more likely to be hospitalized than men (Bonin, Fournier, Blais, Perreault, & White, 2010).

Another recent study classified 369 persons who used mental health services meant for homeless individuals in Montreal and Quebec City. Respondents were categorized according to certain characteristics including primary diagnosis (affective disorder or schizophrenia), gender, social network, age, residential situation, pathological characteristics (antisocial personality disorder, alcohol-related disorders), and number of hospitalizations. The study found a marked difference between men and women[7]. Nearly all the women in this study had an affective disorder (as opposed to schizophrenia). In general they did not suffer from antisocial personality disorders or alcohol-related disorders. Women also had larger social networks than men and used more services compared to men. In this study, women represented the second largest group that was hospitalized for psychiatric reasons in the past year. More women benefitted from psychotherapy and day treatment in their lifetime compared to other groups (Bonin, Fournier, & Blais, 2009).

Mental illness is a particular challenge to effective service delivery as it has been found to increase lengths of homeless episodes among women and make it more difficult to achieve housing stability (Forchuck et al., 2008; Robertson MJ & Winkleby MA, 1996). Though this has not been true of every study (Caton et al., 2005).Women have also cited the need for having services that complement- rather than compete with - other priorities in their lives including securing work and housing. For women who are struggling with basic survival issues, counseling is, perhaps not surprisingly, seen as a lesser priority than securing shelter and other resources (Huey et al., 2013).

Substance Use

Researchers have found differences in substance use between homeless men and women. For example, one study found that women reported less substance use than men. This study also found that men had a stronger relationship between drug use, mental illness and victimization whereas women had a stronger relationship between drug use, alcohol use, and criminal involvement (Stein & Gelberg, 1995).

A recent Toronto-based study on drug use among 603 single men, 304 single women and 284 adults accompanied by children found that 41% of their single female participants reported a current drug problem. In this study, single men were more likely to have a current drug problem compared to the other groups. Those with a current drug problem were also more likely to have become homeless at a younger age, have a lower level of education and have longer episodes of homelessness. Poorer mental health status was also associated with drug problems. Interestingly, among those who reported drug problems in the 30 days prior to their interview, only 27% identified drug/alcohol problems as a barrier to leaving homelessness (Grinman et al., 2010).

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[7] Women represented about 15% of the individuals included in the study.

Another study conducted in British Columbia looked at lifetime and current prevalence of substance use disorders and the demographic and clinical correlates among homeless women. Overall, 82% of the sample had at least one type of current substance use disorder, of which 71% had drug dependence and 38% had alcohol dependence. 58% had concurrent substance use and mental health disorders. 77% of those individuals with current alcohol dependence had concurrent drug dependence. Only 25% of those who had recovered from alcohol dependence had no current substance use disorder. Being younger, living rough, engaging in sex work, and ever attempting suicide were associated with current drug dependence. The authors noted at the rate of substance abuse among this particular sample was "exceptionally high" (Torchalla, Strehlau, Li, & Krausz, 2011).

Substance use among homeless women may seem extremely high in comparison to the general population, but this might not be truly reflective of reality. Author Elliott Liebow summarized this phenomenon succinctly in her 1993 participant-observer book, *Tell Them Who I Am: The Lives of Homeless Women,* "While mental illness, drug and alcohol addiction is often used to explain homelessness, these judgments are almost always made against the background of homelessness. If the same person were seen in another setting, the judgment might be altogether different." (Liebow, 1993, p. xiii) Furthermore, because drug/alcohol and mental health problems are associated with prolonged homeless episodes, drug-users and mentally-ill persons may be over-represented in cross-sectional surveys of homeless populations (Grinman et al., 2010).

A history of substance use history can result in a longer duration of homelessness (Caton et al., 2005) and more episodes of homelessness (Booth BM et al., 2002). Addressing substance use is therefore a high policy priority in many service provision models.

Health Issues

Homelessness and lack of affordable housing has been linked to higher rates of disease and mortality, low personal safety (Aidala, Cross, Stall, Harre, & Sumartojo, 2005; Cheung & Hwang, 2004; Corneil et al., 2006; Riley, Gandhi, Hare, Cohen, & Hwang, 2007; Shannon, Ishida, Lai, & Tyndall, 2006) and barriers to access to health care (Gelberg, Browner, Lejano, & Arangua, 2004; Lewis, Andersen, & Gelberg, 2003; Wei Lim, Anderson, Leake, Cunningham, & Gelberg, 2002). The homeless are also at great risk of accidents and violence leading to hospitalization as a result of their exposed situation.

Canadian women who are homeless are at particular risk for health problems as a result of exposure to pollutants and extreme temperatures, insufficient sleep, lack of funds for basic hygiene products (menstrual supplies, dental care products, soap, etc.) and many other poor living conditions associated with extreme poverty and unstable housing (Whitzman, 2006). As a result of these poor living conditions, homeless women are at a higher risk of nearly every poor health condition and disease compared to women in the general population (S. W. Hwang, 2001; Novac, 2002).

Mortality among young homeless women is high. A Toronto study found that younger homeless women had over 30 times the mortality rate compared to the general population. This relationship held when comparing young women to young men in a situation of low socioeconomic status. Though this trend reversed in the older population. The study found that older homeless women had lower mortality compared to older homeless men (Cheung & Hwang, 2004).

Women face different health concerns than men especially when it comes to reproductive health including pregnancy. In one Canadian qualitative study, women in homeless shelters identified a lack of access to practical and emotional pregnancy supports. Furthermore some women described feeling judged by shelter staff and the public for being pregnant and the 'lifestyle' that led to their pregnancy (Loates & Walsh, 2010).

Unmet healthcare needs are a commonly cited issue among the homeless population. One study

examining 1181 homeless adults in Vancouver, Ottawa, and Toronto found that despite Canada's universal healthcare system, a large proportion of individuals (37%) had unmet healthcare needs in the year preceding the study. The study reported that those who were most vulnerable were finding barriers to service. This included those with a mental health diagnosis, those with more than one chronic health condition, and those with an overall lower quality of life (Argintaru et al., 2013). Unfortunately, gender-specific differences were not explored in this study. The authors speculated that the barriers to healthcare provision were largely non-financial in nature. For example, lack of accessible transportation, discrimination in healthcare settings, competing priorities (survival mode), long waiting times and lack of childcare. Difficulties in accessing healthcare among homeless women have been echoed in several other studies (Bungay, 2013; Khandor & Mason, 2007; Lewis et al., 2003). Research that situates health care access in terms of political, economic, personal and social power has found that the dominant ideologies classifying homeless women as "deviant and of lesser status" directly contribute to experiences of discrimination and health care delivery oversights (Bungay, 2013).

Several challenges to providing adequate healthcare to the homeless population have been cited including under-use of preventive services, challenges with follow-up and communication of test results, inability to properly store medication, lack of homeless-centered mental health services and lack of safe places to recuperate from illness or injury. (H. C. Government of Canada, 2003).

LGBT community

Members of the LGBT community are estimated to be overrepresented among the homeless, however little research has been done to explore this phenomenon (Strang & Forrester, 2004). Transgendered women are particularly over-represented as a result of exclusion in many areas including home, work and school (Mottet & Ohle, 2003).

Researchers have found that the LGBT community experiences homophobia and other forms of discrimination in the shelter environment from staff as well as from other residents. Shelter residents have described feelings of discomfort in sharing accommodation with women of alternate sexual orientations or feelings of disgust, suggesting that alternate sexuality is 'immoral', though these feelings are not shared by all residents (Loates & Walsh, 2010). For example, transwomen are sometimes refused admittance to women's shelters is also common as a result of in-admissible documentation or because the individual has not yet had sex-reassignment surgery (Head and Hands, 2013).

Many shelters are separated along gender lines, which assumes heterosexuality of residents. However, same-sex relationships in the homeless shelter environment are not uncommon. The lack of privacy in shelters and on the street makes these relationships more visible. Depending on shelter staff's interpretation of these relationships, a women's place in the shelter may be jeopardized (Loates & Walsh, 2010).

Sex work

There are not many economic opportunities for homeless and precariously housed women (Simons & Whitbeck, 1991). Women living in low-income and transitional housing are over-presented among sex-workers (Duff et al., 2011, 2011; Surratt HL & Inciardi JA, 2004). Survival sex, loosely defined as trading sex for necessities including food and shelter, is also common among homeless women (CPHA, 2014). Survival sex- and prostitution have been associated with unstable housing (Corneil et al., 2006). Sex work may also cause precarious housing situations. Lazarus et. al. (2011), found that women engaged in sex work had a hard time fighting unjust evictions as a result of their method of earning income (Lazarus et al., 2011).

Raphael (2004) states that there is an "almost unimaginable level of violence in street prostitution" (Raphael, 2004, p. 100). For example, lifetime involvement in the sex trade has been independently associated with rape, mugging, and physical assault (Tischler et al., 2007). The situation would appear to be even worse for homeless women. Studies out of Vancouver found homelessness was independently associated with both increased odds of client violence (Shannon et al., 2008) and sexual violence perpetrated by non-commercial partners (Duff et al., 2011).

One study exploring women and sexuality found that homeless women spoke about the exchange of money in committed relationships. The women interviewed saw this exchange as a needed source of income and not as prostitution (Acquaviva, 2000), though finances are likely not the only force at work. The figuring of economics into intercourse decision-making has also been found among middle-class women (Hite, 2006).

Immigration

Homelessness is stressful and for immigrants in the process of adapting to a new culture, a new environment, and a new language, this stress is compounded (Paradis et al., 2008).

Racialized[8] individuals in Canada are more likely to be poor. Montreal is host to nearly 20% of Canada's impoverished racialized population (National Council of Welfare, 2009). Nearly all racialized individuals living in poverty are first-generation immigrants. One study in Calgary found that immigrant women were less likely than Canadian-born women to receive government income assistance (Thurston et al., 2006).

Migrant women who have not yet received permanent residence[9] in Canada face a number of issues including deep poverty, restricted access to employment and limited health care and social benefits. These women must often rely on under-the table employment and have to go through informal networks to secure housing (Ballay & Bulthuis, 2004; Murdie, 2008). Anything that may disrupt an income source including pregnancy or a medical problem can tip the balance towards homelessness in precarious housing situations (Paradis et al., 2008).

Indigenous peoples

Aboriginal persons are extremely overrepresented among Montreal's homeless population[10]. While First Nations, Métis, and Inuit peoples make up approximately 6% of the general population, they make up about 20% of Montreal's homeless (Gaetz et al., 2013). This is largely attributed to a history of residential schools, discrimination, racism, and systemic oppression that constrains access to services, support and programs (Statistics Canada., 2006). Furthermore, available resources may not be culturally appropriate (Belanger, Weasel Head, & Awosoga, 2011).

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[8] Persons from backgrounds other than Aboriginal who are non-Caucasian (National Council of Welfare, 2009)

[9] Including individuals seeking refugee status, temporary workers, or those living "underground"

[10] There have been multiple literature reviews on homelessness and indigenous peoples, however, much of the research on First Nations, Métis and Inuit peoples in Canada has been designed and interpreted from a Eurocentric perspective. Similarly, this briefing report has been conducted from a non-Aboriginal perspective. Omissions, over-generalizations and misrepresentations are inevitable in this context. Nevertheless, a general picture can be painted, which shows that generations of structural violence have taken their toll. Poverty, racism, historical trauma and forced social participation have contributed to the overrepresentation of aboriginal peoples among the homeless population.

Indigenous women are more likely to experience poverty compared to non-indigenous women (Statistics Canada., 2006). They are over-represented in the federal prison system (Sapers, 2007), Aboriginal women are also more likely to be prostituted and are most likely to be criminalized, physically or sexually abused as sex workers (Balfour & Comack, 2006). The mortality rate for violence against Aboriginal women in their own homes is 3-5 times greater compared to the non-Aboriginal population (Native Women's Association of Canada, 2004). One study found that indigenous people with a history of homelessness had significantly more individual and family health, mental health, and substance abuse problems compared to indigenous individuals with no history of homelessness (Whitbeck, Crawford, & Hartshorn, 2012)

Special Considerations for Research

"*Researchers must respect the safety, welfare, and dignity of human participants in their research and treat them equally, fairly, and not as a means to an end."* – York University Human Participants Review Committee: Guidelines for Conducting Research with People who are Homeless (2010)

Research has an obligation to reduce bias, avoid harming the research participants, maintain confidentiality, and ensure voluntary, informed consent to participate. As a particularly vulnerable and marginalized population, homeless women require special considerations to ensure that these obligations are met and that participants are treated in a respectful manner. Sensitivity and awareness of the power imbalance between the researcher and the participant is paramount (Tri-Council, 2008).

Confidentiality and consent

Confidentiality is very important in research, but especially in studies involving marginalized participants. Due to the stigma surrounding homelessness, the assurance that no identifying characteristics will be revealed outside of the interview is of especially important. With respect to gendered-violence, confidentiality is extremely important for the protection of research participants. Many are fearful of the repercussions in the event of breached confidentiality (Williamson, Abrahams, Morgan, & Cameron, 2014). This includes retribution from associates and service providers. The only possible justification of breach of confidentiality would be if a person discloses risk to themselves or to others. Though this caveat must be made clear to each participant at the time of consent.

Informed consent is part of the process of ensuring that the rights of research participants are respected as such, ethics boards require informed consent for all studies involving human participants. In conjunction with confidentiality, informed consent is defined by seven ethical principles: 1) participants must be informed of the purpose of the research, expected duration, and procedures, 2) they must be made aware of their right to decline to participate or withdraw their participation at any point throughout the process, 3) they must understand the foreseeable consequences of declining or withdrawing, 4) participants must be made aware of any factors that might influence their willingness to participate including potential risks, discomforts, or adverse experiences, 5) they must be informed of any prospective research benefits, 6) they must know the incentives for participation, and 7) they must be provided with the contact information of someone who will be able to answer any questions about research (The American Psychological Association, 2010).

Reducing bias

Much of the information collected at the OBM is currently based on observed behaviours and informal interviews. Research that excludes direct input from the participants will often rely heavily

on the interpretations of those in a more privileged and powerful position than the people being studied, i.e. those who have never experienced poverty and homelessness themselves, and whose perceptions are biased by their own experiences. As a result, research may inadvertently pathologize individual characteristics and ignore larger social contexts. Research of this nature has the potential to ignore the diversity of the homeless population, perpetuate negative stereotypes, disseminate misinformation, and engage in victim blaming, which is harmful to the community as a whole.

Participatory research, defined by active and meaningful involvement by research participants combined with research questions focused on strengths and coping skills can help put findings in context, prevent researcher bias and identify community-level needs that are not obvious to researchers (Paradis et al., 2014; Paradis, 2010; Runnels, Hay, Sevigny, & O'Hara, 2009). To quote Paradis in her 2010 publication, Ethics in Research with Homeless Women:

> *[The participatory] approach to research has a number of benefits. First, it empowers individual participants because it validates their "expert" knowledge about their own needs and experiences. Also, it challenges dominant stereotypes of the community, depicting women who are homeless as competent copers rather than as sick, irresponsible, or lazy* (Paradis, 2010).

Putting research in context

In order for research to be applicable to policy, it must first be contextualized. In an effort to make research more accessible to all audiences, there is a tendency to oversimplify the complexity of 'wicked' social problems, which can lead to an ill-fitting, ineffective policy response. In a discussion paper released in 2008, McLean states:

> *Just as homelessness is multi-faceted so must be any response to addressing this as a social issue. A lack of comprehensive social policy that deals with the intersections between economics, social welfare, health care, justice, education, employment and housing increase the challenges associated with addressing homelessness (p. 6).*

Any research project that aims to inform policy should look carefully at these intersections to reduce the risk of oversimplification, which lead to ineffective responses and potentially harm the people we seek to serve.

> *The search for solutions requires a number of components: descriptions of what is wrong; definition of causes; manufacturing of a sense of urgency to respond; assignment of responsibility, accountability (and even blame where it serves to bolster the position) and; appointment of those who will lead the charge towards the next big thing. In this process the complex, multi-faceted issues that fall under the banner of homelessness become diluted until they bear little resemblance to reality. Plurality becomes singularity and the complex becomes simplified to the point where we can presumably define a major social issue in terms of a basic equation* (McLean, 2008, p. 2).

It is important to be aware of this bias toward the simplification and de-contextualization of findings. A balance must be struck between putting results into terms that everyone can understand and taking limitations and contextual factors into account. This is a process that requires vigilance and open lines of communication. A mix of qualitative and quantitative research is necessary, as is the integrated expertise and involvement of the clients themselves in a way that goes beyond tokenism (Williamson et al., 2014), though this leads to its own set of methodological issues.

Coercion

OBM-led research activities involving current clients can be problematic because the homeless participants in our research are dependent upon the Old Brewery Mission for their most basic needs at the time of data collection. According to Rosenthal (1991), individuals in this situation have a

"captive status." Research on these "captive" participants may reveal as much about the institution as it does about the participants, who may modify their behaviour and answers to fit with institutional norms (Rosenthal, 1991). This may lead to under- or over- reporting as a result of social desirability bias. The fact that the institution itself conducts research may give the impression that individuals are obligated to participate or may coerce them into participating as a method of demonstrating good behaviour. Extra effort must be made to ensure that the participant understands the purpose and process of research activities and that refusing to participate is acceptable and will not affect the services they receive from the shelter, but also, in all likelihood will do little to directly affect their lives (Runnels et al., 2009).

Exploitation should also be considered when deciding on remuneration. While financial compensation is traditionally offered to research participants, the amount offered may be inadequate to attract an acceptable number of voluntary participants. Conversely, a more substantial amount of compensation may be considered coercive for those living in abject poverty as many would find it difficult to turn down even the most conservative of sums (Runnels et al., 2009). A balance must be struck between offering a person a fair amount of compensation for their time, but also an amount that they could reasonably refuse. Furthermore, it is unethical to place restrictions on compensation or to refuse compensation based on how it could be used (Runnels et al., 2009).

Avoiding re-traumatization

Research runs the risk of harming individuals by asking them to recall traumatic events. As we've seen above, many homeless women are survivors of traumatic experiences including physical and sexual abuse, however as a result of their circumstances, few have been afforded the opportunity to recover and heal. Asking specifics about these events have the potential to trigger an adverse response and re-traumatize research participants. While research that inquires about these subjects is not forbidden, it must be undertaken carefully and with respect. The standard research debriefing procedure will not be sufficient and additional, culturally appropriate counseling services should be made available. Additionally support groups organized in tandem with the research process may also be beneficial to the post-research healing process. Researchers should direct participants to available support options and provide access (including transportation) if necessary (York University, 2010).

Conclusions

Finding service solutions is not as simple as transferring services designed for homeless men to a women's shelter environment. Women have different needs and preferences.

It is important to note that this briefing report cannot take into account all of the research that has ever been published on homelessness in Canada. Further, a great deal of work, generally performed by graduate students, has never been published, only disseminated in presentations and conferences (Gaetz, 2004). This report should serve as an overview of issues affecting homeless women, not as a comprehensive summary.

Evidence suggests that women's lives can be improved through access to affordable housing, higher social assistance rates, a livable minimum wage, and more inclusive social and health services (Sakamoto, Ricciardi, & Plyler, 2010; Wellesley Institute, Ontario Prevention Clearinghouse, & Ontario Women's Health Network, 2006). At the shelter level, it has been suggested that effective counseling services should be flexible, inclusive, informal, and grounded in a harms-reduction approach (Sakamoto et al., 2010). One Montreal-based service evaluation found that women had more positive experiences in circumstances when they felt they were being treated as human beings and made to feel that they "existed" throughout the process of accessing services (McAll et al., 2013).

Plenty of research exists on history of childhood violence, and the effect of domestic and street violence on women. However, there is a marked lack of research on homeless women who have been

incarcerated, on transsexual homeless women and the LGBT community in general, and on the effectiveness of specific services/service approaches available to homeless women.

Any research conducted at the women's shelter should be careful to minimize bias, maintain confidentiality, offer voluntary participation with informed consent, and avoid harming participants with traumatic histories. As Pickering et al. (2003) have emphasized, research becomes highly unethical when it makes participants feel stigmatized or when it has a negative psychological impact. (Pickering, Fitzpatrick, Hinds, Lynn, & Tipping, 2003, p. 33). Specifics to ensure these obligations are met will be considered and detailed during the study design phase with adjustments as necessary throughout the process.

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