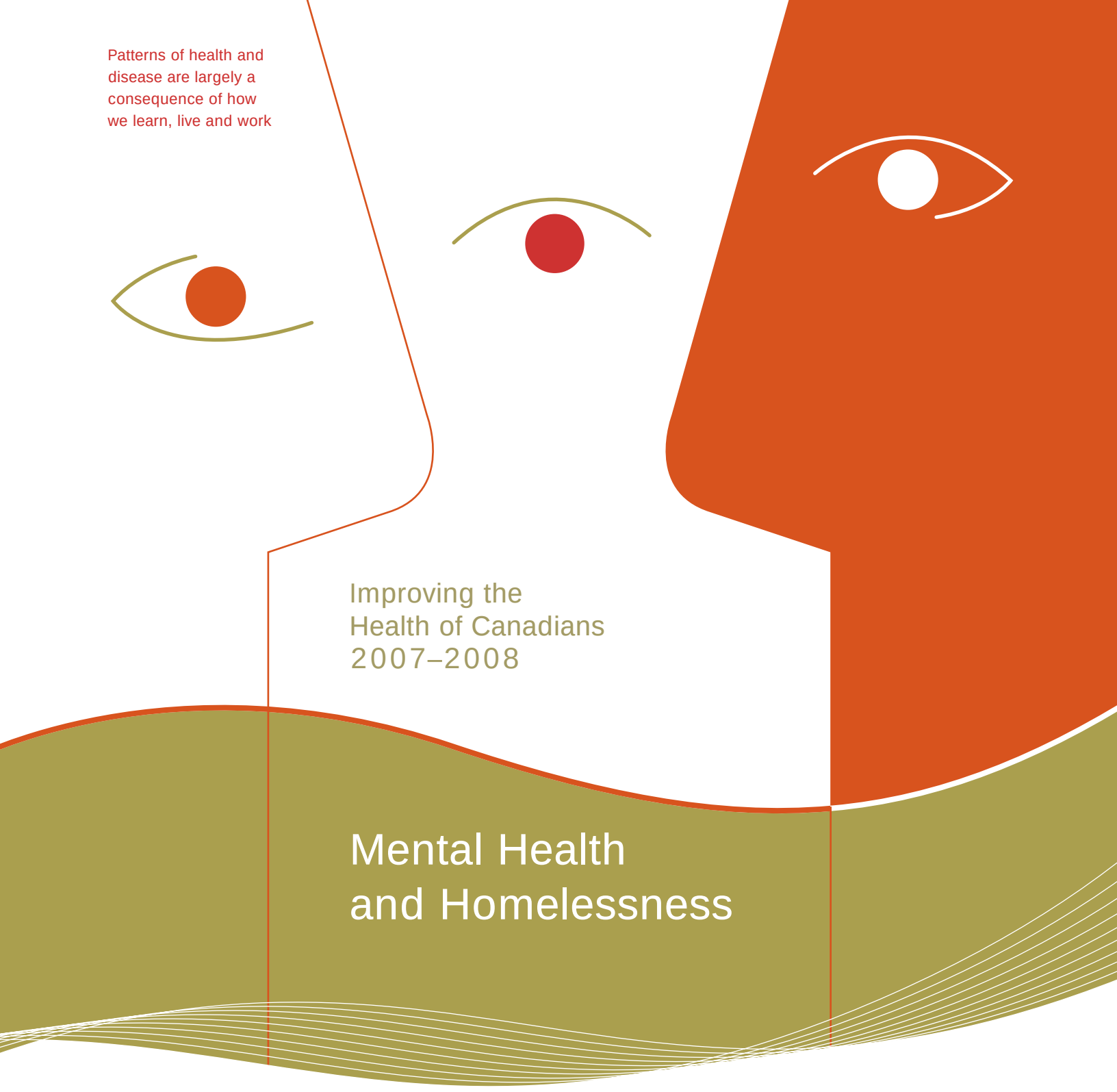
Patterns of health and disease are largely a consequence of how we learn, live and work



Improving the Health of Canadians 2007–2008

Mental Health and Homelessness

Canadian Population Health Initiative

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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About the Canadian Population Health Initiative

The Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information (CIHI), was created in 1999. CPHI's mission is twofold:

- To foster a better understanding of factors that affect the health of individuals and communities; and
- To contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians.

As a key actor in population health, CPHI:

- Provides analysis of Canadian and international population health evidence to inform policies that improve the health of Canadians;
- Commissions research and builds research partnerships to enhance understanding of research findings and to promote analysis of strategies that improve population health;
- Synthesizes evidence about policy experiences, analyzes evidence on the effectiveness of policy initiatives and develops policy options;
- Works to improve public knowledge and understanding of the determinants that affect individual and community health and well-being; and
- Works within CIHI to contribute to improvements in Canada's health system and the health of Canadians.

About the Canadian Institute for Health Information

CIHI collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

CPHI Council

A council of respected researchers and decision-makers from across Canada guides CPHI in its work:

- **Cordell Neudorf (Interim Chair)**, Chief Medical Health Officer and Vice-President, Research, Saskatoon Health Region, Saskatchewan;
- **Richard Lessard (Chair—on sabbatical)**, Director, Prevention and Public Health, Agence de la santé et des services sociaux de Montréal, Quebec;
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Please note that the analyses and conclusions in this report do not necessarily reflect those of the individual members of the Expert Advisory Group or peer reviewers, or their affiliated organizations.

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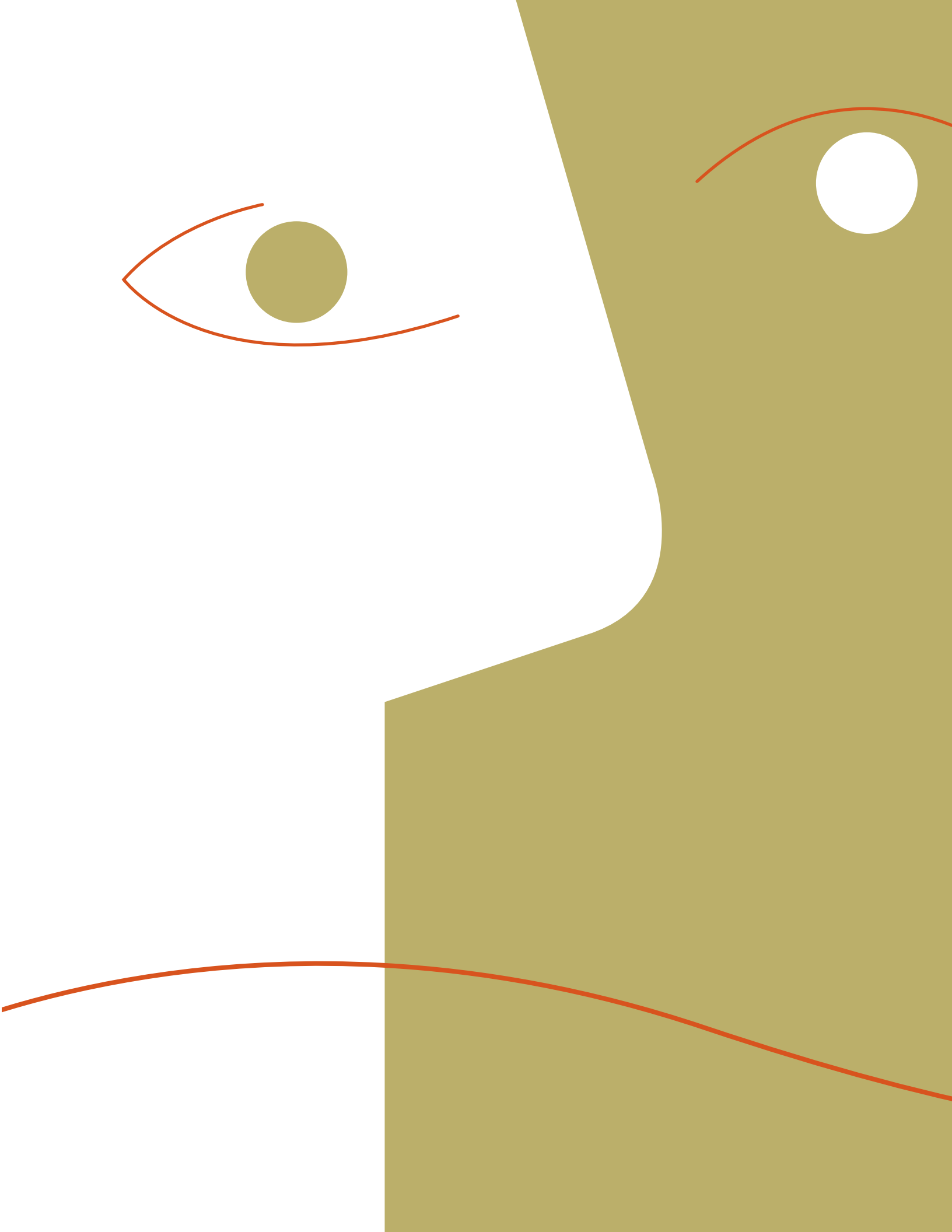
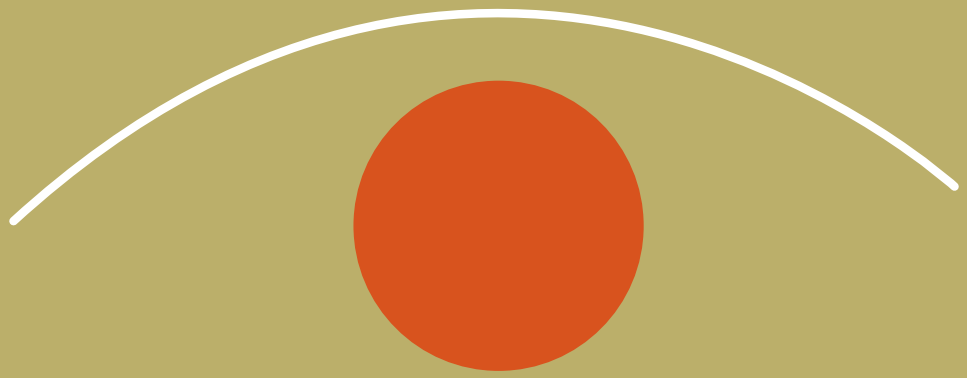
We appreciate the ongoing efforts of researchers working in the field of population health to further our knowledge and understanding of the important issues surrounding health determinants and related health improvements.





Mental Health and Homelessness

Introduction

Mental health is more than just the absence of a mental illness diagnosis.[1] The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[2](p. 1) The Public Health Agency of Canada has also adopted a broad definition: "mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity."[3](p. 2)

Increasingly, mental health is moving to the forefront of discussions and action on overall health and well-being.[4] At the federal level, the Canadian government recently announced funding for the Mental Health Commission.[5] A number of reports on mental health in Canada have also been released: the Public Health Agency of Canada's *The Human Face of Mental Health and Mental Illness in Canada, 2006*[3] and the Senate's *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*.[6] Much is also being done by provinces, territories, health regions and others.

In selecting mental health and resilience as a key theme for 2007 to 2010, the Canadian Population Health Initiative (CPHI) hopes to build on and inform these efforts. Our work will explore positive aspects of mental health and resilience, including self-perceived mental health, coping abilities and self-esteem, as well as the determinants of mental health—what makes people mentally healthy.

Mental health can be influenced by a number of factors or determinants of health, including individual, physical environment, social, cultural and socio-economic characteristics.[3] These and other factors can influence mental health in complex ways that are not always well understood. By focusing on specific groups within the population, such as Canada's homeless, we can further explore these links. This report, *Mental Health and Homelessness*, is the first in a series of three *Improving the Health of Canadians* reports addressing mental health that CPHI will release over the next 18 months.

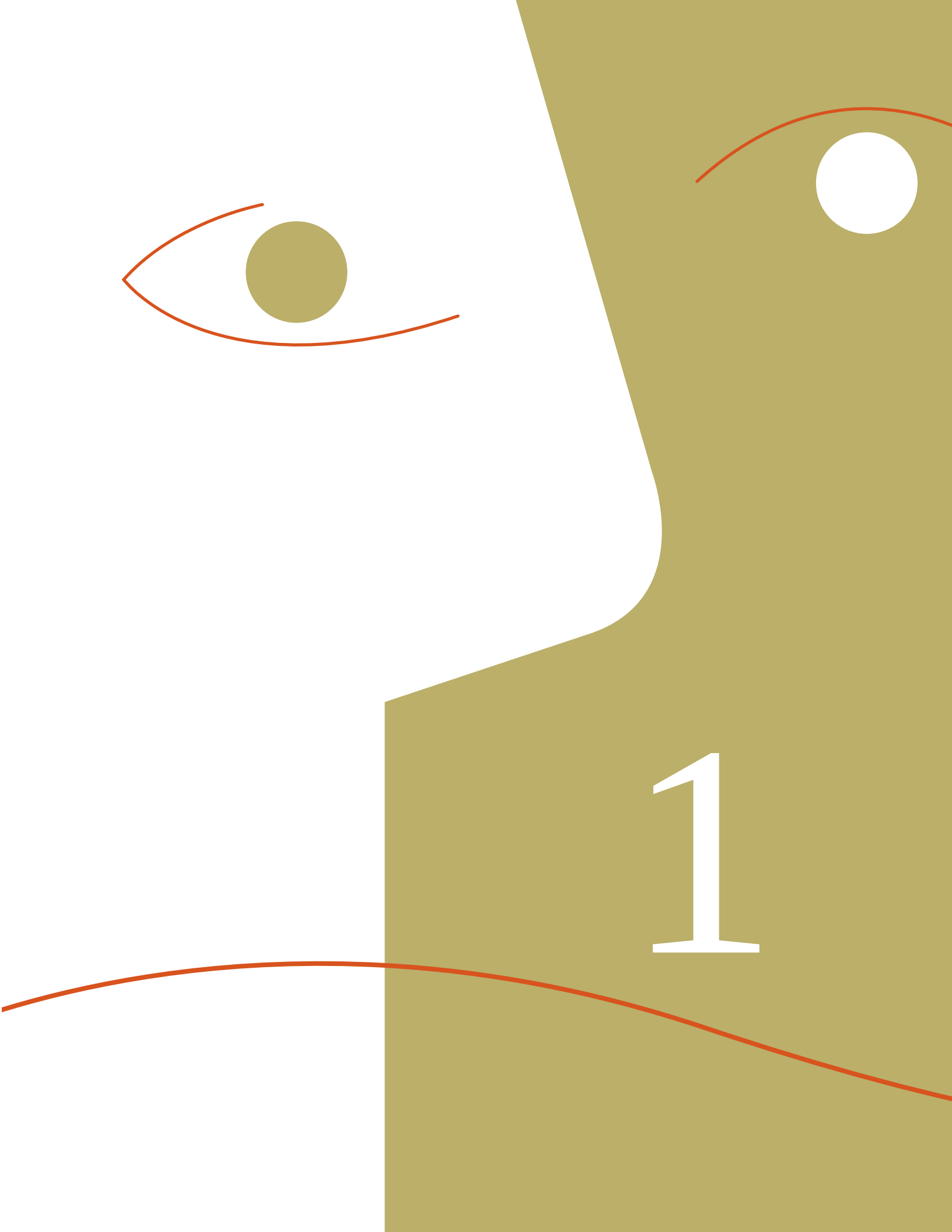
Individuals experiencing homelessness live in shelters, on the street, with friends or family or in other facilities. Statistics Canada estimates that more than 10,000 people in Canada are homeless on any given night.[7] Studies indicate that people who are homeless are more likely to experience compromised mental health[3, 8] and difficulties accessing health services than others.[9]

Many interrelated pathways link mental health and homelessness. A number of factors that affect patterns of mental health or mental illness are also linked to determinants of homelessness.[3, 10, 11] Further, mental health–related issues and mental illness can precede the onset of or contribute to homelessness;[12] they can also be worsened with continued homelessness.[13]

This report presents an overview of research, data, interventions and policy directions related to mental health and homelessness. It is organized into two sections. The first section presents compiled estimates of the prevalence of both homelessness and self-reported mental health issues among the homeless across Canada. The second section looks at the effectiveness of two types of related policies and programs—housing and community mental health programs—and their role in promoting mental health and helping people find a way out of homelessness. The report concludes with an overview of what we know and what we do not know about the links between mental health and homelessness.

CPHI's *Improving the Health of Canadians* Reports

CPHI's *Improving the Health of Canadians* reports aim to synthesize key research findings on a given theme, present new data analysis on an issue and share evidence on what we know and what we do not know about what works from a policy and program perspective. The underlying goal of each *Improving the Health of Canadians* report is to tell a story that will be of interest to policy- and decision-makers in order to advance thinking and action on population health in Canada.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Mental Health and Homelessness

Pathways Into Homelessness

Homelessness or the risk of homelessness is a harsh reality for many Canadians. It is not confined to any one group in society, but may affect youth, men and women, one- or two-parent families, the elderly, new immigrants, Aboriginal Peoples and others.[14] It is not an individual characteristic, but rather a life circumstance that can be temporary, episodic or relatively long lasting.[9]

Studies show that people who are homeless are more likely to experience compromised mental health and mental illness.[3, 8] For some, these issues can precede the onset of homelessness.[12] For others, they can be worsened with continued homelessness.[13] At the same time, it is important to note that not all people with mental illness are homeless, and not all people who are homeless report a mental illness. For example, a 1997 Toronto study of 300 shelter users found that while two-thirds of respondents reported a lifetime diagnosis of mental illness,[15] mental illness was the least reported reason for becoming homeless (4%); loss of job or insufficient income to pay rent was the main reason (34%).[12]

How Was the Literature for This Report Selected?

A search protocol was developed in order to identify studies in the areas of homelessness and housing-related issues, mental health, mental illness and mental health services. The protocol outlined the published journal literature databases to be searched, along with appropriate search terms, as well as web-based grey literature sources (non-traditional literature that is not available through commercial sources) and specific items targeted for hand-searching. Where possible, database searches were limited to studies published in English or French. The search strategy did not make any distinctions on the basis of publication type, date, research type/methodology or geography.

Search strategies were developed for the following databases: Pubmed, PsycINFO, ERIC, EMBASE, Sociological Abstracts, The Cochrane Collaboration and PAIS International. The following web-based resources were searched for books, systematic reviews and grey literature: AMICUS, Native Health Research Database, health-evidence.ca, WHOLIS, EPPI-Centre, Evidence-based Health Promotion, Community Guide and National Center for Mental Health and Juvenile Justice. The following were hand-searched: *Canadian Journal of Community Mental Health*; *Santé mentale au Québec*; *Community Mental Health Journal*; *Canadian Journal of Psychiatry*; *The Human Face of Mental Health and Mental Illness in Canada, 2006*;[3] *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*;[6] an unpublished environmental scan of the mental health field commissioned by CPHI in 2006; and bibliographies compiled by the National Resource and Training Center on Homelessness and Mental Illness.

These searches returned approximately 4,400 articles, which were screened for relevance by title. This reduced the pool to approximately 1,500 articles, the abstracts of which underwent a second relevance review. This left 800 articles, which were reviewed in their entirety. Articles underwent an initial screening on the basis of study type, research focus, year of publication and location of study, followed by a critical appraisal on the basis of research hypothesis, sample descriptors, measures, outcomes and study strengths and limitations. The approximately 180 articles that remained formed the pool of literature available for use in writing this report. These articles also form the basis of an annotated bibliography, which will be available on CPHI's website (www.cihi.ca/cphi). Where possible, Canadian literature is referenced; literature from the United States and Australia was referenced as appropriate or in the absence of Canadian literature.

What Is Homelessness?

At present, there is no universally agreed-upon definition of homelessness. There is a lack of consensus on whom to capture in the definition (for example, those living in shelters only or those living in public places outside of shelters),[16] minimum duration of homeless period[9] (for example, a specific number of days or weeks) and age ranges (particularly in research involving youth).[17]

Most definitions of homelessness capture those without physical shelter who sleep outdoors or in emergency shelters.[9] Others are more inclusive and capture those with shelter that does not meet basic standards of health and safety, including protection from the elements, access to sanitary facilities, personal safety and security of occupancy.[9] For example, different definitions include the following:

- Absolute homeless: "Living on the street, or in places unfit for human habitation (for example, abandoned buildings or vehicles)."(p. 5)[18]
- At risk of homelessness: "Households that spend more than 50% of its total income on housing costs . . ."(p. 5)[18]
- Hidden homeless: Those "who are temporarily staying with friends or family"(p. 11)[14]—also known as couch surfers.[18] Members of this segment of the population are staying neither in shelters nor on the streets and can thus be difficult to count.[14]

What Is the Scope of Homelessness Across Canada?

No one knows exactly how many people are homeless in Canada.[9] As part of the 2001 Census, Statistics Canada documented the number of people using shelters across Canada. The results, mostly from large urban centres, suggest that more than 10,000 people are homeless on any given night.[7]

A number of communities have also undertaken local estimates. Table 1 presents point-in-time prevalence estimates of the number of homeless on a given day in various Canadian cities, as well as annual prevalence estimates of the number of homeless in a given year. The definitions used in these estimates differ, as do counting methods. Table 1 illustrates many of the challenges that face those who try to determine the scope of homelessness in Canada, including the following:

- Information about the homeless is defined, collected and reported in different ways, which limits the comparability of data between cities. Different methods for sampling[16] or counting a city's homeless population[19] can result in over- or underestimates.[14]
- It can be difficult to reach the homeless population (for example, street youth) to conduct research.[17, 20] One reason for this is the fact that not all homeless individuals use formal shelter services.[8]
- There is a lack of current representative information across the provinces and territories. For example, some counts at the city level were undertaken as early as 2001; others were conducted last year.
- Data are collected at different times of the year. Seasonal differences may exist in the homeless population, which can affect estimates.[14]
- Most data are based on snapshots or point-in-time estimates. This approach is easier than estimating how many people were homeless at some point during the year; however, it usually produces lower estimates and may not be representative of the total number of people experiencing homelessness throughout the year.[21]
- Regardless of the approach used, some common themes emerge from the estimates, such as the fact that homelessness is more common for some groups than for others. For example, in Hamilton, Aboriginal Peoples comprise 1.3% of Hamilton's total population and 20% of its homeless population.[18] In Vancouver, Aboriginal Peoples comprise 2% of the total population and 30% of the homeless population.[22, 23]

Not having a clear picture of the prevalence and composition of Canada's homeless population can have far-reaching consequences. Not knowing how many homeless individuals there are, who they are and what their needs are, can make it difficult to accurately determine the need for, or effectiveness of, policies and programs, for example.[24]

Table 1

Number of Homeless (Point-in-Time or Annual Prevalence), by Census Metropolitan Area (CMA)

Point-in-Time Estimate		
City and Date of Data Collection	**Definitions and Estimates**	**Distribution by Sex, Age and Aboriginal Peoples Status***
Victoria[25] (B.C.) January 15, 2005 (midnight–6 a.m.)	**Total homeless** (count of absolute homeless in specific geographic areas and in shelters)**:** 700 Report documents responses by up to 175 homeless individuals who agreed to participate in a survey; 146 (84%) were shelter-less	**Sex:** 103 males (63%); 60 females (37%) surveyed **Age:** 33 (average age of sample) **Aboriginal Peoples:** 68 survey respondents were First Nations
Vancouver[23] (B.C.) March 15, 2005 (12:01 a.m.–11:59 p.m.)	**Total homeless** (without a place of their own to stay for 30 + days)**:** 2,174 • Shelters/safe houses: 939 • Transition houses: 108 • Streets: 1,127	**Sex:** 1,483 males (73%); 534 females (26%) **Age:** 19–24 years: 220 (11%); 25–64 years: 1,651 (83%) **Aboriginal Peoples:** 515 (30%)
Upper Fraser Valley[26] (B.C.) 24-hour survey: night of August 19, day of August 24, 2004	**Total homeless** (sheltered, street, hidden)**:** 411 • Abbotsford: 226 • Chilliwack: 87 • Mission: 75 • Other communities: 23	**Sex:** 277 males (67%); 134 females (33%) **Age:** Under 15–24 years: 90 (23%); 25–64 years: 288 (74%) **Aboriginal Peoples:** 41 (15%)
Edmonton[27] (Alta.) October 17–18, 2006 (5 a.m.–5 a.m.)	**Total homeless:** 2,618 • Sheltered homeless: 844 (32%) • Absolute homeless (no housing alternative): 1,774 (68%)	**Sex:** 1,820 males (70%); 608 females (23%) **Age:** 17–30 years: 678 (26%); 31–65 years: 1,712 (66%) **Aboriginal People:** 986 (38%)
Calgary[28] (Alta.) May 10, 2006 (9 p.m.–midnight on street; 6 p.m.–6 a.m. for services)	**Total number enumerated:** 3,436 • Emergency and transitional facilities: 2,823 (82%) • On the streets: 429 (13%) • Non-shelter service agencies: 184 (5%)	**Sex:** 2,670 males (78%); 766 females (22%) **Age:** 18–24 years: 343 (10%); 25–64 years: 2,562 (75%) **Aboriginal Peoples:** 593 (17%)
Saskatoon[7] (Sask.) 2001 Census Day	**Population in shelter:** 50 **	**Sex:** 20 males; 30 females **Age:** 15–34 years: 20; 35–64 years: 10
Regina[7] (Sask.) 2001 Census Day	**Population in shelter:** 70 **	**Sex:** 65 males; 5 females **Age:** 15–34 years: 30; 35–64 years: 35
Winnipeg[19] (Man.) Night of June 22, 2005	**Total number using emergency shelters** (excluding those on street and hidden)**:** 125	**Sex:** 101 males (81%); 24 females (19%) **Age:** 15–34 years: 56; 35–64 years: 64 **Aboriginal Peoples:** 77 (62%)
Greater Sudbury[29] (Ont.) July 23–29, 2003	**Total number at risk of and currently homeless:** 608 • High risk of homelessness: 371 • Absolute homeless: 237	**Sex:** 59% males; 41% females **Age:** 13–19 years: 80 (13%); 20–59 years: 415 (68%) **Aboriginal Peoples:** 21%
Windsor[7] (Ont.) 2001 Census Day	**Population in shelter:** 200 **	**Sex:** 140 males; 65 females **Age:** 15–34 years: 70; 35–64 years: 110
Hamilton[18] (Ont.) "Any given night" in November, 2004	**Total number in shelter:** 399	**Sex:** 237 males; 20 females **Age:** 16–21 years: 21 **Aboriginal Peoples:** 20%
Toronto[21] (Ont.) Night of April 19, 2006	**Total number** (excluding hidden homeless)**:** 5,052 • Outdoors: 818 (16%) • Shelters: 3,649 (72%) • Violence against women shelters: 171 (3%) • Hospitals/treatment facilities: 275 (5%) • Correctional facilities: 139 (3%)	**Sex:** 1,422 males (73%); 518 females (26%) **Age:** Under 21 years: 150 (8%); 21–60 years: 1,597 (87%) **Aboriginal Peoples:** 312 (16%)
Durham Region[30] (Ont.) March 7–8, 2006 (7 p.m.–7 p.m.)	**Total number of homeless individuals using services:** 133	**Sex:** 53% males; 46% females **Age:** 17–24 years: 14%; 25–64 years: 84%

Table 1 (cont'd)

Number of Homeless (Point-in-Time or Annual Prevalence) by Census Metropolitan Area (CMA)

Point-in-Time Estimate		
City and Date of Data Collection	**Definitions and Estimates**	**Distribution by Sex, Age and Aboriginal Peoples Status***
Kingston[7] (Ont.) 2001 Census Day	**Population in shelter:** 40 **	**Sex:** 25 males; 10 females **Age:** 15–34 years: 10; 35–64 years: 25
Montréal[17] (Que.) 2001 Census Day	**Population in shelter:** 1,785 **	**Sex:** 1,220 males; 565 females **Age:** 15–34 years: 535; 35–64 years: 1,025
Trois-Rivières[7] (Que.) 2001 Census Day	**Population in shelter:** 10 **	**Sex:** 5 males; 10 females **Age:** 35–64 years: 5
Sherbrooke[7] (Que.) 2001 Census Day	**Population in shelter:** 160 **	**Sex:** 115 males; 45 females **Age:** 15–34 years: 50; 35–64 years: 75
Québec[7] (Que.) 2001 Census Day	**Population in shelter:** 255 **	**Sex:** 195 males; 60 females **Age:** 15–34 years: 80; 35–64 years: 160; 65 + years: 20
Saint John[7] (N.B.) 2001 Census Day	**Population in shelter:** 90 **	**Sex:** 85 males; 5 females **Age:** 15–34 years: 15; 35–64 years: 60; 65 + years: 15
Halifax[31] (N.S.) June 17, 2004 (9 p.m.–midnight on street; overnight for services)	• Shelters: 132 • Street: 82 • Transitional housing: 50 • Drop-in or community centres: 27 • Emergency services: 1	**Sex:** 178 males (67%); 87 females (33%) **Age:** Under 18 years: 31 (12%); 19–24 years: 59 (22%); 25–64 years: 171 (65%) **Aboriginal Peoples:** 9 (3%)
St. John's[7] (N.L.) 2001 Census Day	**Population in shelter:** 25 **	**Sex:** 25 males; 5 females **Age:** 15–34 years: 15; 35–64 years: 10
Territories[7] 2001 Census Day	**Population in shelter:** 40 **	**Sex:** 40 males; 5 females **Age:** 15–34 years: 15; 35–64 years: 15; 65 + years: 15
Annual Prevalence		
City and Date of Data Collection	**Definitions and Estimates**	**Distribution by Sex, Age and Aboriginal Peoples Status***
Thunder Bay[32] (Ont.) 2004	**Total bed usage at 3 shelters:** 9,746	No further information provided
London[33] (Ont.) 2005	An average of 526 people per night used emergency shelter	No further information provided
Waterloo Region[34, 35] (Ont.) 2006	2,653 people accessed emergency shelters	Information collected in March and April 1999[35] **Sex:** Women represented approximately 60% of residents in shelter **Age:** Average age: 32 years **Aboriginal Peoples:** 12 (4%)
St. Catharines/Niagara[36] (Ont.) 2003	**Total shelter usage in 2003:** 3,123	Over 1,000 Aboriginal families and individuals required housing assistance in 2002
Ottawa[37] (Ont.) 2006	9,010 individuals stayed in a shelter in 2006	**Sex:** 5,007 males; 1,451 females **Age:** 607 youth

* Because of rounding or non-response, values do not always add up to 100% or to the total sample. In addition, the above estimates reflect a sample of sub- or age-groups that make up the homeless population and thus may not always add up to 100%; please see the respective references for additional information on how a given city's homeless population may be counted.

** The noted figures ". . . have been subjected to a confidentiality procedure known as random rounding to prevent the possibility of associating statistical data with any identifiable individual. Under this method . . . totals and margins are randomly rounded either up or down to a multiple of [5]."[38] (p. 295)

Notes: The above estimates are obtained from reports in which different methods were used to identify and estimate a city's homeless population—in many cases, estimates are "undercounts," as not all people were counted.[7] Point-in-time estimates are not representative of the total number of people who may be homeless throughout the year.[21] Given this, comparisons between cities should not be made.

What Are the Risk Factors for—Or Pathways Into—Homelessness?

A combination of economic, physical, psychological and social factors can play a role in the onset of homelessness. For some, the factors are related to income, employment, housing and other broad social determinants. They can include, separately or in combination:

- The amount of income spent on housing[11, 39] (for example, rent);[40]
- Declines in the amount of new rental housing and vacancy rates for rentors;[11]
- Long waiting lists for subsidized housing;[11]
- Poverty[10] and inadequate income;[10, 11]
- Being in a lone-parent family situation (which is often associated with low income); and[11]
- Loss of employment.[41]

Mental illness[12] and addictions[12, 41] can also be a risk factor for homelessness for some people. These factors tend to be related to many of the above-noted factors—individuals with severe mental illness and addictions may experience limited housing, employment and income options.[42] Mental illness and addictions may not always lead to homelessness. However, among those for whom they may play a role, they can increase the likelihood that one's homeless period will be longer.[42]

The pathways to homelessness can also be social in nature. Among homeless youth, these can include family conflict,[43] dropping out of school[43] or parental substance abuse.[43] Additional factors include those specific to mental health and well-being, such as the loss of support from others,[41] poor self-image (particularly among homeless male youth)[44] and interpersonal conflict.[12, 41]

Physical Health Problems Associated With Homelessness

Current literature indicates that homeless people are at increased risk for a number of physical health problems, including chronic obstructive pulmonary disease and respiratory tract infections, musculoskeletal conditions (for example, arthritis), infectious diseases (for example, tuberculosis, HIV), poor oral and dental health, skin and foot problems,[8] poor management of chronic conditions (for example, diabetes)[45] and unintentional injuries.[8] Evidence also indicates that homeless individuals are at risk for premature death.[46, 47] One study, for example, reported a mean age at death of 39 years among a sample of Toronto homeless women.[48] The life expectancy at birth of Canadian women in the general population was 82.0 years in 2001.[49]

Among the general population, evidence shows a link between physical health, such as persistent pain, and mental health.[3, 50] While research involving the homeless has traditionally looked at physical health outcomes separately from mental health outcomes, some research does report an association between poor self-rated health with a history of receiving help for emotional problems or drug abuse among shelter users.[51] Some studies, such as one conducted in Oshawa (Durham Region), Ontario, also report an association between low self-rated health and low self-reported mental health.[30]

How Are Mental Health and Homelessness Related?

The terms "mental health" and "mental illness" are sometimes used interchangeably or are seen as two ends of a single continuum.[3] However, many definitions emphasize that mental health is more than the absence of mental illness.[1] For example, the Public Health Agency of Canada says that, "mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity."[3](p. 2)

Many studies show that people who are homeless are more likely to experience compromised mental health and mental illness than the general population.[3, 8] For some, these issues can precede the onset of homelessness or, through their interaction with other determinants such as income and employment influences, contribute to homelessness.[42] They may also worsen with continued homelessness[13] or contribute to the duration of homelessness.[42]

Patterns of mental health can be influenced by a number of factors, including personal coping skills; perceived self-worth; one's social environment; and other physical, cultural and socio-economic characteristics.[3] Many of these factors may also be related to the risk of becoming or remaining homeless.[10, 11]

Experts indicate that, through mental health promotion, positive mental health can play a role in one's recovery process.[3] Mental health promotion "empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength" through strategies to increase self-esteem, coping skills, social support and well-being.[3](p. 21) Increasingly, Canadian and international studies of the homeless population have examined these aspects of mental health and mental health promotion, particularly among homeless youth. Examples of their findings are highlighted below.

Stress

Studies in Canada and elsewhere suggest that stress levels are higher among the homeless than among the population as a whole. Overall, data from the 2003 Canadian Community Health Survey (CCHS) indicate that 24% of Canadian adults report having "quite a lot" of stress.[49] Like other similar studies, however, this survey was not administered to homeless populations. Studies involving the homeless often use other measures and are thus not directly comparable. In some cases, comparisons can be made to published scores compiled from the general population; in other cases, studies include non-homeless comparison groups. Two Canadian examples found that:

- In Kitchener-Waterloo, Ontario, street youth reported more stressors in the past year than non-homeless youth (10.4 on average versus 7.2).[52]
- In Ottawa, Ontario, homeless male youth reported an overall stress level that was more than two times higher than that reported by a group of non-homeless male youth.[53]

In the U.S., a Los Angeles study involving youth who were homeless or at risk of homelessness found increases in depressive symptoms and substance abuse disorders, as well as poorer self-rated health with increased stress.[54]

Stress and Victimization Experienced Before and After the Onset of Homelessness

Physical and sexual abuse prior to leaving home are relatively common stressors or traumatic events identified by the homeless (particularly among females).[55] Some also experience abuse while homeless.[56–59]

Researchers have found that other relatively frequent stressors include being threatened,[56, 57] theft,[57] robbery (theft with or threat of force),[59] vandalism[59] and drug-related activities in shelters.[60]

Coping

Coping skills have been linked to health and well-being.[61] A number of studies have looked at how homeless individuals cope with stress. Research suggests that homeless youth have a tendency toward using coping styles and strategies that work to distance them from a stressor rather than actively attempting to solve it. For example:

- In Kitchener-Waterloo, Ontario, a study found that street youth were more likely to engage in substance use and self-harm as a means of coping; non-homeless youth were more likely to cope by talking to someone they trusted or through productive problem-solving.[52]
- In Ottawa, Ontario, homeless male youth were more likely to use strategies such as avoiding the problem, withdrawing from social networks and avoiding negative thoughts/emotions to cope than were non-homeless youth.[53, 62, 63] Among homeless youth only, this style of coping was related to depressive symptoms and various internalizing behaviour problems—the latter of which was measured by anxiety/depressive symptoms, withdrawal and somatic complaints (that is, unexplained physical problems).[53]
- In Los Angeles, California, homeless male and female youth who reported using such strategies as wishing the problem would disappear or using substances tended to have higher levels of stress, social isolation, symptoms of depression and poor self-rated health; in contrast, homeless youth who tried to solve a problem or change a situation reported good self-rated health.[54]

Likewise, among adults, a U.S.-based study found that homeless men with a persistent mental illness reported significantly less use and effectiveness of cognitive (for example, problem-solving methods), socio-cultural (for example, seeking social support) and spiritual (for example, prayer) coping strategies than did homeless men with an addiction and homeless men dealing with a specific crisis situation.[64]

Social Support

Social support has also been linked to health and well-being, and it can play a role in helping people cope with stress.[61, 65, 66] Examples include the number of social relationships, frequency of contact, connections among members of social networks, availability of social support and function of support received (for example, emotional support).[66] The evidence about links between social support and mental health are noteworthy given the reported lack of social support among various segments of the homeless population. For example, one study in Ottawa, Ontario, found that homeless male youth reported less perceived parental support than non-homeless male youth.[53] Another Ottawa study found that 15% of adults living on the street reported receiving no social support.[67]

Various studies report associations between social support and mental health outcomes among people who are homeless. As seeking social support can be a way for people to cope, it is not surprising that these findings are similar to those reported in the coping literature. Examples of findings from existing studies include the following:

- In Toronto, Ontario, compared to street youth with lower levels of social support, street youth with a high level of social support reported a significantly lower mean depression score.[68]
- Among homeless youth in Los Angeles, California, increased availability of social support was associated with reduced depressive symptoms and better self-rated health.[54]
- In Washington, DC, the 26% of runaway and homeless youth who did not indicate they had a current social network had higher odds of using illicit drugs and engaging in risky sexual behaviours.[69]

- Among adults, Nyamathi et al. (2000) found that 51% of homeless women in Los Angeles reported no current substantial source of social support. Compared to these women, homeless women reporting support from individuals who were not substance users reported higher self-esteem, more active coping, greater life satisfaction and lower levels of both anxiety and depression.[70]

Self-Esteem

Self-esteem is another factor often discussed in relation to mental health and well-being. A Toronto study found that street youth with high self-esteem reported being less depressed than those with lower reported self-esteem.[68] A study of youth in substance abuse treatment programs in Ontario found that compared to 66% of non-homeless youth, 50% of homeless youth reported feeling good about themselves.[71]

Similar findings have also been noted in international studies. For instance:

- Relative to different groups of non-homeless youth, a study in Sydney, Australia, found that homeless youth scored significantly lower in four areas of self-concept: impulse control (control of aggression, anxiety, resentment, fear), emotional tone (feelings of tension, sadness, loneliness, inferiority), family relations and level of psychopathology.[72] Among homeless youth, hopelessness was associated with lower overall self-esteem.[72]
- Low self-esteem, along with low support from positive sources, higher support from deviant sources (drug-using family/friends or drinking partners) and avoidant coping (for example, withdrawing from others), was significantly related to high mental distress scores among homeless women in Los Angeles.[73]
- Another Los Angeles study found that 16% of street youth reported low self-esteem, which was itself associated with increased risk of both alcohol and drug use and suicidal thoughts/attempts.[74]

Suicidal Behaviours

Although much remains unknown about the causal pathways between mental health and suicide, suicidal behaviours have been linked to aspects of mental health among homeless individuals. Qualitative studies have found that feelings of hopelessness, loneliness, worthlessness and being trapped were themes underlying homeless youths' experiences with suicide.[75] Existing research shows an association between suicidal behaviours and coping. Among homeless male youth, suicidal behaviours were associated with having a coping style that does not involve actively trying to solve a problem or cope with a stressor.[62]

A number of Canadian studies report higher rates of suicidal thoughts and suicide attempts among homeless youth than among youth who are not homeless. According to the Public Health Agency of Canada, 12% of males aged 15 to 24 and 19% of females aged 15 to 24 report having had suicidal thoughts at some point in their lifetime.[3] Fewer, 2% of males and 6% of females aged 15 to 24, report ever having attempted suicide.[3] Findings from studies involving homeless youth include the following:

- A 2006 survey of youth across B.C. indicated that compared to 4% of males and 10% of females in schools, 15% of males and 30% of females who were street-involved and marginalized reported having attempted suicide at least once in the previous 12 months.[76]
- In Ottawa, Ontario, compared to 4% of non-homeless male youth, 21% of homeless male youth reported at least one past suicide attempt. Compared to 34% of non-homeless youth, 43% of homeless youth reported suicidal thoughts.[62]
- Of homeless youth sampled in Toronto and Vancouver, 46% reported a past suicide attempt.[75]
- In Richmond Hill, Ontario, 20% of homeless youth reported at least one suicide attempt in their lifetime; 25% reported suicidal thoughts.[77]

How Are Mental Illness and Homelessness Related?

The Public Health Agency of Canada defines mental illness as ". . . alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning."[3](p. 2) Compared to the general population, research shows a greater incidence and prevalence of persons with serious mental illnesses becoming or remaining homeless.[78] Other research has documented a higher prevalence of mental disorders among the homeless than among the general population.[79] In Toronto, 67% of shelter users in the Pathways into Homelessness Project reported a lifetime diagnosis of mental illness.[15]

Schizophrenia and Personality Disorder

In Statistics Canada's 2002 Mental Health and Well-being Survey, less than 1% of adults in the general population reported having been professionally diagnosed with schizophrenia.[3] Canadian and U.S. studies, including the following, report higher rates of schizophrenia among the homeless:

- In Toronto, 6% of 300 shelter users reported a psychotic disorder, primarily schizophrenia.[12]
- A Vancouver study reported that 24 of 124 shelter users had a mental health problem; of these, 7 identified their mental health problem as schizophrenia.[80]

Toronto's Pathways into Homelessness Project also found that 29% of shelter users met criteria for anti-social personality disorder (often in addition to another diagnosis such as depression, post-traumatic stress disorder (PTSD) or psychotic disorder).[12] PTSD is a disorder associated with a traumatic event and characterized by various symptoms including persistent and recurring thoughts/images.[81] Research indicates that physical and sexual abuse occurring while people are homeless is a risk factor for the onset of PTSD.[58] In a study involving homeless youth, 24% met criteria for PTSD; 40% who met the criteria for substance abuse disorder also met the criteria for PTSD.[82]

Substance Abuse and Concurrent Disorders

Among the general population, data from Statistics Canada's 2002 Mental Health and Well-being Survey indicate that among females, 4% of young women (15 to 24 years of age) and 1% of adult women (25 to 44 years of age) report alcohol dependence in the previous 12 months. Fewer (2% of young women and less than 1% of adult women) report illicit drug dependence in the previous 12 months.[3] Rates are higher among males: 10% of young men and 4% of adult men report alcohol dependence, while 4% of young men and 1% of adult men report illicit drug dependence in the previous 12 months.[3]

Canadian studies indicate that rates of substance abuse are higher among homeless individuals than among the general population. For example, in Toronto, 68% of shelter users reported a lifetime diagnosis of substance abuse or dependence.[15] Studies conducted in other parts of Canada have found that:

- In Vancouver, B.C., 44% of homeless adults reported use of non-prescription drugs such as marijuana and cocaine within the past month.[80]
- In Edmonton, Alberta, 40% and 55% of homeless youth reported drinking alcohol and using marijuana, respectively, at least two to three times a week.[83]
- Various Canadian studies also report high levels of opioid and non-opioid drug use among the homeless. For example, in Edmonton, 55% of street youth reported using at least one of four drugs (cocaine, heroin, amphetamines or tranquilizers) in the past year.[83] A Montréal study of street youth over a five-year period noted an incidence rate of drug injection use of 8.2 per 100 person-years among a cohort of 415 street youth[84]—at study entry, these youth had never used injection drugs.

Some individuals have both substance abuse disorders and mental illness diagnoses, known as "concurrent disorders."[14] Other terms used include "dual diagnosis," "dual disorder," "comorbidity" or "co-occurring substance abuse disorders and mental disorders."[85] Published literature reviews suggest that homeless individuals with concurrent disorders are likely to remain homeless longer than other homeless people.[86] In Toronto, almost all of the shelter users in the Pathways into Homelessness Project who reported a lifetime diagnosis of mental illness also had a substance abuse disorder.[12]

Depressive Symptoms and Major Depressive Disorder (MDD)

Research also suggests that depression is more common among homeless Canadians than among others. Among the general population, 14% of 15- to 24-year-old females and 17% of 25- to 44-year-old females report having been diagnosed with depression at some point in their life. Reported rates are lower among male youth and adults—7% and 10%, respectively.[3] Methods used in research among the homeless are not directly comparable, but studies have found that:

- Homeless male youth in Ottawa, Ontario, were more likely than non-homeless male youth to report scores for depressive symptoms (39% versus 20%) and internalizing behaviour problems (44% versus 24%) that were within a clinical range. As noted previously, the latter were measured based on the frequency of withdrawal behaviours, symptoms of anxiety/depression and unexplained physical problems.[53]
- One-third (33%) of a sample of Ottawa's adult street population self-reported mental health difficulties; of these, 20% reported depression.[67]
- In Kitchener-Waterloo, Ontario, street youth had a significantly higher mean level of depression than non-runaway youth. About half of the street youth in this study (48%) reported a decrease in their depression level since leaving home, while 28% reported an increase.[52]

Research involving the homeless in the U.S. reports a range of findings. For example, one study conducted in a large northwestern U.S. city found that 12% of 523 homeless youth reported a diagnosis of depression. Rates of depression were higher among females than males (20% versus 7%). About three-quarters of those surveyed (73%) reported experiencing their first depressive episode before leaving home.[87]

This variation may reflect a number of issues including, but not limited to, the use of different measures for assessing prevalence rates[56] or the use of different terminology to reflect symptoms or diagnoses.[16]

Determining the Status of Mental Health and Mental Illness Among the Homeless

Accurately measuring mental health status and mental illness among Canada's homeless population, as well as their use of appropriate mental health services, is complicated. That said, a large number of studies from different parts of the country and using different methods have reported higher rates of mental illness among the homeless than among the general population. Table 2 includes further examples from a sample of Canadian cities, based on different methods, sampling periods and populations. The table also highlights a number of methodological issues:

- The different means by which mental illness among the homeless is defined,[16] which limits the comparisons that can be made between cities, over time, or to the general population;
- The variation in the nature of information reported in terms of specific diagnoses;
- The lack of representative information across the provinces and territories; and
- The use of terms such as "mental illness," "mental health problems," "mental health concerns" and "mental health difficulties"—to name a few—interchangeably.

Use of Mental Health Services

Dozens of different mental health services exist, although the types of service available—and to whom they are available—vary across the country. Not everyone with mental health problems uses these services. This is true for both the homeless population and others, although the circumstances may be somewhat different. For example, while two-thirds of homeless respondents in a Toronto study reported having been diagnosed with a mental illness at some time during their life, 25% reported receiving psychiatric outpatient services in the past year.[12] Likewise, homeless men with schizophrenia in New York City were less likely to report having received assistance with discharge planning for living arrangements, aftercare and finances upon release from hospital than non-homeless men with schizophrenia.[93]

Recent research has also explored the barriers that homeless people identify to getting help. A Los Angeles study reported that 218 of 688 homeless youth perceived a need for help with mental health problems; 95 had gotten help and 123 had not.[94] Youth who identified a need for but did not get help cited various reasons, such as not knowing where or what services to use (53%), feeling embarrassed (47%), not having money to get to the service (36%), fears the service provider would contact family (36%) or police/social worker (36%), thinking the service would not help (33%) and the cost of the service (14%).[94]

When the homeless do use services, studies indicate that there may be a tendency to use clinics and emergency departments (EDs). A study of over 2,900 homeless patients in the U.S. found that 63% received medical care at locations such as outpatient clinics and shelters in the previous year.[95] Published reports put the proportion of the homeless population who have received medical care in the ED in the past year at 32%[95] to 40%.[96] Research also shows that people who are homeless and have a mental illness are more likely to use the ED than those without a mental illness.[95] Factors associated with ED use included health symptoms, injuries, substance dependence and depressive symptoms (among homeless men),[97] being a victim of crime, unstable housing and medical comorbidity.[96]

Table 2

Reported Mental Illness Among Canada's Homeless in a Sample of Canadian Cities

City or Area	Prevalence of Reported Mental Illness Among the Homeless
Vancouver (B.C.)	In 2005, of 1,719 sheltered and street homeless, 23% reported having a mental illness and 49% reported an addiction.[23]
Victoria (B.C.)	In 2005, approximately 41% of homeless adults reported being told they had a mental illness.[25]
Upper Fraser Valley (B.C.)	In 2004, 7% of 219 respondents reported a mental health problem and 51% reported having an addiction.[26]
Calgary (Alta.)	In 2000, 60% reported a mental illness or substance abuse problem.[88]
Edmonton (Alta.)	In 2003, 59% of homeless individuals reported mental health problems (excluding addictions).[89]
Toronto (Ont.)	In 1997, 67% of 300 shelter users reported a lifetime diagnosis of mental illness.[15] In 2006, 27% of homeless individuals (approximately 500) indicated that receiving help with their mental health needs would help them achieve stable housing.[21]
Ottawa/Gatineau (Ont./Que.)	Proportion of 230 homeless individuals reporting a diagnosable mental health problem (based on a self-report screening tool) in 1999: 60% of adult males, 74% of adult females, 56% of male youth, 61% of female youth and 57% of people not using shelters.[90] In 2002, of 80 non-sheltered homeless persons interviewed for a street needs assessment project, 33% self-identified as having mental health concerns (of these, 20% depression, 6% anxiety disorders, 4% schizophrenia and 3% personality disorders).[67]
Hamilton (Ont.)	In 2004, 13% of 302 people who were homeless or at risk of homelessness reported a diagnosed mental illness (excluding depression); diagnosed depression was reported in 11% of the population.[91]
London (Ont.)	In 2002, approximately 130 people were discharged from a psychiatric facility to no fixed address.[92] Approximately 45% of those in emergency shelters had mental health issues.[92]
Waterloo Region (Ont.)	In 1999, 45% of 268 homeless individuals reported having mental health issues: 8% for depression/bipolar disorder, 5% for stress/anxiety/post-traumatic stress disorder and 3% for schizophrenia.[35] A 2006 report notes that 35% to 40% of shelter users are estimated to have a mental health issue and 25% a substance use issue.[34]
Oshawa (Durham Region) **(Ont.)**	In 2006, 28% of 133 respondents self-rated their mental health as medium on a scale of 1 to 10 (poor to very good); 8% self-rated it as low.[30]
Greater Sudbury (Ont.)	In 2003, 12% of 1,601 individuals cited mental illness or other illness as the reason for their homelessness.[29]
Halifax (N.S.)	In 2004, 20% of 266 homeless individuals self-identified as mentally ill.[31]

Notes:

The above information, which reflects the information we were able to obtain as of May 2007, was obtained from representatives of the Canadian Mental Health Association offices across Canada and various published reports.

For some cities, only percentages are reported, as total sample sizes were not indicated or clearly identified in all reports.

As there is great variability in the definitions and collection methodologies underlying this information, comparisons between cities cannot be made.

Data from the Canadian institute for Health Information (CIHI) indicate that mental health and behavioural disorders account for a larger share of ED visits and hospital stays among the homeless than among the population as a whole. The data track ED use in Ontario and a handful of other centres, as well as hospital use outside of Quebec (see Table 3).*

Most of the inpatient hospitalizations tracked for the homeless took place in Vancouver, Calgary and Toronto. Toronto accounted for 78% of all ED visits by the homeless in Ontario.

Table 3

Hospital Use by Homeless Individuals and Others, 2005–2006

	Homeless	Others
Emergency department visits (primarily Ontario)	14,663	5.4 million
Percentage of men	76	49
Average age	40	48
Acute care hospitalizations (excludes Quebec)	3,596	2.4 million
Percentage of men	75	49
Average age	39	46

Sources:
Emergency department visits, National Ambulatory Care Reporting System (NACRS), CIHI 2005–2006—includes data for all hospital-based and community-based ambulatory care: day surgery, outpatient clinics and emergency departments. It primarily contains Ontario emergency data only; however, other provinces are submitting data (for example, B.C., the Yukon, P.E.I. and Nova Scotia).

Acute care hospitalizations, Discharge Abstract Database (DAD) (excludes Quebec), CIHI, 2005–2006—contains demographic, administrative and clinical data for hospital discharges (inpatient acute, chronic and rehabilitation) and day surgeries in Canada.

Mental health and behavioural disorders were the most common reason for ED visits by the homeless, but were not in the top five reasons for visits by other patients (see Table 4). These conditions accounted for more than one-third (35%) of visits by the homeless. Within this category, the most common type of mental disorder was psychoactive substance use (54%) followed by "schizophrenia, schizotypal and delusional disorders" (20%). Reasons for visits for mental health and behavioural disorders varied for homeless men and women. Psychoactive substance use predominated for men (accounting for 62% of visits in this category), but it represented only 30% of visits for women. In both cases, "schizophrenia, schizotypal and delusional disorders" was the next most common reason for visits for mental health and behavioural disorders (28% for homeless women and 18% for men).

Mental diseases and disorders were also the most common reason for acute care hospitalization among the homeless, but were not as common among the rest of the population (see Table 5). In 2005–2006, 52% of inpatient hospitalizations among the homeless (outside of Quebec) were primarily for these conditions.

* Counts are based on residential information obtained by the hospital at initial presentation. As hospital staff may not always be aware or informed of a patient's current housing status, particularly for subsequent visits, this information may not be up to date and thus may reflect an incomplete count. Information reflects only those homeless individuals presenting for medical attention at participating hospitals. In addition, since there is no comparable count of the total population in Canada, rates cannot be calculated and compared with the total population. Emergency department and inpatient hospitalization data were obtained from two different data sources in which somewhat different approaches to capturing data about patients' health problems are used.

Table 4

Top Five Reasons for Emergency Department Visits by the Homeless and Others, 2005–2006

Homeless	Percentage
Mental and behavioural disorders	35
Symptoms, signs and abnormal clinical findings	16
Injury, poisoning and consequences of external causes	14
Contact with health services	14
Diseases of musculoskeletal system and connective tissue	5
Others	**Percentage**
Injury, poisoning and consequences of external causes	25
Symptoms, signs and abnormal clinical findings	19
Diseases of respiratory system	11
Contact with health services	8
Diseases of musculoskeletal system and connective tissue	6

Note:
Columns do not add up to 100%, as only the top five reasons are noted.

Source:
Emergency department visits, National Ambulatory Care Reporting System (NACRS) (primarily Ontario), CIHI, 2005–2006.

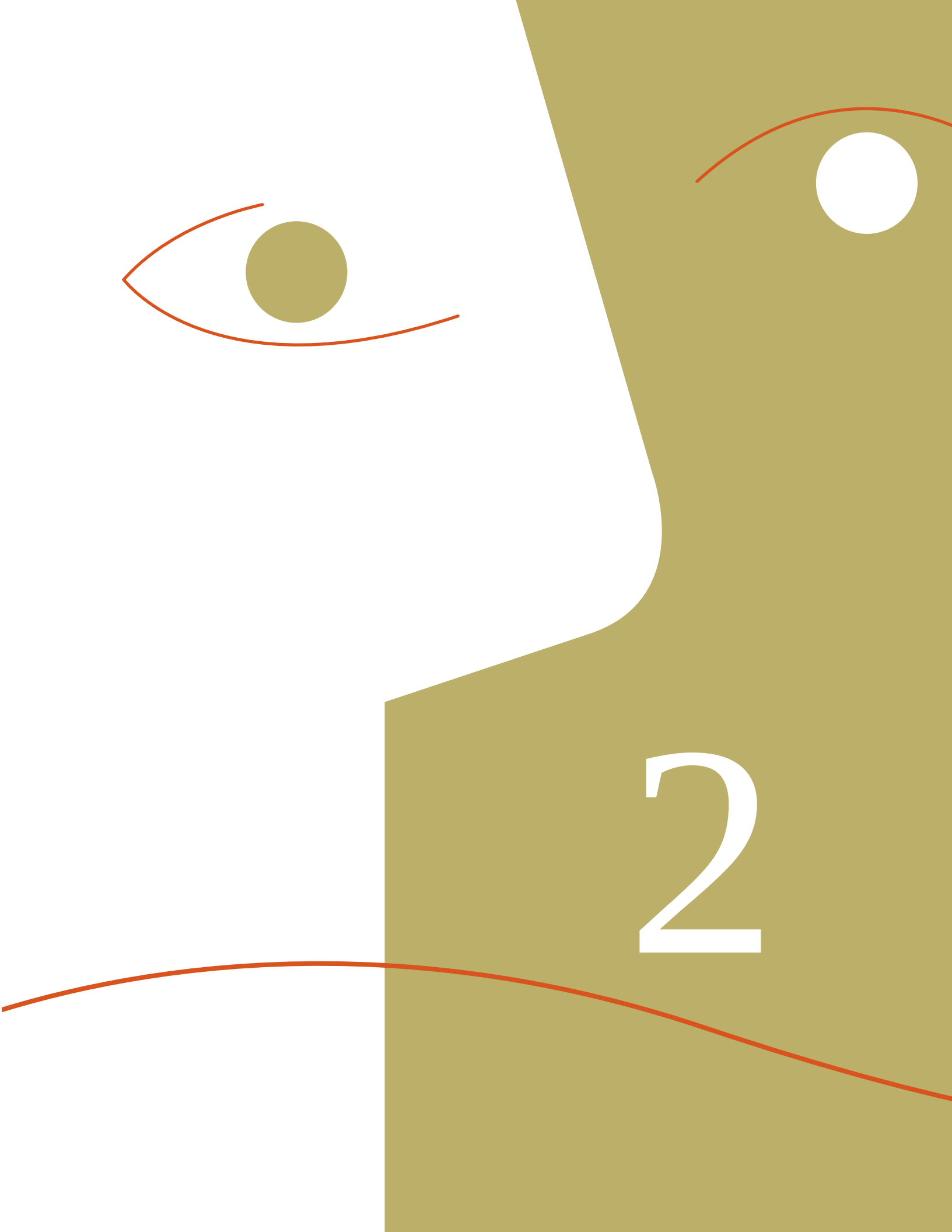
Table 5

Top Five Reasons for Inpatient Hospitalization Among the Homeless and Others, 2005–2006

Homeless	Percentage
Mental diseases and disorders	52
Significant trauma	7
Respiratory diseases	7
Skin subcutaneous and breast diseases	6
Digestive diseases	3
Others	**Percentage**
Pregnancy and childbirth	13
Circulatory diseases	12
Newborns and other neonates	12
Digestive diseases	10
Respiratory diseases	7

Note:
Columns do not add up to 100%, as only the top five reasons are noted.

Source:
Acute care hospitalizations, Discharge Abstract Database (DAD) (excludes Quebec), CIHI, 2005–2006.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Mental Health and Homelessness

Policies and Programs

There are many pathways into homelessness, as well as a variety of factors that can affect a person's chances of becoming homeless. These include issues such as housing challenges, income level and employment status. For some individuals, mental health, mental illness and addictions may also play a role or affect how long a person remains homeless.[12, 41, 44] These factors can also be related and linked to each other.[42]

A wide variety of policies and programs aim to address homelessness, mental illness or risk factors that may contribute to either condition (or to both). Given that there are many factors that affect mental health (including mental illness) and homelessness, we focused on two types of initiatives: housing and community mental health programs. It is important to note that other potentially relevant policies and programs, such as poverty or employment initiatives, may also have a role in supporting individuals in finding a pathway out of homelessness and influencing mental health among homeless individuals. However, a review of the evidence specific to these areas was outside of the scope of this report.

Within the areas that we focused on, we found that few initiatives addressing homelessness have been evaluated for long-term health outcomes. Similarly, many initiatives with a mental health focus do not specifically track results for homeless individuals or whether they affect housing status. In both cases, a few evaluations do exist. The results are highlighted in this section.

How Were the Policies and Programs Highlighted in This Report Selected?

The literature selected in this section of the report was chosen using the same criteria described in the first section. Policies and programs were primarily identified through systematic scanning of government and non-government websites. A search protocol was developed to identify programs, policies and initiatives in the areas of homelessness and housing-related issues, mental health, mental illness and mental health services. Examples from across Canada were selected on the basis of relevance to the topic and availability of detailed information and/or evaluated outcomes. The information presented in this section is neither meant to be an exhaustive list nor to imply that, by omission, other information does not exist. For example, *Shared Learnings on Homelessness—Directory of Organizations* (www.sharedlearnings.org) describes a number of community initiatives that are underway across Canada.

Mental Health Policy in Canada

Mental health policy in Canada has largely focused on those with serious mental illnesses. In the 1800s, individuals with a mental illness were often institutionalized in poorhouses or prisons.[98] By the end of the 19th century, asylums and mental hospitals were developing.[3] Since then, mental health services have continued to evolve. For example, starting in the 1960s, many psychiatric inpatients were discharged to the community when psychiatric hospitals or wards were closed and/or the number of beds in psychiatric facilities was reduced.[98–100] Experts suggest that this move towards deinstitutionalization was prompted by a number of factors including institutional economic constraints, an increased focus on human rights and the development of new drugs and treatments that enabled individuals with a mental illness to be cared for in the community.[3, 98]

While there is no consensus on the impact of deinstitutionalization on the prevalence of homelessness, some researchers have suggested that deinstitutionalization was associated with the growth of new forms of residential or institutional care,[100] as well as increased rates of homelessness.[3, 98, 101] It has also been suggested that community mental health services did not increase at the same rate as patients were deinstitutionalized.[99]

Recent Pan-Canadian Developments

In 1988, the Minister of National Health and Welfare produced a discussion paper entitled *Mental Health for Canadians: Striking a Balance*. The paper outlined a set of principles, such as consumer participation, equality and strengthening community capacity to guide the development of programs and mental health–related policies in Canada.[102] Many of these principles were later reflected in mental health reforms and community mental health interventions[98] that incorporated objectives such as integration, recovery, consumer choice and independent housing.[98]

Traditionally, community mental health programs could be described as having a community treatment and rehabilitation focus. Within this focus, approaches reflected such values as reducing symptoms, preventing hospitalization, professionally prescribed treatment, community-based support, vocational training and housing with an element of support (for example, group homes and halfway houses).[98]

The 1990s saw a shift toward recovery and empowerment that reflected values consistent with the principles outlined in the above-mentioned discussion paper: emphasis on recovery, recognizing strengths, consumer choice and control, community integration, informal supports, supported employment and independent housing with flexible support.[98]

In May 2006, the Senate's report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, recommended the establishment of a Canadian Mental Health Commission and a national mental health strategy[6] (funding was announced by the federal government in March 2007).[5] The report also noted that affordable housing is a key issue for people living with a mental illness: ". . . the percentage of Canadians who are living with mental illness who need access to [adequate, suitable and affordable] housing is almost double the percentage of people in the general population whose housing needs are not being met."[6] (p. 462)

Mental Health Policy: At the Provincial Level

Canada's provinces are responsible for administering and delivering health services.[109] A number of provinces have developed specific initiatives, plans, frameworks or similar structures pertaining to mental health to guide their policies and services. In many cases, they specifically address issues related to homelessness (for example, the provision of supportive housing). Examples include the following:

- *British Columbia's Mental Health and Addictions Reform Initiative*. As part of the Mental Health and Addictions Reform initiative, the British Columbia Ministry of Health formed best practices working groups to identify various services and strategies that produce positive health outcomes for individuals. The working group's findings are reflected in *BC's Mental Health Reform Best Practices*, which includes reports specific to housing and Assertive Community Treatment (ACT), two topics discussed in more detail later in this section.[110]

National Homelessness Initiative

In December 1999, the federal government established the National Homelessness Initiative (NHI) to help address the issue of homelessness in Canada. The NHI involved a wide range of supports and services (such as emergency shelters, skills training and addictions services) to help the homeless and those at risk of becoming homeless achieve independent living. It was ". . . designed to provide supports to 61 designated communities and some small, rural and Aboriginal communities . . ."[103, 104] (p. 1)

During Phase I (December 1999 to March 2004), 6% of NHI-funded projects (sheltering facilities, support facilities and support services) identified persons with mental health problems as major clients; 7% identified substance abusers as major clients and 2% identified those with concurrent diagnoses as major clients.* [104]

To date, only formative evaluation results on specific components of the NHI are available;[105] reports from the final two phases of the NHI are not yet publicly available.

As of April 2007, the NHI was replaced by an enhanced federal strategy—the Homelessness Partnering Strategy (HPS). This new strategy has a broad focus, but generally plans to take a Housing First approach.[106, 107] A Housing First approach provides clients with housing first and then any necessary training or treatment they may require, on a voluntary basis.[108]

* Figures may be larger than stated as 32% of NHI-funded projects that served more than three specific sub-populations were asked to select the "all potential sub-population groups" category (major clients of these projects may have included persons with mental health problems, substance abusers or those with concurrent diagnoses).

- *Alberta's Mental Health Plan: Advancing the Mental Health Agenda*. This plan highlights strategies targeted to specific population groups, including the homeless. Within this plan, programs that provide the homeless with access to mental health programs and referral services on-site at shelters or drop-in centres are recommended. The plan also outlines various priority strategies and actions such as the provision of safe and supportive housing for individuals with severe and persistent mental health problems.[111]
- *Manitoba's Mental Health System*. As part of Manitoba's mental health system, various housing and community living programs are made available to individuals with mental health problems who may be experiencing difficulties living independently. These programs provide participants with a number of housing services, including residential care facilities and supportive housing.[112]
- *Ontario's Mental Health Homelessness Initiative*. Announced in 1999, Ontario's *Mental Health Homelessness Initiative* aimed to ". . . address the housing needs of people with mental illness who were either homeless or at risk of becoming homeless."[113](p. 91) A comprehensive evaluation of the first phase of this initiative determined that housing choice/control and housing quality were related to subjective quality of life.[113]
- *Quebec's Mental Health Action Plan, 2005–2010*. The goal of this action plan is to improve access to quality mental health services for those with mental health disorders and/or those who have a high risk of suicide through the following objectives: action, rehabilitation, accessibility, continuity of services, partnerships and efficiency. Quebec's ministère de la Santé et des Services sociaux is committed to prioritizing access to front-line mental health services and to reducing the stigma that may often be associated with having a mental disorder so that individuals feel comfortable seeking help. The plan will support the provision of quality mental health services to the entire population (for example, youth, adults, communities and Aboriginal Peoples).[114]
- *Newfoundland and Labrador's Framework to Support the Development of a Provincial Mental Health Policy*. As part of this framework, the community resource-based model identifies housing as a key element for supporting the well-being of persons with mental health needs. The framework also aims to incorporate best-practice knowledge in housing and case management services.[115]

Mental Health Promotion Among the Homeless: Housing Programs

Housing is one of various determinants linked to health, well-being and homelessness. CPHI's *Improving the Health of Canadians: An Introduction to Health in Urban Places*[116] highlighted the roles that housing, both as a physical structure and the meaning it holds for individuals, can play in physical and mental health outcomes. It presented evidence of a relationship between the lack of affordable housing and both psychological distress[117] and increased risk of homelessness.[39] Research also shows that securing physical housing resources can be associated with reduced psychological distress among the homeless[118] and play a role in supporting individuals recovering from severe mental illness.[119]

Different types of housing are available to individuals who are homeless and have mental health issues, such as supportive and supported housing. Housing of this nature tends to be small in size and focussed on rehabilitation and community integration.[120] Existing cost-related information also indicates that the costs associated with supportive housing are lower than the costs associated with emergency shelters (see sidebar).[121, 122] Supportive housing includes an element of on-site staff support that varies depending on residents' needs (for example, group homes). Supported housing does not include on-site support staff; it includes elements of recovery and empowerment.[120] Continuum of Care (Treatment First) and Housing First are two models designed to provide housing to the homeless while also addressing existing mental health or mental illness issues.

Continuum of Care Models (Treatment First)

The Continuum of Care model consists of several program components, the first of which is outreach. In this phase, clients are encouraged to accept a referral to a second-step program such as a shelter or drop-in centre. In the next phase, clients are provided with, and required to take part in, any necessary psychiatric or substance abuse treatment. Permanent housing is made available to participants in the final stage, after treatment is completed.[123, 124]

Housing First Models

In 1992, Pathways to Housing (PTH) Inc., a non-profit New York City agency, developed the Housing First model.[108, 123, 124] Housing First programs offer those who are homeless and mentally ill immediate access to housing that is not contingent on sobriety or treatment. Housing First programs tend to promote harm reduction (that is, diminish the harm caused by drinking or drug use) instead of requiring abstinence.[108] They also offer clients a variety of services through interdisciplinary assertive community treatment (ACT) teams, thereby helping to engage those who have not been reached by more traditional approaches.[108, 123, 124]

Effectiveness of Treatment First and Housing First Programs

A number of studies have documented the effectiveness of the Housing First approach in housing retention among individuals who were homeless and mentally ill; evaluations have not typically included evaluation of long-term health outcomes.

- A New York City study found that after a five-year period (1993 to 1997), 88% of participants in the PTH program remained housed compared to 47% of participants in Treatment First programs. This study also found that while dual diagnosis reduced housing tenure among participants in both programs, dually diagnosed participants in the PTH program had a higher housing rate than those in the Treatment First program.[124]
- A recent randomized experiment involving individuals who were homeless and had a diagnosis of severe and persistent mental disorder found the Housing First approach to be more effective than the Treatment First approach in reducing homelessness.[125] Another study found that homeless participants with a major mental illness such as schizophrenia or bipolar disorder who were enrolled in PTH spent more time in stable housing and less time in hospitals than those in Treatment First programs.[126]

Costs Associated With Different Housing Structures for the Homeless

In some Canadian cities, the costs associated with emergency shelters are higher than the costs associated with supportive housing.[121, 122] These findings are consistent with work carried out in the U.S.[127–129] Existing studies indicate that supportive housing is associated with a reduction in the burden on society's emergency and institutional facilities (including jails and hospitals) and results in cost savings.[121, 130] For example, a report prepared for the National Secretariat on Homelessness found a range of estimated costs associated with various housing structures (averaged across Vancouver, Halifax, Toronto and Montréal):

- Existing supportive and transitional housing: $13,000 to $18,000 per year;
- Emergency shelters: $13,000 to $42,000 per year; and
- Institutional care: $66,000 to $120,000 per year.[121]

While this information is telling, it is important to note that cost estimates are often limited by different costing methodologies, different approaches to providing services, clients' differing needs and the lack of information specific to long-term health outcomes.

Mental Health Promotion Among the Homeless: Community Mental Health Programs

As the pathways out of homelessness and into secure housing are not always easily found or immediate, there is value in understanding what strategies are effective at promoting mental health and addressing mental illness among individuals experiencing homelessness. Individuals who are homeless and have a mental illness are often reluctant to engage in some of the more traditional, office-based approaches to providing services.[131] Given this, a number of community mental health programs have been developed.[132] Some provide outreach services, while others provide longer-term services in the form of assertive community treatment (ACT), intensive case management (ICM) or service integration.

Outreach Services

Outreach programs serve as a point of first contact for persons not linked to other models of service. They provide assessment and linking to other longer-term services. For example:

- The Psychiatric Outreach Team of the Royal Ottawa Hospital is a multidisciplinary team comprised of an addiction worker, an occupational therapist, a psychiatric nurse practitioner, a psychiatrist, a psychologist, a recreational therapist and social workers. The team provides psychiatric services to the individual who is homeless or at risk of homelessness, as well as to the partner agency serving the particular individual.[133]
- The Street Outreach and Stabilization (SOS) program of the Canadian Mental Health Association (CMHA) Calgary Region provides individuals who are homeless with help in obtaining mental/health services, financial resources, housing, legal assistance, daily life skills training, transportation training, opportunities for leisure and recreation activities and information about and access to community resources.[134]

Given the nature of outreach services, most evaluations of outreach programs are of a formative and process nature (number of people served, number of referrals or linkages to other longer-term services, etc.) and do not look at long-term health outcomes.

Getcha-nishing Mashkiki Mobile Health Outreach Project[135]
Ottawa, Ont.

Developed in 2000, the Getcha-nishing Mashkiki Project has two goals: to address the health needs of urban Aboriginal People in the Ottawa area experiencing homelessness and to address the underlying contributors to increased risk of homelessness.[135] Objectives of the project are, among others, to stabilize the physical and mental health of Aboriginal Peoples who are homeless; to provide various culture-based addictions interventions; to promote access to various community, health and housing supports; and to facilitate partnerships between agencies who support homeless Aboriginal Peoples. The project reports an approximate cost of $386.00 per client. Highlights from evaluation findings indicate a number of successful outcomes related to mental health and housing, including the following:

- 40% reduced rate of relapse among 221 clients receiving ongoing addictions services;
- 30 clients bridged to permanent housing;
- Increased self-esteem related to cultural identity;
- Enhanced quality of life and spiritual health; and
- Over 900 individual counselling sessions (30% in partnership with mental health).[135]

Assertive Community Treatment (ACT)

ACT teams, typically comprised of psychiatrists, psychologists, social workers, addiction specialists and other professionals, offer intensive case management and support services for individuals with severe and persistent mental health problems. Services are provided on a long-term basis and often right within the client's home community.[136]

Evaluation studies indicate that, compared to those receiving traditional health services, homeless individuals living with a severe and persistent mental illness that were ACT program participants had improved housing and clinical outcomes. They also had greater satisfaction with their general well-being, their neighbourhoods and their health. ACT participants also accumulated fewer psychiatric inpatient hospital days (35 versus 67) and emergency department visits (1 versus 2), as well as more outpatient mental health visits (103 versus 40)—these findings suggested a shift from crisis-oriented services to ongoing outpatient care.[137]

Intensive Case Management (ICM)

ICM is a client-directed form of mental health case management and, like ACT, provides program participants with intensive services and long-term support. Unlike the ACT approach, ICM's services are provided through individual case managers as opposed to a multidisciplinary team.[138, 139]

The Community Mental Health Evaluation Initiative (CMHEI) is a six-year multi-site assessment of community mental health programs in Ontario.[139] As part of this assessment, a clinical trial in Ottawa compared the service use and outcomes of homeless and mentally ill clients receiving ICM to those of clients receiving standard care. Many participants also had other challenges such as concurrent substance abuse.[138, 140] Results showed improvements among clients receiving both ICM and standard care in housing stability and community functioning, as well as decreases in hospitalizations and substance abuse. At the 24-month follow-up, ICM clients showed significantly lower levels of housing instability (10% versus 27%) and fewer hospitalizations (13% versus 32%) than those receiving standard care.[138–140]

Service Integration

Another focus area specific to mental health and homelessness is the integration of various services. In 1993, the U.S. Department of Health and Human Services initiated the 18-site Access to Community Care and Effective Services and Supports (ACCESS) demonstration program as part of a nation-wide agenda to address homelessness among the seriously mentally ill.[141] The goals of the program were twofold—". . . to identify promising approaches to systems integration and to evaluate their effectiveness in providing services to this population."[141] (pp. 369–70) Findings from the ACCESS demonstration program are presented in many published reports. One study found no differences in mental health status and achievement of independent housing between experimental and control-group clients. However, it did find a positive association among participants enrolled in systems that became more integrated with better housing outcomes.[142]

Triage Centre[143, 144]
Vancouver, B.C.

Vancouver's Triage Centre is an example of a Canadian initiative that provides a variety of services for adults with mental illness, including an emergency shelter, outreach services, low-rent housing (in partnership with other non-profit organizations) and supportive housing.

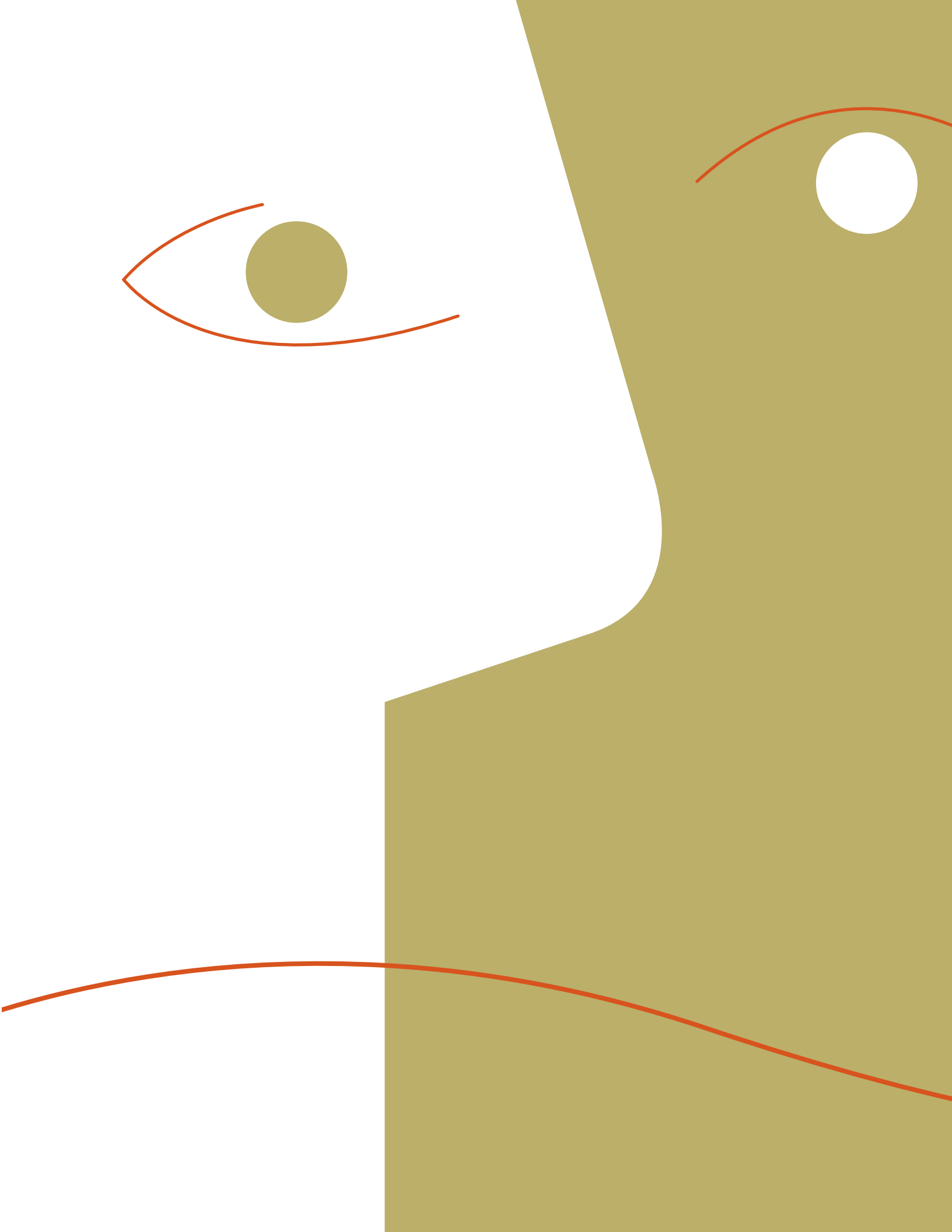
- Its Princess Rooms transitional housing program is a 47-unit rooming house that aims to increase the amount of transitional housing available for homeless and hard-to-serve men and women. During their stay, residents are encouraged to take advantage of services in the community, such as those to help them deal with their addiction and those that provide pre-employment training, with the goal of reintegration into the community.
- Its Triage Outreach Program integrates outreach with help in finding housing. Evaluation outcomes indicate improvements in the quality of accommodation for 76% of outreach clients; a 64% decrease in admissions to emergency shelters (monthly average of 10.87 to 4.00); and increased overall stability as measured by level of crisis work being done, level of substance use, anxiety, suicide and level of emergency service use.

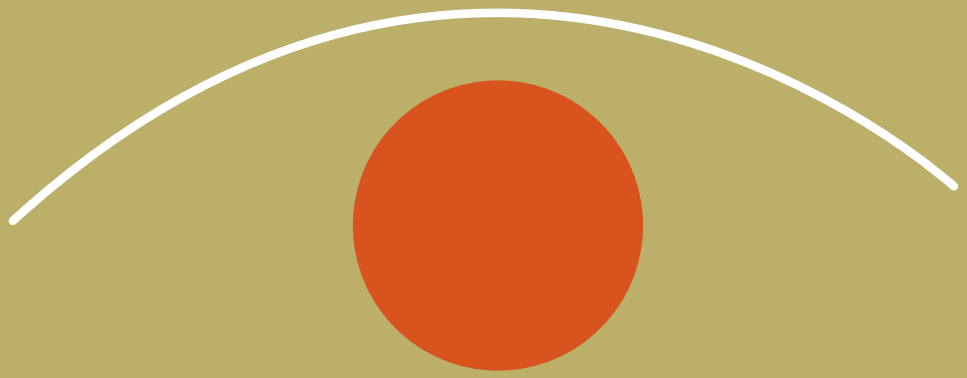
Mental Health Promotion Among the Homeless: A Population Health Approach

Mental health promotion "empowers people and communities to interact with their environment in ways that enhance emotional and spiritual strength."[3](p. 21) It does this through various strategies, including those to increase self-esteem, coping skills, social support and well-being.[3] Mental health promotion strategies, combined with specific treatment for a mental illness, can empower people to achieve well-being, develop healthy relationships and maintain a form of housing and employment.[145]

The various housing and community mental health programs highlighted in this section incorporate elements of mental health promotion in their services for individuals experiencing or at risk of homelessness. The links between the determinants of mental health and the determinants of homelessness are interrelated and numerous. They indicate that there is a role for continued discussion and action to promote mental health among this population. Many strategies to achieve this are related to the population health approach:

- "Focusing on the needs of the population as a whole as well as sub-populations with particular needs;
- Addressing the determinants of mental health and their interactions;
- Basing decisions on evidence of need and the effectiveness of interventions;
- Increasing investments on the social and economic determinants of health;
- Applying multiple strategies in multiple settings and sectors;
- Collaborating across sectors and levels of government;
- Employing mechanisms for meaningful public involvement; and
- Demonstrating accountability for health outcomes."[3](p. 21)





Mental Health and Homelessness

Conclusions

Homelessness is a harsh reality affecting over 10,000 people on any given night in Canada. Some groups, such as Canada's Aboriginal Peoples, are over-represented among the homeless in cities across the country. However, homelessness is not confined to only one group. It can affect all segments of society, including youth, men and women, one- and two-parent families, immigrants and the elderly.

The goal of *Improving the Health of Canadians: Mental Health and Homelessness* is to provide an overview of research, data, interventions and policy-related information specific to mental health and homelessness. Information in this report shows that the pathways linking mental health and homelessness are numerous and interrelated.

- For some individuals, the pathways into homelessness may be more upstream in nature, reflecting issues such as housing, income level or employment status. For others, the pathways may be more personal or individual in nature, reflecting issues such as mental health and well-being, mental illness and substance abuse. Many of these personal and upstream issues are linked to each other.
- Some studies also suggest that the homeless are at higher risk for compromised mental health and mental illness. Other research has found that those with compromised mental health or mental illness are more likely to become homeless.

Understanding the link between mental health and homelessness requires consideration of both individual-level factors and the broader social determinants of health. With this understanding, there is a greater opportunity for interventions and policies to address homelessness and the mental health and mental illness issues affecting the homeless.

Compared to the general population, research indicates that mental illness, addictions and suicidal behaviours are more common among the homeless. Increasingly, researchers are looking at homelessness with more of a focus on mental health and well-being, rather than just a focus on the presence of mental illness. Research indicates a tendency for low perceived self-worth and low social support among the homeless, both of which are determinants of mental health. It also indicates a tendency for coping strategies in which there is a distancing from a stressor as opposed to active problem-solving.

The cross-sectional nature of many of these studies makes it difficult to identify causal pathways. Further, many of these mental health–related factors can be seen as having an individual focus. Despite this, findings indicate there may be value in clinical, outreach and research programs that target specific issues such as coping skills, self-worth and social support along with interventions and policies that target mental illness, addictions and the other determinants of homelessness such as housing, income and employment.

This report also examines the programs and policies specific to mental health and homelessness. Given that there are many factors that affect both mental health and homelessness, we focussed on two types of initiatives: housing and community mental health programs. Our scans found relatively few outcome evaluations. That said, evidence suggests that some housing programs, specifically those with a Housing First approach, are effective at helping the homeless achieve stable housing. Research also suggests there are community-based mental health programs that, through various strategies, provide support to homeless persons with a mental illness. Evidence indicates that some programs are effective at helping homeless individuals achieve stable housing, obtain greater satisfaction with their overall well-being and require fewer crisis-oriented services (such as hospitalizations and emergency department visits).

Given the availability of information and efforts to stay within the scope of this report, there were a number of specific areas that we were unable to address. For instance:

- Further research is needed to determine if positive traits such as resiliency, hardiness, optimism and adaptability can serve as protective factors against the negative mental health outcomes often associated with homelessness.

- Because of the availability of data and research, information presented in this report was primarily specific to homeless youth and single adult males. The report did not look specifically at the following subgroups: one-parent families, children of homeless families, single adult females, women and children in shelters for domestic violence, Aboriginal Peoples, gay/lesbian/transgender youth, immigrants, war veterans and seniors. It is important to identify the prevalence of these groups within the homeless population, as well as their mental health issues and needs.
- The report provided an overview of specific mental illnesses and addictions, but did not delve into these issues in detail. For example, it did not look at age or sex differences in the onset of mental illness, or the impact of the length of homelessness on specific mental health and mental illness issues. It also did not look at other issues such as tobacco as a co-addiction, the impact of developmental disabilities as a concurrent diagnosis with mental illness and the prevalence of fetal alcohol syndrome disorder (FASD) among the homeless, to name a few.

The information in this report indicates that there is a role for everyone across all levels of government and sectors, both within and outside of health, to play in understanding and addressing the link between mental health and homelessness in Canada. Key messages from the report and information gaps remaining in the literature are noted in the pages that follow.

Key Messages and Information Gaps

What do we know?

- Homelessness affects over 10,000 Canadians on any given night, with some groups, such as Canada's Aboriginal Peoples, being over-represented in homeless populations across the country.
- There is great diversity within the homeless population in terms of age, sex, ethnicity, mental health status, mental illness and use of health services.
- The individual and upstream determinants of mental health and homelessness are numerous and interrelated.
- Compromised mental health and mental illness can be a risk for, and outcome of, homelessness.
- Comparability between studies and cities is limited because of variability in definitions of homelessness, methods used to estimate the prevalence of homelessness and methods used to measure the status of mental health and mental illness among the homeless.
- Studies show there is a link between high levels of stress, coping styles and strategies, low perceived self-esteem and low social support with suicidal behaviours, mental illness and substance abuse among the homeless.
- Evidence indicates that Housing First approaches and various community mental health programs (for example, Assertive Community Treatment) can be effective in improving the housing and health outcomes of homeless individuals with mental illness.
- Recently, there has been a trend towards including more aspects of mental health promotion in programs targeting the homeless and individuals with mental illness.
- Existing programs are typically only able to serve a small number of the homeless at a given time, despite large numbers of homeless persons across Canada.

What do we still need to know?

- What is the exact prevalence of homelessness across Canada in the absence of standardized means by which to count Canada's homeless?
- What is the exact prevalence of compromised mental health and mental illness among Canada's homeless population, given variability in the measurement of these issues?
- What are the causal mechanisms underlying the links between mental health, mental illness and homelessness?
- What is the role of such traits as optimism, adaptability and resiliency in protecting against the risk factors for and negative mental health outcomes associated with homelessness?
- What are the causal mechanisms underlying the links between the broader determinants of health and mental health among the homeless?
- Are some mental health issues and subgroups of the homeless population the focus of more study than others? What is the extent of variation in the mental health needs of different subgroups within the homeless population?
- Are the research findings obtained from studies involving homeless youth generalizable to homeless adult populations?
- Are the research findings from U.S. studies generalizable to Canada's homeless population?
- What are the costs of homelessness in terms of quality of life measures?
- What are the total costs (direct and indirect) associated with homelessness to Canada's health system?
- What role does modern-day deinstitutionalization play in providing mental health services to the homeless?
- What interventions to address mental health among the homeless have not worked and why?
- Are different interventions needed, or are some interventions more effective than others at addressing the needs of homeless individuals with one or more diagnosed conditions?
- Do community mental health programs differ in their effectiveness in improving specific mental health outcomes (such as self-esteem) among homeless individuals with and without a mental illness?
- Are community mental health and housing programs equally effective in improving mental health and housing outcomes among specific subsets of the homeless population (for example, youth and Aboriginal Peoples)?

What CPHI Research Is Happening in the Area?

CPHI has funded and commissioned a number of research projects and products related to mental health, including those listed below.

CPHI-Funded Research Projects and Programs

- *How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants* (Public Health Agency of Canada, Laurentian University)
- Material and Social Inequalities in the Montréal Metropolitan Area: Association with Physical and Mental Health Outcomes (M. Zunzunegui, Université de Montréal)
- Children's Mental Health: Preventing Disorders and Promoting Population Health in Canada (C. Waddell, University of British Columbia)
- The Effects of Special Education Interventions on the Academic and Mental Health Outcomes of Children (K. Bennett, McMaster University)
- Mental and Physical Health of Quebec Adolescents in Youth Centres: A Case-Control Study (J. Toupin, Université de Sherbrooke)
- Vulnerable Youth: A Study of Obesity, Poor Mental Health, and Risky Behaviours Among Adolescents in Canada (D. Willms, University of British Columbia)
- Relations Between Social Support, Mental Health and Quality of Life Components Among the Socio-Economically Disadvantaged (J. Caron, Douglas Hospital Research Centre, Montréal)
- *Women's Health Surveillance Report: A Multidimensional Look at the Health of Canadian Women* (M. Desmeules, Public Health Agency of Canada)
- Immigrants, Selectivity and Mental Health (Z. Wu, University of Victoria)

Other Complementary Products

- Collection of Papers: "What Makes a Community Mentally Healthy?"
- Mental Health and Homelessness—supporting documents that will be available on CPHI's website:
  - Annotated bibliography
  - Literature search methodology
  - Data and analysis methodology
  - Policy scanning methodology

For More Information

CPHI's *Improving the Health of Canadians* reports aim to synthesize key research findings on a given theme, present new data analysis on an issue and share evidence on what we know and what we do not know about what works from a policy and program perspective. The underlying goal of each *Improving the Health of Canadians* report is to tell a story that will be of interest to policy- and decision-makers in order to advance thinking and action on population health in Canada.

Improving the Health of Canadians 2004 (IHC 2004)[146] was CPHI's first flagship report. The report was organized into four key chapters: Income, Early Childhood Development, Aboriginal Peoples' Health and Obesity.

After the release of IHC 2004, a decision was made to produce and disseminate the second report, *Improving the Health of Canadians 2005–2006*, as a report series reflecting CPHI's strategic themes for 2004 to 2007: *healthy transitions to adulthood, healthy weights* and *place and health.*

- The first report in the series, *Improving the Health of Young Canadians* (released in October 2005) explored the association between positive ties with families, schools, peers and communities and the health behaviours and outcomes of Canadian youth aged 12 to 19 years old.[147]
- The second report in the series, *Improving the Health of Canadians: Promoting Healthy Weights* (released in February 2006) looked at how features in the environments in which we live, learn, work and play make it easier—or harder—for us as Canadians to make healthier choices about what we eat and how physically active we are.[148]
- The final report in the series, *Improving the Health of Canadians: An Introduction to Health in Urban Places* (released in November 2006) focused on the link between the health of Canadians in urban settings and how various social and physical aspects of urban places influence the daily lives and health of people who live in them.[116]

CPHI's strategic themes for 2007 to 2010 include *mental health and resilience, place and health, reducing gaps in health* and *promoting healthy weights*.[4] *Improving the Health of Canadians 2007–2008* will be comprised of three reports that look at mental health from a population health approach.

Improving the Health of Canadians: Mental Health and Homelessness is available in both official languages on the CIHI website, at www.cihi.ca/cphi. To order additional copies of the report, please contact:

Canadian Institute for Health Information
Order Desk
495 Richmond Road, Suite 600
Ottawa, ON K2A 4H6
Phone: 613-241-7860
Fax: 613-241-8120

We welcome comments and suggestions about this report and about how to make future reports more useful and informative. For your convenience, a feedback sheet ("It's Your Turn") is provided at the end of the report. You can also email your comments to cphi@cihi.ca.

There's More on the Web!

What you see in the print version of this report is only part of what you can find on our website. Please stop by www.cihi.ca/cphi for additional information and a full list of available CPHI reports, newsletters and other products.

- Download a presentation of the highlights of *Improving the Health of Canadians: Mental Health and Homelessness.*
- Sign up to receive updates and information through CPHI's e-newsletter, *Health of the Nation*.
- Learn about previous *Improving the Health of Canadians* reports.
- Learn about upcoming CPHI events.
- Download copies of other CPHI reports published by CIHI.

CPHI Reports Previously Published by CIHI

Name of Report	Author and Publication Date
Place and Health	
• *Improving the Health of Canadians: An Introduction to Health in Urban Places*	CIHI (November 2006)
• *How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants*	CIHI, Public Health Agency of Canada and Laurentian University (September 2006)
• *Kachimaa Mawiin—Maybe for Sure: Finding a Place for Place in Health Research and Policy*	CIHI (October 2005)
• *Developing a Healthy Community Index: A Collection of Papers*	CIHI (February 2005)
• *Housing and Population Health*	Brent Moloughney (June 2004)
• *Prairie Regional Workshop on the Determinants of Healthy Communities*	CIHI (August 2003)
• *CPHI Workshop on Place and Health Synthesis Report (Banff)*	CIHI (June 2003)
Promoting Healthy Weights	
• *Improving the Health of Canadians: Promoting Healthy Weights*	CIHI (February 2006)
• *Socio-Demographic and Lifestyle Correlates of Obesity—Technical Report on the Secondary Analyses Using the 2000–2001 Canadian Community Health Survey*	Cora L. Craig, Christine Cameron and Adrian Bauman (August 2005)
• *Overweight and Obesity in Canada: A Population Health Perspective*	Kim D. Raine (August 2004)
• *Improving the Health of Canadians—Obesity Chapter*	CIHI (February 2004)
• *Obesity in Canada—Identifying Policy Priorities*	CIHI and the Canadian Institutes of Health Research (CIHR) (June 2003)
Reducing Gaps in Health	
• *What Have We Learned Studying Income Inequality and Population Health?*	Nancy Ross (December 2004)
• *Improving the Health of Canadians—Income Chapter*	CIHI (February 2004)
• *Poverty and Health CPHI Collected Papers*	CIHI, Shelley Phipps and David Ross (September 2003)

continued

CPHI Reports Previously Published by CIHI

Name of Report	Author and Publication Date
Healthy Transitions into Adulthood	
• *From Patches to a Quilt: Piecing Together a Place for Youth*	CIHI (September 2006)
• *Improving the Health of Young Canadians*	CIHI (October 2005)
• *You say 'to-may-to(e)' and I say 'to-mah-to(e)'": Bridging the Communication Gap Between Researchers and Policy-Makers*	CIHI (September 2004)
• *CPHI Regional Workshop—Atlantic Proceedings (Fredericton)*	CIHI (July 2003)
Early Childhood Development	
• *Early Development in Vancouver: Report of the Community Asset Mapping Project (CAMP)*	Clyde Hertzman et al. (March 2004)
• *Improving the Health of Canadians—Early Childhood Development Chapter*	CIHI (February 2004)
Aboriginal Peoples' Health	
• *Improving the Health of Canadians—Aboriginal Peoples' Health Chapter*	CIHI (February 2004)
• *Measuring Social Capital: A Guide for First Nations Communities*	Javier Mignone (December 2003)
• *Initial Directions: Proceedings of a Meeting on Aboriginal Peoples' Health*	CIHI (June 2003)
• *Urban Aboriginal Communities: Proceedings of a Roundtable Meeting on the Health of Urban Aboriginal People*	CIHI (March 2003)
• *Broadening the Lens: Proceedings of a Roundtable on Aboriginal People's Health*	CIHI (January 2003)
Cross-Cutting Issues and Tools	
• *Moving Population and Public Health Knowledge Into Action: A Casebook of Knowledge Translation Stories*	CIHI and CIHR (February 2006)
• *Select Highlights on the Public Views of the Determinants of Health*	CIHI (February 2005)
• *Women's Health Surveillance Report: Supplementary Chapters*	CIHI and Health Canada (October 2004)
• *Charting the Course, Progress Report: Two Years Later: How Are We Doing?*	CIHI and CIHR (February 2004)
• *Women's Health Surveillance Report: A Multidimensional Look at the Health of Canadian Women*	CIHI and Health Canada (October 2003)
• *Barriers to Accessing and Analyzing Health Information in Canada*	George Kephart (November 2002)
• *Tools for Knowledge Exchange: Best Practices for Policy Research*	CIHI (October 2002)
• *Charting the Course: A Pan-Canadian Consultation on Population and Public Health Priorities*	CIHI and CIHR (May 2002)
• *Health of the Nation—e-Newsletter*	CIHI (Quarterly)
• *Partnership Meeting Report*	CIHI (March 2002)
• *An Environmental Scan of Research Transfer Strategies*	CIHI (February 2001)

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6. What did you find most useful about this report?

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7. How would you improve this report? Do you have any suggestions for future reports?

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Reader Information

8. Where do you live?

- ❑ Newfoundland and Labrador
- ❑ Nova Scotia
- ❑ New Brunswick
- ❑ Prince Edward Island
- ❑ Quebec
- ❑ Ontario
- ❑ Manitoba
- ❑ Saskatchewan
- ❑ Alberta
- ❑ British Columbia
- ❑ Northwest Territories
- ❑ Yukon Territory
- ❑ Nunavut
- ❑ Outside Canada (please specify country)_____

9. What is your main position or role?

- ❑ Health manager or administrator
- ❑ Researcher
- ❑ Policy analyst
- ❑ Board member
- ❑ Elected official
- ❑ Health provider
- ❑ Student/youth
- ❑ Educator
- ❑ Mental health provider
- ❑ Other, please specify_____

Thank you for completing and returning this questionnaire.

This publication is part of CPHI's ongoing inquiry into the patterns of health across this country. Consistent with our broader findings, it reflects the extent to which the health of Canadians is socially determined, interconnected, complex and changing. CPHI is committed to deepening our understanding of these patterns.

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