Homelessness and Mental Health: Psycho-social Factors Relating to Homelessness in Canada

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Housing is a basic human right and it has strong links with economic, social and cultural aspects of human life. Housing is essential for human survival with dignity. Housing allow people to have privacy, family life, assembly and association. An adequate shelter is   the base for human relationships, the free development of the individual and for the playing of an active role in the social and cultural life of the community (Springer, 2000).

The human right to housing has been universally identified by the United Nations (UN). Article 25 of the Universal Declaration of Human Rights that was adopted and proclaimed by the General Assembly of the United Nations in 1948   recognizes the right to housing as a part of the right to an adequate standard of living. According to Article 25   everyone has the right to a standard of living adequate for the health and well-being of him or herself and of family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Housing has become a global problem and there are millions of people living without adequate housing today. In Canada housing trends and conditions changed over the past few decades and economically and socially disadvantaged layers of the Canadian society are experiencing the harsh reality of homelessness.

Canada is one of the few countries in the world without a national housing strategy (United Nations, 2009). Surveys and statistics over the past three decades have repeatedly shown that the numbers of homeless people in Canada have been steadily increasing. The problem of homelessness in Canada has grown in complexity in recent years creating a massive social problem. In 2006 the United Nations Committee on Economic, Social and Cultural Rights   (UNCESCR) urged the Canadian governments to address homelessness and inadequate housing as a national emergency.

The Federation of Canadian Municipalities the Big City Mayors' Caucus (BCMC) in 1998 declared homelessness in Canada a "national disaster". The United Nations Special Rapporteur on adequate housing Mr. Miloon Kothari described the situation in Canada as a "national crisis" (Mental Health Commission of Canada, Annual Report 2008-2009).

The historical roots of homelessness in Canada are strongly linked to urbanization and deinstitutionalization. Homelessness continues to be a serious public health problem in North America and it could be viewed as one of the aftermaths of unplanned de- institutionalization. The problems associated with homelessness had been identified since 1960s. Addressing the Ontario Association of Housing Authorities in 1965, the former Canadian Prime Minister Lester Pearson emphasized on the necessity of providing affordable housing for the low income groups. Over the years homelessness crisis in Canada has become a huge social problem spreading to major cities.

Many researchers agree that homelessness is a dynamic process that is characterized by continuous change. Furthermore, Peressini & McDonald (2000) view homelessness not as a finite or static process but a fluid and dynamic one characterized by multiple transitions role exits and role entries.

Homelessness is a multi-dimensional problem and a rapidly growing social malady that contributes to create a precarious subculture of homeless. Although some view homelessness   as a reflection of the organization and distribution of society's resources, homelessness is often the result of multiple circumstances. Homeless people are an economically and socially disadvantaged group trapped in a vicious cycle. The homeless population experience significant adversity in their lives. Their psychosocial wellbeing is intensely compromised. As Anucha (2005) elaborates homelessness has become a major social and political problem in North America over the past two decades.

The definitions of homelessness

There are several definitions that describe the social condition which is known as homelessness. In global terms homelessness has a huge variation from street or shanty town dwellers in developing countries, to those in sub optimal housing conditions in Western countries (Williams, 2010). Casavant (1999) argues that the definition of homelessness is at the centre of some major policy considerations.

The United Nations declared 1987 as the International year of Shelter for the homeless and introduced two definitions of homelessness. According to the United Nations, *"absolute homelessness"* describes the condition of people without physical shelter who sleep outdoors in vehicles, abandoned buildings or other places not intended for human habitation. *"Relative homelessness"* describes the condition of those who have a physical shelter, but one that does not meet basic standards of health and safety. It is alternately defined as a "condition and social category of people without a regular house or dwelling because they cannot afford or are otherwise unable to maintain regular, safe and adequate housing or fixed, regular and adequate night time residence " (United Nations).

In 2004, the United Nations, Department of Economic and Social Affairs, defined a homeless household thus.

"Homeless households are those households without a shelter that would fall within the scope of living quarters. They carry their few possessions with them, sleeping in the streets, in doorways or on piers, or in another space, on a more or less random basis"(United Nations Demographic Yearbook Review ,2004).

The legal definition of homelessness varies from country to country. Some research agencies define homelessness considering regional socio-economical parameters. The Canadian Homelessness Research Network gives the Canadian Definition of Homelessness as follows.

 "Homelessness describes the situation of an individual or family without stable permanent, appropriate housing or the immediate prospect means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual /household's financial, mental, cognitive, behavioral or physical, challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is, generally negative, unpleasant, stressful and distressing" (Canadian Homelessness Research Network, 2012).

In addition there are provincial definitions of homelessness. For example in Alberta- the City of Calgary Community and Neighborhood Services defines homeless as "those who do not have a permanent residence to which they can return whenever they so choose"

Despite various definitions and elucidations many experts believe that most of the definitions do not capture the factual nature of homelessness. Some homeless individuals who do not meet the legal definition of homelessness often live temporarily with relatives, friends, neighbors or strangers. Although this population is inadequately housed they do not seek housing support services and   do not show up in statistics.

Housing as a Social Determinant of Health

Housing has been identified as a strong social determinant of health. Many studies concur that there is a direct inter-relationship between health, and housing. According to the World Health Organization (WHO) improvements in mental health and, general health are achieved when housing environments are improved and vice versa (WHO, 1986).

 As described by the WHO the social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Social determinants of health are the economic and social conditions that have a strong impact on mental and physical health. The WHO defines health as a state of complete physical mental and social well-being and not

merely the absence of disease or infirmity. Concepts of mental health include subjective well-being perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities to cope with the normal stresses of life work productively and fruitfully and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling, them to achieve their self-determined goals (WHO, 2003).

Housing is not only a basic human right but also a health promoter. The epidemiological findings suggest strong associations between housing conditions and health effects (Bonnefoy, 2007). The socio –economic conditions in which people live have a dramatic impact on their health, functionality and wellbeing. Evans et al. (2003) have shown that review of 27 studies suggests that overall housing quality is positively correlated with psychological wellbeing.

One of the primary functions of housing is to provide a shelter from outside aggression. Beyond that function however a dwelling is defined as a holding space, a physical and psychological envelope within which intimacy will appear and develop and where each and every individual will find an opportunity to be himself or herself. Thus, what was just a house will become a home. Integrity of body and mind are dependent upon this possibility of living in intimacy (Bonnefoy 2007).

Research has examined the specific health effects of housing conditions. Stable housing in safe and supportive neighborhoods enhances psychosocial wellbeing. Poor housing conditions and overcrowding could impact physical and mental health (Bryant, 2008). Under these situations people face difficulties regarding privacy, personal hygiene, sanitation, rest and recuperation. Representing the spatial point of reference for each individual the home also has a broad influence on the psychosocial and mental well-being by providing the basis for place attachment and identity as well as a last refuge from daily life (Bonnefoy, 2007).

According to the housing statistics in Canada a large number of people live in deplorable housing conditions or face the dilemma of homelessness. Research has shown that Canada has one of the most private-sector dominated market-based housing systems of any western, industrialized nation (Freeman, Holmans & Whitehead, 1996). It also has, the smallest social housing sector among western nations with the, exception of the United States (Hulchanski, 2002). People are compelled to spend a large percentage of a household's income on rent and it prevents families from healthy eating investment in education and recreational activities. These adverse housing situations have affected the vulnerable populations at an extreme level.

Homelessness: Risk Factors
There are a number of risk factors associated with homelessness. A combination of economic, physical, psychological and social factors contribute to homelessness. Main (1988) views homelessness as an interaction between individual characteristics and social factors. Homelessness is a problem particularly for vulnerable groups such as low income families, victims of violence, people with mental ailments, addictions and new immigrants. Generally households that spend more than 50% of total, income on housing costs are considered at risk of homelessness.

Susser , Moore & Link (1993) indicate that adverse childhood experiences play a crucial role in risk of homelessness. Analyzing a Toronto based study Novac (2007) specifies the adverse childhood experiences especially childhood abuse could be a risk factor for homelessness. Numerous research studies support the strong links between adverse childhood experiences and adult homelessness. Herman et al. (1997) found that lack of care and physical or sexual abuse from a parent during childhood sharply increased the likelihood of subsequent homelessness.

Structural causes such as poverty, unemployment and inadequate supply of affordable housing have been identified as powerful risk factors for homelessness and the current recession in Canada has created an economically disadvantaged situation for risk groups.

Furthermore, fiscal, social and public policy and legislation   (taxation policy and expenditure on public and

community housing, health, care, education and vocational training) have strong links   with homelessness. The economic decline, decrease in the employment rate and cuts in welfare benefits have driven thousands of families and children into poverty. The socioeconomic consequences following these circumstances will remain in society for long years.

The risk of homelessness could be collective as well as individual.   A large body of research indicates that psychiatric ailments are dominant risk factor for adult homelessness. Severe mental disorders such as psychotic illnesses are a risk factor, rather than a consequence of homelessness (Herrman & Neil,1996).

Addictions can also be a risk factor for homelessness for some people. People with addictions may experience limited housing, employment, and income options. Many research studies indicate that rates of substance use are disproportionately high among the homeless population. For example Grinman et al. (2010) found that the prevalence of drug use was found to be very high among homeless individuals in Toronto compared to rates previously reported for the general population.

The new immigrants face a great risk finding affordable housing in Canada. Many experience housing problems upon their arrival to Canada. Preston et al. (2009) describe the results of a pilot study that was conducted in York Region indicating that homelessness is a real risk for immigrant families living in suburbs such as York Region. Many immigrant families living in other regions and cities in Canada face similar problems.

Various studies have confirmed that new immigrants and refugees in Canada are at-risk for homelessness. The reports indicate that increasing numbers of new immigrants and refugees are using shelter and other social services. Although there are many significant differences between immigrants and refugees (refugees escape from an armed conflict or political persecution and they do not choose to become refugees, but the migrants choose to leave and settle in a country of their choice) both groups face numerous challenges and obstacles when they come to Canada.

Among the challenges language barriers, lack of recognition of foreign work experience and academic credentials and discrimination play a critical role.   These hindrances have a significant impact on housing.   A study on housing discrimination in Canada Novac et al. (2002) indicated that racial discrimination constitutes a significant barrier to integration for immigrants in Toronto and surrounding areas.

Hannat (2004) found that about 20% of immigrant households are struggling with core housing needs and that this rate rises to 39% for recent, immigrants which are more than double that of non-immigrants.

Despite being more highly educated and skilled than previous cohorts today's newcomers have not fared as well as their predecessors in terms of employment and earnings. They are more likely to live in poverty and to depend on social services. Their settlement is undermined by a web of interconnected legal and policy barriers that hamper their access to employment and vital services. The poor outcomes experienced by many recent newcomers are reflected in their housing situations. According to 2001 census data, 36% of recent immigrant households were living in unacceptable housing conditions (called "core housing need") as defined by Canada Mortgage, and Housing Corporation compared to 13.7% for non-immigrant households (Wayland, 2007).

Canada Homeless Statistics
Homelessness is particularly problematic to measure when there is no clearly defined and universally accepted definition. There are many difficulties to enumerate homelessness in Canada due to practical problems. Many surveyors find it difficult to interview or conduct a census among a group of people who have no fixed addresses and who are also apprehensive to interact with others. Stephen W. Hwang, Associate Professor- Department of Medicine, University of Toronto (personal communication, 2013) points out that there are accurate statistics for a number of cities in Canada which have done censuses of homeless people. However, these counts are done using different methods and are not done in every city. Therefore it is not possible to add them up to get an estimate.

The headcount of people defined as homeless remains the commonest approach to measurement. Homeless people constitute a rare and elusive population, but additionally counting the numbers homeless is made more difficult as a result of the absence of agreed definitions across time and place of what constitutes homelessness (Williams,

2010).

Although accurate statistics on the homeless population are hard to collect some government agencies and Non-governmental organizations have gathered data on homeless people dwelling in various major Canadian cities. Statistics Canada estimates that more than 10,000 people in Canada are homeless on any given night (Statistics Canada, 2001). Some experts believe that Canada's true homeless population ranges between 200,000 and 300,000 (National Housing and, Homeless Network, 2007). Scott (2007) estimates that homeless population in Canada varied between 150,000 to 300,000. According to the State of Homelessness in Canada: 2013 report nearly 200,000 Canadians experience homelessness each year, with as many as 1.3 million experiencing homelessness in the last five years (Gaetz, et al., 2013).

Statistics reveal that the homeless population in Canada is increasing annually in larger numbers. Homeless is sweeping across major cities in Canada. Homelessness has reached unprecedented levels in Vancouver. According to the Mental Health Commission of Canada the homeless population in Vancouver grew by 235% from 1994 to 2006 (Mental Health Commission of Canada - Annual Report 2008-2009). In addition this report revealed that almost a third of Canada's homeless are youths aged 16-24.

The total number of homeless people found in the Metro Vancouver region was 2,650 in 2011 (Metro Vancouver Homeless Count, 2011). This count included people found homeless in the Metro Vancouver region and staying in emergency shelters and accessing other human services. The actual number could even be significantly higher.

According to the 2001 census the city of Toronto had 2.6 million residents. Reports on Toronto Shelter Support and Housing in 2006 more than 30,000 women, men and children seek refuge in city's homeless shelters annually. According to the Statistics Canada (2001 Census) there were 150,000 households paying more than half their income on shelter and on the brink of homelessness. The 2004 Toronto Report Card on Homelessness reports an estimated 32,000 persons in the GTA are homeless. The Toronto Homeless Memorial (located outside the downtown Church of the Holy Trinity next to the Eaton Centre) recorded 34 deaths of people without homes in 2012.

2011 statistics from The Alliance to End Homelessness Ottawa indicate that in Ottawa, 7,299 individuals accessed shelters. This figure included 3223 men, 1,087 women, 401 youth, and 841 families. (The Alliance to End Homelessness Ottawa, 2012).

The social service agencies of Winnipeg report that there is a marked increase of homeless people in Winnipeg. The City of Winnipeg is made up of approximately 633,451 people. It is estimated that there are about 135,000 people at risk of becoming homeless. The City of Winnipeg has the largest Aboriginal identity population of all Canadian cities and there are disproportionately high numbers of Aboriginal people represented in Winnipeg's homeless population. While 8.4% of the population of Winnipeg identified themselves as Aboriginal in 2001, estimates suggest that 60 - 70 % of the homeless population in Winnipeg was Aboriginal (The University of Winnipeg-Homeless Facts, Homelessness in Winnipeg).

In 2011, the city of Montreal had a population of 1,649,519 people (Statistics Canada. 2012). Many social service agencies in Montreal report that there are a large number of people in the city with no fixed address. According to the Réseau d'aide aux personnes seules et itinérantes de Montréal (RAPSIM) the homelessness problem in Montreal amounts to 25,000 to 30,000 people
(Réseau d'aide aux personnes seules et itinérantes de Montréal).

The statistics of 2012 Edmonton Homeless Count that was organized by Homeward Trust under the direction of the Homeless Count Committee found 2,174 homeless individuals in Edmonton. 46% of those counted were observed to be of Aboriginal Ethnicity (Edmonton, Homeless Count, 2012).

According to Calgary's last homeless count in May 2006, 3,436 men women and children were counted as homeless a 32 per cent increase over the last count. The numbers have been increasing an average of 35 per cent every two years since 1994. If this trend holds the City of Calgary estimates that there will be more than 15,000 people homeless on any given night in Calgary by 2016 (Calgary's, 10 Year Plan to, End Homelessness).

The Saskatoon Housing and Homelessness Plan (2011-2014) indicate that the housing prices have risen in Saskatoon and affordability has decreased. Between 2007 and 2008, Saskatoon's housing prices increased by 51.7%, the largest increase in the country. These economic changes affected a large number of people with low income. In Saskatoon, there are indications that homeless individuals tend not to occupy the types of visible public areas as is the case in municipalities such as Vancouver and Toronto. Saskatoon does not have the public transit infrastructure (e.g. subway or light rail transit) found in larger municipalities where homeless individuals might stay to shelter from the elements. Thus it is expected that fewer individuals are outdoors relative to some of the larger Canadian cities (The Saskatoon Housing and Homelessness Plan 2011-2014).

The 2008 Homeless Count estimated that 260 people (228 adults and 32 children) in Saskatoon were homeless. (The Saskatoon Housing and Homelessness Plan 2011-2014).

In 2012 the Halifax Report Card on Homelessness   indicates the number of homeless people has risen sharply. The number of individuals who stayed in a shelter increased 14.8 per cent from 2009 to 2011(Halifax Report Card on Homelessness, 2012).

Family Homelessness

According to Statistics Canada (2008), in 2006 approximately 3.4 million Canadians (10.5%) were living in low-income households. In cities across Canada, there are a growing number of families with children who face the dismal problem of homelessness. Social service agencies have identified numerous   reasons for family homelessness and problems such as growing poverty, unemployment, lack of affordable housing, lack of welfare programs, breakdown in family support structures, family violence, addiction issues etc. play a critical role. Some view family homelessness as a consequence of poor economic conditions and insufficient social welfare support rather than personal deficits.

Many agencies define homeless family as a family with at least one parent or a legal, guardian and one or more children under the age of 18. Family homelessness is spreading throughout Canadian society following systemic and structural issues and individual family circumstances. Family homelessness has become an acute but an under studied problem in major cities in Canada.

Becoming homelessness is an overwhelming experience for families. It disarrays family functioning, family life and is an extremely traumatic episode for the family members. Bassuk et al. (1996) indicate that majority of homeless families are headed by single-parent females and homeless mothers experienced more residential instability than the housed mothers. When families become homeless, children are at great risk. It has a long lasting damaging impact on children. These negative life experiences disrupt their emotional wellbeing, education and development. Moreover, these deprived childhood experiences could affect their adulthood. DiBiase et al. (1995) found that homeless preschoolers have lower self-concepts and display more deviant behaviors on the Child Behavior Checklist than housed preschoolers of the same socioeconomic status.

Youth Homelessness

Homeless young people have been defined as those between 12 and 24 years of age who have spent at least one night on the streets, in a public place (e.g., parks, under highway overpasses, abandoned buildings), or in a shelter (Thompson , Safyer & Pollio, 2001). Youth homelessness has become one of the acute social problems in Canada and some agencies estimate that a large number of youth living in streets, shelters, with friends and various other places that are not suitable for human habitation.

On most occasions these youth did not select to live on the streets and many unavoidable circumstances forced them to become homeless. Among these circumstances poverty, family breakups, physical and emotional abuse, unemployment, substance abuse, mental health issues have a significant influence. In certain instances sexual orientation had played a contributing factor for youth homelessness. Van Leeuwen and colleagues (2006) argue that earlier LGB sexual identity development are risk factors for homelessness among LGB youths and believe that LGB youths compose 15% – 36% of homeless youths.

Homeless youth are a psychologically and physically vulnerable group. Their psychosocial health is severely compromised by the adverse life experiences on the streets. Their basic problems are associated with need for personal shelter, hot meals, warmth, personal hygiene and safety. Being on the streets their overall wellbeing and identity are deeply damaged. Corliss et al. (2011) hypothesize that youth homelessness is linked with numerous threats such as violence, substance use, and mental health problems.

While living on the streets these youth are unable to relax, rest and being with one's self, unable to enjoy nature, silence cannot have privacy. They are unable to form meaningful human relationships and unable to achieve social and vocational skill development. These young individuals struggle with their self-identities since they have no permanent mailing address, no place to keep their possessions safe and no home to return. They are constantly moving and have no sense of attachment to one place. The streets become their universe. The homeless youth could become the victims of street violence, tendency to get sexually abused, could become the victims of forced prostitution and sometimes compelled to engage in sex trade to avoid starvation. They are constantly targeted by the police and other law enforcement authorities. Homeless youths are vulnerable to victimization, including robbery, rape, and assault (Hoyt et al., 1999).

Various reports indicate that homeless youth engage in high-risk behaviors such as using intravenous drugs, needle sharing, living with strangers and survival sex. Rice et al. (2001) indicate that adolescents who report sexual activity and sexual risk taking are more likely to report homelessness experiences. These high risk behaviors make them vulnerable to sexually transmitted infections (STI), Hepatitis C virus (HCV) and the human immunodeficiency virus (HIV).

Homelessness is a key risk factor for injection initiation among street-involved youth (Feng et al., 2012). Often these youth share needles. Miller and colleagues (2009) suggest that most new hepatitis C virus (HCV) infections in North America are linked to injection drug use. According to Roy et al. (1998) substance use is more prevalent, among street youth than it is in the general youth population. Street youth have various drug habits and they abuse a wider variety of substances such as marijuana, methamphetamines, crack cocaine etc. Tompsett and colleagues (2013) indicate that adolescents who experience homelessness are at higher risk for abusing substances and for being exposed to substance-using peers.

Streets youth have severe hygiene problems following inadequate or infrequent hygiene practices. Many individuals suffer from oral infections, skin infections and scalp infections such as head louse (Pediculus humanus capitis). Street involved youth often have nutrition-related health problems. In addition, extreme weather conditions -severe cold in winters and heat waves in summers can deteriorate their overall health.

Deterioration of physical health, substance abuse, adverse life experiences, life stresses could cause hopelessness and despair among the street youth and they are at heightened risk for suicidal ideation and suicide attempts. Hadland et al. (2012) indicate that Street youth represent a marginalized population marked by early mortality and elevated risk for suicide. A considerably higher rate of suicide exists among youth who are street-involved or homeless than among the general youth population (Frederick, Kirst & Erickson, 2012).

Street youth are often treated as social misfits and very high discrimination is imposed on them. Most of the civilized citizens do not want to interact with them and many employers do not wish to hire them. They become trapped and unable to free themselves from the streets even when they get support from the social service agencies. The bad experiences that they undergo at the streets often hound them and they have already lost the sense of trust. They do not have faith in the justice system, low enforcement and even social service agencies. These social victims need effective psychosocial care to successfully integrate into society.

Homelessness among Aboriginal People

The Aboriginal people of Canada as defined by the Constitution Act 1982 comprise the Indian, Inuit and Métis peoples of Canada. They may be members of a Band or First Nation and/or Registered or Treaty (i.e., registered under the Indian Act of Canada with proven descent from a First Nation that signed a treaty). There are approximately 630 First Nations governments or Bands across Canada (Aboriginal Affairs and Northern Development Canada).

According to the Department of Human Resources and Skills Development Canada, homeless counts over the

years have shown that aboriginal people are over-represented in the homeless population. The 2005 statistics confirm that 62% of homeless people in Winnipeg were Aboriginal. These statistics further indicate that homelessness among aboriginal people in various cities. Based on data 46% in Saskatoon (2008), 15% in Calgary (2008), 66% in Prince George (2010), 38% in Edmonton (2010), 24% in Metro Vancouver (2011) (Human Resources and Skills Development Canada). The Mayor's Task Force on Homelessness suggests that Aboriginal people comprise 15% of the homeless population in Toronto (MTFH, 1999; 66).

The homelessness among the aboriginal people in Canada is more distinctive than in other populations. It has to be discussed with the historical and socio political circumstances.   Aboriginal people in Canada have been negatively impacted by assimilatory policies and government acts. The Indian Acts in 1876 and 1951 allowed the Federal the Government to control most aspects of aboriginal life. These legislations interfered with their traditions, culture, language and livelihoods. The years of oppression and institutionalized discrimination against the aboriginal people lead to disintegration of their   emotional, mental, and spiritual wellbeing. Until the 1960s, Aboriginal people in Canada were not considered citizens, but were treated as wards of the state and had similar legal rights as children (Wente, 2000). The echoes of social and political subjugation still affect the aboriginal community.

A large number of homeless aboriginal population belongs to the lost generation – the victims of residential schools. The residential schools were opened in 1880 by the Canadian government and administered by churches. The main aim of these residential school systems was to indoctrinate aboriginal children into Euro-Canadian culture and assimilate them into mainstream Canadian society. The residential school system conducted an assimilationist policy that lasted until the early 1980s (Wente,2000). As Miller (1996) points out aboriginal children in these residential schools were often denied the right to go home and were not allowed to have interactions with their biological parents.

Jamieson (1978) emphasizes that those in residential schools, frequently experienced physical, sexual, mental, and emotional abuse. According to Morrisette (1994) the residential schools have left a permanent mark on survivors. These collective traumas may be closely linked to the adverse social issues including homelessness among the aboriginal people in Canada. Wente, (2000) indicates that psycho –political -social factors have created   what is known as residential school syndrome have impacts on homelessness (Wente, 2000).

There are multiple factors that contribute to Aboriginal homelessness. Aboriginal people experience homelessness following psychosocial and socio-economic reasons. Urban migration from reserves to urban centres following economic reasons aggravated aboriginal homelessness. In 1950s with the beginning of a shift in the location of the Aboriginal population from reserve to urban, following the general population and subsequently many Aboriginal people became a visible presence on the streets of Canadian cities (Wente, 2000).

Helin (2002) has shown that historical policies and practices of assimilation had deeply damaged the aboriginal individuals, families and communities. As a result of collective trauma people have lost their trust in governments and housing and social service agencies. Therefore many homeless aboriginal individuals are reluctant to seek help. The cultural loss of residential schools leaves many people feeling disconnected from their community and culture, as well as a shame at being an Aboriginal. (Wente, 2000).

Aboriginal people who experience homelessness are a socially disadvantaged group. Often they rely on informal support from family and friends rather than the official services and many homeless aboriginal people do not come under government statistics. Research has shown that Aboriginal people experience higher levels of poverty, poorer physical and mental health, lower educational attainment and higher unemployment than non-Aboriginal Canadians (Wente, 2000). Culturally appropriate long term effective measures would be needed to resolve the homelessness among aboriginal people.

Homelessness: Impact on Physical Health

Homelessness has a damaging impact on physical health. There are many conditions that negatively affect the physical health of the homeless people. They face chronic malnutrition and are often exposed to environmental hazards in cold winters and in hot summers. In addition poor hygiene conditions that have been associated with homelessness deteriorate their health.

High prevalence of various skin infections in the homeless population has been documented. Various infectious

and noninfectious skin conditions have been described among the homeless, with trauma, superficial fungal infections, and foot problems being the most prevalent (Stratigos & Katsambas ,2003). They suffer from various foot problems from callouses to cellulitis. Wrenn (1991) indicate that foot problems are a major cause of illness and may represent up to 20% of the medical complaints of homeless people.

Homeless people are found to be with poor oral health. Gelberg and colleagues (1988) elaborate that persons who are homeless have more grossly decayed and missing teeth than the general population and even the impoverished population living in residences.

Hwang (2001) points out that homeless people are at increased risk of dying prematurely and suffer from a wide range of health problems including seizures, chronic obstructive pulmonary disease, musculoskeletal disorders, tuberculosis, and skin and foot problems. The incidence of active TB among homeless people in Toronto is 71 per 100 000 and this rate is about 10 times the average Ontario rate (Yuan et al., 1997). Cheung & Hwang (2004) point out that Homeless woman 18–44 years of age were 10 times more likely to die than women in the general population of Toronto.

Homeless people are susceptible to Human immunodeficiency virus (HIV) and Hepatitis C.
Unsafe practices such as survival sex and needle sharing may have aggravated the condition.
Lee and colleagues (2000) indicate that homeless people are one of the most vulnerable with regard to HIV transmission. Hepatitis C rates among homeless people in Toronto are 29 times higher than in the Canadian population (Remis et al., 1998).

Research had found that homeless individuals poorly manage chronic health conditions such as Diabetes Mellitus, Hypertension and other systemic ailments. Sometimes their physical health could be severely compromised by violent physical attacks or by unintentional injuries such as road traffic accidents. As indicated by Roy et al. (2004) homeless people have higher mortality rates than the general population.

Hwang (2001) indicate that the homeless people have high levels of morbidity and mortality and may experience significant barriers to accessing, health care. The health issues of the homelessness population are not being addressed adequately. Many homeless individuals face various restrictions and discriminations accessing health services. Khandor and colleagues (2001) did a study in downtown Toronto between November 2006 and February 2007   and found that the existing health system was not adequately addressing the health care needs of homeless people in Toronto.

Compared to the general population the homeless people are at a severe disadvantage particularly in health. Frankish , Hwang & Quantz   (2005) note that homeless people have poorer health than the general population and often experience a disproportionate burden of acute and chronic health issues including concurrent mental health and, substance use disorders. It has been noticed that the average life expectancy of a homeless person in Canada is 39 years, half the national average (Grenier, 1996).

Homeless people experience a wide range of physical health problems. These physical illnesses   could affect their mental health and overall psychosocial wellbeing.

Mental Illnesses Relating to Homelessness

According to the WHO Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being and it is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease (WHO). Mental health has been identified as one of the key factors that help to maintain stable housing. Local and international studies show that Psychiatric disorders are one of the strongest and most consistent risk factors for homelessness.

A large body of research had shown the distinct relationship between homelessness and mental illnesses. Furthermore the researches indicate that people who are homeless are more likely to experience mental illnesses than the general population (Hwang, 2001). Therefore mental illness and homelessness have bidirectional

connections.

There are a number of symptoms such as paranoia, anxiety, depression, delusions, hallucinations and disordered thoughts associated with mental ailments. These detrimental symptoms drastically affect person's cognition and functionality. People with severe mental illnesses sometimes lack knowledge, skills and attitudes to maintain housing. Therefore mental illness could increase a person's vulnerability to homelessness. According to the Mental Health Commission of Canada an estimated 25 % to 50% of homeless people have a mental illness (Mental Health Commission of Canada, Annual Report 2008-2009).

Mental illnesses among the homeless population often remain undiagnosed and untreated. Bassuk and colleagues (1984) clinically interviewed seventy-eight homeless men, women, and children staying at an emergency shelter and found that the majority of them had severe psychological illnesses that largely remained untreated. Approximately 91% were given primary psychiatric diagnoses and one-third had been hospitalized for psychiatric care. Unfortunately many homeless individuals have no way to receive appropriate treatment and they could suffer lengthy periods and sometimes for life. The results of 1997 Toronto study of 300 shelter users indicate that two-thirds of respondents reported a lifetime diagnosis of mental illness (Goering et al., 2002). Moreover in 1999 Mayor's Homelessness Action Task Force survey reported that between 30% and 35% of homeless people and 75% of homeless single women in Toronto have a mental illness (MHATF, 1999).

Adverse Childhood Experiences and Adult Homelessness

Many experts believe that childhood psychological trauma especially physical and emotional abuse could be a risk factor for the development of psychological problems as an adult and also a   risk factor for adult homelessness. The potential long-term sequelae of child maltreatment include increased risks of the development of mental health disorders (Buckingham & Daniolos, 2013). Furthermore Schilling et al. (2007) argue that very strong association between childhood adversity and depressive symptoms, antisocial behavior, and drug use during the early transition to adulthood.

Adverse childhood experiences such as physical abuse, sexual abuse, parental mental illness, loss of parent, parental separation, witnessing domestic violence etc. could have a negative impact on adult life. Social and material disadvantage experienced in childhood continues to have long-range adverse effects on behavior, perception and worldview. Adverse childhood experiences have been found to be associated with poor physical and poor mental health, impaired functioning, and increased substance abuse in the general adult population (Lu et al., 2008).

Researchers indicate a relationship between childhood trauma, social problems, housing instability and poor adult health outcomes. Some express the view that homelessness constitutes a long-term consequence of childhood trauma. Herman et al. (1997) argue that adverse childhood experiences are powerful risk factors for adult homelessness.

A strong and graded association between childhood trauma and subsequent residential instability and engagement in high-risk behaviors has been identified. Zlotnick and colleagues (2004) specify that studies have noted high prevalence rates of adverse childhood experiences and adulthood substance abuse among homeless adults. Moreover Torchalla et al. (2012) describe a Vancouver based study that explored self-reports of five childhood maltreatment (CM) subtypes and their associations with current suicide risk in a sample of 500 homeless persons. The researchers found mental disorders and female sex were independently associated with suicide risk.

According to Dr Graham Pluck -Honorary Research Fellow Academic Clinical Psychiatry Department of Neuroscience University of Sheffield (personal communication, 2013) childhood trauma has long lasting consequences for homeless people; it is probably the single most important factor leading to their later life problems.

Schizophrenia and Risk of Homelessness

Schizophrenia is a chronic severe debilitating mental illness. There are a large number of homeless individuals suffering from Schizophrenia. A considerable number of the victims do not receive appropriate effective treatment and a large portion remains undiagnosed.

Schizophrenia is characterized by positive symptoms (delusions, hallucinations, thought disorder, disorganized behavior) negative symptoms (amotivation, lack of emotional responsiveness, poor self-care) and cognitive symptoms (problems associated with executive functioning memory and attention deficits). These symptoms profoundly affect the functionality of the homeless victims, distancing them from support services.

In Statistics Canada's 2002 Mental Health and Well-being Survey, less than 1 percent of adults in the general population reported having been professionally diagnosed with schizophrenia (Public Health Agency of Canada, 2006). Folsom & Jeste (2002) note that Schizophrenia is much more prevalent among homeless persons than in the population at large. A Vancouver, British Columbia, study reported that 24 of 124 shelter users had a mental health problem; of these, 7 identified their mental, health problem as schizophrenia (Acorn, 1993).

Schizophrenia has been identified as one of the leading risk factors for long-term homelessness. The illness directly affects self-care and social relationships impacting employment and housing.

Individuals with schizophrenia have a tendency to avoid people following social anxiety and go in to social withdrawal. These individuals could leave their families and live in isolation. Often they become social drifters. They live on streets and disconnect from relatives and friends. When they do not receive appropriate medication and social support their schizophrenic symptoms could aggravate further. Delusions and hallucinations that they experience push them further in to isolation. As a negative coping method some abuse alcohol or illegal drugs and these practices further deteriorate their mental health. Sometimes these psychotic symptoms make them aggressive and frequently they get arrested by the police. Although the police interventions help them to get hospitalized, hospitalization itself may not completely answer the issues relating to homelessness. Upon their discharge from the hospital most of the victims end up again on streets.

Patients diagnosed with schizophrenia and with a concurrent disorder are at more risk of becoming homeless. Olfson et al. (1999) state that in patients with schizophrenia, the risk of becoming homeless after hospital discharge was increased for those who had a comorbid drug use disorder increased psychiatric symptoms or poor global functioning. Alcohol and substance abuse are high among the homeless individuals affected by schizophrenia. Koegel and Burnam (1988) found that the rate of schizophrenia was nine times as high in homeless alcohol-dependent persons.

Bipolar Affective Disorder
Bipolar Affective Disorder also known as Manic Depression is a medical diagnosis characterized by wide mood alterations, with periods of both depression and mania. A person experiencing depression or mania may have intense mood swings and changes in thinking and behavior (Canadian Mental Health Association). Bipolar disorder is associated with significant functional and social impairments. The World Health Organization has ranked bipolar disorder among the top 10 conditions associated with quality-adjusted life-year decrements in the Global Burden of Disease report (Lopez et al., 1998).

Bipolar Affective Disorder is a severe relapsing mental illness and it could deleteriously impact overall function especially impeding personal relationships. People affected by Bipolar Affective Disorder experience high residential instability (McCarthy et al., 2007). The intermittent manic and depressive episodes often lead to medication non-adherence, substance abuse and risky behaviors. There are numerous social consequences associated with Bipolar Affective Disorder including a tendency to become homeless. Copeland and colleagues (2009) found incarceration and homelessness were strongly and bi-directionally associated among veterans with bipolar disorder.

Persons with bipolar disorder often require intensive pharmacological and psychosocial treatment (Bauer et al., 2002). Discontinuation of treatment especially mood stabilizers could lead to relapses. Persons with bipolar disorder exhibit unique symptoms that can worsen public health outcomes, including homelessness and

incarceration (Solomon et al., 1999). In addition
Kilbourne et al.(2005) believe that some risk factors for homelessness occur disproportionately in persons with bipolar disorder.

Homelessness has serious disadvantages to the patients diagnosed with Bipolar Affective Disorder. Loss of a stable home can interfere with treatment retention (Siegel et al., 2006). Once they become homeless they do not adhere to treatment and ongoing stress factors could worsen the symptoms. While living on the streets many begin to abuse alcohol and other illicit street drugs. These factors further deteriorate mental health factors causing severe functional disabilities. Patients with comorbid bipolar and substance use disorders are at particularly high risk for a host of negative consequences (Gaudiano et al., 2011).

For individuals with Bipoloar Affective Disorder, the negative street experience may have damaging effects. During manic phase he or she could experience impulsiveness, increased libido and hostility all of which can lead to risk-taking behavior. However in contrast during a depressive phase, the individual's mental state can lead them to commit acts of self-harm and to a more serious extent even suicide. The evidence suggests that the risk of violence is greater in bipolar disorder than in schizophrenia (Volavka , 2013).

Lifetime prevalence of bipolar spectrum disorders has been found to be between 2.6% and 5% (Angst, 1998). For those who do not receive adequate medication and psychosocial rehabilitation the illness could be lifelong. Therefore the homeless individuals with Bipolar Affective Disorder are at a serious risk.

Substance Abuse and Homelessness

The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines substance abuse as a pattern of maladaptive substance use that is associated with recurrent and significant adverse consequences. According to Susser et al. (1993) substance abuse increases the risk of homelessness.

A significant number of researches indicate that homeless people have higher rates of substance use than people who are in stable housing. For example Baumohl et al. (1991) point out that homeless people have much higher rates of substance use than the general population.

Alcohol and substance abuse are associated with negative social outcomes. The individuals diagnosed with alcohol and substance abuse have a social history of   unstable relationships, family conflicts, loss of jobs and these circumstances could eventually lead to homelessness. Sometimes homelessness itself is a precipitating stress factor to indulge in alcohol and drug abuse. Research suggests that there are bidirectional processes underlying the link between drug use and homelessness such that the presence of one may predispose an individual to the other (Johnson, 1997). Des Jarlais et al. (2007) argue that chronic homelessness, sub-standard housing and housing instability are all associated with more drug and alcohol use including injection risk behaviors.

Alcohol abuse is prevalent among the homeless population. Alcohol use disorders are widespread with lifetime prevalence rates of about 60% among homeless men. Problems with alcohol are 6–7 times more prevalent among homeless people than in the general population (Hwang, 2001). Fischer & Breakey (1987) believe that 30% to 40% of homeless people have alcohol related problems. These problems include alcohol-related liver disease, alcohol induced blackouts, depression and anxiety related symptoms, street violence, accidents etc.

Milburn (1989) points out that   10% to 20% homeless have problems with other drugs. There are a number of street drugs including cocaine, marijuana, heroin, methamphetamine etc. used by the homeless people in Canada. According to Hwang (2001) Cocaine (especially crack) and marijuana are the illicit drugs that are most often used by the Canadian homeless population. Often these drugs are used by intravenous injections. The use of drugs by injection represents a major health hazard and injection drug has been identified as a leading cause of HIV and Hepatitis C.

The prevalence of mental health problems and addictions among homeless people is significantly higher than in the general population. An estimated 25 to 50% of homeless people have a mental illness and up to 70% of those with a severe mental illness also abuse substances (Mental Health Commission of Canada Annual Report 2008-2009).

According to the Centre for Addiction and Mental Health (2006) Studies estimate that approximately 30% of people diagnosed with a mental, health issue will also have a substance use issue at some point in their lives.

Sometimes alcohol and drug abuse are complicated by concurrent conditions. According to the research homeless individuals are found with a combination of mental health and substance use issues. Concurrent disorders have been found as one of the high risk factors for homelessness. Courtenay-Quirk and colleagues (2008) rightly argue that mental illness and substance-use disorders generally are associated with increased risk of homelessness. Tessler & Dennis (1989) indicate that approximately 10% to 20% of homeless persons are dually diagnosed with severe mental illness and alcohol or other drug problems.

Although alcohol and substance abuse is a pathological condition many homeless individuals with alcohol and substance abuse issues face discrimination, harassment and systemic barriers. Many shelters do not admit anyone who is under the influence of alcohol or drugs. Therefore the victims often are left to fend for themselves and they are reluctant to seek support that is being offered by the humanitarian agencies. In order to provide a quality service these obstacles ought to be addressed.

Depressive Disorder and Homelessness

The World Health Organization (WHO) defined depression as a common condition presenting with a depressed mood, loss of interest/pleasure, feelings of guilt/self-worth, disturbed sleep/appetite, decreased energy, and poor concentration (WHO, 2009). Depression is a major comorbidity among the homeless population. High levels of depressive symptoms are prevalent among the homeless individuals who lack social support and other essential services.   Individuals who are episodically homeless or who are homeless for the first time appear to experience higher rates of depression than the chronically homeless (Goering et al., 2002).

van Beljouw   et al. (2010) indicate that low levels of social support predict escalated depressive symptoms in patients with baseline depressive or anxiety disorders. According to the research   homeless adults are 2 to 4 times more likely to be depressed than adults who are not homeless (Wong & Piliavin, 2001).

Homeless individuals have numerous reasons for elevated rates of depression. Rohde et al. (2001) argue that increased levels of adverse life events (physical as well as psychological), lower levels of social support, poor health and limited access to health care, increased substance abuse, and fewer financial resources   could have a negative impact on psychosocial health causing depression.

Homeless individuals have a wide range of physical health problems. These health problems impact on their psychological wellbeing. La Gory et al. (1990) strongly argue that homeless adults with chronic health problems may be at greater risk for depression. Depressive symptoms have strong links with alcohol and substance abuse especially among the homeless youth. Christiani et al. (2008) indicate that substance use among homeless young adults is frequently mediated by poor coping skills and depression. Younger persons, the chronically homeless, the street-based homeless, the sick, and the less educated are also more likely to experience depression (La Gory, Ritchey & Mullis, 1990).

Depression related symptoms could cause disturbed behavior among the homeless people. Nyamathi et al. (1998) point out that   emotional distress is associated with higher rates of risk-taking behavior in the homeless. Nock & Kessler (2006) indicate that mood disorders and especially major depression have emerged as key predictors of suicidality.

PTSD and Homelessness

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder characterized by reliving a psychologically traumatic situation long after any physical danger involved has passed through flashbacks and nightmares (Canadian Mental Health Association). International studies indicate high prevalence rates of post-traumatic stress disorder within homeless populations (Taylor & Sharpe, 2008).

To become homeless is a traumatic experience, also to live on the streets frequently facing violence and life

threatening events increases stress and anxiety. Unfortunately violence has become a frequent occurrence and a negative experience that most of the homeless people encounter. Homeless people are usually concentrated in the worst neighborhoods that have limited opportunities and high rates of crime and violence (Aidala & Sumartojo, 2007).

Homelessness and trauma go hand-in-hand. Sometimes a sudden traumatic event could trigger homelessness. Homeless individuals are victims of prolonged repeated trauma and homeless experience has a cumulative negative impact on psychosocial health.

Research and surveys concur that street youth have been affected by PTSD. Bender (2010) and colleagues postulate that homeless youth experience disproportionately high rates of trauma and posttraumatic stress disorder. Family violence has been identified as one of the leading factors for youth to become homeless. These victims were subjected to physical and psychological abuse within the family circle and these negative circumstances force them to move to the streets.

 PTSD can be developed among the youth with past overwhelming experiences of violence. In addition rape and incest too have damaging effect on women who are forced to leave their homes. A considerable number of women who became homeless following sexual violence suffer from Rape Trauma Syndrome. Molnar et al. (1998) state that physical and sexual abuses prior to leaving home are relatively common stressors or traumatic events identified by the homeless particularly among females.

Streets offer no salvage to the homeless and they frequently experience violent assaults. Hwang (2001) indicates results of a Toronto based survey in which the researchers found that 40% of homeless individuals had been assaulted and 21% of homeless women had been raped in the previous year. Many homeless people had succumbed to street related violence in Canada over the years. Hwang (2001) points out that homeless men are about 9 times more likely to be murdered than their counterparts in the general population.

Homelessness PTSD and drug abuse sometimes are closely interwoven. To cope with PTSD symptoms victims abuse alcohol or street drugs. Coffey et al. (2002) are of the view that trauma-related cues could trigger substance cravings in people with PTSD. 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 (Ayerst, 1999).

A number of PTSD symptoms affect the victims to be socially isolated and emotional numbing, flashbacks, mistrust, fear feelings, avoidance etc. distance homeless individuals from supportive housing workers. Hence the homeless individuals with PTSD are less likely to seek support services.

Traumatic Brain Injury and Homelessness

Traumatic brain injury (TBI) is an acquired disability. According to the current research Traumatic Brain Injury has a profound impact on homelessness. Waldmann (2004) argue that Traumatic brain injury may be common in the homeless population.

Head injuries could cause cognitive and behavioral changes among the victims. The victims often have impulsiveness, irritability, low frustration threshold, temper outbursts, mood fluctuations, impaired planning, impaired problem solving, lack of initiative, socially inappropriate behaviors, social skills deficits and other symptoms that directly affect their psychosocial health. A number of case studies reveal that as a result of cognitive and personality changes following head injuries many victims have ended up on the streets. Contrariwise homeless people could receive head injuries while living on the streets. Homeless people experience high rates of injury of all types and are frequently victims of assault (Kushel et al., 2003).

Traumatic Brain Injury is a known risk factor for homelessness (Herman et al., 1997). Based on Toronto's shelter system study Hwang and colleagues (2008) found that prior traumatic brain injury is very common among homeless people and a history of traumatic brain injury was more common among homeless men than among

homeless women. The studies elsewhere have shown comparable results. For instance in a study of 80 consecutive entrants to a men's shelter in London England, 46% of entrants had a lifetime history of head injury severe enough to cause unconsciousness Bremner et al., (1996). A study of 90 homeless men at a shelter in Milwaukee Wisconsin found that 80% of participants had possible cognitive impairment and 48% had a history of traumatic brain injury involving loss of consciousness (Solliday-McRoy et al., 2004).

Hwang et al. (2009) believe that difficult behavioral patterns of the homeless individuals could be connected with unrecognized consequences of traumatic brain injury. These unrecognized consequences of traumatic brain injury and may include cognitive impairment, attention deficits, disinhibition, impulsivity and emotional lability.

Commenting on traumatic brain injuries in the homeless population from (a Toronto based study), Hwang and colleagues (2009) found a history of traumatic brain injury was associated with adverse health outcomes among homeless people. Poor health outcomes included seizures, mental health problems, drug abuse problems, and poorer physical health status.

Rates of traumatic brain injury are much higher among the homeless population than in the general population and that sustaining a traumatic brain injury may be a risk factor for homelessness (Oddy et al., 2012).

Self-Harm and Suicide Among the Homeless People

Self-injurious behavior (SIB) and Suicidal behaviors including suicide ideation, plan, and attempts are prevalent among the homeless people. In Canada, suicide occurs at a rate of 11.3 per 100,000 of the general population; the rates are higher for men (20.7 per 100,000) than for women (3.7 per 100,000) (WHO, 2009b). Nonetheless rates of suicides among the homeless populations are higher than in the general population. People in the homeless shelter population with a history of a psychiatric disorder constitute a high-risk group regarding the elevated suicide and unintentional injury mortality (Feodor Nilsson et al., 2013). Although the homeless population has been considered as high risk group Desai et al. (2003) point out that the homeless population has not been extensively studied with regard to suicide risk.

There are major reasons associated with suicide risk among homeless people. Many homeless individuals were victims of childhood trauma, family instability, foster care, family history of psychiatric illness, and criminal justice involvement (Desai et al., 2000). Research suggests that childhood trauma and adverse early life experience have negative impact on adult life. van der Kolk et al. (1991) suggest that childhood abuse can lead to a variety of negative health outcomes and behaviors, such as substance abuse, suicidal behaviors, and depressive disorders. Furthermore, Dube and colleagues (2003) acceptably argue that a powerful graded relationship exists between adverse childhood experiences and risk of attempted suicide throughout the life span.

Numerous studies coincide high rates of mental illness and substance abuse among the homeless people. Rosenheck &Koegel (1993) indicate that there are high rates of mental illness and substance abuse disorder prevailing among the homeless population and these factors are strongly associated with increased suicide risk.

The homeless people encounter barriers and hindrances when they try to obtain medical care. It is obvious that the main barrier to good health among the homeless is their lack of the adequate, safe, accessible and affordable housing that is linked to employability, community support, personal health care and access to health services. Homelessness renders access to general health care services difficult or impossible (Chenier, 1999). Restricted accesses to health care and health inequalities have created a mortal outcome among the homeless people. Rosenheck & Lam (1997) hypnotize that reduced access to health care among the homeless people may result in failure to identify and manage suicidal symptoms.

Homeless youth are a population at a high risk for suicidal behavior (Kidd, 2006). These youth have undergone abusive, neglectful, and unstable family histories and encountered victimization on the streets. In addition high rates of physical and mental illness have been reported among the street youth. Homeless youth have high rates of self-harm, attempted and completed suicides than the general youth population (Yoder, Hoyt, & Whitbeck, 1998).

Self-injurious behavior (SIB) is common among homeless youth. Self-injurious behavior can be defined as any type of direct bodily harm or disfigurement that is deliberately inflicted on oneself that is *not* considered to be

socially acceptable (Simeon & Favazza ,2001). Self-inflicted injuries include burning oneself, drug and alcohol overdoses, punching /kicking walls or other objects, embedding objects in the skin, head banging, swallowing objects etc. Desai et al. (2003) indicate that youth, substance abuse, and psychiatric symptoms were all significantly associated with suicide attempts. Kidd (2006) argue that disempowerment, perception of no control over their circumstances , social isolation , low self-esteem and the feeling of being trapped increases the risk of suicide among the street youth.

Case Studies

1) Mr. RX is a descendant of First Nations. His father was abusing alcohol and mother died when Mr. RX was very young. The family was affected by severe poverty and sometimes Mr. RX and his brother went to bed on an empty stomach. His grandmother came for his refuge and looked after them providing every comfort within her capacity. He was profoundly attached to the grandmother. Mr. RX was emotionally shattered when he lost his grandmother at the age of eight and up to date this overwhelming experience   troubles him. After the grandmother's death he was looked after by a relative. During this time a number of times he was sexually abused by an uncle. Mr. RX could not continue his school education regularly and remained a semi-literate person. When he became an adult he did odd survival jobs to survive. He left his native place and came to Toronto looking for new job opportunities. He could not find   regular employment and most of the time he was unemployed. He became a couch surfer in Toronto and eventually ended up on the streets.   During this period Mr. RX became severely addicted to alcohol. Once he passed out and was admitted to the emergency. He was treated at the hospital for several weeks and upon his discharge Mr. RX was referred to a human service agency. The agency closely worked with Mr. RX and they were able to send him to transitional housing and later to supportive housing. Today Mr. RX is functional and manages himself. He has reduced harmful usage of alcohol to a significant extent and is collaboratively working with his mental health workers.

1) Mr. BXX was severely troubled by witnessing family violence as a toddler. His father physically abused his mother and in one of the events she was brutally assaulted and she had a miscarriage. He saw his mother lying on the floor covered with blood. This image was deposited in his mind for decades. When Mr. BXX became a teenager he realized that he had a different sexual orientation and feared to reveal it to the family and friends. He began to experiment with drugs and wanted to leave his home. At the age of 17 Mr. BXX experienced auditory hallucinations, passivity feelings and had delusions. He was referred to a Psychiatrist and diagnosed as having Schizophrenia. He was prescribed medication. Mr. BXX left home and lived with multiple partners. After one and a half years he discontinued his medications and had a major relapse. He was hospitalized and treated with antipsychotics. After his discharge Mr. BXX lived with his brother and when he had arguments with the brother he used to sleep under bridges or abandoned buildings. He was homeless in and out. The psychiatric outreach helped Mr. BXX to work with a supportive agency where he was able to find affordable housing with his ODSP. The agency offered psychiatric rehabilitation and today Mr. BXX is housed and on monthly medicate which keeps his schizophrenic symptoms at bay. He is functional and planning to start an income generating project.

1) Mr. LX was diagnosed with Acute Transient Psychotic Disorder at the age of 16 and treated with antipsychotics by his Psychiatrist. Following the treatment he became symptoms free and continued his studies. He completed his higher education and worked as an Engineer. Later he migrated to Canada and worked in a factory. While working in the factory he felt that he was under employed and found it difficult to adapt to the new environment and to the new culture. During this time he experienced a relationship problem with his girlfriend and became depressed. He left his job and stayed with some of his relatives. It was a highly stressful period for Mr. LX and he became more and more socially isolated and disregarded self-care. His behavior became bizarre and he was forced to leave his relative's apartment. Mr. LX started spending time on the streets. After many months his family made strenuous attempts to locate Mr. LX and with the help of a volunteer and found that he was attending a meals program at the Salvation Army in Hamilton. His family members tried to get him out of the streets but each time they went near him Mr. LX refused to communicate with his family.

1) Mr. FX experienced physical and psychological abuse under foster care and left home as a teenager. He used to stay with friends and strangers in various places. While spending time with street gangs Mr. FX started abusing cannabis and cocaine. He was exposed to numerous violent events. Several times he was severely assaulted by the drug dealers and during one such occasion he sustained a head injury and was admitted to the hospital. Once he witnessed the death of a friend following an overdose. Mr. FX suffered from intrusions, flashbacks and nightmares. There were marked features of affect deregulation, emotional numbing and intense rage in him. His social service workers found it difficult to establish a rapport and trust

in the early stages of the therapeutic relationship. He had fear and distrust for strangers and even for the human service workers who genuinely wanted to help him. With tireless and prolonged efforts his workers were able to establish trust and rapport. Today Mr. FX is out of the streets and lives in a supportive housing scheme.

1) Mrs. TXX and family migrated to Canada from the South East Asian region seeking economic opportunities. The family had numerous issues while adapting to a new culture in Canada. The family had financial problems and although her husband made frantic efforts to find a job his attempts failed. After many months Mrs. TXX found a survival job but her wages were hardly enough to support the family. Frustration and family tension surged and the husband became abusive and violent. He frequently physically abused Mrs. TXX and following an unbearable situation she decided to move to a shelter with her five year old daughter. The family was broken up and Mrs. TXX became homeless. Without any option she went to a women's shelter.

1) Mr. CXX was a homeless man who lived in streets for long years until he found support and housing. Although he lives in   supportive housing still he is troubled by the reminiscences of past trauma. He is fearful of strangers and unable to connect with new friends. He likes to live in isolation and only connects with his housing worker once or twice a week for very brief sessions. Mr. CXX has difficulty in concentrating and often forgets things. He has a number of somatic complaints including fatigability and chest discomforts. He has OCD type of checking behavior and frequently checks the locks on doors. He has unexplainable fear that someone might break in to his house and harm him. Mr. CXX's housing worker is taking fruitful efforts to eliminate anxiety related symptoms that hinder his functionality.

Combating Social Stigma and Discrimination

Homeless people undergo intense stigma and discrimination that destructively affect their psycho social health. There are a vast collection of myths and assumptions held by the society about homeless people. The general notion include homeless people are lazy, do not like to work, often indulge in alcohol and drugs and commit crime. Sometimes the mainstream media reinforce such ideas. These harmful false massages often work against the homeless population.

Stigma and discrimination frequently work against homeless victims in all aspects of their lives. The victims experience (individual and systemic) negative attitudes (prejudice) and negative behavior (discrimination) against them. Stigma is often internalized by the victims. According to Goffman (1963, 3) stigma is an attribute that is deeply discrediting that reduces someone from a whole and usual person to a tainted, discounted one. Describing the injurious nature of stigma Goffman (1963, 42) states that a stigma does more than identify a person in the way a social role does; it handicaps a person in a way that forces him to face unwitting acceptance of himself by individuals who are prejudiced against persons of the kind he can be revealed to be.

Major misconceptions about homeless people lead to discrimination against them. Hewstone et al. (2002) describe discrimination as intolerant behavior to those who are perceived to be different, including harassment that stems from bias and emotional responses such as fear and hate. Stigma and discrimination create an immense barrier between the victims and support services. Hence the victims have less trust regarding the support services and often live on their own. Kidd (2007) state that the perception of discrimination based upon negative stereotypes is related to feelings of worthlessness, loneliness and social alienation, and suicidal thoughts.

There are a number of mental health implications due to social stigma experienced by the homeless. Alcohol and substance abuse self-harm and suicides have close links with stigma and discrimination imposed on homeless people. Kidd (2007) found that homeless youths' experience of stigma played a major role in their mental health status and level of suicide risk.

Social stigma and discrimination are hindering factors that obstruct personal growth. It is essential to eliminate such negative features. Educating the general public about the myths associated with homelessness people is important. Active measures should be implemented to confront discrimination and challenge negative stereotypes.

Psychosocial Rehabilitation of the Homeless Individuals

Homelessness is not a disease neither a personal weakness. Homelessness arises as a result of complex psychosocial reasons. Homelessness has multiple faces and has multiple etiological factors. The homeless individuals are unambiguous victims who need support and empathy.

The social condition which is known as homelessness extinguishes imperative social skills that are essential to maintain housing. Therefore providing supportive housing for the homeless individuals may not be adequate. People who experience the social malady of homelessness need Psychosocial Rehabilitation to enhance and reestablish their skills to maintain housing.

Rehabilitation is an ecological approach that aims at the long term recovery and maximum self-sufficiency. In 1996 the World Health Organization came out with a consensus statement on psychosocial rehabilitation. The WHO defined psychosocial rehabilitation as a process that facilitates for individuals who are impaired, disabled or handicapped by a mental disorder to reach an optimal level of independent functioning in the community (WHO, 1996). Warren (2002) is of the view that addressing the broader emotional, social and economic needs of survivors is a critical aspect of the rehabilitation process. Support survivors in becoming reintegrated into all aspects of community life including education, employment, recreation and social and political activities. Research suggests that subsidized housing combined with mental health services may be an effective intervention for successfully placing individuals who have a mental illness and a history of homelessness into community housing (O'Connell et al.,2008).

To offer psychosocial rehabilitation to the homeless individuals it is essential to connect with the clients and establish rapport trust and strengthen the therapeutic relationship. Therapeutic relationship that is offered by the housing worker is a growth promotional factor for the client. Many victims have physical and psychological ailments that they received prior to becoming homeless and during the time of homelessness. A large percentage had undergone re-traumatization. During the process of psycho social rehabilitation the efforts should be geared to minimize re-traumatization.

The homeless victims have fragile mental and physical health. Appropriate long term treatment should be provided without systemic barriers. Drake et al. (1997) highlight the importance of integrating treatment for mental illness, substance dependence for the clients while providing housing interventions. The goal of a harm reduction approach is to decrease some of the negative impacts associated with drug and alcohol the person continues to use. Many experts have recommended harm reduction method to address the vicious cycle of mental illness, substance use and homelessness. For instance, Hass (2001) emphasizes the successful outcome that was achieved in a harm-reduction initiative in a group of homeless people in Ottawa. Podymow and colleagues (2006) are of the view that managed alcohol programs for homeless people with chronic alcoholism can stabilize alcohol intake and significantly decrease hospital emergency visits and police encounters.

Recovery has a prime importance in the psychosocial rehabilitation process. Recovery is a journey of healing and transformation. It helps the homeless individual to move away from the streets and live in a home where he can have a meaningful life. Anthony et al. (2012) defines recovery as a deeply unique process of changing one's attitudes, values, feelings, goals, skills, and or roles. The culture plays a key role in the recovery process. Culture plays an important role in recovery as sources of strength and enrichment for the person and the services.

The adverse events that instigate homelessness and the life experience of homelessness itself have an opposing impact on social skills. Strengthening of the social skills are essential as a part of psychosocial rehabilitation. Social skills play an important part in maintaining housing. In addition strategies should be incorporated to increase the community integration and independence.

Skill development, vocational training and income generation help to provide financial stability for the homeless people. Economic empowerment gives a sense of security and self-pride for these underserved population. Providing cost-effective supportive housing is essential to maintain   productive lives and psychosocial stability.

Discussion

In Canada over the years homeless people have increased in large numbers. The causes of homelessness are complex and multifactorial. Psychosocial reasons have been identified as one of the primary causes of homelessness. A large number of researches have examined the mental health factors associated with homelessness. According to the Mental Health Commission of Canada nearly 25 % to 50% of homeless people have a mental illness (Mental Health Commission of Canada- Annual Report 2008-2009).

Housing is an important determinant of psychosocial health. A growing body of research indicates bidirectional link between mental illnesses and maintenance of housing. Studies also indicate that people with mental health problems who have experienced homelessness can maintain housing with recovery oriented support. People with major mental illnesses maintain housing with support services. Approximately 60% of people with schizophrenia live with their families (Seeman, 1998).Lauriello et al. (1999) indicate that less than 20% of people with

schizophrenia are employed in the competitive market place.

Mental functioning is fundamentally interconnected with physical and social functioning and health outcomes. Health promotion is the process of enabling people to gain increasing control over their health and improve it (WHO, 1986). The empirical data has shown that psychosocial rehabilitation helps the homeless victims to reintegrate in to society as productive members. Research suggests that housing combined with mental health services is an effective intervention for helping homeless persons with psychiatric disorders, addictive disorders, or both to access and maintain community housing (Hurlburt, 1996). A broad range of mental health care and social support help to maintain housing and avoid homelessness.

Research and data have also shown that mental illnesses are not totally prevailing among the homeless populations. There are a large number of homeless victims without any kind of mental illness or addiction issues. Many of them have survived years on the streets without basic life necessities. Hence these individuals have so called the "street smartness" with extreme survival skills. These unconventional social skills could be used to rehabilitate the victims.

Homeless people experience discrimination. The society tends to view homeless people as lazy and often indulge in drugs and alcohol. According to Anucha (2005) theoretical explanations that frame homelessness as an individual deficit see it as arising from the personal circumstances or the 'fault' of those who are homeless as in the case of mental illness and addiction which make such individuals unwilling to work. The high prevalence of psychiatric disorders among the homeless generally reinforce such a position. There is a growing tendency of criminalization of homelessness. The Criminal Code of Canada (s.175) forbids loitering in public places. Sometimes homeless victims end up in jail. Homelessness and incarceration appear to increase the risk of each other (Greenberg & Rosenheck, 2008). There are clear causal and consequential links between homelessness, poverty, discrimination and poor public health outcomes (Lynch, 2004).

Homelessness is not an individual's problem. It is a politically sensitive social problem. Homeless victims often come from disadvantaged minority communities and they are over-represented in the homeless population. Aboriginal people of Canada have a number of socio-economic disadvantages including housing. According to the statistics youth and family homelessness increased by a considerable percentage in the past few years. Recent immigrants are at risk of becoming homeless. A study on housing discrimination in Canada Novac and colleagues (2002) concluded that racial discrimination constitutes a significant barrier to integration, for immigrants in Toronto and surrounding areas. Social awareness, advocacy programs, strengthens anti-discrimination bodies and legislations would be needed to address these problems.

Poverty has profound impact on mental health and housing. Statistics Canada reveals that in 1998, 16.9 percent of Canadians were living below the low-income cut off. A greater proportion of single individuals and senior citizens are likely to be living below the poverty line. (Statistics Canada, 2000). The welfare reforms and public expenditure cutbacks have impacted the homeless population receiving help. Murphy (1999) describes decline in welfare support and disintegration of progressive social welfare policies has caused social problems including homelessness. Income assistance for low income families keeps thousands of families away from becoming homelessness.

There are number of support services and agencies (Government and NGOs) that work with the homeless population. Millions of dollars spent on numerous programs annually. Regrettably a large number of homeless victims do not get adequate support services. Often the money doesn't reach the homeless. One of the Ottawa based studies found that 15% of adults living on the street reported receiving no social support (Farrell, 2001). The funds should be used prolifically to support the victims. The social service agencies have to be more effective and train skillful human service agents to combat the social malady of homelessness.

Medical problems are common among homeless people and often they do not receive primary health care. Inflexible health care models have prevented homeless victims receiving appropriate medical care. This has been identified as a systemic barrier. Majority of the homeless people suffer from systemic ailments respiratory infections and illnesses related to hygiene and personal care. Effective street outreach services should be implemented to provide basic medical care for the homeless.

Homeless persons and families face difficulties finding emergency shelters. To avoid lengthy procedures and documentation a large number of victims decide to live on streets. Increased availability and easy access to emergency accommodation are highly essential. Organizing day programs providing meals for the street dwelling individuals help to connect with them and subsequently assist them to transfer to temporary housing. Providing social skills training and vocational training help the homeless people to establish independent living. Provision of

affordable social housing would be a satisfactory permanent solution for homelessness.

Homelessness is influenced by the structural, personal, and political factors. Political grandstanding is essentially required to help to end homelessness. To addresses the crisis of homelessness and inadequate housing in Canada, Bill C-400 has been presented before Parliament. The debate will begin in 2013 to discuss the legislative process. Bill C-400 urges to improve housing services under a human rights framework. These legislations should promote effective welfare support for the homeless victims, because quality safe and affordable housing is a basic human right.

Conclusion

Homelessness has become a prominent problem in Canada creating a huge public health crisis. Over the years this problem was not addressed adequately and it has grown in to a social and political problem. Many reasons have been identified as factors contributing to homelessness. Growing poverty, social inequalities, unemployment, mental health contribute as key factors.

Although housing is a basic human right, housing inequalities have violated the human rights for a greater degree. Housing has important health concerns. Housing is a strong social determinant of health. Research concur homeless people experience a wider range of physical and psychological health reacted problems. Homeless people have much higher mortality rate.

Canadian homeless statistics vary and there are many practical issues to enumerate homelessness in Canada. Despite the enumerating difficulties many major cities in Canada have, their annual homeless counts. These statistics indicate that the homeless populations grow in the major Canadian cities. According to the recent data family and youth homelessness are on the rise.

There are major psychiatric illnesses found among the homeless population. In addition mental illness is one of the risk factors of homelessness. Homelessness and mental illness have a bidirectional connection. Psychiatric symptoms aggravate the functionality of the homeless victims and distance them from the support services. A considerable percentage of homeless individuals indulge in alcohol and street drugs as a negative stress coping method. Data indicate that suicide and self-harm rates are very high among the homeless victims.

Homelessness is associated with stigma and discrimination. Judgmental negative views on homeless victims affect their psychosocial wellbeing. Supportive housing helps the victims to move away from the streets. These victims need long term psychosocial rehabilitation to reintegrate them in to society as productive members.

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