HOUSING, POVERTY AND MENTAL ILLNESS: 
BREAKING THE TRIANGLE OF DISADVANTAGE

Based on MSW Thesis by Joanne Kowalchuk (2003) entitled:

**Housing Needs of Long-Term Consumers of Mental Health Services in Regina**

- **3 main questions:**
  1) What are the barriers to residential stability for this population?
  2) What factors appear to be associated with overcoming these barriers?
  3) What housing models may need to be developed that could contribute to reducing these barriers?

- **Community Partners:**
  Community Care Branch, Saskatchewan Health

  Regina Mental Health Clinic, Regina Qu’Appelle Health Region

- **Phase I:**

  **Quantitative Housing Satisfaction Survey**, presented to all clients of Rehabilitation Services Unit by their case managers over an approximate 2-month period:
  - 235 surveys distributed (of 629 total Rehabilitation Services clients) = 37%
  - 114 completed surveys = a response rate of 49%

- **Phase II:**

  **Qualitative**, in-depth interviews with both consumers and their case managers:
  - 34 of the 114 consumers wished to participate in the in-depth interviews
  - all were offered interviews and 19 were completed
  - follow-up interviews were conducted with 12 case managers for a total of 31 in-depth interviews
KEY FINDINGS

❖ Phase I:

- 25% of respondents were unsatisfied with their current housing
- however, if those who were “satisfied, but would move” (27%) were included, this figure could be as high as 52%. It may be that satisfaction surveys, when administered to people who have lived in poverty for many years, do not provide an accurate measure. In this case, satisfaction may well have been measured by what respondents could afford and not related to an assessment of quality housing.
- a statistically significant relationship between age and housing stability was found, in that those 51 and over were more stable in their housing than those respondents 50 years of age and under. However, the qualitative data indicated that this may be as much or more a generational and economic issue and not only related to psychiatric stability or institutionalization histories.

❖ Phase II:

I. Disability, poverty and housing
- complex but clear relationship between employment (unemployment, underemployment, cyclical loss of employment), psychiatric relapse and loss of housing

II. Supports
- consumers preferred practical and financial supports while case managers chose more service-oriented types
- 18 out of 19 consumer respondents said they needed more monthly income
- 10 out of 19 said they needed help with transportation

III. Housing
- all 19 consumer respondents wanted to live in their own house or apartment
- 18 out of 19 preferred not to have on-site professional mental health staff
- ¾ did not object to living in the same building as other consumers provided they had their own private apartment

IV. Quality of life
- diminished expectations related to life experiences of poverty and social marginalization may well explain the divergence between consumer and case manager assessments of current housing.
V. **What is needed with regard to housing?** There was virtual consensus between consumer respondents and their case managers:

*Safe, permanent, decent, affordable* housing, especially for *women* and *younger consumers*, as well as *crisis housing* for women and consumers generally.

**Affordable:**
- subsidized social housing
- subsidized home ownership
- subsidized Supportive and Supported apartment programs
- housing supplements for psychogeriatric care

♦ All of the low-income respondents living in *market rent apartments* were paying over 30% of their income to rent, with the average at 46%. This means that all of these consumers were in *core housing need*; a criteria in itself, considered to indicate persons ‘at risk’ of homelessness.

**Decent:**
- re-institution of rent controls
- regulation and inspection of rental properties
- establishment of a Housing Advocate

VI: **More than bricks and mortar: The comfort of home**

The qualitative results indicated a number of properties or qualities of housing that are important in order for people to make a home, in addition to those of ‘decent’ and ‘affordable’:

- access to an **outdoor area, sunlight, a view**
- **location**, with regard to safety, as well as proximity to services and supports
- acceptable **noise** levels
- **freedom/privacy**
- the ‘relational environment’: **people** (formal and informal supports), **pets**, a **phone** and access to **transportation**
- **size** (enough space/rooms)
SUMMARY

- Consumers want permanent, safe decent, affordable, private homes or apartments in the community.

- While some prefer the social benefits of congregate apartments with common areas and ¾ do not object to living in the same building as other consumers, most do not want on-site mental health staff.

CONCLUSIONS

1) There is a pressing need for the inclusion of younger, long-term mental health consumers as a priority population for social, subsidized housing programs. This would help to ameliorate the effects of cyclical loss of employment as a result of psychiatric relapse due to work stress – and therefore, the cyclical loss of housing that many consumers contend with.

2) The development of Supported and Supportive Apartment programs should also be undertaken as a priority housing need.

3) Increased financial assistance in the short term, as well as the development of a long-term guaranteed disability security program is crucial in alleviating the serious issues related to living in poverty that this population contends with.

RECOMMENDATIONS

- **Housing** (short-term)

  1) Establishment of a Housing Committee, including all 3 levels of government, non-profit, private and community sectors

  2) Expand mandate of the Regina Housing Authority to include younger, long-term consumers of mental health services as a priority population

  3) Housing supplements for psychogeriatric care

  4) Appointment of a Housing Advocate

  5) Re-structuring of the Office of the Rentalsman
- **Housing** (long-term)
  
  6) Re-investment by Federal government in social housing
  7) Development of a home ownership subsidy program
  8) Development of Supported and Supportive Apartment programs
  9) Development of a Crisis Stabilization Unit
  10) More short and long-term housing options for women only

- **Supports** (short-term)
  
  11) Increase in SAP entitlements
  12) Transportation funding for specific needs
  13) Funding for ‘creative’ educational pursuits
  14) Expansion of Home Care

- **Supports** (long-term)
  
  15) Establishment of a disability security program
  16) Development of employment strategies/program

SEE TABLE 1. HOUSING MODELS ON FOLLOWING PAGE FOR SYNOPSIS OF THOSE USED IN THIS STUDY...
<table>
<thead>
<tr>
<th>Name &amp; (Approach)</th>
<th>Main Characteristics</th>
<th>Literature References</th>
<th>Local Examples</th>
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</thead>
<tbody>
<tr>
<td><strong>Independent Living Model</strong> (Supported)</td>
<td>housing <em>de-linked</em> from mental health services</td>
<td>Carling (1990, 1992, 1995)</td>
<td>Phoenix Apartment Living Services (PALS) Program</td>
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<td></td>
<td>permanent, fully integrated community housing</td>
<td>Hurlburt (1997)</td>
<td>Home Care/Meals on Wheels</td>
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<td><em>flexible &amp; portable support services</em> going to the home</td>
<td>Tanzman (1990, 1993)</td>
<td>CMHA House Cleaning &amp; Yard Services</td>
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<td></td>
<td>Flexible &amp; portable support services</td>
<td>Psychosocial Rehabilitation Journal (Vol. 13, No. 4, 1990)</td>
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<td><strong>Supported Apartment Model</strong> (Supported)</td>
<td>housing <em>de-linked</em> from mental health services</td>
<td>Boydell &amp; Everett (1992)</td>
<td>Salvation Army Waterston House Apartments</td>
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<td></td>
<td>permanent, private, independent apartments</td>
<td>Everett &amp; Steven (1989)</td>
<td>Regina Housing Authority Senior's Housing &amp; Huston Heights</td>
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<td></td>
<td>common room, with coffee, TV &amp; optional recreational activities available</td>
<td>Johnson (1997)</td>
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<td>24-hour live-in <em>caretaker</em> (non-professional)</td>
<td>Thériault, Jetté, Mathieu &amp; Vaillancourt (1998)</td>
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<td>no program expectations as a condition of housing</td>
<td>Goering, Durbin, Trainor &amp; Paduchak (1990)</td>
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<td>other tenants may be mental health consumers</td>
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<td><em>congregate</em> setting</td>
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<td><strong>Supportive Apartment Model</strong> (Supportive)</td>
<td>housing <em>linked</em> to mental health services</td>
<td>McCarthy &amp; Nelson (1993)</td>
<td>Phoenix Residential Society Westview</td>
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<td>other tenants are mental health consumers</td>
<td>Nelson, Hall &amp; Walsh-Bowers (1995, 1998)</td>
<td>(Dual Diagnosis Program)</td>
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<td>program expectations as a condition of housing</td>
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<td>(Acquired Brain Injury Program)</td>
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<td>24-hour professional staffing</td>
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<td>permanent, private, independent apartments</td>
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<td>common room, with coffee, TV &amp; optional recreational activities available</td>
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<td><strong>Group Home Model</strong> (Supportive)</td>
<td>housing <em>linked</em> to mental health services</td>
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<td>Phoenix Residential Society Phoenix House</td>
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<td>24-hour professional staffing</td>
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<td>private bedrooms</td>
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<td>may be permanent home but is often <em>short-term</em></td>
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<td><em>congregate</em> setting</td>
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<td><strong>Approved Home Model</strong> <em>Custodial Care</em> (Supportive)</td>
<td>permanent housing <em>linked</em> to mental health services</td>
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<td>31 Currently Operating in Regina</td>
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<td>24-hour non-professional, family care</td>
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<td>sometimes lack of privacy (shared bedrooms)</td>
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