Promoting Inclusion through Supported Housing: Policy Implications

By

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A Thesis submitted to the Faculty of Graduate Studies of

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In Loving Memory of

JAMILA MILAN

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ABSTRACT

This thesis focuses on inclusive housing, and how housing policies can more effectively meet the needs of Winnipeg residents living with mental illness. To understand people's barriers to accessing decent and affordable housing, the thesis calls for both a literal and interpretive reading of an existing data set composed of nine interviews with people living with mental illness who reside in Winnipeg. The analysis indicates that while people living with mental illness experience an explicit financial barrier to attaining safe and stable housing, there are a number of interdependent barriers that have negative impacts on individuals' abilities to choose, get and keep housing in Winnipeg.

This body of information will serve to guide the development of *integrated and inclusive* housing policy that will be more responsive to the housing needs of this section of the population in Winnipeg.

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CHAPTER 1—THESIS ROADMAP

INTRODUCTION

As Canadians, many of us are accustomed to a certain life style which enables us to enjoy specific comforts, such as adequate housing and the ability to develop a sense of home. History clearly shows that many Canadians have not been as fortunate to enjoy such comforts. Particularly, people living with mental illness have encountered heightened barriers to accessing stable and decent housing in the community. Consequently, people living with mental illness struggle to achieve a decent quality of life because of the time and effort spent on acquiring and/or maintaining housing. Although these housing barriers are a result of a complex array of social forces, the rudimentary grounds for these barriers stem from the misunderstandings and stigmas associated with mental illness. As this thesis outlines, there have been considerable advances in the realm of housing for people living with mental illness – progressing from institutionalization to opportunities for supported housing. However, much remains to be done in the realm of housing policy in order to work toward normalizing housing options for people living with mental illness.

Before describing the context for this thesis, it is important to note that *people living with mental illness* comprises a broad and diverse population. However, for the scope of this thesis, focus is placed on people who have identified that they are experiencing some form of mental illness and are therefore connected to the mental health system. The rationale for this stems from the data generation process, as explained below.

Nevertheless, the analysis and recommendations set forth in this thesis may be applicable to people living with mental illness but not currently connected to the mental health system.

The housing crisis encountered by people living with mental illness is multifaceted, and this makes this issue persistent (Thomas & McCormack, 1999). It has been estimated that approximately 20% or one in five Canadians will be affected by mental illness in their life time (Kirby & Keon, 2006; Salmon et al., 2006). This fact alone indicates how common mental illness is in Canadian society. Despite the commonplace occurrence of mental illness among Canadians, other illnesses such as cancer are more likely to receive people's understanding and empathy as compared to mental illness (Bedford, 2007).

The numbers of people with a mental illness who are homeless or who are living in substandard housing are more difficult to pinpoint because of the housing instability and transient nature of this group of people (Frankish et al., 2005). The 2001 Census approximated that 14,000 people were homeless that particular year, however this does not necessarily include those who are 'couch-surfing' (i.e. staying at friends' houses temporarily) or those at risk of being homeless (Huff, 2006; Frankish et al., 2005; Salmon et al., 2006). According to a 1999 study conducted in Toronto, approximately 35% of homeless people (and up to 75% of homeless women) experienced some form of mental illness (Quon, 2006). People living with mental illness are in greater risk of being victims of physical harm and violence. In Toronto, for instance, 40% of homeless people

were attacked and 21% of homeless women reported being raped in 2004 (Frankish et al., 2005).

The Canada Mortgage and Housing Corporation approximated that 15% of the total Canadian population is in core housing need (quoted in Quon, 2006). This number almost doubles to 27% for people living with mental illness (Quon, 2006). Specifically, the proportion of Canadian people living with mental illness who are living in substandard housing – that is housing that is not affordable, adequate nor suitable – has been estimated to reach 140,000 people (Kirby & Keon, 2006).

The incidence of housing need arises precisely because this group experiences heightened challenges in choosing, getting and keeping housing. This exacerbates the housing instability of this portion of the population (Thomas & McCormack, 1999). The scarcity of community-based programs addressing the social needs of people living with mental illness also presents a challenge for this section of the population (Carling, 1995). The housing problem is further complicated by the relapsing nature of mental illness, which has the potential to result in sudden and/or continuous hospitalization (Carling, 1995; Thomas & McCormack, 1999). These unavoidable circumstances enhance the probability of losing housing and thus not being able to develop a sense of home (Carling, 1995).

Equally significant to the housing challenges encountered by this group is that individuals with mental illness are commonly situated within the poverty margins of society (Allen,

2004; Carling, 1995; Thomas & McCormack, 1999). This adds complexity to the housing crisis they encounter. Housing is particularly inaccessible in the private market due to stereotypes, myths and discrimination toward people living with mental illness (Carling, 1995; Milne, 1982). Housing accessibility for people living with mental illness is challenged by other low-income households which stand a better chance of accessing housing units because they are not stigmatized and are considered more appropriate residents (Carling, 1995). Lastly, people living with mental illness commonly have a limited number of integrated supports – including a combination of financial, social, and natural supports – compared with other sections of the population (Thomas & McCormack, 1999). This factor, taken in combination with psychiatric disability, stands as a significant barrier to finding housing in the real estate market (Thomas & McCormack, 1999). Housing security and social/community integration along with the availability of flexible mental health services can serve to minimize instances of relapse (Bryant, 2004; Carling, 1995; Trainor, 2006). The provision of these supports in an individualized manner would significantly enhance individuals' ability to access housing in the real estate market.

As alluded to above, people living with mental illness face persistent challenges which prevent them from choosing, getting and keeping quality housing in the community. The ongoing housing barriers faced by people living with mental illness – who compose a significant portion of the Canadian population – necessarily serve as pressure to develop housing policy that will encourage positive change in the lives of people living with mental illness. The elaboration and analysis of this issue will hopefully serve to

illuminate the urgency of the housing crisis endured by this population. Urban planners have the training and resources to assist in developing housing policy that enhances opportunities for normalized and affordable housing for people living with mental illness. Furthermore, planners are in an excellent position to ensure that the voices of people living with mental illness are an inherent component to the process of developing inclusive housing policy.

PURPOSE OF THE THESIS

The thesis enhances the literature on normalizing housing options for people living with mental illness, with the understanding that flexible, individualized supports are necessarily critical for the success of this group's housing stability. In this context, normalizing housing for people living with mental illness refers to maximizing people's ability to attain housing in the real estate market (George et al., 2005). The key to normalizing housing for this population is ensuring that individuals have a selection of housing – based on their needs and preferences – where they can truly lead a life of dignity, without the stigma of experiencing mental health issues (George et al., 2005).

Specifically, the thesis synthesizes relevant aspects from inclusive housing policy, mental health and planning discourse. This synthesis is particularly significant for the Winnipeg context as there is little locally-based research highlighting the amalgamation of these areas of study. The objective of the analysis in chapter 5 has been to comprehend and appreciate the housing challenges that people living with mental illness residing in Winnipeg encounter and the options they identify for minimizing these challenges.

Furthermore, this is an important topic to explore within a planning perspective because currently, planning literature falls short of confronting the social and housing barriers that this population has had to endure following deinstitutionalization. This research has fused a range of information – including historical, social, and political – that will raise the profile of the issue within planning debate on both on academic and professional levels. Also, the recommendations outlined in the thesis can assist in guiding planners when developing and implementing policies regarding the housing that people living with mental illness have identified as desirable and beneficial. Finally, the research creates a body of knowledge that can assist planners, service providers, and government officials to grasp a better understanding of one of the many minority groups that have traditionally been, and continue to be neglected in society. This knowledge will therefore encourage more democratic planning practices so that this vulnerable population receives one of the most fundamental human rights that every citizen should enjoy – that is, adequate, affordable and integrated housing.

The research was undertaken with the goal of answering the following questions:

1. Why do people living with mental illness feel that housing stability is particularly important for their mental well being?
2. What challenges do people living with mental illness feel most prevent them from choosing, getting and keeping decent and affordable housing in Winnipeg?
3. What policy tools can enhance integrated housing opportunities for people living with mental illness who reside in Winnipeg?

The first question is fundamental for this investigation because if we are to move toward normalizing housing options for people living with mental illness, we must first listen to the voices of this group of people. It is critical to understand the perspectives and opinions of people living with mental illness regarding the role and importance of housing stability for their mental health. Although housing has been identified as a social determinant of health – which is true for every member of society – the specialized needs of people living with mental illness can heighten the importance of housing for the mental stability of this population in comparison to other groups.

Question two is essential because it focuses on the experience of people living with mental illness in Winnipeg. Specifically, this question attempts to highlight the local barriers and challenges that people living with mental illness encounter when attempting to choose, get and keep housing in the community. Although the literature identifies that this group experiences challenges on an international level – i.e. beyond the Canadian borders – this question seeks to identify the local forces that play a role in perpetuating the housing crisis experienced by people living with mental illness in Winnipeg.

The final question addresses the notion of developing inclusive housing policy in the Winnipeg context. This question seeks to amalgamate the first two questions in that developing policy tools is highly dependent on the personal experiences of this group of people and the housing precedents identified as successful in other jurisdictions. On the one hand, it is critical to understand the housing experiences of people living with mental

illness who reside in Winnipeg, particularly their specific housing challenges. On the other hand, it is equally critical to analyze inclusive housing policy tools in other jurisdictions. These two elements will begin to elucidate the menu of policy tools that could ensure that housing policy in Winnipeg is reflective of not only the needs of people living with mental illness, but the needs of other groups who experience significant housing challenges.

The research and analysis have been informed by the concepts of housing as a key determinant of health and the importance of integrated and inclusive housing for the mental health of all Canadians. Specifically, the analysis highlights a series of themes which support the notion of housing as a social necessity, as prescribed by the Canadian Mental Health Association – Winnipeg Region (2007):

> The Ottawa Charter for Health Promotion identifies shelter as a basic prerequisite for health. Further, the United Nations recognizes housing as a human right to be protected under international law. Canada has endorsed such rights guaranteeing 'an adequate standard of living including adequate food, clothing and housing.'
>
> *The lack of affordable housing cuts significant numbers of Canadians off from supportive communities, access to employment and, indeed, from the exercise of their citizenship rights. Quite apart from the morality of the situation, this represents an enormous waste of human potential with serious consequences for the community at large* (Hulchanski (a), 2003).

THEORETICAL FRAMEWORK

Planning for People Living with Mental Illness

From a planning perspective, normalizing housing options for people living with mental illness is a critical component if Winnipeg is to be truly inclusive and democratic. Within planning theory, several theoretical concepts effectively give structure and guidance to this research. The theories discussed here are those of advocacy in planning and more contemporarily, radical or insurgent planning as prescribed by Leonie Sandercock.

Advocacy in planning evolved in response to the social inequalities experienced by minority groups across North America (Davidoff, 1965). Advocacy in planning was especially relevant in North American cities because society had increasingly become urban and ethnically diverse. The traditional role of planners, maintained prior to the 1960s, was rendered inadequate with the increased presence of sub-populations (Davidoff, 1965), including people living with mental illness. Traditionally, city planning had been limited to a technical and knowledge-creating profession (Davidoff, 1965). The city planner has conventionally been associated with land use planning and the physical organization of a city. Focusing on the organization of physical environments liberated the planner from expressing personal values or judgments. Making a personal judgment and acting upon that judgment to defend a value has been lacking from the traditional planning profession (Davidoff, 1965). However, during the 1960s, the concept of planner as technician was slowly being contested in response to the changing nature of society (Davidoff, 1965). The ephemeral quality of cities is constantly creating social conditions which urge the attention of the planning profession.

But, it is not the physical planner who will be suited to confront these issues (Davidoff, 1965; Sandercock, 1998). Therefore, the planning profession has encountered pressure to develop realms of planning that will be better suited to confront the social inequalities and discrimination facing contemporary groups in society. Such realms of planning must necessarily include engaging citizens in the planning process, valuing the preferences and needs of distinct populations and ensuring that people gain knowledge to participate in the decisions that will inevitably affect their lives.

The lack of citizen participation in the political planning process has kept the voices of minority groups at the fringe of engaging in the decisions that affect their lives. As stated by Davidoff (1965), one of the major problems that limit the amount of citizen participation in the political planning process is the use of specialized vocabulary. Plans and policies are separated from public grasp and comprehension through inaccessible vocabulary, excluding the average citizen from understanding and engaging in the decision-making process. If political planning decisions are meant to serve the public and enhance quality of life, it is crucial that the diverse groups that define society be given a fair opportunity to engage in that decision making process. Thus, advocacy planning refers to the realm of planning that encourages planners to represent clients who have personal values regarding the distribution of rights and resources within society (Davidoff, 1965). In an increasingly urban and diverse society, planners' roles must be flexible and considerate of the multiple publics within society. Representing diverse groups in the political arena allows for a critical analysis of established policies. The

representation of diverse groups in the political arena further highlights how set policies fall short of meeting the needs of the many groups within society.

Although advocacy planning was a clear step toward embracing the diverse publics in society – primarily those that were underrepresented – the movement faced strong criticism. At the onset of the movement, and primarily due to the lack of experience in working for minority groups, advocate planners were criticized for their lack of proficiency in confronting the issues that afflicted disenfranchised groups (Hartman, 1970). Representing minority groups and working *for* them, as opposed to *with* them, created the skepticism that advocacy planning could achieve its goal of democracy and inclusivity (Clavel, 1983). The premise that advocate planners were to work for their clients did not allow the clients to learn from planners' expertise and rather perpetuated their state of disempowerment in the absence of planners' services (Clavel, 1983). In addition, advocacy planning was criticized for not engaging people from diverse racial and ethnic backgrounds in the planning process (Knack & Peters, 1985). In other words, the realm of advocacy planning was limited to include middle and upper class white planners, who in an attempt to play down the controversial issues of racism, turned to confronting other urban problems, such as urban poverty (Knack & Peters, 1985).

The shortfalls of advocacy planning gave way to the development of radical planning. The elements of radical planning have been particularly critical in guiding this investigation.

Radical planning reflects society's demand that the planning profession develop practices which are inclusive of multiple populations. Such populations include people living with mental illness whose experiences have not been considered valuable in the traditional planning process. Radical planning developed in response to the inability of modernist planning to effectively embrace such diversity (Sandercock, 1998). Above all, radical planning is the analysis of discrimination and inequality (Sandercock, 1995). With this analysis, systemic processes of marginalization based on ethnicity, culture, gender and ability are comprehended, thus giving way to the possibility of social transformation (Sandercock, 1995). Radical planning, unlike modernist planning traditions, does not maintain the notion of the public interest (Friedmann, 1987; Sandercock, 1995). Rather, radical planning liberates marginalized groups from social oppression, with the understanding that the planner's role is one of facilitation and mediation (Friedmann, 1987). Therefore, the planner must not only understand the client group, but must also value the knowledge and expertise of the client group so that together the planner and client group can move toward social transformation (Beard, 2003; Friedmann, 1987). Radical planning thus reacts to the deficiencies of modern planning practice and seeks to embrace social, cultural and environmental justice in societies defined by a range of publics and experiences (Sandercock, 1998).

Recognizing advocacy in planning and embracing radical planning have served to mould the framework and process of this research. This theoretical framework has been critical in conducting research with people living with mental illness. The theoretical concepts described above have served to help consciously maintain the overall goal of this study –

that is, to make this sector of the population an integral component of the research to affect change and enhance the quality of life of people living with mental illness.

Planners' Role in the Provision of Housing for People Living with Mental Illness

As alluded to by the theoretical concepts outlined above, the planning profession is not only relevant, but can potentially be a valuable asset to the realm of housing provision for people living with mental illness. Given that the needs of marginalized groups are politically and socially charged elements that are made visible in the urban fabric, planners are unavoidably implicated. The housing crisis endured by people living with mental illness has been neglected by planners for far too long and is precisely the realm in desperate need of planners' services (Hartman, 2000; Sandercock, 1998).

The role of the urban planner has undergone a dramatic transformation from experts versed in the techniques of creating knowledge to professionals who can take part in utilizing and sharing their knowledge to affect change in collective action (Beard, 2003). More specifically, the notion of empowerment can play a fundamental role in the provision of housing for people living with mental illness (Carmona et al., 2003; Rocha, 1997). The notion of empowerment has been identified as an effective technique to build capacity in marginalized groups so that they can engage and actively participate in the decisions that will affect their lives (Rocha, 1997). This technique can be used as a framework for planners to allow the voices of people living with mental illness to be heard and valued in the process of developing integrated and inclusive housing that will more effectively respond to their diverse needs. The empowerment ladder, as described

by Rocha (1997), has a total of five rungs, but the realm that planners can most utilize in this debate is *political empowerment*.

Political empowerment embraces and values all members of the community as equals capable of contributing to society (Rocha, 1997). Empowerment becomes political action geared to affecting institutional change. In this process, planners become fundamental in representing marginalized groups on the political stage thereby facilitating the group's access to resources, such as financial resources and housing (Rocha, 1997). Political empowerment focuses on achieving tangible results along with building capacity in disenfranchised groups (including people living with mental illness) so that eventually, they are capable of engaging and participating in the decision making process on their own accord (Rocha, 1997).

With this theoretical foundation in mind, the question is no longer how planners can work *for* marginalized groups, as it was in the days of advocacy planning (Davidoff, 1965). Today, the question becomes how planners can utilize their knowledge in collaboration with marginalized groups so as to build capacity and work in collective action to affect change. Whether planners take on an advocacy role, a political representative role or one of educating decision-makers regarding the housing needs of people living with mental illness and the benefits of the supported housing model, it is critical that planners respect, value and tap into the knowledge, experiences and truths held by both people living with mental illness and community-based housing providers. Only then will planners begin to

confront the housing crisis that people living with mental illness have and continue to endure.

In light of the lack of participation and inclusion of people living with mental illness in the decisions that affect their lives, qualitative research which collaborates with people living with mental illness represents a step in the right direction. The city planning literature regarding research conducted specifically with people living with mental illness is scarce at best (Walker & Seasons, 2002). However, this research field has been documented – although not extensively – in health/medical related journals such as *Nursing Ethics* and *Journal of Psychiatric and Mental Health Nursing*.

Qualitative research conducted alongside people with mental disabilities or illnesses has been gaining value in academia both for the advancement of knowledge and as a means of affecting change. Approximately twenty years ago, the involvement of people with mental illness in social research was highly uncommon and mostly non-existent in some professions. However, the seminal work of Habermas in his 1972 *Knowledge and Human Interests* along with the influential 1968 writings of Paulo Friere, have played significant roles in illuminating the value of involving the subjects of the research in the research process itself (Ramcharan, Grant & Flynn, 2004). The medical fields, such as nursing, have increasingly been acknowledging the value of engaging people living with mental illness in the process of research to understand the challenges that this population encounters on a daily basis (Davies, 2005).

The development of emancipatory and participatory research represented a backlash against the dominant grand theory – that is, rational theories which were based on the notion of the public interest (Ramcharan, Grant & Flynn, 2004). The social sciences have been moving away from this modern theory to embrace postmodern theorizing (Ramchara, Grant & Flynn, 2004), which has encouraged the acceptance of multiple publics in society and further encouraged the valuing of their experiences in order to affect change (Ramcharan, Grant & Flynn, 2004). The evolution of both emancipatory and participatory research thus gave oppressed groups of society, such as people living with mental illness, the means with which to address issues relevant to their lives. This further began to create opportunities for amplifying their historically silenced voice.

Understanding the history behind this research field and the impetus behind the development of emancipatory and participatory research has been essential for this research. This knowledge has served to remind me of the great value of allowing the voices of people living with mental illness come through in the investigation with the greater goal of affecting change in the lives of this historically oppressed group of people.

ETHICS

As mentioned above, the research has focused on people living with mental illness. This group has been identified as a vulnerable population because they have historically been marginalized and stigmatized. Working directly with human participants required undergoing the process of ethics review through the University of Manitoba. Specifically, ethics approval was attained for conducting the interviews for CMHA for

the purposes of building for a housing forum that took place in October 2006. In addition to ethics review, several basic guidelines were adhered to when interacting with the research participants. First, and given the direct involvement of CMHA with people living with mental illness, the interviewees were recruited with guidance from CMHA. Once the interviewees were selected, they were provided with a comprehensive and concise delineation of the housing forum and the thesis project, including the goals, objectives, research questions, and their role in the study. Also, the interview process honored the principles of confidentiality, which ensured that all information attained from the interviews was amalgamated for the purposes of analysis. Thus, all names and personal information have not been included in this thesis report. This has ensured that the participants' identities have remained anonymous. Finally, individuals were included in the research only after they gave their written consent.

The existing data set has been used for this thesis with the consent of both CMHA and the interview participants. The interview guide utilized for the nine interviews has been attached as Appendix A.

CHAPTER SUMMARY

Chapter one gave a brief overview and introduction into the topic of housing challenges encountered by people living with mental illness. The focus of this chapter has been to outline the purpose of the thesis, the research questions that have shaped the research, and the theoretical planning framework within which this research falls. The chapter concluded with outlining the ethical considerations that this research entailed.

Chapter two discusses the historical overview of housing for people living with mental illness. Specifically, the discussion begins by contextualizing the research with a gender-based analysis of mental illness, defining housing affordability and core housing need, illuminating housing as a determinant of health and the process of the deinstitutionalization of psychiatric services. Then, the provision of social housing in Canada are briefly discussed followed by a historical road map outlining the housing situation – specifically the two housing models – that have led to the most recent and progressive model of housing for people living with mental illness.

Chapter three focuses on the contemporary housing situation for people living with mental illness. Attention is given to explaining the supported housing model and how defining elements of supported housing can assist in developing housing policy which enhances the housing opportunities for this section of the population. Second, this chapter gives examples of precedents of supported housing that have proven successful in different jurisdictions.

Chapter four gives a detailed description of the analytical methods of the research. Specifically, the chapter outlines the process through which the analytical arguments presented in chapter five were developed.

Chapter five is dedicated to presenting and explaining the literal and interpretive themes derived from analyzing the existing data set. These explanations will then be used for addressing the research questions identified in chapter one.

Chapter six concludes with a discussion of the recommendations and the research direction that this topic can take in order to further enhance current literature and research in this area of study.

CHAPTER 2: HISTORICAL MILIEU

This chapter discusses the historical milieu that has impacted the current housing situation for people living with mental illness. This will assist in contextualizing the research and further position the thesis within the overarching paradigm of housing as a social necessity. Chapter three will then proceed to discuss the more recent and progressive housing options that have evolved out of previous housing models.

The following literature review begins by highlighting the significance of a gender-based analysis when discussing the housing crisis endured by people living with mental illness. The literature review then positions this research within the milieu of social housing provision in Canada, housing affordability and housing as a social determinant of health. More broadly, the literature review establishes this research within the context of the paradigms that have evolved within the mental health system and the different housing models that have aligned with the specified mental health paradigms. The literature review further explores policy tools that could enhance options for normalizing housing for people living with mental illness.

GENDER-BASED ANALYSIS: WOMEN & MENTAL ILLNESS

Mental health services in Canada have historically been delivered in a gender neutral manner, overlooking sex and gender and how these two critical elements influence the consequences of mental illness (The Canadian Women's Health Network, 2006). In this context, *sex* refers to variations arising from biology (Salmon et al., 2006). *Gender* on the other hand, refers to the socially determined expectations allotted to both women and

men (Salmon et al., 2006). This oversight may have been due to the fact that research and treatment have placed greater attention on men as opposed to women, or because men, in some instances, more commonly report the prevalence of mental illness and the consequences that arise thereof (Greaves, 2006). As the following statistics will show, the prevalence rates regarding the impact of mental illness are higher for women than they are for men. This suggests that the delivery of mental health services in a gender neutral manner may have been influenced by the traditional normalization of men's experiences of health care, among other areas of social inquiry. Needless to say, mental illness affects both women and men.

Gender analysis in the delivery of mental health services in Canada, including the provision of housing, can no longer continue to be overlooked. Although the occurrence of mental health issues is fairly similar for both genders in Canada – affecting 11% of women and 10% of men – Canadian women make up the largest proportion of hospital patients and compose the majority of paid and unpaid care providers in the nation (Salmon et al., 2006; The Canadian Women's Health Network, 2006). Branne (2006) has found that women are more prone to developing symptoms of certain mental illnesses in response to their constant role as caregivers. As women make up the majority of caregivers in Canada, they are more vulnerable to anxiety, stress and depression than their male counterparts (Branne, 2006). Salmon et al. (2006) reported that 5.5% of women and only 3.5% of men declared experiencing depression. More Canadian women – 6% of women as compared to 4% of men – have also declared warnings of panic disorder, agoraphobia and/or social phobia (Salmon et al., 2006). Consequently, women

are consumers of mental health services more often than men and have also reported the need for more choices in support services than are available presently (Salmon et al., 2006).

According to the Canadian Community Health Survey, women make use of primary health care services for symptoms of mental health 2.9 times more often than men (Salmon et al., 2006). Although more women than men are utilizing both primary and mental health care services for mental health issues, the Canadian Community Health Survey reported that 22% of women (compared to only 20% of men) declared that the current system of health care falls short of adequately meeting their mental health care needs (Greaves, 2006; Salmon et al., 2006).

It has been shown that with flexible and adequate mental health services and meeting certain basic needs such as housing, individuals suffering from mental illness are capable of leading normal and fulfilling lives (Carling, 1995). As a result, psychiatric and medical professionals have begun to value the diverse roles that women living with mental illness engender – particularly the role of partner/spouse and mother – and further analyze how these roles are critical to individuals' autonomy and resilience (Salmon et al., 2006). Women living with mental illness who take on the role of mother and therefore primary caregiver of their child may require specialized supportive housing options that may not be necessary for men (Salmon et al., 2006). In addition, the prevalence of homelessness among women with mental illness has been reported to be the result of unique housing issues (Salmon et al., 2006). For instance, homeless women

suffering from mental illness or substance abuse who are either mothers or expectant mothers have identified that the reasons for their homelessness are associated with the lack of safe housing alternatives in the case of domestic violence, inadequate and unaffordable housing situations, and the loss of a partner (Salmon et al., 2006).

Gender analysis is an instrument that can assist decision makers and policy officials in critically understanding the biological, social and economic differences between women and men in order to guide the establishment and analysis of programs and policies that are responsive to the distinct needs of each gender (Salmon et al., 2006). Specifically, a gender-based analysis of social and/or housing policies encourages programs that are responsive, convenient and safe for women suffering from mental illness and substance misuse (Salmon et al., 2006). Based on the above statistics, such programs can include secure and permanent housing for women suffering from mental illness who are (expectant) mothers; safe and permanent housing for women suffering from mental illness who have been victims of domestic violence; and services that provide resources and counseling on issues such as reproduction, financial management, and other skills training (Salmon et al., 2006). The development of social and/or housing policy intended to enhance the housing opportunities for people living with mental illness must not be done without first acknowledging that both sex and gender impact the experience of mental illness (Marrow et al., 2006; Salmon et al., 2006).

HOUSING AFFORDABILITY & CORE HOUSING NEED

The statistics indicating the level of housing instability that plagues women and men living with mental illness suggest that there is a significant need among this group of people for acceptable housing. As such, a clarification of acceptable housing and core housing need is necessary. According to the Canada Mortgage and Housing Corporation (2005), *acceptable housing* is defined as housing that is adequate, suitable and affordable. An *adequate* residence is one which is not in need of exceptional renovations (Canada Mortgage and Housing Corporation, 2005). Housing *suitability* identifies dwellings that have sufficient bedrooms – as measured by the National Occupancy Standard (NOS) requirements – for the members of a household (Canada Mortgage and Housing Corporation, 2005). *Affordability* refers to housing that costs no more than 30 percent of the total pre-tax household income (Canada Mortgage and Housing Corporation, 2005). Lastly, *core housing need* refers to people who cannot access housing that satisfies the three standards of adequacy, suitability and affordability described above (Canada Mortgage and Housing Corporation, 2005).

In 2001, 6.5 percent of households – or 702,000 – in Canada utilized 50 percent or more of their income on housing and 20.2 percent – or 2,179,400 – of households in Canada utilized 30 percent or more of their income on housing (Canada Mortgage and Housing Corporation, 2005; The Canadian Chamber of Commerce, 2005). This information becomes relevant when considering that specific sections of the population are more likely to fall within core housing need (Skelton, 1998). Such individuals include those who are unemployed or receiving income from the government which includes a large

proportion of people living with mental illness, along with youth and Aboriginal households (Canada Mortgage and Housing Corporation, 2005; Skelton, 1998). In order to develop housing policy that is more responsive to the unique housing needs of people living with mental illness, it is necessary to look at the notion of an acceptable housing and core housing need, particularly the number of Canadian people living with mental illness who experience housing instability. At the very least, this will give planners and policy officials an idea of how many people are in critical housing need and thus provide a statistical framework from which to work.

HOUSING AS A DETERMINANT OF HEALTH

Having discussed the statistics – a form of quantitative data – that suggest the significant housing need among people living with mental illness, the discussion turns to consider housing as a social determinant of health – a qualitative analysis – to gain a more holistic understanding of this issue. The quality of housing, housing security and social integration play a significant role in both the physical and mental health of all individuals, regardless of ability (Bryant, 2004). A lack of access to affordable housing and an adverse physical state of residential units are strongly correlated with impaired physical and mental wellbeing (Bryant, 2004). Specifically, an adverse physical state refers to housing or apartment units with defective heating or cooling systems, the occurrence of radon or lead, cockroaches, overcrowding or excessive density. The persistence of these issues develops into physical and mental (or emotional) health problems such as anxiety, low confidence, social isolation and an overbearing sense of powerlessness to change these conditions (Bryant, 2004). Furthermore, marginalized and

disabled people face additional challenges in acquiring housing through the real estate market, being left to endure derelict housing conditions in unsafe neighbourhoods (Bryant, 2004).

When a disproportionate amount of an individual's income is used toward housing, this diminishes the availability of income for other critical necessities such as food. This enhances food insecurity, housing insecurity, fosters under-nourishment and inevitably hinders the state of an individual's health (Bryant, 2004; Ogaranko, 2001). Although people are generally capable of dealing with stressful situations, when the 'biological stress reaction system' is constantly and acutely provoked – which is the case for people suffering from housing insecurity – both the mental and physical health of an individual suffer (Bryant, 2004).

The *Ottawa Charter for Health Promotion* has declared housing as a fundamental necessity for health (Bryant, 2004). Nevertheless, the prevalence of a nation-wide housing crisis illuminates that the housing policy and models of affordable, low-income and/or social housing have fallen short of meeting this need (Bryan, 2004). This becomes reflected primarily in the health of those most affected by housing insecurity. Of particular importance for people living with mental illness is a the ability to choose, get and keep the housing they deem appropriate, with an emphasis on normalized housing which would foster community integration, personal empowerment and autonomy. This necessarily calls for the development of housing and social policy that specifically

positions the needs and preferences of people living with mental illness at the core of the process of policy development.

DEINSTITUTIONALIZATION & THE AFTERMATH

People who have experienced mental illness have been devalued in society, ostracized from public life thereby minimizing possibilities for social and community integration (Carling,1995). The myths or stigma that society commonly holds regarding people living with mental illness historically maintained the belief that the institution was the most appropriate environment for this group of people (Carling, 1995). Psychiatric institutions thrived on the assumption that treatment and services were more effectively distributed in bulk within controlled settings; that people with a mental illness were incapable of caring for themselves or establishing a normal life in society; and that through medication and guidance individuals' 'defects' could be mitigated or at least controlled (Carling, 1995; Government of Canada, 2006).

During the 1950s and 1960s, the violation of human rights of psychiatric patients within institutions was being contested by family, friends, professionals and advocates (Bridgman, 2003; Miano, 1996). Deinstitutionalization was thus the result of civic protests coupled with economic decline and medical advancements (Golomb & Kocsis, 1988; Miano, 1996; Trainor, 2006). Economically, deinstitutionalization was the means through which the costs allotted to the care provided in large-scale institutions could be transferred to community-based programs that would ideally cater to greater numbers of people (Sealy & Whitehead, 2004). In addition, the process of deinstitutionalization was

driven by the inhumane conditions within psychiatric institutions (Carling, 1995). These were made apparent through patients' comments to family members and undercover interviews with patients publicized through the media (Bergman, 1975; Miano, 1996). Deinstitutionalization was further legitimized through legislation which defended the rights of psychiatric survivors to dwell in the least restrictive setting, alluding to a model of community-based service delivery (Miano, 1996). In other words, in-patients were slowly transferred from psychiatric institutions into residential communities. However, the provision of community-based mental health services developed at a much slower rate than that of deinstitutionalization (Bergman, 1975; Carling, 1995; Sealy & Whitehead, 2004).

This apparent step forward in social justice for psychiatric survivors had unforeseen consequences. The communities that experienced an influx of ex-psychiatric patients were not equipped on many levels to cater to this population (Carling, 1995; Golomb & Kocsis, 1988). There was a lack of community-based housing that would allow for a sense of normalcy and independence (Bergman, 1975; Miano, 1996). In addition to a lack of community- based housing, communities lacked mental health programs that are critical to servicing this population and the staff to manage such service facilities (Trainor, 2006).

The deficiencies presented by communities at the onset of deinstitutionalization altered the lives of ex-psychiatric patients and usually not for the better. Individuals released from psychiatric institutions were either placed within institution-like settings situated

within communities such as group homes or hostels; taken in by family members; re-institutionalized or left to wander the streets due to a lack of accommodation options (Thomas & McCormack, 1999). Multiple studies, such as one conducted by Thomas and McCormack (1999), indicate that people with mental illness have a significantly enhanced risk of becoming homeless – up to five times – in comparison to other populations. Not only does the lack of adequate and affordable housing deter access to treatment, services and an acceptable quality of life, but it also renders people living with mental illness vulnerable to violent attacks and murder when left homeless (Thomas & McCormack, 1999). The history of deinstitutionalization thus enforces the need to develop housing and social policy that enhances decent and affordable housing options and thus the housing stability of people living with mental illness.

DEINSTITUTIONALIZATION: CANADIAN CONTEXT

The process and consequences of deinstitutionalization can be observed in many advanced welfare states. However, it is beneficial to understand the Canadian context with regard to deinstitutionalization and housing provision if the housing crisis endured by people living with mental illness in Winnipeg is to be addressed.

The first province in Canada to spearhead the process of deinstitutionalization was Saskatchewan, where in the 1950s patients were being discharged from psychiatric hospitals into residential communities (Sealy & Whitehead, 2004; Trainor, 2006). Between the years 1960 to 1980, most Canadian provinces implemented some form of deinstitutionalization of mental health services however the provinces varied regarding

the time and rate at which deinstitutionalization was carried out (Sealy & Whitehead, 2004). By 1994 and 1995, Nova Scotia had replaced Saskatchewan in having the highest rate of deinstitutionalization (Sealy & Whitehead, 2004). Manitoba and Quebec became active in deinstitutionalizing mental health services particularly during 1994 to 1995 and then again from 1998 to 1999 (Sealy & Whitehead, 2004). The last province to catch up in the national rate of deinstitutionalizing mental health services was Prince Edward Island (Sealy & Whitehead, 2004).

In terms of mental health reforms in the Province of Manitoba, the policy implementation of the early 1990s outlined the 25% decrease in the amount of temporary psychiatric beds in Winnipeg. This inevitably signified a decreased availability of institution-based mental health care (Tataryn et al., 1994). It was approximated that close to 80% of the bed closures would be associated with mental health care aimed at adults living with severe mental illness (Tataryn et al., 1994). In order to minimize the negative consequences of these changes, the Mental Health Division of Manitoba Health planned on enhancing the housing and social services offered through community-based organizations in Winnipeg (Tataryn et al., 1994). Ideally, the implementation of these policies would serve to improve accessibility to health care for those living with mental illness in Manitoba (Tataryn et al., 1994). However, Manitoba mental health care services are increasingly utilized by people with mental illness that are within the middle and higher income range of the population (Tataryn et al., 1994). This unevenness leaves those with low-income and people below the poverty line – both of which define the majority of people living with mental illness in Manitoba – facing additional barriers in

accessing psychiatric care and consequently achieving housing stability (Tataryn et al., 1994). The additional barriers for acquiring housing and mental health services that low income individuals face is another element that calls for the establishment of housing and social policy that begins to fill the needs of this population so that they too have the opportunity to lead fulfilling lives and become contributing members of society.

TRENDS IN SOCIAL HOUSING PROVISION, CANADA

Although deinstitutionalization was driven by a set of specific forces, the challenges and barriers encountered by people living with mental illness in acquiring and maintaining homes following deinstitutionalization have inevitably been dependent on the system of housing provision in Canada. Analyzing the dynamics of social housing provision in Canada will enhance an understanding of the connection between housing provision and the housing need that people living with mental illness continue to endure.

Following World War II, Canada experienced a scarcity of housing, which became the force behind the first forthright government involvement in the delivery of public housing (Shaffner, 1975). In 1949, the federal-provincial partnership was established for the provision of public housing (Shaffner, 1975). The public housing model, by its very mandate of supplying housing options for low-income households and households below the poverty line, significantly improved the accessibility of housing for the poor (Shaffner, 1975). However, this model was not as responsive as it could have been to the different housing needs of specialized groups of people such as people living with mental illness – particularly in providing access to the mental health services required by this

group of people (Carling, 1995; Sewell, 1994). In 1973, the public housing program was put aside to make way for a decentralized housing model (Sewell, 1994).

In response to the rising housing costs across Canada, the federal government established the non-profit and cooperative program in 1973 (Sewell, 1994; Skelton, 1998; Shaffner, 1975). The non-profit housing program encountered initial barriers due to a lack of experience in the provision of housing (Skelton, 1998). However, this program allowed community-based organizations and faith-based groups to respond to the needs of specific groups in the community that presented significant housing need (Skelton, 1998). This phase further reflected the potential of the third sector to respond to the housing crisis experienced by those living in poverty, which includes people living with mental illness (Sewell, 1994; Skelton, 1998).

In 1992, the federal government declared that following 1994, new non-profit housing would not receive financial support from the federal government (Sewell, 1994; Skelton, 1998). This freeze in federal funding for new non-profit housing programs left the third sector encountering significant barriers in the provision of social housing (Sewell, 1994). To date, the federal government has made funding available to a number of organizations however there has been a lack of a permanent program dedicated to financing the third sector in housing provision since the freeze in federal funding (Skelton, 1998). Specifically, within Manitoba, one such funding resource is the Affordable Housing Initiative. The Affordable Housing Initiative is a five-year partnership between the federal and provincial governments, which has allotted approximately $50 million to

enhance the availability of affordable rental and new housing units in Manitoba (Manitoba Family Services and Housing, 2007). The programs under this initiative are devised to assist sections of the population that fall within the low- to middle-income margins of society, including people with disabilities (Manitoba Family Services and Housing, 2007).

In the early 1980s, the issue of homelessness became persistent and the need for special purpose housing became apparent (Carling, 1995). However, within the social housing programs, limited consideration was given to housing that specifically catered to those with special housing needs, including people living with mental illness (Carling, 1995). The agreement between the federal government and certain provinces allowed only 10% of the financial support to be directed toward special housing (Sewell, 1994).

History has shown that enhanced housing needs especially affect certain minority and marginalized groups (Sewell, 1994; Skelton, 1998) and that the past social housing models were not as effective as they could have been for these groups of people (Sewell, 1994), including people living with mental illness. It is for these reasons that understanding and analyzing the history of social housing provision in Canada is critical. Comprehending the history of housing provision in Canada will serve to help policy officials and decision makers learn from the mistakes and deficits of the past in order to enhance the opportunities for safe, decent and affordable housing for people living with mental illness. Furthermore, understanding the history of social housing provision in Canada – primarily the non-profit and cooperative housing programs of the past –

highlights that this era gave way to the development of an infrastructure of people with the necessary expertise to establish low cost housing in Winnipeg today (Skelton, 2000). Specifically, the implementation of the non-profit and cooperative housing programs produced a set of people that, upon the availability of financial resources, will have the necessary skills to utilize the funds effectively and thus develop social housing that is responsive to the needs of vulnerable populations, including people living with mental illness.

Social Housing Provision: Promising Tools

The housing challenges faced by people living with mental illness, much like other populations requiring social housing in Winnipeg, can be minimized by considering the following policy tools. The following represent a menu of policy tools that could serve to enhance the provision of social housing in Winnipeg and across the province:

Administration & Organization

- The implementation of a national housing policy is critical to minimize the challenges faced by populations living below the poverty line, which includes people living with mental illness (Hulchanski, 2003; The Canadian Chamber of Commerce, 2005).
- Enhancing the shelter element of the provincial social assistance allowances would allow for greater freedom in selecting and maintaining housing (Hulchanski, 2003). It is particularly necessary to ascertain that the shelter

element of social assistance takes into consideration the cost of rental units on the private market within the respective jurisdictions (CHRA, 2005).

Supply: Availability of Affordable Housing

- It is critical that the provincial government set aside a sufficient amount of deconcentrated low-cost housing units specifically for people living with mental illness (Hulchanski, 2003). To effectively accomplish this, the establishment of a 'community and housing investment' system can work toward enhancing the availability of low cost housing that is created and managed by public-private and nonprofit-private collaborations (Hulchanski, 2003).
- As an alternative to the traditional citing of affordable housing units within concentrated areas such as inner city neighborhoods, exploring innovative funding and liability agreements as a means of promoting the remediation and redevelopment of brownfield sites as potential residential areas with a mix of tenure types and housing costs (The Canadian Chamber of Commerce, 2005). This would serve to minimize discrimination and stigmatization of low-income or subsidized households.
- Engage the non-profit sector – which has developed the experience and expertise in the provision of housing for specialized groups in society – to work towards increasing the supply of low cost housing in Winnipeg (Skelton, 2000).

Demand: Financial Accessibility

- Develop a long-term shelter allowance program designed specifically for people living with mental illness (Manitoba Housing and Renewal Corporation, 2005).
- Households that fall within the poverty margins of society, particularly the working poor, can extensively benefit from an income supplement to position them above the poverty line and enhance their accessibility to greater options of safe and decent housing (Hulchanski, 2003).
- Rent Supplement Programs commonly establish agreements with landlords, which creates the incentive for landlords to set aside a percentage of their housing units for low-income individuals and households. The tenants would be on a rent-geared-to-income situation thereby allowing the individual/household to pay no more than 30% of their income for shelter purposes (CHRA, 2005).
- Offering portable housing allowances that are attached to the individual – rather than to housing units – would present the individual with greater freedom to move should their family or economic situation happen to change (CHRA, 2005; Dickie, 2005; The Canadian Chamber of Commerce, 2005; Trainor, 2006).
- Aside from the construction of new affordable housing units, people living with mental illness can benefit from government subsidized rents of older housing units to make them affordable for this section of the population (CHRA, 2005; Trainor, 2006).
- Long-term low cost housing is possible by utilizing capital grants along with long-term rent supplements which would facilitate a rent-geared-to-income

situation and consequently the accessibility of market rental housing for people living with mental illness (CHRA, 2005).

- In addition to rent supplement programs, determine the effectiveness of creative housing options for people living with mental illness such as a homeownership subsidy programs, rent-to-own opportunities, and co-operative housing options which are designed to house both people living with mental illness and those people not affected by mental illness.

Although the above policy tools primarily focus on people living with mental illness and their ability to choose, get and keep housing, these policy considerations are also relevant for the general provision of social housing in Winnipeg and across Manitoba.

HOUSING OPTIONS FOLLOWING DEINSTITUTIONALIZATION

Following the deinstitutionalization of large numbers of patients beginning in the 1950s a limited set of residential units were established within communities (Carling, 1995). The push toward developing mental health programs within residential communities was in part driven by civil rights movements (Carling, 1995). However, the residential options provided within neighborhoods contradicted these ideals – that is, fewer restrictions and greater freedom and autonomy for ex-psychiatric patients (Trainor, 2006). Although standard rental housing, available at market value, was and continues to be available, it is typically too expensive to be accessible to people living with mental illness who depend on social assistance (Carling, 1995). This population also faces difficulties in accessing rental housing because they encounter discrimination by landlords who will rent their

units to this population only as a last resort (Milne, 1982). One of the viable options for many ex-psychiatric patients was to congregate in low-cost single-room-occupancy hotels, which were typically situated in derelict areas of inner cities across North America (Carling, 1995; Walker & Seasons, 2002). Next to single-room-occupancy hotels, the most common type of accommodation for psychiatric survivors was mental health housing, or facilities which 'bundled' services – making housing available upon acceptance of a treatment program (Allen, 2004). More specifically, the mental health housing popular during the 1960s and 1970s included nursing facilities, intermediate care facilities, group homes, boarding homes and hostels (Massey & Wu, 1993; Milne, 1982). These specialized facilities became highly restrictive environments and due to the number of clients they serviced, the living conditions became crowded and depressing (Milne, 1982). The restrictions placed on clients' level of independence and the lack of privacy and flexibility within mental health housing typically hindered individuals from developing social skills; limited participation in community life; and further limited the development of social networks. Residents of such restrictive housing options experience constant uncertainty and fear because in such 'bundled' facilities, residents are required to uphold a specific treatment program in order to maintain their housing (Allen, 2004). Such accommodation ensures a level of behavioral control over residents. This perpetuates the very institutional environment that limits personal growth and further minimizes any future possibilities for an independent lifestyle. The specific housing models that have developed within the mental health system will be discussed in greater detail in following sections.

In considering the selection of housing for people living with mental illness, individuals who were released from psychiatric institutions were omitted from decision-making regarding their community housing. This role was taken on by case managers, mental health service staff, or other psychiatric professionals (Massey & Wu, 1993). This was the case because professionals and/or service providers were thought to be the most knowledgeable and competent to decide the dwelling suitable for their clients. Thomas and McCormack (1999) and Milne (1982) demonstrate that the residential choices determined by mental health professionals differ significantly from the preferences of people living with mental illness. When given the opportunity to express their preferences, people living with mental illness simply desire the opportunity to live a normal life, in an average residential neighborhood, within their own home – much like the general population (Thomas & McCormack, 1999; Walker & Seasons, 2002). The literature suggests that analyzing and valuing the housing preferences and specific needs of people living with a mental illness will allow a more democratic and just process of establishing residential options (Milne, 1982). As such, it is especially important to value the life stories of people living with mental illness, particularly their housing preferences, in order to develop housing and social policy that will work to enhance opportunities for affordable and safe housing.

SHIFTING PARADIGMS WITHIN THE MENTAL HEALTH SYSTEM

The mental health system has undergone slow but clear paradigm shifts – that is, gradual transformations in the world views or ideologies that shape the outcomes in society (Parkinson, Nelson & Horgan, 1999). These gradual paradigm shifts highly influence housing options for people living with mental illness. Specifically, each paradigm shift embodies the method in which people living with mental illness are conceptualized, 'treated', and therefore, housed (Nelson, Lord, & Ochocka, 2001). Within the mental health system, the philosophical shift has progressed from a *medical-institutional* approach, to a *community treatment-rehabilitation* approach, to an *empowerment-community integration* philosophy (Nelson, Lord, & Ochocka, 2001). The medical-institutional approach simply defined people living with mental illness as patients incapable of contributing to society and thus resulted in the warehousing of people living with mental illness in large scale institutions (Parkinson, Nelson & Horgan, 1999). In the late 1960s, the medical-institutional approach waned in the mental health system to give way to the community treatment-rehabilitation ideology (Nelson, Lord & Ochocka, 2001). The community treatment-rehabilitation approach encouraged a shift away from warehousing individuals in psychiatric institutions and promoted the treatment of individuals in less restrictive environments such as residential communities via housing programs (Parkinson, Nelson & Horgan, 1999). Specifically, with regards to housing, the community treatment-rehabilitation ideology promotes the notion of a housing continuum, which allows people living with mental illness to 'graduate' from housing options with intense support and management (such as group homes) to less restrictive settings (such as supportive apartments) (Nelson, Lord & Ochocka, 2001). Although the

community treatment-rehabilitation ideology is a step forward from the medical-institutional approach, there are specific limitations to this philosophy. For instance, the importance placed on the notion of a housing continuum minimizes individuals' ability to develop a sense of home and perpetuates their involvement in 'housing programs' (Nelson, Lord & Ochocka, 2001). Second, the continual influence of mental health professionals in the daily lives of people living with mental illness reserves an unequal power balance between the 'clients' and the 'professionals', thereby minimizing the importance of the lived experiences and preferences of people living with mental illness (Nelson, Lord & Ochocka, 2001). Finally, the community treatment-rehabilitation ideology promotes housing programs that, despite their physical presence in residential communities, work against the social integration of people living with mental illness into the communities in which they live (Nelson, Lord & Ochocka, 2001). The empowerment-community integration ideology makes up the most recent set of values to mould the mental health system and is of primary concern for the scope of this document (Nelson, Lord, & Ochocka, 2001).

The empowerment-community integration paradigm is defined by three elements. These include 'consumer inclusion and empowerment', 'community support and acceptance', and 'social equity and attainability of resources' by all citizens regardless of ability (Nelson, Lord, & Ochocka, 2001). 'Consumer inclusion and empowerment' is the method of gaining independence and personal strength by interacting with other citizens (especially people that do not live with mental illness) and partaking in valued roles in society – such as student or employee (Nelson, Lord & Ochocka, 2001). Another vital

component of the 'consumer inclusion and empowerment' element is the unequivocal presence of people living with mental illness and/or their family members within the political arena to be able to voice their concerns and demand a range of choices (Nelson, Lord, & Ochocka, 2001). This, in turn enhances the development of personal empowerment and the sense of control over one's own life (Nelson, Lord, & Ochocka, 2001).

'Community support and acceptance' refers to social integration and inclusion within the community in which the individual lives (Nelson, Lord, & Ochocka, 2001). Social integration and inclusion moves beyond simply being physically present within a geographically-set residential area to feeling as an integral component of the community (Nelson, Lord, & Ochocka, 2001). An important component of 'community support and acceptance' is conceptualizing individuals living with mental illness as people first – as opposed to a diagnosis or a client/patient – and therefore de-linking treatment/services from residential environments (Carling, 1995; Nelson, Lord & Ochocka, 2001). Also important within the 'community support and acceptance' element of the *empowerment-community integration* paradigm is ensuring that people living with mental illness have access to generic community services such as recreational facilities, which becomes a means of developing informal or natural social networks (Nelson, Lord & Ochocka, 2001).

Lastly, 'social equity and attainability of resources' refers to the right that all citizens have to adequate, safe, and affordable housing (Nelson, Lord, & Ochocka, 2001). If

vulnerable populations, such as people living with mental illness, encounter barriers to attaining adequate and safe housing, they have the right to be offered the necessary financial resources to enable them to access adequate housing (Nelson, Lord, & Ochocka, 2001). The general population has the right to live in the type of housing and community that they choose. So too do people living with mental illness have the right to exercise that freedom (Nelson, Lord, & Ochocka, 2001).

The gradual shift in philosophy which has been responsible for shaping the outcomes of the mental health system can explicitly be seen in the models of housing that have been available to this group of people. The *medical-institutional* approach is consistent with both large scale psychiatric institutions and custodial housing (Parkinson, Nelson, & Horgan, 1999). The *community treatment-rehabilitation* approach is consistent with supportive housing which maintained the link between housing and treatment (Parkinson, Nelson, & Horgan, 1999). Finally, the *empowerment-community integration* approach is embodied in the principles of supported housing, which conceptualizes individuals as people first and de-links treatment/services from housing (Parkinson, Nelson, & Horgan, 1999). It is critical to understand the characteristics of each housing model in order to understand the dynamics that have led to the current state of affairs in terms of housing for people living with mental illness. Therefore, the discussion will now turn to describing each housing approach in greater detail.

The Custodial Housing Model

The custodial housing model first appeared in the 1950s and 1960s throughout both Canada and the United States (Parkinson, Nelson, & Horgan, 1999). The principles of the custodial housing model are exemplified in nursing homes, single-room-occupancy hotels, foster families, board-and-care homes and 'homes for special care' (Lightman, 1992; Nelson & Smith-Fowler, 1987; Parkinson, Nelson, & Horgan, 1999; Ridgway & Zipple, 1990a; Ridgway & Zipple, 1990b). Custodial housing is characterized by for-profit management of the custodial services, on-site supervision (which may or may not be 24-hour), and strict institutional rules and regulations (Parkinson, Nelson, & Horgan, 1999). Residents of custodial housing pay the cost of the shelter and the custodial services provided (Parkinson, Nelson, & Horgan, 1999). The services that are made available in these settings are limited to the provision of food, maintenance, and the distribution of medicines (Parkinson, Nelson, & Horgan, 1999). Due to the restrictive and controlled nature of these settings, residents have minimal say in the type of food, accommodation, roommates, and care-givers in the custodial environment (Parkinson, Nelson, & Horgan, 1999). Individuals housed in custodial settings are conceptualized as patients and clients – which gives prevalence not to the person but rather to the diagnosis and serves to perpetuate residents' disability (Parkinson, Nelson, & Horgan, 1999; Trainor et al., 1993). Also, as a result of zoning parameters, custodial housing and group home settings are commonly situated in low-income core neighborhoods (Taylor, Elliot, & Kearns, 1989; Parkinson, Nelson, & Horgan, 1999). The placement of custodial settings in core neighborhoods – neighborhoods of poverty and crime – makes an already vulnerable population even more susceptible to violations, discrimination and attacks.

Although the literature defines custodial housing utilizing discrete characteristics and qualities, it must not be overlooked that custodial housing models have been as unique and diverse as their providers. Custodial environments mimicked the very institutions that they were meant to replace by continuing to disrespect residents' preferences and violate their human rights (Parkinson, Nelson, & Horgan, 1999). As a result, custodial settings received significant criticism from people living with mental illness, family and advocates (Parkinson, Nelson, & Horgan, 1999). The foremost criticism was that custodial settings merely perpetuated the warehousing of individuals living with mental illness, thereby fostering and prolonging the residents' disability and dependence on others (Hall, Nelson, & Smith-Fowler, 1987; Nelson, Hall, & Walsh-Bowers, 1997; Parkinson, Nelson, & Horgan, 1999; Segal & Liese, 1991). Another criticism of this housing approach is the lack of attention to residents' personal strengths, focusing rather on their disabilities, which serves to foster dependency and further perpetuates residents' disabilities (Parkinson, Nelson, & Horgan, 1999).

According to a study on levels of adaptation conducted by Nelson et al. (1997) – who monitored individuals living in board-and-care homes, group homes, and supportive apartments – the residents of the custodial settings displayed very little development in terms of 'personal growth', 'perceptions of control', 'quality of life', 'meaningful activity', and 'independent functioning'. There was evidence to indicate that some residents of the custodial settings enhanced their level of involvement in the community through such tasks as paid employment and voluntary jobs (Nelson, Hall, & Walsh-

Bowers, 1997). The success in terms of community involvement, however, is dependent on the amount of encouragement and guidance that residents receive from the service providers within each setting. On the other hand, Segal and Kotler (1993) determined that residents of custodial settings experienced decreased adaptational abilities throughout the time span of one decade. Studies such as these are influential in illuminating the deficits of the custodial housing model and further serve to encourage innovations in policy and practice regarding the integration of decent and affordable housing for people living with mental illness.

Upon deinstitutionalization, custodial housing was the first response to providing housing for individuals in the community. However, with shifting paradigms in the mental health system and increasing research comparing life outcomes of this housing approach versus supportive housing, such as the study conducted by Nelson et al. (1998), suggest that custodial housing is increasingly becoming obsolete. Canadian researchers such as Geoff Nelson and his colleagues in Ontario suggest that custodial housing has served its purpose of supporting individuals living with mental illness, but this came at the expense of residents' sense of control and independence (Nelson, Walsh-Bowers & Hall, 1998). As such they encourage increased opportunities for supportive and supported housing for people living with mental illness (Nelson, Walsh-Bowers & Hall, 1998).

The Supportive Housing Model

At the close of the 1960s, greater interest by family members, professionals, and people living with mental illness to advocate for less restrictive settings gave way to the ideology

entitled 'community treatment and rehabilitation' (Anthony & Liberman, 1986; Nelson, Hall, & Walsh-Bowers, 1997; Parkinson, Nelson, & Horgan, 1999). The supportive housing model attempts to support people living with mental illness in ways consistent with this ideology (Parkinson, Nelson & Horgan, 1999). This is a method of moving toward greater independence and self-control through a hierarchy of skills building and training. Within supportive housing, people living with mental illness are conceptualized as residents (Parkinson, Nelson, & Horgan, 1999). The principle behind the supportive housing model is to work toward individuals' independence by graduating through different levels of support, which are attached to different types of housing (Parkinson, Nelson, & Horgan, 1999). The supports and services range from high intensity, which is commonly provided in group homes; intermediate support, also provided in group homes; and low support, which can be attained in supportive apartments (Nelson, Hall, & Walsh-Bowers, 1997; Parkinson, Nelson, & Horgan, 1999). The potential for attaining independence is indicative of a focus on residents' strengths, however, the on-site supervision and services demonstrate a focus on disability (Parkinson, Nelson, & Horgan, 1999).

Facilities falling within the supportive housing model include group homes, half-way houses, supportive apartments and independent housing units (Nelson, Hall, & Walsh-Bowers, 1997; Parkinson, Nelson, & Horgan, 1999). The spectrum of housing options available within this model is responsive to the diversity of needs and abilities maintained by this particular population.

Residents are positioned within one of the three support levels based on their social abilities. When residents portray evidence of improvement, they progress to housing that offers less intense supports (Parkinson, Nelson, & Horgan, 1999). As residents progress through the system, the amount of housemates decreases with the intent of fostering greater independence and self-control (Parkinson, Nelson, & Horgan, 1999). Most supportive housing settings are defined by group situations, and are therefore aimed at enhancing residents' interpersonal skills and skills associated with conflict resolution (Parkinson, Nelson, & Horgan, 1999). Supportive housing may also offer residents the freedom to explore the community alone, participate in informal community activities, and thus enhance a sense of autonomy (Parkinson, Nelson, & Horgan, 1999).

Unlike custodial settings, which are provided on a for-profit basis, supportive housing typically offers non-profit housing units (Parkinson, Nelson, & Horgan, 1999). The services provided in supportive housing are based on the psychosocial rehabilitation model, which encourages the building of life and social skills, and promotes community based recreational involvement (Parkinson, Nelson, & Horgan, 1999). In order to gain entry into supportive housing, residents must agree to receive the services that are tied to the housing (Parkinson, Nelson, & Horgan, 1999). Parkinson, Nelson & Horgan (1999) have found that residents of supportive housing struggle with a sense of privacy and have minimal choice regarding the housing allotted to them, their housemates, or the services attained on-site.

Nelson & Smith-Fowler (1987) along with McCarthy & Nelson (1991) have found that residents' adaptational abilities have improved within supportive housing as compared to custodial settings. Specifically, findings from research conducted by Nelson & Smith-Fowler (1987) and McCarthy & Nelson (1991) suggest that supportive housing residents – including individuals living in halfway houses and small scale group homes – experience fewer instances of rehospitalization and greater ability to maintain work (either paid or voluntary) as compared to residents of custodial settings. Individuals residing in supportive housing were also found to progress in their level of community involvement, self-confidence, autonomy, and socialization along with reductions in the use of treatment and medicine (Nelson & Smith-Fowler, 1987). A Toronto study conducted by Boydell & Everett (1992) suggests that residents of supportive apartments were able to reduce their utilization of professional treatment and services by approximately 60 percent over the course of one year. The most significant negative outcome with supportive apartments is the prevalence of social isolation as a result of the decreasing number of housemates (Parkinson, Nelson, & Horgan, 1999).

The nature of 'graduating' from one residential setting to another indicates a transient lifestyle, one which would minimize a sense of housing stability and independence. However, the dual focus of the supportive housing approach on both residents' strengths and disabilities demonstrates that this is a step forward from the custodial model but is by no means devoid of flaws.

In the Canadian context, the extensive studies conducted on supportive housing by Ontario researchers such as Geoff Nelson from Wilfrid Laurier University in Waterloo, John Trainor from the Centre for Addiction and Mental Health in Toronto, and Tim Aubry from the Centre for Research on Community Services in Ottawa, have found significant evidence illuminating the benefits of supportive housing on people living with mental illness (Nelson, 2006). This research has not only served to highlight the positive outcomes that have been achieved by residents of supportive housing, but has aimed to inform policy and practice so as to be more responsive to the needs and preferences of people living with mental illness (Nelson, Walsh-Bowers & Hall, 1998) . This work has also helped improve the supportive housing stock available to individuals living with mental illness in Ontario (Nelson, 2006). Although there are clear deficits in terms of adaptational outcomes and quality of life in the supportive housing model, it is a clear step forward from the custodial model and a stepping stone toward enhancing best practice in mental health through supported housing.

Residential Continuum & Housing as Housing Approaches of the Supportive Housing Model

To develop housing options that will support greater independent living by people living with mental illness, it is useful to consider two approaches within the supportive housing model. These approaches include the *level of care* or *residential continuum* approach, and the *independent housing* or *housing as housing* approach (Galster et al., 2003). The former embraces the diversity in clients' needs by developing a range of residential settings that differ in the degree of professional supervision and in-house treatment

(Galster et al., 2003). This gives the resident greater control in selecting the housing of their choice and the housing that is most appropriate for meeting their specific needs, along with greater control in the amount of treatment or social services utilized.

The *independent housing* or *housing as housing* approach develops housing as a decent, affordable and hygienic environment in which to live, rather than a setting in which to be treated (Walker & Seasons, 2002). With this in mind, the overriding endeavour is to normalize both the residential environment and the surrounding neighborhood without placing obligations on the client to accept on-site services, treatment or supervision; although these are made available through community-based services (Galster et al., 2003). For the *residential continuum* and *housing as housing* principles to function effectively, the feature of deconcentration and freedom of choice is vital for the provision of housing for people living with mental illness (Galster et al., 2003).

Although supportive housing offers a range of choices for people living with mental illness, including group homes and supportive apartments (Nelson, Hall, & Walsh-Bowers, 1997; Parkinson, Nelson, & Horgan, 1999), the principle of graduating through different levels of support obstructs individuals' opportunities for attaining a permanent residence. Furthermore, the different levels of support available through the supportive housing model are either directly or indirectly attached to the housing units (Parkinson, Nelson, & Horgan, 1999). When services are linked to the housing, individuals lack the sense of autonomy to develop a true sense of home, and may further perpetuate people's experience of their residence as housing or treatment centre rather than home (Allen, 2004).

Chapter two outlined the relevant historical context which has affected the contemporary housing situation for people living with mental illness. Specifically, the chapter began with a gender-based analysis of mental illness. This was followed by a description of housing affordability and core housing need, which was proceeded by an explanation of how housing directly impacts individuals' health. Finally, the chapter progressed through the historical context leading up to the most current and progressive housing model available to people living with mental illness, including a discussion of the deinstitutionalization of mental health services, social housing provision in Canada, and the two primary housing models available to people living with mental illness following deinstitutionalization. The following chapter discusses the paradigm shift in the mental health system that has begun to address these issues of autonomy and permanency of housing through the supported housing model. The supported housing model places greater focus on empowering people living with mental illness, and ensuring that they are given the opportunity of attaining normalcy in life through permanent housing options which are completely de-linked from mental health services.

CHAPTER 3 – NORMALIZED HOUSING

While the previous chapter was dedicated to discussing the historical context of housing options available to people living with mental illness, this chapter advances to discuss the most current and progressive model of housing available to people living with mental illness – that of supported housing. The overall doctrine of supported housing is giving people living with mental illness the opportunity to live in normalized, deconcentrated and integrated housing, with the understanding the support services are not on-site but are available in an individualized and flexible manner. This chapter will also highlight, by example, that this type of housing is not only possible, but has proven successful in diverse jurisdictions.

MOVING FORWARD: THE SUPPORTED HOUSING MODEL

The most recent paradigm shift to develop in the mental health system is entitled *empowerment-community integration* and is embodied in the model of supported housing (Carling, 1995). Empowerment-community integration encourages greater opportunities for people living with mental illness (with the assistance of a rehabilitation service provider) to choose, get, and keep their housing, rather than positioning them in a dwelling chosen by a case manager (Allen, 2004; Carling, 1995).

The supported housing model is defined by three fundamental components: the valuing of individuals' preferences, ordinary and deconcentrated housing (as opposed to clustered housing or 'mental health housing'), and a person-centered support system (Carling, 1995). An equally important principle of the supported housing model is the separation

or 'de-linking' of the supports and services component from the housing component, thus giving the individual complete control over the level of services and treatment utilized (Parkinson, Nelson, & Horgan, 1999). Social and community integration and the fostering of individuals' empowerment are also significant elements (Parkinson, Nelson, & Horgan, 1999). The benefits – particularly greater personal empowerment and self-determination – have rendered the supported housing model the foremost prospective trend in the mental health system (Carling, 1995).

The growing trend toward supported housing has been driven by a set of forces. Specifically, facilities which bundled services were identified to be too expensive to reach the numbers of people living with mental illness (Glaster et al., 2003; Walker & Seasons, 2002). Second, history has illustrated that housing which is allotted a specific label, such as *special needs housing* or *housing for the mentally ill*, is more prone to encounter community opposition and minimize community and social integration as opposed to deconcentrated, ordinary housing (Galster et al., 2003; Milne, 1982; Walker & Seasons, 2002). Finally, the mental, physical and spiritual benefits of conceptualizing residence as home – as opposed to residence as treatment facility – are gaining significant value and legitimacy within the mental health system (Walker & Seasons, 2002). The supported housing model has been developed to address these concerns and also to maximize individuals' sense of self and control.

Supported housing units are defined as deconcentrated, ordinary, long term and/or permanent houses or apartment units not unlike those occupied by all Canadian citizens

(Galster et al., 2003). This gives people with mental illness the opportunity to live independently and enhances their chances of feeling as integral members of the community (Galster et al., 2003).

Residents of supported housing – who were given choice and freedom over their housing – have been able to achieve housing stability, enhanced personal fulfillment and diminished instances of relapse or rehospitalization (Allen, 2004; Galster et al., 2003; Parkinson, Nelson, & Horgan, 1999; Walker & Seasons, 2002). Another significant benefit associated with the supported housing model is that it serves to minimize unnecessary stereotypes and myths regarding the integration of people living with mental illness into residential neighborhoods (Walker & Seasons, 2002).

On the other hand, there are several disadvantages inherent in the supported housing model that must not be overlooked. For instance, independent living encouraged through the supported housing model minimizes the peer support present in group settings and can correlate with lonesomeness and segregation (Parkinson, Nelson, & Horgan, 1999; Walker & Seasons, 2002). When left alone, there is also the possibility that residents experience apprehension and stress regarding the payments (or lack of income) to maintain the residence (Bryant, 2004; Parkinson, Nelson, & Horgan, 1999; Walker & Seasons, 2002). This makes the availability of rental subsidies and rent supplements highly beneficial to people living with mental illness (Parkinson, Nelson, & Horgan, 1999).

Lastly, there are several barriers to implementing the supported housing model. The general deficiency of affordable housing across Canadian jurisdictions is a major dilemma deterring the implementation of supported housing (Walker & Seasons, 2002). This issue is further augmented by the limited income that a majority of people with mental illness receive which makes supplementary financial support a necessity for this group of people (Walker & Seasons, 2002). Also, people living with mental illness are discriminated against by landlords in the private rental market which diminishes their opportunities to access the limited amount of low-cost rental housing that is available (Carling, 1995; Walker & Seasons, 2002).

The discussion of the three housing models that have followed the process of deinstitutionalization – the custodial housing model, the supportive housing model and the supported housing model respectively – has illuminated the fundamental differences between each model and the direction that the mental health system is beginning to take. Contemporary academics and researchers interested in the issue of housing for people living with mental illness are increasingly understanding and valuing the empowerment-community integration paradigm and the findings from the research that have documented the advantages and deficits of each model. Allen (2004), for instance, supports the notion of housing as a fundamental determinant of health. Allen (2004) further believes that custodial housing models have created living environments that minimize individuals' quality of life and prevent them from achieving a sense of self-determination, which inevitably impacts health. Allen (2004) maintains that supportive housing with flexible and person-centered supports is particularly beneficial to

individuals living with mental illness. Similarly, Trainor (2006) argues that the custodial housing model does not allow for rehabilitation and recovery and only serves to perpetuate the conceptualization that people suffering from mental illness cannot recover or lead fulfilling lives. Unlike Allen (2004) who fully encourages increased opportunities for supportive housing, Trainor (2006) maintains that there is a need for a spectrum of housing options with a range of on-site supports for those who are not able to live alone. However, Trainor (2006) suggests that the mental health system would benefit its patrons by maximizing supported housing options for those who are able to live independently.

Aligned with the beliefs of Trainor (2006), but from the perspective of city planning, Walker and Seasons (2002) consider the custodial and supportive housing models to be options of the past with minimal benefits to individuals living with mental illness. Walker and Seasons (2002) recognize both the benefits and deficits of the supported housing model, however, they explicitly support the underlying components that define this model, such as freedom of choice, empowerment, resilience and self-determination. Through innovation and research, Walker and Season (2002) believe that the supported housing model can be improved to enhance the quality of life for people living with mental illness. Lastly, Nelson (2006) and his colleagues have been influential in conducting research that highlights the outcomes of supported housing for people living with mental illness. Based on the findings from this research – including studies conducted by Parkinson, Nelson & Horgan (1999) and Parkinson & Nelson (2003) – Nelson and his colleagues encourage enhancing the numbers and accessibility of supported housing units for people living with mental illness.

Thus, there is increasing pressure to organize initiatives and direct funding toward enhancing the supported housing stock in jurisdictions across Canada. For instance, such initiatives are being undertaken by the Waterloo Regional Homes for Mental Health, Inc. in Waterloo, Ontario (Nelson, 2006).

HOUSING AS INTEGRATED & INCLUSIVE

The lessons learned from the traditional housing options made available to people living with a mental illness and the history of housing provision in Canada have illuminated the need to step beyond prescribed housing models which have isolated and segregated people based on psychiatric diagnosis and stigma. Based on these learned lessons, it is imperative to establish an integrated and inclusive approach to housing delivery for all sectors of the population, including people living with mental illness. Explicitly defining the meaning of these two terms, particularly how it relates to the quality of life of people living with mental illness, will minimize the establishment of housing that claims to be inclusive and integrated, when it really only positions individuals in residential neighborhoods without facilitating a sense of community integration. The establishment of clear and concise definitions of integration and inclusion will help those responsible for the provision of housing in Winnipeg by giving them a better understanding of what levels of integration are beneficial and desired by this particular population.

According to the Canadian Oxford Dictionary (2000), integration is the coming together or intermixing of people who were previously segregated. The concept of integration is

to prevent the drawing of a line of difference and division based on social cleavages such as race, ethnicity, sexuality and ability. Quite similarly, and again according to the Canadian Oxford Dictionary (2000), inclusion is the prevention of the ostracizing of any group of society and to embrace them as part of the whole. Based on these quite simple definitions, holistic integration is dependent first on physical proximity and acceptance. As such, integration facilitates people with a mental illness to form social relationships and regularly communicate with people who do not live with mental illness (Allen, 2004). Inclusion, on the other hand, requires altering unsubstantiated perceptions and conceptualizing all people – regardless of race, ethnicity, culture and ability – as people first (Carling, 1995).

Integrated housing goes beyond merely establishing 'housing' in a residential community that explicitly caters to people living with a mental illness. In order to go beyond physical integration and achieve physical and social/community integration, the categorization of people as mentally ill should be dropped when developing integrated housing options. This is not to say that the need for mental health services should be overlooked. However, when people are bound within a particular categorization such as 'mental health service consumer', this in itself creates a divide between the 'special group' and the rest of the community (Carling, 1995). Equally important is to begin to conceptualize residential accommodation as a home rather than as a treatment center. The housing models traditionally developed for people living with mental illness have only served to segregate the residents based on mental health and thus reinforce the stigma that they are different from and consequently inferior to the general public (Allen,

2004). Successfully integrated housing for people living with mental illness looks and is treated no different than the houses occupied by the general Canadian population (Allen, 2004).

Individuals' preferences and freedom of choice are also significantly relevant and important to establishing integrated housing. Although freedom to choose and personal autonomy are indispensable for recuperation, accommodation options have typically been chosen by mental health professionals based on psychiatric diagnosis and analysis of behavior (Allen, 2004; Milne, 1982). This method of establishing housing options ignores and devalues the needs and preferences of people living with mental illness (Allen, 2004).

As previously mentioned, access to informal community social networks is an important element of integrated housing. Natural, social networks for individuals living with a mental illness should not be limited to other people experiencing mental health issues (Carling, 1995). In other words, the neighborhood should provide opportunities for people living with mental illness to informally interact with diverse members of the community, which will enhance the quality of social contacts, serve to informally communicate employment opportunities, and enhance cultural enrichment – all of which are necessary for obtaining normalcy and a sense of personal independence (Allen, 2004; Carling, 1995; Godblatt, 1982).

The supported housing model has been acknowledged within the mental health system as the most forthcoming model with significant benefits for individuals living with mental illness (Walker & Seasons, 2002). The supported housing model further exemplifies the qualities of integrated and inclusive housing as outline above. However, the model cannot fully succeed without first ensuring that appropriate policies are set in place to facilitate the implementation of effective supported housing programs. Unfortunately, there are two pervasive barriers in Winnipeg to the development of supported housing – or quite simply the facilitation of low-cost housing for people living with mental illness. One barrier, which is on the *supply* side, is based on the general deficiency of good quality, safe, and affordable housing stock. The second barrier relates to *demand.* This refers to the financial barriers facing a large proportion of people living with mental illness (The Canadian Chamber of Commerce, 2005). Specifically, individuals living with mental illness do not have sufficient funds to access decent and safe housing through the private market without falling short of other basic necessities such as food, medicine, recreation, etc. Needless to say, different levels of government have attempted to attend to the housing crisis endured by low-income and poverty stricken households. However, there is considerable room to progress on the policy side to improve the housing crisis prevalent in Winnipeg and across the nation (The Canadian Chamber of Commerce, 2005).

Based on the extensive literature on housing for people living with a mental illness, particularly the literature regarding individuals' housing preferences, the principles of

integrated and inclusive housing are significant prerequisites for facilitating housing policy which facilitates greater options for supported housing in Winnipeg.

HOUSING PRECEDENTS

Having completed the literature review and the analysis of the different models of housing that have been available to people living with mental illness, I have undertaken an extensive internet search to find housing programs which meet the criteria of supported, normalized housing for people living with mental illness. The criteria include the following elements, as discussed in the review above:

- Accepting people living with mental illness as people first;
- Social and community integration/acceptance rather than just physical integration;
- Conceptualizing residences as homes rather than housing or treatment facilities;
- The use of generic/ordinary houses and apartment units;
- Valuing individuals' preferences;
- The availability of flexible, person-centered services; and
- Access to generic community-based recreational facilities and therefore natural social networks.

Needless to say, the housing programs described here do not meet all of the criteria, but offer a glimpse into the different approaches of providing affordable and permanent housing options to people living with mental illness. Furthermore, they represent both the widespread need for adequate, low-cost housing by this population and the steps forward that are being taken to respond to this longstanding need.

Coast Mental Health, Vancouver

The Coast Foundation was established in 1974 to begin to respond to the needs of people living with mental illness for community-based services. Coast is a collaborative community that provides services and programs which encourage 'restoring health, personal growth, and a return into society' for people who are connected with the mental health system (Coast Mental Health, 2007). Coast is particularly innovative because the patrons of Coast are an integral component in planning program advancements and evaluating program outcomes (Coast Mental Health, 2007).

During the 1970s, Coast purchased its first three apartment blocks, attained and managed five community houses and launched the East 11th Clubhouse. In the 1980s, Coast tapped into public housing programs to construct two additional apartment blocks, managed the first community-based residential care facility in British Columbia and established both the Clubhouse Program and the PACT Employment Services. In the 1990s, Coast established the Mental Health Resource Centre. During this time, Coast also constructed three additional apartment properties through collaborative endeavours that utilized public and private funding. Furthermore, during the 1990s, Coast enhanced its Supported Independent Living Program which offered rental subsidies for housing on the private real estate market (Coast Mental Health, 2007).

Among other rehabilitative and recovery programs, Coast has led the way in establishing supportive and supported housing opportunities in British Columbia through Coast Apartment Blocks, Supported Independent Living Program, Satellite Apartments and

Transitional Housing Program (Coast Mental Health, 2007). Parallel to the housing programs, Coast offers addictions services, health care and clinical mental health care services and skills building programs (Coast Mental Health, 2007).

Coast asserts that their programs are indeed successful because those who are classified as 'the hardest to house' – including people facing multiple challenges including addiction, mental illness, HIV/AIDS – are not only their patrons, but remain housed and receive the individualized services to live autonomously (Coast Mental Health, 2007).

Coast further affirms that (Coast Mental Health, 2007):

All Supported Housing Programs have a very high standard of accommodation. The key components of the Coast Supported Housing Programs for the mentally ill are:

- *Affordability of the apartments, rent is subsidized in all cases.*
- *Privacy of self contained suites.*
- *Cooperative, stigma, free environment of block apartments.*
- *Access to skilled community mental health support workers.*
- *Development of and readjustment of an individual service plan unique to each resident.*
- *Strong sense of community and mutual support.*
- *The security of tenure for the apartments.*
- *Links to clinical mental health services, health care, addiction services and other community supports.*

Although some of the housing programs offered to people are more reflective of the supportive housing model – particularly the 'supported apartment blocks' which have on-site staff – there are some housing options which are reflective of the supported housing model. These options include Supported Independent Living (SILP) and Satellite Suites. The SILP gives patrons the ability to select a rental unit in the private real estate market. The Satellite Suites function similarly to SILP, with the exception that these are owned by Coast.

Supported Housing Program, Canadian Mental Health Association, Richmond, British Columbia

The Supported Housing Program offered by CMHA – Richmond, offers independent housing and non-mandatory rehabilitation services to people living with mental illness. Patrons occupy subsidized apartments without the presence of on-site staff through Richmond, BC. Tenants have the option of seeking support from Community Living Support Workers, who are available during regular business hours. As part of the Supported Housing Program, CMHA – Richmond provides only support services to those individuals already living autonomously (Canadian Mental Health Association – Richmond, 2004).

CMHA – Richmond also works collaboratively with the Greater Vancouver Mental Health Services and Richmond Mental Health Residential Facility

Operators to provide the Community Independence Program (CIP). This program provides an occupational therapist which provides an 'individualized rehabilitation assessment' to determine the assets, skills and supports required by each individual to achieve a successful autonomous life in the community (Canadian Mental Health Association – Richmond, 2004). This program is specifically designed to meet the needs of people living with a serious mental illness who require enhanced support to make an effective transition to independent living. Because these individuals require additional support services, they are not eligible for the Supported Housing Program (Canadian Mental Health Association – Richmond, 2004).

Community Housing Associates of Baltimore

The Community Housing Associates (CHA) of Baltimore is a not-for-profit housing development and management arm of the Baltimore Mental Health Systems (BMHS). CHA was established in 1989 with the overarching goal of connecting (but not linking) housing development and administration with the mental health profession (National Housing Institute, 1996). With the goal of assisting its tenants to achieve independence and resilience, CHA builds and operates housing for people living with mental illness who are able to live independently. These housing units are situated in a range of neighbourhoods scattered throughout Baltimore. With the understanding that a big proportion of the population of people living with mental illness do not own personal

transportation, CHA develops housing in close proximity to public transit stops (National Housing Institute, 1996).

CHA housing includes six one-bedroom suites and 16 three-bedroom suites. Specifically, CHA tenants include 36 adults living with mental illness and nine families – each with one adult living with mental illness. CHA also leases its' three-bedroom units to local mental health service providers (National Housing Institute, 1996).

The majority of units are row-houses that contain up to two individualized units. Typically, the townhouses require only small renovations which ensure that the buildings maintain their exterior look and thus continue to fit into the neighbourhood. This further ensures that there is no need for zoning alterations to the housing (National Housing Institute, 1996).

Patrons of CHA are matched up with case managers, who organize the individual's access to mental health services (National Housing Institute, 1996).

CHA housing is not advertised publicly. Rather, tenants are chosen from two waiting lists – including CHA's waiting list and the waiting list of community-based mental health service providers (National Housing Institute, 1996).

CHA Tenants pay 30% of their income on rent. In many cases, to ascertain that residents will pay their rent on time, the shelter portion of their Social Assistance cheque is given directly to BMHS (National Housing Institute, 1996).

Of particular importance is that the leases utilized by CHA do not indicate nor imply any information pertinent to the diagnosis of the individual. Further, tenants do not run the risk of loosing their housing should they refuse the services of a case manager. The only way in which tenants can loose their housing is if they contravene their lease agreement (National Housing Institute, 1996).

To ensure that the quality of the units is kept to standard, CHA performs a site inspection of each unit every year (National Housing Institute, 1996).

Before acquiring and renovating any housing, CHA consulted with representatives from the different neighbourhoods in which housing units were going to be situated (National Housing Institute, 1996). As a result, CHA has not encountered community opposition to their housing projects.

This housing program has been included as a precedent because there are a few elements that render it as innovative. First, CHA's initiative delinks housing from on-site mental health services, while making these services available to tenants. Also, CHA does not threaten tenants with losing their housing should they refuse mental health services. Finally, part of their criteria for selecting housing is to ensure that it is dispersed in

diverse neighbourhoods across Baltimore and that the housing needs minor repairs, which allows the properties to maintain their physical character, thereby fitting in with the surrounding neighbourhood.

Prairie Housing Co-operative, Winnipeg

The Prairie Housing Co-op was established in 1982 and was designed specifically with the needs of people living with disabilities in mind. However, the co-op does not house only people living with disabilities, but rather accommodates a mixture of people living with and without disabilities (Wetherow & Wetherow, 2003).

Like many housing cooperatives, the Prairie Housing Co-op is based on a system whereby the residents pay for a co-op membership so that together, the residents rent or purchase the property in which they live (Wetherow & Wetherow, 2003). Consequently, the management and accountability of the property is shared by all the tenants. Typically, the residents select a Board of Directors – all of whom are members of the co-op – which manages finances, along with other shared responsibilities, for example.

Shortly after the development of Prairie Housing Co-op, L'Avenir (French for *the future*) Community Cooperative was developed to supplement the needs of some of the residents of the Prairie Housing Co-op (Wetherow & Wetherow, 2003). L'Avenir offers individualized services to individuals living with intellectual disabilities who live in Prairie Housing Co-op (Sutherland & Beachy, 2004). However, this model is designed to de-link services from housing so that if an individual refuses services, they do not run the

risk of losing their housing. Alternatively, if an individual decides to move out of Prairie Housing Co-op, they can continue to access services offered by L'Avenir (Sutherland & Beachy, 2004).

In Winnipeg, Prairie Housing Co-op units are located in a variety of neighbourhoods, including the Exchange District (Murdoch Management, 2006). For instance, 113 Market Avenue has been designated as a Prairie Housing Co-op. This particular property fits seamlessly into the surrounding historic buildings and is situated within close proximity to a range of amenities, including public transportation. Fourteen of the 28 suites in 113 Market Avenue offer the option of rent-geared-to-income (Murdoch Management, 2006), which ensures that eligible residents pay no more than 30% of their income on rent.

There are several benefits to the cooperative housing model, such as Prairie Housing Co-op. First, it provides individuals with the opportunity of low-cost, long-term, and stable housing (Skelton, 2002). Second, this housing option enhances individuals' ability to attain a sense of community (Skelton, 2002), and thus, to develop and maintain the social networks that are difficult to establish for people living with mental illness. Furthermore, cooperative housing gives people more liability in their property – i.e. they feel more responsibility to care for their property because they have invested in it (Wetherow & Wetherow, 2003). Although this type of housing could potentially include more than one person living with a mental illness in the same building, it is critical to ensure a mixture of people living in the co-op (Wetherow & Wetherow, 2003). This eliminates

concentrating and/or ghettoizing people living with mental illness in one location and allows them to interact with people from different backgrounds, thereby enhancing their sense of normalcy and integration.

This chapter has focussed on the supported housing model, which delineates the most current and progressive housing approach for people living with mental illness and is the focal point for this thesis research. Furthermore, this chapter outlined the characteristics that define integrated and inclusive housing. To crystallize the discussion of housing as integrated and inclusive, the chapter concludes by offering a sample of how housing organizations in diverse jurisdictions have developed programs that offer permanent and low-cost housing options for people living with mental illness. Needless to say, the above precedents do not fulfill all of the criteria for integrated and inclusive housing. However, it provides a good illustration of the possibilities for implementing supported housing options for people living with mental illness in large cities.

CHAPTER 4 – RESEARCH METHODS

This chapter aims to clarify the process that was followed in the organization and analysis of data pertinent to the issues discussed above. It will clarify how I have created and used the data set, particularly how I have formulated the themes and presented the arguments in chapter five. Like Mason (2000), I am convinced that the qualitative analysis of data is more effective and proves more credible when the author's voice and outlook are transparent throughout the arguments. After all, "*data cannot exist in an uninterpreted or literal form*" (Mason, 2000, p. 179: emphasis added). With this transparency, the reader can gauge the accuracy and reliability of the arguments presented (Mason, 2000).

RESEARCH METHODS AND ANALYSIS

The information that will address the research questions stated above will derive from analyzing an existing data set composed of a series of nine focused interviews. The interviews themselves (see the interview guide in Appendix A) were completed for the purposes of a housing forum that was held by the Canadian Mental Health Association – Winnipeg Region (CMHA) in late October of 2006. The purpose of the housing forum was to bring together housing providers and policy specialists to discuss policy tools that would enhance opportunities for decent and low cost housing for people living with mental illness in Winnipeg. The interviews conducted for the housing forum were intended to give a better understanding of the challenges and barriers that local people face in choosing, getting and keeping low cost housing in Winnipeg. Specifically, the interviews were utilized at the housing forum by presenting a sample of housing histories

developed from the interview data. The thesis extends the analysis of this set of existing interviews.

As a result of working with the Canadian Mental Health Association – Winnipeg Region as a student intern over the summer of 2006, I was given the opportunity of conducting the nine interviews that comprise the existing data set. The Canadian Mental Health Association – Winnipeg Region assisted in suggesting and recruiting potential interview participants. Consequently, the interview participants are all people who have identified that they are experiencing some form of mental illness and are therefore connected to the mental health system.

The interview participants consisted of five women and four men, all of whom are adults currently living independently in the community. While all nine participants have moved out of their family home directly to housing in the community, two participants openly acknowledged having been hospitalized due to a relapse in their mental health. Aside from the two participants who have been hospitalized, there was no indication that any one of the nine participants experienced long-term institutionalization due to their mental illness. Despite participants' lack of a direct connection to psychiatric institutions, it was critical to outline the history of deinstitutionalization as this has influenced people's contemporary experiences of housing and social services in the community.

Although the thesis research has utilized this existing data set, the analysis for the thesis is separate and distinct from the analysis that CMHA has envisioned. The aim in

analyzing the existing data set for the thesis project has been to undertake an innovative form of analysis and to contribute the findings to communities of scholars and practitioners, both in CMHA and elsewhere, who might take direction from the results and methodology.

Although the analysis has been conducted on an existing data set, the fundamental research method that has permitted this analysis has been the focused interview. The focused interview was the ideal research method for the scope of this thesis because it facilitates an in-depth understanding of how specific people conceptualize a specific situation (Zeisel, 1984). In this case, the focused interview has amplified the voices of a sample of Winnipeg residents living with mental illness regarding the challenges and barriers they encounter when attempting to choose, get and keep housing. Furthermore, having the focused interview as the basis for the analysis gives me, as the researcher, the opportunity to view the generalized concept of 'the housing crisis encountered by people living with mental illness' through a more experiential lens (Zeisel, 1984).

The interview guide (Zeisel, 1984) was structured around a *housing history* perspective and is thus an experiential research approach (Tomas & Dittmar, 1995). Developing and analyzing the housing histories of people living with mental illness has enhanced an understanding of the unique housing challenges that this population experiences directly from the individual's lived experiences with housing in Winnipeg (Tomas & Dittmar, 1995). Furthermore, adopting a housing history approach in the research method has crystallized the notion of the 'housing crisis of people living with mental illness'

identified in the literature. The housing history method of approaching the data has specifically drawn focus on the experiences of the research participants so that they can have an active voice in suggesting solutions to affect change in the future (Tomas & Dittmar, 1995).

After reviewing literature on different theories and methods of analysis (Mason, 2000; Neuman, 1997), I concluded that my analysis has been framed primarily by interpretive social science, and secondarily by elements of critical social science (Neuman, 1997). Specifically, I approached this research from the perspective that in order to amplify the voices of people living with mental illness, I must necessarily understand how people living with mental illness conceptualize and interpret their own housing situations. In other words, it is essential to view the housing crisis endured by people living with mental illness from their perspectives. From a critical social science standpoint, this understanding would serve as a catalyst for positive change in housing policy and thus in the quality of lives of people living with mental illness. Or, as Neuman (1997) states:

> Critical research can be best understood in the context of the empowerment of individuals. Inquiry that aspires to the name critical must be connected to an attempt to confront the injustices of particular society or sphere within the society. Research thus becomes a transformative endeavour unembarrassed by the label political and unafraid to consummate a relationship with an emancipatory consciousness (p. 47).

The analysis of the interviews can take three different forms – including a literal reading, an interpretive reading or a reflexive reading (Mason, 2000). For the purposes and goals of this research, the interview data has been analyzed according to an interpretive reading. An entirely literal reading would not fulfill the theoretical and methodological concerns of this thesis as an absolute objective account is not possible and further suggests an ultimate reality (Mason, 2000). The social world and individual lived experiences by no means represent an ultimate reality or universal truth, and are therefore instilled with interpretations, biases and value (Mason, 2000). An interpretive reading of the data has thus allowed for an analysis of both the participants' understanding and interpretation of their own lived experiences and the researchers' understanding and interpretation of the participants' lived experiences (Mason, 2000).

RESEARCH ANALYSIS PROCESS

Having reviewed the different methods of sorting and cataloguing qualitative data, I have concluded that one method would prove most effective. According to Mason (2000), there are three ways in which qualitative data can be organized, including cross-sectional and categorical indexing; non-cross sectional data organization; and utilizing diagrams and other forms of graphic representations. For the purposes and nature of my research, I selected the cross-sectional and categorical indexing approach. Through this approach, I was able to apply a series of categories across the entire data set. The cross-sectional indexing process further allows for efficient retrieval of specific pieces of information, which do not necessarily emerge consistently throughout the data (Mason, 2000).

Second, the cross-sectional indexing approach facilitates an interpretive reading of the data as the data is organized according to themes or subheadings which can be compared, contrasted and/or synthesized (Mason, 2000). Finally, this approach will assist in cross-checking between the research questions, data, and the analysis with a focus on how the data begins to respond to the research questions identified in chapter one (Mason, 2000).

In the process of developing indexing categories, the reader must note that the indexing categories were not developed with a concrete or preconceived argument in mind. Rather, they were developed only after reviewing the actual content of the data. This process alone indicates my use of an interpretive reading of the data. Specifically, I have chosen an interpretive reading of the data because becoming familiar with the data first has allowed me to formulate arguments based on my interpretation of participants' housing histories, thereby highlighting the lived experiences of the sample of nine Winnipeg residents living with mental illness. However, as the researcher, I am not without bias (Mason, 2000). Having conducted the literature review and having been involved in the interview process itself – for the purposes of the housing forum for the Canadian Mental Health Association – the categories, themes, and arguments that I have developed have most likely been impacted by the knowledge and experience I have attained in the initial stages of the research. Being of the mindset that housing is a social necessity for all members of society, the arguments presented in chapter five will clearly indicate this bias. This bias has been identified with the understanding that the arguments would not have been made, had they not been supported by the data set.

In the initial stages of cataloguing the data, and in order to begin to conceptualize and understand the data that I was working with, the categories took a literal form, being based primarily on what was conveyed directly from the text. However, with time and after reviewing the data repeatedly, the categories began to take an interpretive form. Rather than being dependent on a direct reading from the text, the categories began to reflect my interpretation of what the data was implying (Mason, 2000). Not only was I able to reflect on what was evident in the data itself, I also began to question what elements were not evident and why. Generally, the final categories are reflective of individuals' perspectives, feelings, actions and reactions.

Throughout this process, I have ensured a regular cross-checking between the interview questions, the research method and the research data. I believe that this has assisted in ensuring consistency from one research step to the next. This cross-checking has also helped me to stay on track in terms of the overarching goal and purpose of my research. For instance, through this process of cross-checking, I was able to validate the use of open-ended interview data for the research method. The data obtained from the open-ended interviews is instilled with the values, worldviews and experiences of the sample of Winnipeg residents living with mental illness. The views and experiences of people living with mental illness are precisely what I aspired the research to illuminate. Further, I was able to validate the use of reading the data interpretively. As previously mentioned, I have selected an interpretive reading of qualitative data because it has given me, as the researcher more freedom, and the research process more fluidity, so that the experiences of people living with mental illness form the basis of the arguments. On the other hand,

an interpretive reading has welcomed my understanding of the data along with my own outlook regarding the housing situation of people living with mental illness in Winnipeg.

The process of cross-checking between the interview questions, the research method and the research data has further given me the opportunity to contemplate on how and why I was making specific arguments. Based on the data and my aspirations for the research, the content of chapter five will indicate that I am arguing in two distinct ways: interpretively or narratively and evocatively or illustratively (Mason, 2000). Specifically, the arguments outlined in chapter five have been presented because I believe that my explanations and interpretations are valid, relevant and purposeful, particularly because I have identified and understood my own biases. Furthermore, the arguments I have made in chapter five are based directly on the experiences of people living with mental illness, which are imbued with emotion, their realities, and their hardships. Therefore, an interpretive reading of the data has been chosen as the primary analysis method because it has allowed me to develop arguments that will not only begin to give the reader a greater understanding of people's lived experiences, but will also begin to draw on human emotion and compassion.

Chapter four has given a detailed explanation of the research methods and research analysis selected for this thesis. Focus was placed on discussing the process by which the interpretations outlined in chapter five were derived. The following chapter highlights the findings derived from both the literal and interpretive reading of the data.

CHAPTER 5 – ANALYSIS

This chapter presents the interpretations that have resulted from reading, contemplating and analyzing the data set. The focus of the analysis has been placed on learning about the complexities that have been made apparent in the data set regarding the unique needs, barriers and desires that people living with mental illness experience in their housing situations. The following discussion will elucidate how the sample of nine Winnipeg residents living with mental illness – who comprise the data set – conceptualize their specific housing situations. It begins by outlining the summary of people's housing situation from a literal reading of the data set. The summary of people's housing situation is followed by a series of four themes that illustrate the complex social elements which serve as barrier to choosing, getting and keeping decent housing – all of which were identified from an interpretive reading of the data.

SUMMARY OF HOUSING SITUATION: LIVED EXPERIENCES

Similar to physical illnesses, people living with mental illness experience both their illness and their housing situation in their own unique ways. This section by no means implies that the housing situation experienced by people living with mental illness is generic, much less universal for all people experiencing mental health issues. However, there are several commonalities that can be appreciated with the opportunity to glimpse into the lives of people living with mental illness who reside in Winnipeg. These commonalities include transient housing situations, the prevalence of core housing need, rooming houses, and living within neighbourhoods experiencing symptoms of decline and disinvestment.

Transient Housing

Having the space and time to develop a sense of 'home' and knowing that we can rely on that home are of utmost importance to our mental wellbeing. However, having access to a house or a dwelling of any kind is not necessarily synonymous with having a strong sense of home. Developing a sense of home is a process which requires time and stability. Both the continuity of time and stability within one dwelling have proven deficient in the lives of all of the participants. It is important to note that the housing histories developed for each interview participant began from the moment that they became aware that they were experiencing some form of mental health issue. Despite focusing in on a specific time frame of their lives, all participants have changed living arrangements multiple times. Specifically:

- participant one moved ten times in approximately 26 years;
- participant two moved three times in approximately 5 years, but estimated that he has moved over 40 times during the span of his life;
- participant three moved nine times in approximately 25 years;
- participant four moved eight times in approximately 18 years;
- participant five moved five times in approximately 16 years, but estimated that she has moved over 45 times during the span of her life;
- participant six moved eight times in approximately 25 years;
- participant seven moved ten times in approximately 17 years;
- participant eight moved five times in approximately two years; and
- participant nine moved six times in approximately four years.

The transient nature of an individual's housing situation is both time consuming, and further takes a toll on the individual's quality of life. First, it is difficult to establish a sense of stability and continuity both in terms of personal satisfaction and social relationships when individuals are continually moving from one living arrangement to the next. In line with this, other realms of life, such as personal or professional growth and development suffer because individuals invest added time and energy into thinking about their housing instability and searching for alternative living arrangements.

This finding should be understood in light of one important methodological limitation, namely, the way in which the number of moves per person was derived. Given the qualitative nature of the research method, the housing moves per person are based on participants' recollection of their housing histories, rather than on quantitative measurements, such as statistical data.

Housing Stress

The data indicates that although the participants' financial situation seemed to fluctuate during their 'housing history' time period, the majority – that is, seven out of the nine participants – experienced multiple instances of housing stress. Housing stress relates to the financial burden and the health implications in relation to individuals' housing situations. Within the group of seven participants who experienced housing stress, there were a total of 12 instances of core housing need. Out of a total of 12 instances of core housing need experienced among the seven participants, individuals were paying an average of 64.6 percent on housing costs.

How much of your income would you say you were utilizing for paying the rent?

A lot. I think social assistance was paying me like… I would say that it was 70-80% of my income was going to my sister for living in her place.

What was the quality of that place, when you were living with your sister?

It was very crowded because I was obviously living with two of her families so it was quite crowded.

How many people were living in that place?

It was my sister and her two boys, so that is three and then for…I don't know, a month or two, my other sister and then another person had moved in because we were all going through a tough time, so yeah, at one point there would have been six people.

INTERVIEW 8

Parallel to individuals' housing stress, their living arrangements for which they were paying over 30 percent of their total pre-tax income on housing was far short of 'acceptable housing'.

How much of the income that you were receiving went toward the rent?

That would have been really up and down. I would say up to even 80% because I was doing soup kitchens a couple of times. I was having trouble staying on assistance at the time, I was trying out welfare but I was actually relying mostly on a very small check from unemployment, so the money was very spotty. I was just turning from bad to worse. And I was having a really bad time with insomnia so I wasn't really able to keep a job. Yeah, so that was almost every dollar seemed like it was going toward the rent, although it was probably the cheapest rent I ever paid too.

Back to what I said earlier about having a common sense, I kind of knew it was bad but I said I was only going to stay there for one month because I had to get off of the streets but it ended up being longer. But, that was really bad. The suites hadn't been cleaned at all. I ended up bleaching the floors and the walls just because they were so awful, I was afraid of getting something, so that kind of paints a picture.

INTERVIEW 9

Upon analyzing the participants' explanation of their financial situation in relation to housing, it became apparent that both the experience of core housing need and the lack of acceptable housing place a significant strain on their mental health. The financial burden of paying a large proportion of their income on housing and the inability to change the quality of their living arrangements aggravate any existing stress brought about by their mental illness, such as depression.

Rooming Houses

Rooming houses across the nation are infamous for cheap rents, poor living conditions, and being a tangible symptom of neighbourhood decline and disinvestment (Ontario Tenants Rights, 2006). Winnipeg is no exception to this commonly held perception. However, it should be noted that due to the inexpensive rents of rooming houses, they are often the last resort for people who are at risk of homelessness. Specifically, rooming houses offer single rooms with shared common areas - such as kitchen and bathroom – to renters.

While they may not always be adequate nor offer permanent stability, rooming houses have proven to represent the only housing choice for several participants. A total of three participants identified that they moved into a rooming house – often more than once – because it was the only living arrangement available for the amount of income they received.

Where did you go to from there?

I went to a rooming house on Furby.

Did you feel any sense of choice or control living there?

Nope. I just moved in and I needed a place to live and it was all I could afford because my welfare worker was being stubborn.

INTERVIEW 4

Expressions such as these were common among those participants that openly acknowledged having to live in a rooming house.

So the quality wasn't bad, you were saying?

Not compared to living on the street.

So where did you go to after Furby and William?

I went to the rooming house on Home and then I went to a rooming house on Victor.

How about the safety factor, on Home Street?

Well, you know, you are living in a rooming house, what does it matter?

INTERVIEW 6

Upon examining statements such as the ones above, there is the sense that the participants give in to their limited financial situation and despair – or lose hope – over the inability to improve their living arrangements.

While most of the participants did not discuss explicitly resorting to a rooming house, five out of the nine participants discussed rooming houses in a negative tone – referring to them as the worst choice of housing, before homelessness, particularly for women.

When I was looking for apartments, for what welfare gives you, the holes in the walls or shared rooms with a bunch of men and stuff where it wouldn't be safe for a young woman to live. So, my options were really, really limited, it was really scary, if you look in the paper and you look at

> what you could get for $285, like you get a closet with a shared bathroom with maybe five other men in a rooming house.
>
> INTERVIEW 1

Both the female and male participants that discussed their experiences in rooming houses conceptualized this living arrangement with one overarching similarity. This similarity refers to the insecurity over both their mental health and their physical wellbeing as a result of residing in a rooming house. This similarity is second only to the participants' inability to trust the other tenants residing in the house. These sensations of anxiety – particularly the inability to feel secure in one's own home – are additional factors which aggravate participants' mental wellbeing.

> *Where did you move to after that?*
>
> I was at a place on Langside for a while, an actual rooming house. I was kind of on the street for most of the next month, and then I jumped to a rooming house on Langside. So, I felt that was a forced move, I just didn't get lucky finding a nice place so I felt that was a forced move. Actually that was the worst place I have ever lived that one, coming up.
>
> *What were the positive and negative elements of the neighborhood?*
>
> The only positive thing at all was that you had a roof over your head, beyond that there was very little that could be said.
>
> INTERVIEW 9

Based on the above quote, it becomes evident that participants' only positive perception of rooming houses is based on having a shelter in which to take refuge. However, despite participants' negative conceptualization of rooming houses, participants present the understanding that if an opening in a rooming house did not become available, they would have been left homeless. This suggests that there is a dual perception among participants towards rooming houses – that being that rooming houses are the last rung in

the availability of living arrangements, but they serve a fundamental purpose by providing the essential shelter that the streets lack.

Residing in Inner City Neighbourhoods

The final relationship that became apparent within the data set is how participants experience and conceptualize the neighbourhoods in which they have lived. This is another key element which exemplifies the housing situation that each participant has experienced. Although the specific neighbourhoods in which individuals have resided have changed constantly during their housing history time period, the characteristics of the neighbourhoods are somewhat reiterated from one participant's account to the next.

Given the income received by participants, the housing choice available to them, and thus the neighbourhood choice available to them are somewhat limited. Specifically, all nine participants highlighted that they have been relegated to the inner city or neighbourhoods shouldering the inner city at multiple points in their lives. The main reason that participants site for living in the inner city area is that inner city neighbourhoods, like neighbourhoods shouldering the inner city, have the highest availability of inexpensive housing.

> *If you had your choice, what neighborhood would you like to live in?*
>
> I would like to get out of the North End. But that is nearly impossible because the North End is actually the cheapest place to live.
>
> INTERVIEW 2

Unfortunately, being relegated to the inner city, participants also experience the side effects of the symptoms common to inner city neighborhoods in Winnipeg – that is, symptoms of decline and disinvestment.

Despite their differences, core neighborhoods have one common historical link in their shift from centrally located industry and manufacturing districts to the decentralization of these manufacturing districts throughout the urban fringe (Ross & Leigh, 2000). This alone has served to create a common bond among inner city neighborhoods across North America. Industrial restructuring has thus transformed core neighborhoods into areas of economic disinvestment, mass unemployment, and a slowly but gradually decreasing population (Ross & Leigh, 2000). Inner city areas are commonly defined by concentrated urban poverty with the respective social, economic, and environmental problems. It should be noted that there are exceptions to this generalization of inner city areas, such as communities which have either been developed for people in the higher income bracket or gentrified.

Low-income and/or minority communities of the inner city are commonly identified according to specific and definite characteristics. These include, but are not limited to, a housing stock that is in a state of disrepair; a lack of available jobs; a lack of adequate education and a visually depressing area identity (Grammenos, 2001). On a social level, inner city neighborhoods are commonly associated with substance abuse; the perception of high crime rates and a lack safety; a concentration of social services in response to these social issues; and a general lack of leadership (Grammenos, 2001). Also, core

neighborhoods have commonly been referred to as 'concrete jungles' alluding to the significant deficiency of natural and/or green places, such as parks. Finally, inner cities across North America have been conceptualized as remote, inferior and therefore segregated from the city system – that is from the regional economy, general society, and the regional ecosystem (Grammenos, 2001).

Although every neighbourhood is distinct and is influenced by unique social and economic forces, the characteristics of inner city neighbourhoods cited above are exemplified in all nine participants' experiences.

> *What challenges or stresses did you encounter while living there?*
>
> The filth, the graffiti, the fact that nobody cared, had no respect for where they lived and the noise, I had people pounding on my door in the middle of the night, I think it was the guy underneath me that was selling drugs, that is what I heard, people would come to the wrong apartment or the wrong floor.
>
> When a woman is knocking on your door on a Sunday afternoon and you complain about it that she is trying to sell drugs and the response is, well, make a complaint, and so three or four people complain formerly, written complaints, and the result is, well, you should have called the police. You know, and she is still there. And she would get into fist fights with another guy in a different apartment and be drunk and beating each other up and stuff.
>
> I just wish that I didn't have to spend so many years there where I was really scared, and I could hear the fighting in the hallway and right across this NRC building, I used to call the beer garden because people would sit and drink, they would pass out and fall down, the ambulances would come because they hit their head.
>
> INTERVIEW 1

While three of the participants revealed that they themselves have been personally affected by the violence resulting from the social situations in their neighbourhood or

within their housing, the remaining participants have not been directly impacted by such violence. However, whether or not the participants have been directly affected by violence, they are fully conscious and emotionally impacted by the violence, and the alcohol and drug consumption that they have been exposed to.

What do you think of your neighbors?

Some of the neighbors are pretty good, but some of them are so violent. They are always, almost half of our street, people drink all the time. Every time there is a pay day, people are drinking.

What are the positive or negative elements of the neighborhood that you are in?

The neighborhood? You don't want to go there. Just the other night, it actually started early in the morning, about 8 o'clock in the morning, some guys are firing off guns in the area and it was on the news this morning.

INTERVIEW 2

Experiences such as the one exemplified by the quote from interview 2 are common among the participants. Story after story reveals that regardless of individuals' background or mental illness, they feel forced to live in neighbourhoods where they lack a sense of safety, security and peace.

What was the quality of that neighbourhood?

It was on prostitution row, right downtown. The units were not safe and the neighborhood was pretty disgusting and it wasn't even subsidized, I couldn't even get a subsidy, I was getting EI.

It was very dangerous. I was so stressed out. I mean, I got broken into twice. Both times I was at home. I was sleeping. And there were all of these street people trying to camp out on the door step. It was not safe.

That place was terrifying, it really was. It was very bad. It was an inner city neighborhood. That was the second worse neighborhood in the city. But it was such a horrible neighborhood. It was very dangerous to sit outside. I hated that place with a passion.

Based on each story, it is evident that each participant has accepted living in the inner city, but they recognize that the main reason that they have lived in the area is because of the inexpensive rents of housing. Upon analyzing each participant's reactions to the quality of the neighbourhoods, the sentiment is that while some participants have become accustomed to the inner city – and even fond of the inner city because of the convenience factor – the majority of participants would like the opportunity to gain access to housing in a neighbourhood away from the city core. Even if they are not completely sure of which neighbourhood they would like to live in, analyzing the data reveals that they certainly desire having a choice regarding neighbourhood. Participants indicated that having a selection of neighbourhoods – and thus access to different amenities – would be beneficial to their mental health.

HIDDEN BARRIERS TO CHOOSING, GETTING AND KEEPING HOUSING

The above section was meant to give a detailed description of what the sample of nine Winnipeg residents living with mental illness themselves identify as the difficulties they experience on a daily basis and how this impacts on both their housing and quality of life. With this experiential discussion as a basis, the following sections outline the four 'themes' that were identified through the interpretive analysis of the data set. Specifically, the following sections detail the four hidden barriers identified from an interpretive reading of the data, all of which appear to negatively impact people's ability

to choose, get and keep decent housing. The four themes include *deficiency*, *social support networks and housing*; *resources and employment*; and *emotional affinity*.

Deficiency

Upon interpreting the data, the first argument I propose is that all nine participants experience a deficiency in three distinct, but interrelated ways. Deficiency here refers to the lack of an essential asset, which is critical for one's wellbeing. Deficiency in this context also refers to an asset which influences whether or not people fall within the poverty margins of society.

First and foremost, the data suggests that seven out of the nine participants experience a lack of formal education. While all nine participants expressed financial stability to be the main barrier to accessing decent and safe housing, there is the understanding that education can enhance their opportunities for attaining financial stability.

> *From your perspective what are the main barriers that prevent you from getting the housing of your choice?*
>
> Money. Well, if you want a half decent place, you have to have the right kind of money, because I am on social assistance right now and I am having a hard time because of my education.
>
> INTERVIEW 2

For the seven out of the nine participants that discussed their desire for education opportunities, education represents a means to enhance their knowledge and skill set. By increasing their knowledge and skill set, participants will be better positioned as potential candidates for employment.

Following from education, participants identified the need for employment opportunities. Again, even though money was identified as the primary barrier to accessing decent and safe housing, it follows that in order to improve their financial situation individuals require stable and permanent employment.

> *Is there anything else that prevents you from getting the housing that is ideal for you? What are the things that block you from attaining the housing that you want?*
>
> Employment. I don't know if I am capable of working yet, I want to go back to work I have been telling myself I want to go back to work but I don't know if I could handle the stress. I don't even know if I want to go back to school, that is why I am here, they are helping me figure out what to do.
>
> INTERVIEW 4

Even though the data suggests that participants experience a deficiency in education and employment, the main deficiency among all of the nine participants is awareness. Upon analyzing the data, it appears that all nine participants lack an awareness of the scope of services available to them in the community. I argue that knowledge and awareness of available community-based services is critical to enhancing an individual's opportunities for education, skills-development, and employment. When people are connected to their community and aware of what their community has to offer, they are better positioned to make informed decisions about education, employment and housing.

Based on the three deficiencies outlined above, it only follows that the sample of nine people living with mental illness who reside in Winnipeg lack financial stability. Specifically, the nine participants feel that, even though they are receiving social assistance, they do not have a sufficient amount of money to live comfortably.

Is there anything that makes it hard for you to live in the community?

> It is not really hard, it is just that, in a way it is hard because welfare does not give you enough money to live on, you have to struggle to get by with things.
>
> INTERVIEW 2

This observation parallels the literature, which indicates that people living with mental illness commonly fall within the poverty margins of society. Although no one participant explicitly identified themselves as falling within the poverty margins of society, the data indicates that this is in fact the case. This financial instability plays a direct role on people's ability to choose, get and keep the housing they deem appropriate. For two participants, the lack of financial stability resulted in several instances of homelessness. Needless to say, this greatly impacts the quality of life that individuals are able to achieve.

However, there is one complexity that impacts this observation. People require permanent and stable housing in order to have the time and peace of mind to concentrate on developing their skills and attaining employment. However, in order to access decent and affordable housing, people must have financial stability. This is precisely the predicament for the sample of nine people living with mental illness who reside in Winnipeg. Perhaps the first step toward addressing this predicament is to facilitate people's ability to gain awareness of, and coordinate the array of community-based services that are currently available to them.

Social Support Networks & Housing

As most of us can attest, social support networks play a necessary and critical role in our daily lives and are essential to our sense of belonging. Specifically, social support networks refer to a group of friends, family members, colleagues and other relationships that offer support and reliance (Mayo Clinic, 2006). While participants did not explicitly refer to their 'social support network', their discussions and reactions to questions inquiring about housing challenges and supports indicates that this is indeed a prevalent force affecting both their mental health and their housing situation.

> *What challenges did you encounter while living in this particular housing situation?*
>
> Well, I did have a bit of a challenge because I just turned ill in the spring so I did tell a few people off and I did some things I wasn't supposed to do. I had to make apologies to these four people and my psychiatrist wrote them a letter too and my worker from the YMCA Learning and Leisure Program wrote a letter too and after all of that they said that they will consider taking me back and guarantee that if I do get ill again tell somebody instead of just letting it go through.
>
> INTERVIEW 3

This quote exemplifies the implications that a lack of a strong social network can have in moments of elevated stress. Although this participant received assistance from formal supports, including his psychiatrist and the Learning and Leisure Program, he did not have someone on whom to rely or someone who could advocate on his behalf at the moment of his relapse. Had this participant had someone on whom to rely, such as a friend or family member, this may have enhanced people's understanding of his illness and minimized people's immediate reaction to take action to evict this participant from the apartment block. In other words, having an established social support network can

assist individuals living with mental illness to prevent problems from escalating, particularly in moments of relapse.

> *What types of support were you accessing at the moment?*
>
> And had it not been for Mary – she used to work here. She is dead now of course. Had it not been for her, I would have thrown myself under a train. It's true, you know, it's true because I didn't know what to do, where to go or anything else.
>
> *Were there any friends or partners or neighbors?*
>
> No, I don't know anybody, I never have and I never will.
>
> INTERVIEW 6

When considering that mental illness is cyclical in nature – that is, people experiencing mental illness can experience severe bouts of mental illness and then have periods of remission – complicates individuals' ability to cultivate and maintain constant and stable relationships.

> *What kinds of supports did you have while living in this housing situation?*
>
> I never had any friends because I was ill most of the time, I was profoundly and severely depressed so it was hard to maintain friendships or relationships.
>
> When things got really bad though, I can tell you, I had my grandparents alive at the time and that is where I would go sometimes for a month or two because I couldn't manage, like I couldn't, financially…they basically took care of me when I was really, really sick. On a farm actually and it was hard on my grandparents because they didn't understand why I would sit for days and all I could do was cry but they loved me.
>
> I started therapy when I was 17 and I am 39 now, and I am still seeing the same psychiatrist, so that has been an ongoing support. So I had my grandparents, I have my psychiatrist, and the people here at CMHA have been absolutely wonderful.
>
> INTERVIEW 1

Although this participant explicitly indicated the lack of friends in her life, she felt a solid source of support from her grandparents. They may not have fully understood her mental illness however the simple fact that they were available whenever she needed them gave her the opportunity and space to heal. This participant felt loved and cared for in her worst moments, which further minimizes the additional stress of not knowing where to go or whom to turn to in moments of relapse.

In addition, this quote further demonstrates another commonality among the nine participants. This commonality refers to the prevalence of formal supports. Many of the relationships that remain constant are those that involve mental health service providers, such as psychiatrists, community mental health workers and other medical professionals. Not only do formal supports supersede natural support networks, but they also tend to be more stable than natural supports. This finding should be considered on the basis that the nine participants are all connected to the mental health system, which is certainly not the case for all people experiencing mental illness in Winnipeg.

In addition to the cyclical nature of mental illness, the data reveals that the difficulty for people living with mental illness to cultivate and maintain social relationships is partly due to the preconceptions held by society towards people experiencing mental health issues.

> I really think that there is a huge stigma about mental illness, and that really needs to change and I don't know if it is advertising or people going out into the community and talking about mental illness...you know, like in schools because people really don't know. I am 39 and I really don't want to hide who I am and what I have been through or lie and even my

> psychiatrist says don't tell people, in a job interview, don't say anything, I mean, he knows what it is like but it shouldn't be some dirty little secret and I think of my illness of diabetes, if I don't take insulin every day I will get sick, otherwise I am fine. So, if we could just wave a magic wand and remove that stigma that would be wonderful place to start.
>
> INTERVIEW 1

In this instance, participant one was referring to the general conceptualization that society maintains toward people living with mental illness. Although she was not directly referring to the impact that stigma plays on an individual's ability to cultivate and maintain friendships, analyzing the data indicates that stigma indeed plays a critical role in developing and maintaining social support networks.

> *What about friends? Do you find that friends support you at all?*
>
> No, I don't really have any. I have what I called some friends of convenience. I had some real friends in high school, but over the years, it was just a matter of them moving away from the city, not that they decided they didn't like me. Then, later on it was what I call friends of convenience…people that I would rather not associate with but I would seem to run into them everyday anyway, whether they were just across the hall in the apartment block or whatever. And instead of being lonely, keeping company with them but then it get problematic and then I don't really like them or maybe they like me too much and it becomes annoying so I have burned my bridges with all of those people and I can't say I have friends right now.
>
> *If you had your choice would you like to live alone or with other people?*
>
> No, I have had bad experiences living with roommates. Since I am a mental case, I can't really afford good friends, even though I don't mean it in terms of money although that is part of it too, I can always get into situations where people are steeling form me or they just not nice to get alone with, and I am just getting too old now so I would rather be by myself so although in an apartment block you have some distance, but maybe you can socialize a little bit too would be ok.
>
> INTERVIEW 9

In all nine housing histories, relationships – whether formal or informal – were critical to both the physical and mental health of the participants. Participants that mentioned that they had good friends and those that mentioned that they have maintained a steady relationship with mental health service providers both alluded to the positive role of friends, family and professionals in their lives. This is testament to just how essential a combination of both formal and informal support networks is for people living with mental illness. Four out of the nine participants indicated that the supports that they received were, at times, literally life-saving supports, where people provided food, money, and/or shelter in times when these necessities were scarce, if available at all. Coincidentally, the four participants who indicated that their friends and/or a particular service provider offered them life-saving support were all women.

> *What challenges were you experiencing while living in that particular housing situation?*
>
> The one problem in one place was that a big grocery store, I was lucky I had a bike and I could ride it. At least in the summer, I don't ride in the winter I am not that good. So that is when I would run into problems with getting fresh fruits and vegetables. I mean getting to the store, I had to get on the bus and carry everything so, when I was getting sicker and sicker it was getting tougher and tougher but I did have a good friend with a car. If I didn't have her, I don't know what I would have done.
>
> I would have gotten very thin if it wasn't for a couple of friends. And then unfortunately one of my good friends moved away. But, I had one good friend left and if it wasn't for her, I don't know what I would have done because I got injured, I fell and I broke my wrist in four places. I really smashed it up. I was in big trouble because of terrible weather, gross, horrible weather – some of the worst winters on record. But, no, I wouldn't have eaten. And as it was, I had no phone and I had no way of contacting people. I mean I couldn't even afford a phone, it was very rough. So, no, there was support from my good friend but I was leaning on her pretty heavily.
>
> INTERVIEW 5

In addition to representing a source of support and reliance in times of relapse, social support networks minimize an individual's sense of loneliness and desolation. When people living with mental illness have a core network of friends, family or colleagues, they are able to maintain the perception that they are not alone, and therefore belong, something which all people strive to achieve, regardless of mental health. The presence of a social support network further enhances an individual's sense of self-worth, contribution to society, and being an asset to their friends/family/colleagues. This is especially relevant when people living with mental illness are exposed to diverse people, with different backgrounds and distinct roles in society.

Furthermore, contemplating on and analyzing the data suggests that there is a strong connection between housing and the ability to cultivate and maintain social relationships. When individuals lack the stability of a permanent and decent home, they experience continual anxiety and pressure to find their next dwelling. This undoubtedly hinders individuals' confidence and aspiration to seek out social relationships, which may seem unimportant in comparison to finding and/or maintaining a roof over their heads. On the other hand, when individuals are capable of cultivating and maintaining informal social supports, these supports can assist individuals in either finding living arrangements or maintaining their current housing.

Resources & Empowerment

In light of their financial situation, the sample of people living with mental illness who reside in Winnipeg share the need for community-based services to assist them with their

diverse needs. Interestingly, without explicitly acknowledging the importance and critical role of community-based services in their lives, all nine participants discussed the range of community-based resources that they have tapped into. In this context, a resource refers to a source of support or assistance that individuals can access when they are in need. Given their diverse backgrounds and experiences, the resources are not constant nor the same from one participant to the next. The one exception to this observation is the Canadian Mental Health Association, which, given the context for recruiting the interviewees, all participants are accessing. Nonetheless, all nine participants are making use of some form of community-based services to assist them with different realms of their lives. The resources that individuals are utilizing include mental health services, skills development services, and medical services among others.

> *What services were most beneficial to you at that time?*
>
> I would have to say the Club House is beneficial because I do go to that. It is a program that supports mental health clientele. You do chores there, you can eat lunch for $2.50 and have breakfast there for $1.50, you can buy drinks there, like Seven Up, Coke, Pepsi, Coffee, Tea. Sometimes in the day there is free coffee, free tea to drink. There are counsellors there, job developers there type of thing, another person who teaches you how to use the computer and the internet and stuff like that. Yeah, it is a good support system. You hang out with different individuals that hang out there and you don't have anything to do with them outside the program. It is just healthier that way I find.
>
> INTERVIEW 3

While this participant explained fairly thoroughly the services offered at the 'Club House', other participants were not aware of the 'Club House' when asked. This indicates that while all of the participants do not have an exhaustive knowledge of available community-based services, the services that they are aware of and accessing are a critical component for their mental health. Furthermore, the resources that people are

accessing both directly and indirectly impact their housing experience, options and accessibility. When people have access to community-based resources, they expand their opportunities for networking and gaining valuable knowledge. This networking and knowledge-building may assist them in learning about forthcoming housing options, tenants rights issues, and other fundamental issues or opportunities that affect the quality of their housing, and thus their lives.

> *In this housing, what supports and services did you access? Did you start coming to CMHA while you were living there?*
>
> Seneca House. It is kind of repose for people. You have to be a consumer of mental health services and you can stay up to five days and they give you a room and the food is free. So, it's a place to get your head together for a while. But unfortunately you can only stay for five days and then you can only do that maximum once a month, but they actually helped me find my current apartment. Yeah, that was definitely a helpful service. It was recommended by my psychiatrist who told me about that place.
>
> INTERVIEW 7

In addition to participants making use of community-based services, the data suggests that participants are accessing other resources which are equally important and beneficial to their mental health.

> *What supports and services were most helpful to you at that time?*
>
> The drop-in, the drop-in at the community centre because I was able to have access to a phone, socialize, use a computer…it was safe there. I started going back to the community centre, I started volunteering…no, I didn't start volunteering yet but I was thinking about it, I started going to church…that helped.
>
> *What are the positive or negative elements you find about the neighborhood?*
>
> The positive is that I am right next door to a shopping place, I am still close to the Health Sciences Centre for my appointments, I am close to

> CMHA for my appointments, I still go to the Community Centre, and now I am volunteering.
>
> INTERVIEW 4

In the case that individuals' housing situation is stressful and tense in nature, community-based resources serve several purposes. As previously stated, community-based resources expand individuals' 'service network' and knowledge regarding housing options. Second, community-based resources represent an opportunity for individuals to escape their daily routine and the pressure brought about by their housing. In some cases, community-based resources represent more than a simple escape from their housing situation – these services become a safe haven for individuals who live in fear.

> *In that place, what supports and services were most helpful?*
>
> At the time, anything I could get for free, at this point any appointments that I could get with my psychiatrist or vocational rehabilitation. Appointments were nice because they would take me out of the environment and give me a break and give me a chance to think straight if only for one hour.
>
> INTERVIEW 9

When individuals enhance their use of community-based resources, they improve their chances of meeting people from diverse walks of life, who may potentially serve as housing advocates for them in the future, particularly in times of relapse. Also, becoming actively involved in alternative community-based resources, such as volunteering in community centres and church groups, enhances individuals' sense of integration into the community in which they live.

> *You have said that you have done volunteer work, do you think that has helped you out?*
>
> Oh, for sure. It has been a huge…I started that because of my illness, I can't have children of my own. I have a couple of nieces that I enjoy a lot.

> Yeah, I started doing that and I got involved with the Homework Club and it was great, it was so close to me, and these kids are from war torn countries and English is their second language, and I really had a lot of fun with them. I learned a lot and I decided to share my passion for learning with others. But if the government could say, for volunteers, because I did over 200 hours from October to June, if they would throw me an extra $50 or something, that would have helped a lot, but I did it for free and I would do it again.
>
> INTERVIEW 1

As interview one exemplifies, accessing community-based resources symbolizes a real escape from individuals' situations. These resources further give individuals the opportunity of interacting with and learning from other people's situation. Ideally, interacting with diverse people with distinct needs will open the possibility for contributing to and making a difference in another person's life. This in turn enhances individuals' sense of contribution and worth.

However, the data further suggests that each individual participant is not quite making use of the range of community-based resources that are currently available. For example, one participant may utilize two to five resources and the next participant may be utilizing a set of two to four completely different resources. This indicates that there is an overall lack of knowledge regarding the range of community-based resources – including medical, social, and recreational – that are currently available to them in the community. This lack of knowledge hinders individuals' freedom to choose the resources that best suite their needs and to empower themselves through knowledge.

Although empowerment can be an elusive term, and cannot be given from one person to another, people have the capacity to empower themselves with the appropriate resources.

In line with this is the importance of education in the lives of people living with mental illness. Education will better prepare individuals for the job market, which will further minimize people's financial instability and thus improve their ability to choose, get and keep housing. Gaining education and awareness represent an essential step toward self-empowerment for people living with mental illness.

Emotional Affinity

In the midst of stress, anxiety and distrust, people commonly seek out a source of tranquility which serves to minimize their troubles. This affinity towards some 'thing' does not necessarily occur on a conscious level – as is the case for the participants. Examining the data set indicates that eight out of the nine participants are captivated by something in which they find an inherent sense of peace, tranquility and self-awareness. Their sense of calm is enhanced when participants feel that their 'object of affinity' is accessible to them, despite their financial situations.

Coincidentally, the eight participants who alluded to having an 'object of affinity' described two main objects, which minimized their stress and provided them with comfort. These two 'objects of affinity' refer to pets and to natural spaces, such as urban parks.

A total of three participants expressed their affinity towards their pets – all of which were cats.

What was the quality of this particular housing?

> Well, compared to my last housing situation, in terms of the last apartment I lived in another city, this is…I can have my cat. I mean that is big for somebody who lives alone and who has had the same cat for 20 years, I mean the thought of having to give her up, you know she is 20 years old, you know is not tolerable and that is all there is to it. I will lie, cheat and steel in order to be able to keep her until she dies and that is very important.
>
> INTERVIEW 5

In some instances, participants refuse to accept available housing if the housing did not allow pets.

What housing situation have you considered your favourite one?

> I don't really know. It's something I believe too much, you get what you pay for and if you can't really afford a nice place then you don't get one. Again, I could be standing in line for public housing but I have heard that…you know, I have a cat, so that becomes a problem if I am looking for a place or I have to move because I am not willing to give up the cat. So when I am looking for place that becomes a big consideration. I don't really know how to answer that question, my favourite type of place. I find that well, some things are the same, but then every different place has unique problems too. I really don't know how to answer that question.
>
> INTERVIEW 9

As these two quotes exemplify, for people who lack a social support network and whose housing situation is transient in nature, the presence of their pet represents a source of companionship. Further, the presence of a pet reassures individuals that they are not alone. Whether participants conceptualize the importance of their pets consciously or unconsciously, the presence of a pet fills the void of not being able to rely on alternative and stable relationships.

In terms of the second 'object of affinity' described by the participants, natural spaces, including parks, trees, and even natural sunlight, represent an essential resource for six out of the nine participants. In fact, recalling the interview process itself, when the participants acknowledged parks and other natural spaces, their facial expression softened revealing the sense of peace and liberation that this resource brings to their lives.

> *What is the quality of this particular housing?*
>
> It is peaceful, it is bright, it is huge and I got 12 foot ceilings and I love plants, I have over 30 plants, some of them are almost 12 feet tall. So, it has been a really healing experience for me.
>
> INTERVIEW 1

The affinity towards natural spaces became especially apparent when participants were asked about their ideal or preferred neighbourhood. The overall sentiment was that many of their dwellings have been situated within urban – mainly inner city – residential neighbourhoods. As previously mentioned, urban inner city neighbourhoods are commonly described as concrete jungles. This signifies that there is an overall deficiency of natural spaces. Within the six participants that alluded to their affinity with natural spaces, this deficiency has not gone unnoticed.

> *If you had your choice, in which neighborhood would you like to move?*
>
> St. James.
>
> *What makes that attractive to you?*
>
> More open space, there is a lot of open space there; it is not so crowded with buildings, not like here.
>
> INTERVIEW 4

This quote – which is very similar to others described by the six participants – reinforces the notion that contact with natural spaces play a positive role on individuals' mental

health. Research conducted by Roger Ulrich at Texas A&M University attests to the inherent benefits of natural spaces on individuals' health (World Science, 2007). Specifically, Ulrich's study indicated that hospital inpatients whose windows opened onto natural space recuperated sooner that those patients who had a view of an adjacent building (World Science, 2007). Although Ulrich's study highlighted the improvement of individuals' physical health, participants' discussion regarding their affinity towards natural spaces indicates that mental health also benefits from accessing and interacting with 'nature'.

> *What did you like about it living in the area?*
>
> The trees and the river and the private space of not hearing the constant traffic of where I am now. The park was really nice to go to and also the Assiniboine Forest. That part of it really helped to deal with the stress of living there. I actually had to sleep sometimes down in the shed. I tried to get the shed and sleep there overnight because this guy, he would have, he is just disturbing, a very disturbed man. He would have parties and women ruckussng, it was the most toxic thing I had ever experienced.
>
> *Did you feel safe in the area?*
>
> I felt safe in the park but I didn't feel safe going back to my place.
>
> INTERVIEW 7

The above quote is truly representative of the six participants who alluded to an affinity with natural spaces. For these participants, natural spaces transcend visual beauty and recreation. They represent an escape from their housing situation, a place to think introspectively, and a space in which they can feel at peace and secure.

When considering the implications of emotional affinities on choosing, getting and keeping housing, the importance of pets and access to natural spaces become quite

relevant and important. First, giving people the opportunity of retaining their pets within the housing of their choice, ensures that the companionship provided by pets, which at times may be the only source of companionship for individuals, is not threatened. Second, when individuals' housing creates significant stress in their lives, having access to natural spaces relieves some of the stress induced by their mental illness and their housing situation. Furthermore, when people are preoccupied with anxiety, depression and apprehension – whether due to their mental illness or the instability of their housing – having access to natural space represents a source of liberation and freedom from their daily routine and experiences.

This chapter has examined the housing situations – or lived experiences – of the sample of nine Winnipeg residents living with mental illness. The chapter begins by illustrating how the interview participants conceptualize their housing situation and the common characteristics delineated from one housing history to the next. The similar characteristics include transient housing, the prevalence of core housing need, rooming houses and living within neighbourhoods experiencing symptoms of decline and disinvestment. This summary of participants' housing situation was derived from a literal reading of the data set. The summary of people's housing situation was followed by an outline of the hidden social barriers that directly impact people's ability to choose, get, and keep decent and low cost housing. These hidden social barriers were identified through an interpretive reading of the data set and include deficiency; social support networks and housing; resources and empowerment; and emotional affinity.

CHAPTER 6 – CONCLUSION

This concluding chapter will discuss how the interpretations of the data gathered, discussed in chapter five, address the three questions that have served to guide this study. Question three will be addressed by highlighting a series of recommendations that have been generated based on the interpretive reading of the data. Once the research questions have been addressed, the discussion will turn to identifying the limitations of the study along with future directions for this research.

ANALYTICAL DISCUSSION

A series of three questions were identified at the beginning of the research process to help maintain focus and give direction to the research. These questions are as follows:

1. Why do people living with mental illness feel that housing stability is particularly important for their mental well being?
2. What challenges do people living with mental illness feel most prevent them from choosing, getting and keeping decent and affordable housing in Winnipeg?
3. What policy tools can enhance integrated housing opportunities for people living with mental illness who reside in Winnipeg?

Based on the interpretive analysis of the research, several arguments and themes were identified that begin to address the questions above.

Why do people living with mental illness feel that housing stability is particularly important for their mental well being?

First, having analyzed the data, participant's stories indicate that the main reason they feel that housing stability is particularly important for their mental wellbeing is the freedom that housing stability allocates to the different spheres of their lives. In other words, when people have stable housing and do not have to worry about losing their current housing and finding alternative living arrangements, they are able to invest their time and energy in developing and enhancing other realms of their lives, such as personal and professional development and cultivating social relationships.

The benefits of permanent and stable housing on individuals' mental health have been reported by authors such as Allen (2004); Parkinson, Nelson & Horgan (1999); and Walker and Seasons (2002). These authors have indicated that residents of supported housing – that is, ordinary and permanent housing – have reached personal fulfillment and diminished instances of relapse of their mental health.

Conversely, when individuals' housing situation presents a constant instability and angst, a major proportion of their time and effort is directed at ensuring that they have a roof over their heads, while also ensuring that other necessities such as food do not fall short.

What challenges do people living with mental illness feel most prevent them from choosing, getting and keeping decent and affordable housing in Winnipeg?

To address question two, I return to the argument that all nine participants experience a deficiency in three distinct, but interrelated ways. These deficiencies include education, employment and awareness. On the surface it is easy to say that people living with mental illness experience difficulty in choosing, getting and keeping housing because they do not have enough money. This point is highlighted in the literature. Walker and Seasons (2002) and The Canadian Chamber of Commerce (2005), for instance, have indicated that people living with mental illness are financially limited, which enhances the need for supplementary financial supports.

However, the data suggests that the money barrier is affected by other forces in the lives of people living with mental illness. First, when people do not have the fundamental education to read and write effectively, this represents an impediment to attaining a stable and permanent job opportunity. And, only when individuals have the competitive edge – that is, the necessary knowledge and skills – to compete in the job market will they become successful candidates for employment. Both education and employment better position people for receiving a continual flow of income. This in turn will improve individuals' capacity to choose, get and keep the housing they deem appropriate.

The element that ties these two 'deficits' together is awareness, or the lack thereof. For people considered members of a vulnerable population – which includes people living with mental illness – it is particularly difficult to coordinate the mass of community-based services available to them. Having the awareness of the resources that are

available to them in the community will enhance their knowledge of available and relevant education and employment opportunities. The barrier then, is trying to balance the stress of not having financial stability to afford decent and low-cost housing, the stress and pressure brought about by their mental illness, and the uncertainty of knowing where to go or with whom to consult regarding their unique and diverse needs.

RECOMMENDATIONS

To address the final question – that is, *what policy tools can enhance integrated housing opportunities for people living with mental illness who reside in Winnipeg?* – I suggest a series of recommendations that have crystallized from interpreting the data set.

1. As history has shown, people living with mental illness have traditionally been, and for the most part continue to be, kept at the margins of the discussions and decisions that affect their lives. Therefore, it is essential to begin to engage people living with mental illness in the process of developing housing and social policy which will have a direct impact on their quality of life. Planners, particularly, are in a valuable position to engage the community and ensure that the voices of people living with mental illness are an integral component. Ideally, this process of engagement would ensure that people living with mental illness voice their concerns and preferences, and it would also help to demystify the myths and stigma commonly held in society that are associated with people living with mental illness.

2. In response to the transient nature of individuals' housing situations, as identified in the data, there is the need for both housing subsidies and portable housing allowances. Housing subsidies, which are attached to specific housing units, and portable housing allowances, which are attached to the individual rather than to housing units, would enhance individuals' housing and neighbourhood options. These two housing policy tools would also give people living with mental illness greater freedom to move should their economic or family situation happen to change. Again, this finding is supported in the literature which indicates that people living with mental illness are commonly situated within the low-income margins of society, which calls for supplementary financial supports (Walker & Seasons, 2002).

3. As an alternative to Manitoba Housing and generic private rental units, there is the need for additional cooperative housing units. Especially for people living with mental illness, cooperative housing represents a shift in mentality from thinking about how much money individuals can contribute to their housing to thinking that individuals living with mental illness are capable of contributing a certain, fixed amount of money over a long period of time. Furthermore, having the stability of long term and permanent housing would enhance people's ability to cultivate and maintain the social support networks, which require a major investment of time and effort particularly for people living with mental illness.

4. The data suggests that all nine participants are receiving social assistance but continue to experience instances of core housing need and even homelessness. Therefore, there is

great need to re-analyze rental values in the private market and the money allocated to people through social assistance. It is becoming increasingly critical to ensure that social assistance is reflective of market rents to minimize people's need to dip into the money they require for food, clothing and other daily necessities.

5. When planning and developing low-cost housing, people living with mental illness, like other low-income populations, would benefit if these units were widely distributed throughout the city. As Allen (2004) has indicated, people living with mental illness are often financially limited to attain housing at the rates available in the real estate market. Despite this limitation, people living with mental illness desire a real choice of normal housing in the community – that is, housing that does not discriminate them based on ability nor income. Thus, distributing social housing throughout the city serves two fundamental purposes. First, scattering low-cost housing units throughout the city would minimize instance of concentrated poverty. Second, scattering low-cost housing throughout the city would give people situated within the low-income margins of society the opportunity to access natural spaces such as urban parks, which are deficient in the inner city but more prevalent in suburban residential neighbourhoods.

6. The interpretation of the data suggested that the sample of nine Winnipeg residents living with mental illness lack a thorough awareness of the resources that are currently available to them in the community. Having an awareness of the available community-based resources would enhance people's knowledge regarding prospective housing

opportunities and related housing issues that community-based agencies are familiar with due to their connection to the community. This highlights the need for a 'one-stop shop' of information regarding community-based resources. For instance, a 211 initiative across Manitoba would be an effective tool for people living with mental illness. This sort of initiative would maintain an up-to-date database of local services and how to access each service. Ideally, this tool would include consultants who would assist individuals to identify their need and the most relevant service to address the identified needs. A 211 initiative would be especially helpful for people living with mental illness as it would assist them in coordinating the wide assortment of services available to them in the province.

7. Parallel to the 211 initiative, greater collaborations across different levels of government and sectors – including the federal government, the provincial government, the municipal government, non-profit housing providers, community-based mental health service providers, and community resident organizations – would hopefully ensure that people will have access not only to affordable housing but also financial assistance, community-based mental health services, assistance with education and employment, and options for community-based recreational activities. This multi-sector collaboration would ideally enhance individuals' residential stability, independence, community integration and a sense of self-control.

8. Before considering specific housing policy tools that would enhance integrated housing opportunities for people living with mental illness who reside in Winnipeg, there

is one fundamental necessity that is currently absent or fragmented in Winnipeg. This refers to specific numbers – including demographic and statistical information – regarding people living with mental illness and their housing situation in Winnipeg. In the initial stages of this research, specifically in trying to find the number of people in Winnipeg who live in core housing need or those who live in inadequate housing situations, the available data was either fragmented or somewhat dated. Therefore, there is the need to develop statistical information regarding the number of people living with mental illness who experience core housing need, those who are in need of adequate housing, and those who are homeless. This will represent the foundation from which to develop housing and social policy which is responsive to the numbers of people living with mental illness who are in need of housing. This data may also help to illuminate the number of people living with mental illness who are falling through gaps in terms of housing services.

LIMITATIONS OF THE STUDY

While this research was an essential asset to understanding the housing experiences of people living with mental illness and, specifically, the barriers that prevent them from choosing, getting and keeping decent housing in Winnipeg, there is one fundamental limitation that must be noted. The research focused on people who have self-identified as experiencing mental illness and who are therefore connected to the mental health system. This illuminates only one sub-group of the total number of people living with mental illness who reside in Winnipeg. Specifically, the perspectives of people who have not self-identified as experiencing mental illness and are therefore not connected to the

mental health system, and those who are homeless or couch-surfing have not been included in this study. Therefore, the findings that derived from interpreting the data set are inclusive of only a fraction of the population of people living with mental illness who reside in Winnipeg.

DIRECTIONS FOR FUTURE RESEARCH

Given the limitation of the study, research regarding the housing crisis endured by people living with mental illness would highly benefit from including the perspectives of people who are not currently connected to the mental health system. This understanding would enhance the comprehensive scope of this research and further begin to illuminate the gaps in service provision and the demographic characteristics of the people who are falling through such gaps. Furthermore, expanding the research to include the range of people living with mental illness will further highlight the complex and unique housing needs of people living with mental illness who reside in Winnipeg. This will assist policy makers and policy analysts to understand that there is a range of forces, in addition to the financial barrier, that must be considered when developing housing and social policy that is inclusive of, and responsive to the needs of people living with mental illness.

CONCLUDING REMARKS

The above arguments have primarily derived from an interpretive analysis of the housing histories shared by people living with mental illness who reside in Winnipeg. Given the interpretive nature of the analysis, the arguments are not an objective account of

participants' experiences, but rather represent the collaboration between participants' housing experiences and my own understanding and reasoning, from the perspectives of both researcher and a member of a minority population in Winnipeg.

Having had the opportunity to conduct the interviews themselves, I have appreciated that the emphasis of this work should not be on numbers, but on human relationships and understanding that the implications of this research result in one living and breathing human being either accessing housing, or alternatively, resorting to homelessness.

The implication for planners is that people living with mental illness continue to be relegated to the margins in the arena of discussing the decisions that directly impact their lives. With this understanding, planners have the expertise and skill to play the role of amplifying the voices of people living with mental illness in Winnipeg, particularly in the process of developing and analyzing housing policy. By incorporating and collaborating with people living with mental illness in this process, the benefits are two-fold. Not only will planners, policy analysts and decision makers better understand the consequences that their policies and actions have on Winnipeg residents, people living with mental illness who are included in the decision making process will gain the knowledge of housing policy in Winnipeg, which will give them the resources to empower themselves so as to affect change in their own lives.

The analysis has demonstrated that the housing crisis endured by people living with mental illness requires not only bricks and mortar – or enhancements to the housing

policy field - but further requires soft services, implying enhancements to the social policy field as well. There are multifaceted forces at work and systemic barriers that minimize people's opportunity for accessing decent and affordable housing. Specifically, the conclusion that derives from the arguments presented in the analysis is that currently, there are silos of social services available to people living with mental illness and the community at large. These services are precisely what assist individuals in learning and making informed decisions about housing. With the assortment of resources currently available, people living with mental illness experience difficulty in effectively navigating through this maze of services. These multifaceted, systemic barriers must first be understood and then conceptualized as meaningful and necessary contributions to the housing policy arena.

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APPENDIX A: INTERVIEW GUIDE

Research Instrument: Interview Questions
These questions have been designed around your housing experiences from the moment you became aware that you might have a mental illness to the present. I would be very grateful to you for discussing your personal housing history with a particular focus on the challenges and barriers that have influenced your opportunities for acquiring an affordable, good quality and long-term residence.

A. **Housing History**
We will begin by discussing your housing situation since the time your first became aware that you might have mental health issues.

- When did you become aware that you were experiencing mental health issues?
- Where were you living at this time?

(repeat for each housing situation)

- With whom were you living?
- Where any of your roommates people who also were experiencing mental health issues?
- What type of dwelling was this? (family home, private rental [apartment or house], personal owned home, non-profit or coop, public housing)
- Were you receiving Employment and Income Assistance?
- Were you working?
- How much of your income were you utilizing toward housing cost?
- What was the quality of the house/apartment? (# of people vs. # of rooms)
- What challenges did you encounter with living in this housing situation?
- How much choice did you feel you had in this living arrangement?
- What were the positive and negative elements of that neighborhood?
- Within that neighborhood, did you have easy (walking) access to different amenities such as grocery stores, pharmacy, family, friends, work, services and support?
- In this particular housing situation, what supports and services did you access (these could include support services from family, friends, a partner, neighbor, formal services or other supports)?

- What supports and/or services were most helpful?
- How long did you live in this housing situation?
- What circumstances led you to move from there? (Was this a voluntary choice or did you feel influenced/forced to move?)
- Where did you move to after this housing situation?

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can you please elaborate/clarify/explain

B. **Favourite Housing to Date**

3. Which housing situation was your favourite one?
a) What was it about the housing situation that made it your favourite?

C. **Housing Support Services**

1. If you had your choice, what services would be helpful to you if they were available?

D. **Housing Preferences**

1. If you had your choice, what type of housing would be ideal for you?

2. From your perspective, what are the main barriers that prevent you from getting the housing of your choice?

3. Would you like to keep living where you are right now or would you like to move someplace else?
    a) If you would like to stay, why?
    b) If you would like to move, why?

4. If you had your choice, in which neighborhood would you want to live?

5. If you had your choice, would you like to live alone or with other people?
    a) Who would you like to live with?
    b) Why would you like to live alone?

E. **Quality of Life/Community Living**

1. Is there anything that makes it hard for you to live in the community?
2. What (would) help(s) you to live in the community?

APPENDIX B: CONSENT FORM

Research Project Title: **Promoting Inclusion through Supported Housing: Policy Implications**

Researcher(s): **Tamara T. Peralta**

Sponsor: **The Canadian Mental Health Association – Winnipeg Region.**

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Background to the Research
This research will explore the notion of inclusive and integrated housing, focusing on how housing policies can more effectively meet the needs of Winnipeg residents living with mental illness. The fair access to safe and affordable housing along with an individual's ability to choose, get, and keep the housing they deem appropriate plays an influential role in the recovery and resilience of individuals. The goal of the interview is to understand the barriers of accessing decent and affordable housing by people living with mental illness. In addition to understanding the barriers to decent and affordable housing, the project aims to uncover innovations in policy and practice of integrated and inclusive housing in diverse jurisdictions. This knowledge will serve to guide the development of 'integrated and inclusive' housing policy that will be more responsive to the housing needs of people living with mental illness who reside in Winnipeg.

The interview will last approximately one hour. You will be asked to discuss the differences that you have experienced in different housing situations – including, but not limited to custodial settings, group homes, supportive housing, private rental apartment, or family home. You will be asked a series of questions in relation to the difficulties and barriers that you have encountered in each housing situation along with the elements that have helped you feel a sense of stability in your housing and/or community. The questions will focus on your perspectives regarding each housing situation and seek to understand your housing preferences.

There is no risk involved in your participation in this research project. As compensation for participating in the interview, you will receive an honorarium of $50.00.

Tape-Recording
For the purposes of the Canadian Mental Health Association's Housing Forum in late October 2006, the interviews will be tape-recorded and transcribed for research purposes, so that analyzing the material at a later date will be completed with greater ease and efficiency. Your consent for participating in the study indicates that you have understood and granted permission that the interview will be tape-recorded. Although portions of the interview may be utilized in the housing forum, your name or any other personal information will not be included in any publicly dispersed materials arising from this research. Where information acquired from the interview will be utilized in the final thesis report, names and other personal information will be omitted.

Use of Data, Secure Storage and Destruction of Research Data
Portions of the interview will be presented at a Housing Forum held by the Canadian Mental Health Association in late October of 2006, in order to give participants at the housing forum an understanding of the challenges that people living with mental illness encounter in accessing decent and affordable housing. Also, information obtained by the researcher will be utilized in a major degree project report. However, for both the housing forum and the thesis report, your name and personal information will be treated as strictly confidential and stored in the researcher's home, and subsequently destroyed once the project has been completed. Upon completion of the research project, you will have gratuitous access to your tape-recorded interview and any public reports utilizing data from your interview that may be published by the Canadian Mental Health Association. Such material will be made available through the Canadian Mental Health Association – Winnipeg Region.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Principal Researcher: **Tamara T. Peralta, Master of City Planning Student, University of Manitoba.**
Name of Supervisor: **Ian Skelton**

This research has been approved by the Joint-Faculty Research Ethics Board (JFREB). If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Thank you for participating in this project. Your cooperation and insights are very valuable, and are greatly appreciated.

I, _____, consent to the dissemination of material
[Name of Participant: *please print*]
provided to Tamara Peralta. I understand that for the purposes of the major degree project, all information will be treated as confidential, stored in a private and secure place, and subsequently destroyed once the project is completed and disseminated. I further understand that my interview will be tape-recorded and may be utilized at a housing forum in October 2006.

Signature of Participant: _____ Date_____

Name of Researcher: _____ Date_____

Signature of Researcher: _____ Date_____