



# Supportive Housing Needs Of Women with Mental Health Issues

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The project was conducted by the Social Policy Research Unit, Faculty of Social Work, University of Regina in partnership with the Regina Young Women's Christian Association. The Advisory Committee consisted of representatives from the YWCA, the Canadian Mental Health Association, Regina Branch, Mobile Crisis Services, Inc., the Regina Mental Health Clinic and the Social Policy Research Unit.

Agencies participating in the data collection included the YWCA (Women's Residence and Isabel Johnson Shelter); Mobile Crisis Services, Inc. (Mobile Crisis Services and Crisis Management); Welfare Rights Centre; Regina Health District (specifically the Regina Mental Health Clinic; the Long Term Care Program and In-Patient Mental Health Services, Regina General Hospital); Transition House; Phoenix Residential Society; Canadian Mental Health Association, Regina Branch; Regina Women's Community Centre; and the Domestic Violence Intervention Project and Domestic Violence Outreach Program, Family Service Regina. We thank all of the staff members—too numerous to mention by name—who participated in the data collection process.

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## **I. Introduction**

It is becoming widely known and accepted that we are in the midst of a housing crisis in Canada, particularly in our major cities. Economic restructuring has resulted in dwindling opportunities for full participation by increasing numbers of people, especially women. Changes in family structure as a result of family breakdown have led to more and more single-parent, particularly women-led, households (Baker, 1995; Vosko, 1996). Government restructuring has reduced access to the public safety net while social assistance payments have effectively decreased in relation to the cost of living (Pulkingham & Ternowetsky, 1996). Social housing programs have been discontinued and public housing projects abandoned (Klodawsky & Spector, 1997). The economic savings implicit in the push for psychiatric de-institutionalization have not been adequately reinvested in community care programs (Hulchanski, Eberle, Olds & Stewart, 1991; Lightman, 1997; Nelson, 1987). Increasing population shifts to larger, urban centres as a result of economic restructuring, declining housing stock because of demolition or gentrification, and the abolition of rent controls and resulting escalation of rent beyond the means of low-income people have greatly exacerbated the housing situation (MacNeil & Warnock, 2000).

It is also becoming common knowledge that about one-third of the homeless population suffers from mental illness, that women, families with children and youth are among the fastest growing portion of the “new” homeless population, and that people with addictions also constitute a large and difficult-to-serve proportion of this group (Golden, 1999; Hulchanski et al., 1991; Rossi, 1990).

Regina is no exception. While the absolute homeless are not able to survive on the streets in Saskatchewan’s extreme climate, our population of marginally homeless (housed) people is growing, along with the affordable housing crisis (Hughes, 1998; MacNeil & Warnock, 2000; Rice, 1998, 2000). This problem becomes even more severe for those people who have special needs. This group of people requires not only safe, affordable housing, but also supports to help them find and maintain a home in the community. Women with mental health issues are among the hardest hit, with few supportive housing options available to them in the city of Regina.

In terms of emergency housing for women in Regina (excluding shelters related specifically to domestic abuse), there is a significant gap. While the Regina YWCA provides a women’s residence of 35 beds, the residential programs and services offered to men in Regina far exceed this number. For instance, the YMCA has eight rooms in its residential program. The Salvation Army offers a number of different programs and residential options to men. The Supportive Residential Program (SRP) in Waterston Centre provides an intensive, 24-hour residential program for 15 men who have been diagnosed with a long term psychiatric illness and have exhausted community residential living options. This program (SRP) is a joint pilot project between the Salvation Army, Waterston Centre, Crisis Management/Mental Health Services and the Regina Health District Long Term Care Program. The Salvation Army also runs Waterston Centre (Men’s Hostel) which provides short-term, long-term and emergency residential services

for 75 men, and Waterston House, a 40-suite apartment complex for the homeless and low-income men of Regina. This brings the total beds/housing options available specifically for men in Regina to 138 as compared to the 35 beds available to women.

This project is viewed as making a contribution to the response to the national crisis of homelessness, especially as it affects those with mental health and related problems. The primary emphasis of this work is on the supportive housing needs of women who do not easily fit into many of the existing programs, particularly as availability of low-income housing appears to be diminishing in Regina. The essential goals of the project were to identify and document the scope of the problem as well as the existing services and their availability in Regina.

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## II. Literature Review

In this literature review we consider a number of broad, interrelated topics in order to inform the specific topic of supportive housing needs of women with mental health concerns. One is housing. Another is mental illness and the various kinds of supportive housing needed by people coping with a mental health problem. Yet another is the topic of homelessness and its interrelationship with mental illness, addictions and abuse. All of these various topics will be considered from the point of view of women, with an emphasis on women's unique experiences and needs. How does women's experience differ from men's and how might women's needs for housing and support also be substantially different?

### *Housing*

Homelessness is not only a reflection of poverty and poor health but also a critical determinant of it (Clapham, Kemp & Smith, 1990; Golden, 1999; Klodawsky & Spector, 1997).

The United Nations (UN) definition of homelessness includes two categories of people: 1) the absolute homeless—referring to those living on the streets, in emergency shelters or hostels; and 2) the relative homeless—referring to people who live in homes that do not meet basic UN standards. These standards include five essential requirements: adequate protection from the elements, access to safe water and sanitation, *affordable prices, secure tenure and personal safety*, and proximity to employment, education, and health care (Fallis & Murray, 1990; Hulchanski et al., 1991).

The UN's definition of relative homelessness is similar to the Canadian concept of core housing need; a methodology developed by Canadian Mortgage and Housing Corporation (CMHC) to measure the nature and incidence of housing problems (Pomeroy, 1996). The methodology assesses three basic areas: affordability (paying 30

percent or more of income for rent), adequacy (lack of basic plumbing or need for major repair) and suitability (overcrowding). “Households experiencing one or more of these problems and having incomes below the core need income thresholds are defined as being in core housing need” (Pomeroy, 1996: 6).

This “at risk” group, while currently housed, may, “with the slightest deterioration in income or family circumstances, be pushed along the continuum towards its bottom end of no fixed address and no shelter” (Murray, 1990: 19). Between 1991 and 1996, the number of Canadian rental households in core housing need increased by one-third—to approximately 1.15 million people (Skelton, 1998). Pomeroy (1996) notes that for welfare recipients, the core housing need measure can be misleading as shelter rates usually exceed 30 percent of total income. In Regina, however, it appears that most welfare recipients subsidize their shelter allowance with food and other basic needs allowances because actual rents are far higher than what the shelter rates allowed by Saskatchewan’s Department of Social Services will accommodate (MacNeil & Warnock, 2000).

Major societal changes have characterized the post-war years and resulted in significant changes in women’s housing needs. One such change is the dramatic increase in lone-parent families, which are predominantly mother-led. Increasing rates of separation and divorce are the primary reason for this increase; however, the secondary reason is the rising number of births outside of marriage (Baker, 1995). Of all lone-parent families, aboriginal households are among the poorest in the country, with “62% of Aboriginal lone-parent households off-reserve in core housing need...to a high of 72% in Saskatchewan” (CMHC, 1997: 1). Further, “The highest levels of core housing need in the country (just over 80%) are found among young, female Aboriginal lone parents living as renters in the urban areas of Winnipeg, Saskatoon, Prince Albert and North Battleford, and in Vancouver” (CMHC, 1997: 3). In 1997 in Saskatchewan, approximately one-third of social assistance recipients was single parents, predominantly women (Saskatchewan Social Services, Annual Report, 1996/97).

Related to this changing family status demographic is women’s increased participation in the labour force. However, while labour force participation of women has increased, women’s relative position within it has deteriorated. Systemic discrimination and racism, segregated work opportunities as well as relegation to part-time, temporary and service-sector positions all combine to undermine women’s economic status and full participation in the work force (Baker, 1995; Vosko, 1996). High rates of unemployment, underemployment, low minimum wages and inadequate social security programs further limit opportunities, not just in the labour market but in the housing market as well.

The province of Saskatchewan lifted rent controls in 1992. In 1996, Boardwalk Equities moved into the province and began buying up rental properties, renovating and raising rents. One of their first purchases was Gladmer Park, a (former) low-income housing complex whose rents have now almost doubled (MacNeil & Warnock, 2000). According to Regina’s *Leader Post* (Brock, 2000), Boardwalk now owns 20 percent of Regina’s private rental market housing.

It is clear that many women are excluded from home ownership because of their low incomes, and they are subject to the vagaries of the private rental market. According to 1996 Census data, 78 percent of elderly, unattached women in Regina were renters. Eighty percent of them were paying more than 30 percent of their income on rent (Statistics Canada, 1996). According to MacNeil and Warnock (2000), between 1990 and 1995, the number of rental households in Regina paying 30 percent or more of their income on rent doubled—increasing from 6.9 to 14 percent of their total income. “The North Central area had the highest incidence (32.1 percent) of rental households spending more than thirty percent of their income on housing, followed by Transition (31.4 percent) and Core (30.6 percent)” (MacNeil & Warnock, 2000: 45). The authors conclude: “It is clear that women, lone-parent families, Aboriginal and unattached persons are disproportionately represented in the areas of low-income and housing affordability problems” (MacNeil & Warnock, 2000: 46).

### ***Homelessness and Mental Health Issues***

Once a homogenous group of predominantly older, white, alcoholic men, the new homeless are a heterogeneous group consisting of families, women, children, youth and the mentally ill. They are younger and poorer than in years’ past and racial and ethnic minorities are over-represented (Golden, 1999; Murray, 1990; Novac, Brown & Gallant, 1999; Rossi, 1990). There are complex inter-relationships between poverty, homelessness, mental illness, addictions, abuse and gender that must be considered as part of an overall picture related to economic and political restructuring taking place all over the world (Farge, 1989).

The first major influx of mentally ill people to the homeless population took place as a result of the de-institutionalization movement beginning in the late 1950s. However, insufficient funding was made available and the planning was inadequate to successfully re-establish people back into the community. Consequently, programs have remained largely uncoordinated, fragmented and inadequate to meet the needs of this very vulnerable population (Golden, 1999; Ridgway & Zipple, 1990). Despite the elimination of approximately 80 percent of psychiatric beds in Canada over the past 25 years, funding has remained largely with institutions rather than being transferred to community care (Hulchanski et al., 1991; Lightman, 1997; Nelson, 1987).

Saskatchewan was a world-leader in this movement and a pioneer in the development of community psychiatry (Dickinson, 1989). It was the first province to participate in de-institutionalization and, as such, has been involved in many innovative initiatives regarding community care (Adamowski, 1999). However, Dickinson (1989) reports that in Saskatchewan in 1968, 80 percent of the mental health budget was still being spent on institutions. Grant Rathwell, Program Consultant with the Community Care Branch, Saskatchewan Health, advises that a key principle of health renewal in the transfer of responsibility to the health districts in 1995 was the “one-way valve”

concept—a concept which means the districts can reallocate funding from institutions to the community, but not from community care to institutions. However, while the exact figures are difficult to determine, particularly since the move to health districts, the spending ratio has probably remained very similar over the last two decades. This is because gains made in the development and enhancement of community care programs have been largely offset by the extremely high and escalating costs of institutional care (Rathwell, 2000).

Although the figures vary, estimates of the psychiatrically ill portion of the homeless population usually fall between 30 and 40 percent (Golden, 1999; Hulchanski et al., 1991). Bruce Rice, Senior Policy Advisor with the Social Development Division, City of Regina, advises that Saskatchewan currently has no agency collecting information on homelessness, but initiatives related to the Big City Mayors Caucus of the Federation of Canadian Municipalities and to the Saskatchewan Housing Corporation's Poverty Reduction Indicators Committee are beginning to address the issue. Statistics provided to the City of Regina by the Salvation Army indicate that bed-night use of their shelters has increased substantially—from 22,818 in 1991 to 31,015 in 1997. During the same period, bed-night use in the YWCA women's residence increased from an estimated 7,721 beds to 10,734 beds. It should be noted that these numbers include permanent residents, not just transient clients (Rice, 1998, 2000). Bob Hughes, Vocational Counsellor at the Mental Health Association, Regina Branch, indicates that homelessness is a significant problem in Regina but that it presents itself differently than in other large urban centres. Although not as evident in winter, Mr. Hughes says that "those who are homeless are living transiently at various places throughout the city, with other people or in shelters" (Hughes, 1998). MacNeil and Warnock (2000: 47) concur, stating that in Saskatchewan, "homelessness is primarily identified with overcrowded housing."

Another relevant issue concerns the difficulties of obtaining adequate housing for those with concurrent or dual diagnosis such as mental health problems and addictions (Buckner, Bassuk & Zima, 1993; Golden, 1999). This population is viewed as being at greatest risk of homelessness, victimization, illness and death (Novac et al., 1999). The group is also considered to be subject to greater isolation and mistrust of others and are resistant to treatment and to seeking care (Buckner et al., 1993; Novac et al., 1999). It is estimated that up to 20 percent of the homeless have severe mental illness and addictions and are not receiving treatment. This population has high rates of psychiatric hospitalization, disruptive behaviour and suicides. Mental health facilities are generally unwilling or unable to work with people with addictions, while addiction treatment facilities are not able to deal with the mentally ill (Golden, 1999). The Task Force indicates that for the population dealing with both mental health problems and addictions, there is a need to develop a strategy for those with concurrent disorders, and that strategy involves outreach, community-based supports and harm-reduction facilities (Golden, 1999; Novac et al., 1999). A recent (1999) strategic planning initiative undertaken by the Mental Health Advisory Committee of the Regina Health District identified that those most in need of mental health services in Regina are those with major mental illnesses and those with dual diagnoses, including those with addictions and mental health diagnoses.

In addition to a high incidence of addictions and mental health problems, the homeless population is subject to a much higher incidence of physical health problems. A wide range of chronic conditions and infectious diseases are prevalent. Because of a complex combination of factors, including resistance to seek medical attention and systemic barriers to doing so, untreated minor injuries and illnesses tend to become serious, sometimes life threatening (Buckner, 1991; Novac et al., 1999).

In Canada, the recent City of Toronto report on homelessness (Golden, 1999: 64) confirmed the overrepresentation of Aboriginal people among the homeless population. Studies conducted across Canada in 1987 indicated that in Winnipeg, Aboriginal people were a “significant” percentage of the episodic and chronically homeless. “The survey also revealed that native households appear to be living in the worst housing in terms of housing conditions” (Murray, 1990: 23).

Another major change in the homeless population is the significant increase in the numbers of women. The influx of people who suffer from psychiatric illness to the homeless population may best explain this change, as approximately 75 percent of homeless single women are deemed to be mentally ill (Golden, 1999). Novac et al. (1999: 29) report “more homeless women [in Toronto] with severe mental health problems, including more young women whose mental health problems are generally undiagnosed....There are also more women who refuse medication and avoid all contact with the medical and psychiatric system.” In the past, long-term homeless women tended to be socially isolated, older and alcoholic. Today, younger homeless women tend to be younger and drug addicted, with the addiction process taking place much more rapidly (Novac et al., 1999).

According to Bassuk (1993: 337), “Approximately one-half of homeless women are currently caring for dependent children.” This does not mean that single homeless women are childless, however. Many have relinquished their children to foster homes, adoption agencies or other placements (Bassuk, 1993; Murray, 1990). Many homeless youth have come from backgrounds of foster or institutional care, as well as from families fragmented by poverty, addiction and abuse. Novac et al. (1999) report that one-third of street youth in Toronto is female. “As more women, absolutely and proportionately, become homeless, greater diversity among them becomes apparent” (Novac et al., 1999: 27). This new population of homeless—families (many are lone-parent women) with children, single women and youth (many are female, pregnant or young mothers)—can be viewed as part of a continuum, one that reflects “a combination of complex social, economic, political and physical events” (Hulchanski et al., 1991: 9).

A frequently occurring experience of homeless women, children and youth is a history of physical and/or sexual abuse. Browne (1993) surveys numerous studies conducted in the United States that show extremely high rates of victimization, with some rates as high as 89 percent among poor and homeless mothers. Farge’s (1989: 139) study of single female hostel users in Toronto found that 50 to 85 percent were child abuse survivors. The recent Golden Report (1999) on homelessness also acknowledged abused

women and children as constituting a high percentage of the homeless population in Toronto, one requiring increased resources and specialized supports and services. The report estimated that 75 percent of women who arrive at shelters have been abused and that “40 to 80 percent of children...have witnessed violence in the home” (Golden, 1999: 61). Breton and Bunston (1992: 29) recommend that “the problem of family violence should be part of any policy dealing with women’s homelessness.”

Minority and poor women have been found to be at particularly high risk of violent victimization. Parallels in characteristics between homeless women and women who have experienced violence and victimization are also clear. Symptoms of Post Traumatic Stress Disorder (PTSD), as well as depression and substance abuse are among the most common outcomes. Living in poverty and homelessness are, in themselves, risks for developing an emotional disorder. There is, therefore, a complex interrelationship between traumatic victimization and homelessness which demands that violent histories be acknowledged and addressed (Browne, 1993).

Novac et al. (1999) articulate a “dynamic” interrelationship between violence against women, mental illness and homelessness—one which drives women both away from and into relationships with men:

Childhood abuse, previous victimization, and revictimization are all more prevalent among homeless women than among the general population....This underlies a key distinction between women’s and men’s homelessness. Women require housing that is both affordable and safe....[It is also the reason] why “sex-segregated housing options, especially at the level of emergency housing, must be available. (Novac et al., 1999: 27, 55, 9)

The Women’s Services Network’s (WSN) report on alternative housing for women also highlights gender differences in addressing women’s specific housing needs. The report recommends sex-segregated buildings for women, based on their unique needs for secure tenure and personal safety as a result of past histories of physical and sexual abuse in the home and sexual harassment in mixed settings. While the report indicates a strong preference for self-contained apartments, building location is also a crucial factor in addressing safety issues: “By locating buildings in unsafe neighbourhoods, women’s fear for their personal safety when out at night can double” (Women’s Services Network, 1996: 68).

Goering, Paduchak and Durban (1990) surveyed 38 homeless women in Toronto regarding their housing preferences and found them equally divided on the issue of all-women residences. However, all of the women desired a safe, secure, normal living environment and acknowledged their need for a range of support services.

### ***Supportive Housing***

Novac and Quance (1998) identify three different models of supportive housing. The *alternative* housing model maintains a focus on stable, subsidized housing within a community development framework, with the emphasis on resident participation. The *supported* housing model has its roots in the patients’ rights movement and is associated

with “de-linked” services. Proponents of this “consumer-driven” or “client-centred” approach (Carling, 1990, 1992, 1995; Carling & Hogan, 1992; Goering et al., 1990; Ridgway & Zipple, 1990; Tanzman, 1990, 1993; Yeich, Bybee, Mowbray & Cohen, 1994) believe that most consumers want permanent, regular, integrated housing in the community, coupled with individualized support services. Supported housing is based upon the concept that supports are provided for as long as necessary, that supports can be provided in people’s homes and that as needs change, services and supports can be introduced or withdrawn (Carling, 1990; Ridgway & Zipple, 1990). Although these authors do not advocate congregate care settings, they do advocate the consumer’s right to choose. This *supported* housing approach is based on principles of full community integration and citizenship and freedom of choice and is supported by numerous consumer preference studies (Tanzman, 1990; Yeich et al., 1994; Goering et al., 1990). *Supportive* housing “links” housing to support services and can encompass a broad range of programs from board and care homes (approved homes) to group homes to apartment complexes.

The Golden Report (1999) cites the advantages of supportive housing such as keeping vulnerable people housed, reducing the use of emergency services, re-establishing social networks and enhancing the ability to contribute to the community. Supportive housing is also cost effective; for instance, housing units with medium supports cost from \$30 to \$40 per day whereas shelters cost \$38 per day and psychiatric hospitals, \$360 per day. The Task Force defines supportive housing as part of a continuum between institutional care and independent living; it may include group homes with on-site staff, individual units with services tied to housing or individual units with portable services, as well as transitional housing. Criteria should be flexible enough to enable people who do not have a formal diagnosis but are viewed as being “hard to house” to access supportive housing (Golden, 1999).

The WSN’s report (1999) advocates “de-linking” housing and support services and considers the problems of lack of security of tenure and lack of resident control as part of the “institutional” approach to service provision. The report views de-linking of housing and support services as consistent with the principles of integration, stability, independence and consumer choice and control, and it advocates permanent housing provision, portability of support services and flexibility of services to meet individual needs.

Adamowski (1999) reports that while the home care services that have developed across Canada have the “potential” to assist in integrating the mentally ill into the community, this has not happened. She contends that there has been no development of financing mechanisms, organizational settings or personnel trained to provide home care services to this population. She goes on to assert that “any discussion regarding community integration of persons with chronic mental illness cannot begin without addressing the two biggest obstacles to working with this population—housing and poverty” (Adamowski, 1999: 25).

D. White (1992) addresses the concept of continuity of care in relation to the provision of support services to people with mental health problems. She postulates that

the “continuity of care” model reflects institutional thinking that has been transferred to community-based programs through the process of de-institutionalization. This concept has implications for supportive housing development in that linked or delinked support services appear to reflect this philosophical difference.

In her qualitative study of seven men living in a hostel in a medium-sized Canadian city, K. White (2000) highlights this phenomenon. She found that the men had become dependent on their social service workers and the health care system to make “life choices” for them, and that they had lost interest in obtaining regular housing.

Hurlburt, Wood and Hough (1996b) support the “consumer-driven” approach, but they provide a qualification regarding its success when substance abuse is a factor (Hurlburt et al., 1996a). They report a significant relationship between drug and alcohol abuse and inability to achieve stable housing in the community. The Golden Report (1999) specifically recommends that harm-reduction facilities be established to serve those who cannot comply with programs that require total abstinence.

Therriault, Jette, Mathieu and Vaillancourt (1998) provide an evaluation of social housing with community support that serves a diverse group of disadvantaged clients in the central districts of Montreal. The FOHM (*Federation des OSBL d’habitation de Montreal*) offers a social housing program to people who suffer from physical or mental health problems, contend with drug or alcohol addiction or have AIDS. The FOHM provides a “light and flexible form of supervision” to tenants who without this support, would likely find themselves either homeless or institutionalized. The findings indicate a substantial improvement in quality of life of those living in the housing units which are clean, safe, permanent and affordable (i.e., 25 percent of income). The tenants indicated a 233 percent increase in satisfaction with their housing after moving into the units. While this housing can be viewed as a congregate setting, it appears to be highly valued by the tenants, with 91 percent expressing satisfaction with their housing after moving into a FOHM unit as compared to 27 percent before moving in.

Pulice, McCormick and Dewees (1995) conducted a qualitative study in Vermont and reported that the majority of mental health consumers surveyed preferred not to live alone and did not object to living with other consumers. A Canadian study by Pomeroy, Cook and Benjafield (1992) compared social support in three residential settings: independent living, living with family and living in a group home. They conclude that those living independently were at a “serious disadvantage.” Another qualitative study conducted in Canada concludes that both common and private space were essential elements in meeting the supportive housing needs of mental health consumers (Johnson, 1997).

There are many different definitions, approaches and philosophies regarding what constitutes “supportive housing” and the form it should take. The crucial need for more and better alternatives, however, is not in question (Hall, Nelson & Fowler, 1987; Lightman, 1997; Nelson & Earls, 1986; Ridgway & Zipple, 1990). While community care continues to be held up as the most effective and efficient means of service

provision, the vast majority of resources are still going to institutions (Kay & Legg, 1986; Hulchanski et al., 1991; Lightman, 1997; Nelson, 1987).

While community services remain underfunded, uncoordinated and inadequate to meet the needs of the long-term mentally ill population, a corresponding rise in poverty and a decrease in both employment opportunities and the supply of safe, decent, affordable housing have exacerbated the crisis (Carling, 1995; Hurlburt et al., 1996b; Yeich et al., 1994). At the same time, there is no question that all persons, regardless of disability, race, gender or ability to compete in the marketplace, have a right to decent and affordable housing as a social right of citizenship (Carling, 1992, 1995; Clapham et al., 1990).

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### **III. Research Methodology**

This needs assessment is part of a larger project which began in the fall of 1998 in conjunction with the Urban Housing Policy Options for Women Project undertaken by Marge Reitsma-Street of the University of Victoria and her colleagues (Reitsma-Street, Schofield, Lund and Kasting, 2000). Reitsma-Street approached Gloria Geller suggesting that Regina join her project. Reitsma-Street and her colleagues then visited Regina in October 1998 and met with municipal and provincial government representatives from Saskatchewan Housing, Women's Secretariat, Department of Social Services and the City of Regina, along with representatives from various community agencies.

In discussing the housing needs of women in Regina, the Director of Housing Programs at the YWCA identified a population of women for whom the YWCA had begun to provide long-term and supportive housing. These women were dealing with a variety of mental health and addictions problems and required considerable social support. After several meetings and discussions, the decision was made to conduct some research on this particular population. A focus group was held March 31, 1999 at the YWCA. Participants included service providers as well as researchers and policy analysts from a variety of agencies serving the population of women within the Regina Health District. This included the non-governmental sector and municipal and provincial government departments (Geller and Reitsma-Street, 1999; Geller, 1999).

At the time of the focus group, it was determined that further information was needed on the extent and the nature of the needs of the population of women and that a needs assessment was required in order to obtain this information. Funds were sought and obtained from the Saskatchewan Housing Corporation, Department of Municipal Affairs, Culture and Housing, the Women's Secretariat, the City of Regina and Health Canada, with the support of the Regina Regional Interdepartmental Committee. The major work of the needs assessment began November 1999 with the hiring of a research assistant. An advisory committee to the project—composed of representatives from the YWCA, the Regina Branch of the Canadian Mental Health Association, Mobile Crisis Services, Inc.,

the Regina Mental Health Clinic and the Social Policy Research Unit (including the principle investigator and the research assistant)—was established.

Both quantitative and qualitative methodologies were used in the data collection process. Those agencies serving both men and women collected quantitative data on both sexes, while the in-depth interviews were conducted with women only. Quantitative data were obtained through the completion of an information sheet by staff of a number of organizations, including the YWCA (i.e., Women's Residence and Isabel Johnson Shelter), Regina Transition House, Mobile Crisis Services, Welfare Rights Centre and the Regina Health District (i.e., the Regina Mental Health Clinic, the Regina General Hospital In-Patient Mental Health Services, the Supportive Residential Program, Salvation Army Waterston Centre and the Long Term Care Program). The Supportive Living Unit at Pioneer Village, the Long Term Care Program, the Domestic Violence Intervention Project and Domestic Violence Outreach Program, Family Service Regina also participated but did not collect information sheets because the clients they would have surveyed during the data collection period were already being recorded by other participating agencies. The data were obtained in a variety of ways including telephone requests made directly by people seeking housing for themselves or requests from other agencies on behalf of people seeking housing, as well as from direct interviews conducted by staff of the various agencies through to completion of forms based upon administrative information. The Regina Mental Health Clinic provided statistical information about the users of its service over a period of a year (from April 1, 1999 to March 31, 2000). These data are found in Appendix A of this report. As well, statistical data on provision of services by the YWCA and the Long Term Care Program, Regina Health District (April 1, 1999 to March 31, 2000) were provided and are included in these findings.

Agencies participating in the qualitative data collection included the YWCA, Mobile Crisis Services, Welfare Rights Centre, the Regina Branch of the Canadian Mental Health Association, Phoenix Residential Society and the Regina Women's Centre. Qualitative data were obtained through in-depth interviews with eight women coping with a mental health issue and who have experienced difficulty in meeting their supportive housing needs. The interviews offer a comprehensive and detailed discussion of the women's experiences over several years in their efforts to obtain adequate housing and social supports for themselves and, in some cases, for their families. They also reflect thoughtful suggestions for needed changes to existing services and innovative ideas for future programs.

Data obtained from the focus group held in March 1999 are included in this report as required in order to clarify the perspective of the service providers. The nature and availability of crisis housing, supportive housing and long-term residential services as well as other relevant information about services available in Regina are documented. The survey of community resources is attached to this report in the form of a "Community Directory." (See Appendix B). The directory has three sections: policy and research resources, housing resources and mental health and other support services. While the directory is much broader in scope than the specific focus of our project, it is

by no means an all-inclusive listing of resources available in Regina. It evolved as part of the research process and perhaps could best be thought of as an aide in collaboration and communication between concerned citizens, researchers, policy-makers and service providers.

During the course of the needs assessment, numerous meetings were held with participants, potential participants and other interested agencies and service providers. The size and structure of each participating agency determined the number of meetings required and whether the researchers met with one staff person, a representative group of staff or the entire staff. As one of two main partners in this research project, the YWCA hosted all advisory committee meetings and involved a number of its staff in the process. Some participants had specific staff in place to address housing issues such as the Regina Mental Health Clinic and the Welfare Rights Centre and, in these cases, the majority of contacts were with these staff.

In the case of the researcher's lack of familiarity with some programs, on-site visits were arranged by the Long Term Care Branch, Regina Health District. Both the SRP (at the Salvation Army's Waterston Centre), and the SLU (Regina Pioneer Village Ltd. Supportive Living Unit) extended invitations to tour the facilities and attend regular staff meetings.

The Canadian Mental Health Association, Regina Branch invited the researchers to attend a staff meeting to present the history, purpose and goals of the research and to attend and present information to one of the association's group programs for women. Both occasions resulted in a good discussion of the topic, from personal experiences to philosophical orientations underpinning housing and the supports offered to the population.

A special "Women and Housing" meeting was held at the YWCA with invitations to all residents, including the women in the Isabel Johnson Shelter. The meeting was well attended by approximately 15 women. Specifics regarding the housing needs survey were discussed, as were more general housing issues which have an impact on women in Regina. The women expressed many concerns related to their ongoing experiences with lack of safe, affordable housing appropriate to their needs.

The findings of this research were released at a community forum on June 13, 2000. Participants attending the forum included all those involved in some way with the project. These included service providers, funders, policy developers in the areas of housing, social services and mental health (at the health district and the municipal, provincial and federal government levels). Participants at the forum participated in the research through the process of prioritizing their recommendations which, they believed, should come out of this report.

The goals of identifying and documenting the scope of the problem, as well as the existing services and their availability were achieved by triangulation of the data. That is, through a quantitative survey of housing needs, qualitative, in-depth interviews,

documentation of existing community resources and through feed-back and input from a cross-section of those concerned with this issue.

### ***Limitations of the Research***

Although every effort was made to be as comprehensive as possible in obtaining information about women with mental health issues seeking housing over the four month data collection period of this project, there were a number of barriers and constraints to obtaining the data.

The project sought to obtain data from women with mental health issues who requested assistance over the telephone or in face-to-face interviews. The staff person answering the telephone call would respond to the request made by the caller as a first priority. In order to complete the information sheet, the staff worker then had to obtain the caller's consent in order to complete the form or to use the information obtained from the woman for research purposes. It must be pointed out that while efforts were made to explain the significance of advising the caller of the research and asking for consent, it was not always possible for staff of the agencies to change their role from agency worker to one with a research focus. It is important, therefore, to recognize that the data obtained through this process, while representative of those asking for assistance to obtain housing for themselves or their clients during this time period, are actually a sample of the population rather than the entire population in need of housing over the time of the project.

Before discussing our research findings, we first present information on the different types and amount of supportive housing available in Regina.

### ***Types and Amount of Supportive Housing***

The following identifies the variety of supportive housing and their availability for people with mental health issues in Regina.

*A mental health approved home* is a family home that has been licensed under *The Mental Health Services Act* and operates under the Mental Health Approved Home Program. An approved home provides long-term, supervised accommodation for up to five persons who have mental illness or psychiatric disorders. An approved home operator must be certified by District Mental Health Services and must live in the approved home. Approved homes offer various levels of care. At the present time, there are 26 approved homes operating in the city of Regina and providing accommodation to 95 residents.

*Group homes* are administered by non-profit organizations such as Phoenix Residential Society (see descriptions below). They are regulated by *The Residential Services Act* and supervised by District Mental Health Services. Group homes usually provide rehabilitation and training for more independent living but do not usually provide a long-term home. There is currently one group home operating in the city of Regina.

*Personal care homes* are privately owned and operated homes for the care of up to 40 residents. These homes do not receive any government subsidy and the fee is negotiated between the resident and the personal care home operator. They are regulated by *The Personal Care Homes Act* and supervised by District Health Services. There are currently 77 personal care homes in the city of Regina, with capacity to serve 501 residents.

*Special-care homes* provide nursing care for persons who need full time care and supervision. Standards for special-care homes are regulated by *The Housing and Special-care Homes Act*, which is administered by Saskatchewan Health but District Health Boards are responsible for inspections and ensuring that standards are met. Presently, there are 1,220 special-care home beds in Regina.

*Note:* The information and statistics included above were obtained from a variety of sources, including the Schizophrenia Society (Dafoe, 1999), Community Care Branch, Saskatchewan Health (2000), Personal Care Home System Provincial Report (2000) and the Regina Mental Health Clinic (2000).

#### *Phoenix Residential Society*

- *Phoenix House* provides psycho-social/psychiatric rehabilitation services to eight individuals in a group home staffed on a 24-hour basis.
- *Phoenix Apartment Living Services (PALS) Program* provides rehabilitation and supported living services for up to 60 individuals living in a home of their choice in the community.
- *Westview (Dual Diagnosis) Program* provides psycho-social/psychiatric rehabilitation services and addiction recovery services to 10 individuals in a supported apartment program staffed on a 24-hour basis.
- *Pearl Manor (Acquired Brain Injury) Program* provides psycho-social and behavioural/cognitive rehabilitation to six to eight individuals in a supported apartment program, staffed on a 24-hour basis, which includes respite accommodation. Rehabilitation and supported living services are also provided to up to 10 individuals living in a home of their choice in the community.

#### *Long Term Care Program*

- *Regina Pioneer Village Ltd. Supportive Living Unit (SLU)* provides an alternative residential living option for residents who have a diagnosis of a long-term psychiatric illness, do not require the intensive physical care of level 3 or 4, and have exhausted community residential living options. The program is based on a social/rehabilitative model of care and is for residents who require a less restrictive environment than generally provided within a special-care home. The unit has 13 single rooms with private bathrooms and a common living space.
- *Salvation Army Waterston Centre Supportive Residential Program (SRP)* provides a 24-hour residential program for individuals diagnosed with a psychiatric illness and/or substance abuse. The program provides a residential program with a social/rehabilitative care model and is an alternative to institutionalization. The program can accommodate up to 15 men, with eight rooms for those requiring a more

intensive supportive residential program and seven other rooms for men with more manageable behaviours.

*YWCA Women's Residence* provides 35 social housing rooms—approximately 80 percent of which are filled by women with mental health issues. The remaining beds are used for short-term crisis housing and for teen women requiring housing under the care of the Department of Social Services. Each room contains a fridge. There is a shared bathroom on each of the two floors of residence and a communal lounge, with kitchen facilities, that is shared by all of the residents. The purpose of the YWCA women's residence is to offer safe, secure and affordable housing to meet the varying needs of women in the community.

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#### **IV. Quantitative Research Findings**

In this section, we present the quantitative research findings obtained from the information sheets completed by a variety of organizations over a four-month period. The agencies involved and the number of forms completed are identified. For the purpose of reporting the data gathered, we have provided two groupings: 1) data primarily gathered from telephone requests, interviews and administrative files from non-government agencies and from in-patient psychiatry at the Regina General Hospital and 2) data obtained from the Regina Mental Health Clinic. These latter data, obtained from administrative files, supplement the data provided by the Regina Mental Health Clinic to us on Regina residents who received services at the clinic between April 1, 1999 and March 31, 2000. Data made available by the YWCA on the supportive housing services provided during 1998 are also presented. The Long Term Care Program, Regina Health District statistics for April 1, 1999 through to March 31, 2000 are provided here as well.

##### ***Number of Respondents***

Research was conducted over 4 months from January 1 to April 30, 2000. A pilot study was conducted in the latter part of December and the findings from the pilot are included below. There were 80 information forms returned (67 female and 13 male), including one form indicating refusal to participate.

Table 1 lists the participating agencies and the number of forms each organization returned.

**Table 1. Number of Responses by Agency and Gender**

<i>Agency</i>	<i># Responses*</i> <i>Female</i>	<i># Responses</i> <i>Male</i>
YWCA	20	0
Transition House	6	0

Mobile Crisis Services	1	0
Welfare Rights	8	1
Salvation Army (SRP)	0	3
General Hospital In-Patient Mental Health Services	7	3
Regina Mental Health Clinic	25	6
Total	67	13

\*1 refusal.

The majority of the forms were completed for women seeking housing during the four months of the project. The YWCA returned 20 forms, one of which was from a woman who refused to participate; therefore, there were 19 useable forms. The remaining non-government agencies returned 16 forms from women and four forms from men seeking housing. Regina General Hospital (in-patient psychiatry) returned 10 forms in all—7 from women and three from men—and the Regina Mental Health Clinic completed 31 information sheets.

### ***Mental Health Issue***

The focus group respondents defined the population experiencing mental health issues in need of supportive housing as women who are “difficult to manage” and “difficult to serve” because

- *of mental health issues; criminal justice issues; addiction issues, crisis behaviours*
- *of the number of agencies involved and the services that are needed*
- *the women have been abused*
- *they are at high risk of hurting themselves or somebody else*
- *they are likely to live in poverty*
- *they are people who either refuse services or use too many services*
- *they have more multifaceted problems*
- *they experience behaviour issues and/or personality disorders*
- *they have long-term mental health issues*
- *they are resistant, challenging women*
- *they are suicidal, self-destructive, self-abusive*
- *they have difficulty coping, for whatever reason*
- *they are difficult-to-engage women who want something but may not know what it is*

It was noted at the time that there does not have to be a diagnosis through the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). Those representing the YWCA were concerned about labeling the women as mentally ill. In the focus group discussion it was stated that people ask for help, not for treatment or for a program. “They want some sort of help and their picture of the help is often very, very different from ours.” Non-government agencies such as the YWCA, which serves a population in need, are not necessarily concerned about official diagnosis prior to providing services.

For the purposes of this research, the italicized descriptions above served as guidelines for determining which of the respondents fit the category of “someone with a mental health issue.” It was not necessary for respondents to have a specific mental health label. Respondents identified with mental health issues are those with one or more psychiatric diagnosis, including those whose forms were completed by the Regina Mental Health Clinic and in-patient psychiatry patients, those receiving substance abuse treatment, those using the services of the Regina Mental Health Clinic, and those using one or more psychiatric medications.

Based upon the information provided, respondents defined as not having a mental health issue are those who do not meet any of the above criteria and/or for whom their mental health status is uncertain. Table 2 specifies the number of individuals for whom an information sheet was completed and who are either with or without a mental health issue (or uncertain).

**Table 2. Number of Participants with or without a Mental Health Issue, by Type of Agency\***

<i>Agency</i>	<i>Mental Health Issue</i>	<i>No Mental Health Issue/Uncertain</i>
Non-governmental	23	15
General Hospital In-Patient Psychiatry	10	0
Regina Mental Health Clinic	31	0
Total	64	15

\*1 refusal

All of the individuals for whom forms were completed by the Regina Mental Health Clinic and the General Hospital In-Patient Psychiatry Unit are defined here as having a mental health issue. Of the 38 people for whom forms were completed by non-governmental agencies, 23 (60%) are in the “have a mental health issue,” group while the remaining 15 (40%) either did not appear to fit this category or it was not possible to determine. Information gathered on this second group is presented below as a way of comparing the housing needs of the two different groups.

***Non-government Agencies and Hospital In-patients Statistics***

***age and sex of participants***

Table 3, below, indicates the age and sex of participants whose information forms were completed by non-government agencies and hospital in-patient psychiatry. Information about participants whose information forms were completed by Regina Mental Health Clinic officials are discussed in another section.

**Table 3. Age and Sex of Participants from Non-government Agencies and Hospital In-Patient Psychiatry**

<i>Age</i>	<i>Mental Health Issue Female</i>	<i>Non-Mental Health Issue/Uncertain Female</i>	<i>All Male</i>
16-18	0	1	0
<b>19-24</b>	<b>6</b>	<b>1</b>	<b>1</b>
<b>25-34</b>	<b>9</b>	<b>5</b>	<b>2</b>
<b>35-44</b>	<b>8</b>	<b>3</b>	<b>0</b>
45-54	2	1	0
55-64	1	2	3
65-74	2	0	1
Total	28	13	7

The majority (82%) of women with a mental health issue whose forms were completed by non-governmental organizations and in-patient psychiatry was between the ages of 19 and 44. A smaller number (18%) was 45 years and over, while none was under 19 years. The men tended to be a little older; four of the seven men were 55 and over. Nine (69%) of the women who do not appear to have a mental health issue were between the ages of 19 and 44. The youngest woman in this sample (aged 16–18) was among those women not having a mental health issue or for whom this is uncertain.

#### ***non-government and housing requirements***

All of the men and the majority of women were seeking housing for themselves only. Three of the women who did not appear to have a mental health issue had three or more dependent children, while eight women (about 30%) with mental health issues were seeking housing for themselves and, on average, between one to five children. Only one woman with a mental health issue required housing for herself, her partner and three children. Two of these women were seeking housing for themselves and another adult. Participants or their supporters were seeking either short-term or long-term housing. Table 4 presents short-term housing requirements for participants from non-government organizations and in-patient psychiatry.

**Table 4. Short-term Housing Requirements for Participants from Non-government Organizations and In-Patient Psychiatry**

<i>Short-term housing</i>	<i>Mental Health Issue Female</i>	<i>No Mental health Issue/Uncertain Female</i>	<i>All Men</i>
YWCA	5	1	0
Apartment or YWCA/other short term	3	3	1
Women’s shelter	1	1	0
Men’s hostel	0	0	1
Total	9	4	2

Most of the women grouped as having mental health issues who required short-term housing identified the YWCA as their preferred choice, while some identified either the YWCA or an apartment. More of the women grouped without mental health issues required an apartment or other short-term facility along with the YWCA. One woman from each group required housing in a women’s shelter. The two men requiring short-term housing identified a men’s hostel and an apartment as their preferences.

**Table 5. Long-term Housing Requirements for Participants from Non-government Organizations and In-Patient Psychiatry**

<i>Long-term Housing</i>	<i>Mental Health Issue Female</i>	<i>No Mental health Issue/Uncertain – Female</i>	<i>Male</i>
YWCA	4	1	0
1 or 2 bedroom apartment	10	4	2
3 or more bedroom apartment or house	3	3	0
Phoenix - Westview	1	0	0
Men’s hostel/residence	0	0	3
Total	18	8	5

Thirty-one of the participants required long-term housing. Four women with mental health issues and one woman who did not appear to have a mental health issue (representing 16 % of all) indicated a preference for long-term housing accommodation at the YWCA. Another woman with a mental health issue required supportive housing, specifically at Phoenix Residential Society in the dual diagnosis program. Thirteen of the women with mental health issues and seven not appearing to have such issues (representing 65% of all) were seeking apartments or houses with anywhere from one to five bedrooms. Several of the men were seeking long-term housing at a men’s hostel or other residence, while the others wanted apartments.

At the time the forms were completed, most of the participants were still seeking accommodation and had not found suitable housing. They stated they would continue looking for housing from various sources, including the newspaper, and with the help of friends, family members and the social service agencies that are part of this study.

However, the men requiring shelter at the Salvation Army Waterston Centre appear to have been successfully housed there.

### *reasons for needing housing*

There were a variety of reasons the participants required housing. For instance:

- Seven women with mental health issues were leaving a psychiatric facility and were not able to return to their homes (in most cases, because their husbands did not want them to return);
- Several of the women had left an abusive situation;
- Some women were leaving both a women's shelter and a psychiatric facility;
- One woman was leaving jail;
- Some women living at the YWCA wanted greater privacy and more space and independence;
- Several women living in inadequate housing wanted to live in a better neighbourhood. (One woman noted that her home had been broken into).

Women not identified with a mental health issue were in need of housing because, in some cases, they

- wanted better and/or larger accommodation,
- were leaving a woman's shelter and/or abusive situations, or
- were passing through Regina.

The reasons given by men requiring housing included:

- eviction because of behaviour related to addictions;
- leaving a psychiatric facility; and
- supportive environment needed for medical reasons or because of the inability to manage finances.

### *supports in use or needed*

From the above, it is apparent that the majority of the participants require apartments or homes rather than an environment which offers built-in supports. However, it is also apparent that almost all participants make use of various social support services in the community:

- almost all of the individuals in this study are recipients of social assistance through the Saskatchewan Assistance Plan (SAP).
- the majority of women identified as having a mental health issue use the Regina Mental Health Clinic out-patient psychiatric services.
- several women had recently resided at a women's shelter due to living in an abusive situation.
- other services accessed include Crisis Management and Mobile Crisis Services, Welfare Rights Centre, addictions treatment programs, the food bank, the YWCA and in-patient psychiatry at the Regina General Hospital.

- other services identified as being used or required include Phoenix Residential Society programs, Child and Youth Mental Health Services, Four Directions Health Centre, Catholic Family Services, Parent Aid, problem gambling services and harm reduction methadone treatment.

Women who do not appear to have mental health issues made use of some of the same services—but not to the same extent. Many of these women were recipients of SAP and used the services of the YWCA, Welfare Rights, women’s shelters, Soul’s Harbour; home care, meals-on-wheels and the food bank. Generally, women without mental health issues did not appear to access the services of the Regina Mental Health Clinic.

The men made use of the Salvation Army Hostel for Men, were recipients of SAP, required alcohol addiction treatment, and used the services of Regina Mental Health Services, Crisis Management, Phoenix Residential Society programs, Welfare Rights and the food bank.

*Over all, the participants in this study live in poverty. Their housing choices are limited by the lack of resources to rent or buy adequate, safe and affordable housing in Regina.*

### ***Long Term Care Program Statistics***

Statistical data provided by the Long Term Care Program, Regina Health District indicates that between April 1, 1999 and March 31, 2000 there were 540 people placed in long term care in Regina. Of these, 44 (8%) had a medical history which included a psychiatric diagnosis; 25 were female, 19 were male.

### ***Regina Mental Health Clinic Statistics***

Data were provided by the Regina Mental Health Clinic regarding services provided to Regina residents between April 1, 1999 and March 31, 2000 in the program areas of Adult Therapies and Rehabilitation. Rehabilitation services are of a long-term nature for individuals with long-term chronic mental illness while adult therapies are generally of a shorter-term and more acute nature. For the purposes of this report, we shall focus on the data provided on rehabilitation clients who make use of the supportive housing services of the clinic, although significant comparisons are made between these two groups. The data provided by the clinic are attached in Appendix A. These statistics do not include specialty programs, clients that see psychiatrists only and clients living outside the city limits.

During the twelve-month period, the mental health clinic served approximately 1,107 clients—605 women (55%) and 502 men (45%). Adult therapies were received by a total of 573 individuals—351 women (61%) and 222 men (49%)—while rehabilitation services were provided to 534 individuals —254 women (48%) and 280 men (52%). It is important to note that a significant proportion of both groups live independently and alone, 185 using adult therapies and 198 using rehabilitation services. However, while

204 (36%) of those using adult therapies live with their families, only 73 (14%) of the rehabilitation clients live with their families.

The data on marital status of clients of the clinic indicate that only 52 individuals (10%) were married or living common-law among rehabilitation clients as compared to 229 (40%) adult therapy clients. Further, 412 (77%) rehabilitation clients have never been married as compared to 197 (34%) adult therapy clients. This becomes even more significant when the ages of these two groups are noted. The average age of rehabilitation clients is 46 as compared to 38.8 for adult therapy clients. Most clients in each group are in the 25-54 age group. This would indicate that the clients who have long-term mental illness are considerably less likely to be living in family or other types of relationships and, thereby, have greater need for a supportive living environment. As well, housing costs for single people are considerably higher than for persons who are able to share accommodation. Rehabilitation clients make use of various types of special needs housing including supportive housing (24), approved homes (68), personal care homes (5), group homes (11), special-care homes (13), long-term care (6) and treatment centres (5).

The employment situation of rehabilitation clients further reinforces the fact that a substantial proportion of this population remains outside mainstream society. A full 315 (almost 60%) of this group are unemployed even though 415 (78%) of rehabilitation clients had secondary or post-secondary education.

In the next section, we draw upon findings from the information sheets completed by housing workers using administrative information from files with the Regina Mental Health Clinic over the four-month period from January to April 30, 2000.

### *age and sex of participants*

A total of 31 information sheets were completed over the time period—25 (81%) for women and six for men. Twenty-one (68%) of the women were aged 25-64, two were younger and two were 75 years and over. Five of the men were aged 25-54, and one was over 75 years.

### *housing requirements*

All clients of the Regina Mental Health Clinic for whom forms were completed required housing for themselves only, with the exception of one woman who was looking for housing for herself and her partner. Six women required short-term housing in the form of approved homes, personal care homes, convalescent homes, Phoenix Residential Society programs or access to the Supportive Living Unit at Pioneer Village. Two men required supportive housing. Long-term housing needs of 19 women included approved homes (8) a bachelor or one-bedroom apartment (5), Supportive Living Unit (2), long-term care facility (2) Phoenix Residential, Westview Apartments (1). Four men required long-term care in the form of approved homes (3) or personal care homes (1).

There is a substantial difference in the type of housing needs between the Regina Mental Health Clinic rehabilitation clients and those served by the non-governmental agencies discussed above. It is evident that the majority of these rehabilitation clients require extensive support and are generally unable to live independently in comparison to many of those discussed previously, a large proportion who can maintain various levels of independent living in an apartment or house along with differing amounts of support to maintain themselves within their own homes. These differences are further confirmed when we consider the reasons this group has for needing housing.

### *reasons for needing housing*

Reasons identified for needing housing include difficulties with current approved home or with personal care which required an alternative placement; leaving temporary placement; need for greater supports; greater physical care needs; leaving psychiatric facility; independent living not successful; cannot live with a family member who is asking that they leave; and living in substandard housing. (In some cases, this latter reason was identified by a caseworker rather than the client).

The men had very similar reasons for needing a new housing situation such as leaving Phoenix Residential housing and being discharged from Pioneer Village, ill health of caregiver in a personal care facility, not managing independent living and leaving a psychiatric facility. Although some of the reasons for the housing needs are similar to those of the people discussed above, there was generally much more of a need for all-encompassing support, including 24-hour supportive housing.

### *supports in use or needed*

Supports being used by the women in this group, along with the services of Regina Mental Health Clinic, include financial assistance from the government (with almost all of the women receiving SAP). Other supports being used or required include: Home Care, Phoenix Residential Services, Crisis Management, the food bank, addictions treatment, Balfour Tutorial and problem gambling services. Along with the services of the Regina Mental Health Clinic, the men were using services of Phoenix Residential Society, Crisis Management and the Public Trustee. The variety of services accessed by this group was considerably fewer than those discussed above.

We turn next to the qualitative information obtained through in-depth interviews with eight women, some of whom also responded to the information sheet inquiry.

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## V. In-depth Interview Analysis

### *Profiles of the Women*

This section is based on in-depth, semi-structured interviews conducted with eight women who cope with mental health issues and have supportive housing needs. Profiles of the women have been compiled in an attempt to provide an understanding of their specific needs and to impart a sense of their lives and histories. Their names have been changed and details have been omitted or altered in order to preserve their privacy and confidentiality; however, the essence of their stories remains intact.

The women's ages range from 20 to 50. Most of the women are white; two are Aboriginal. Five of the women are unemployed and rely on social assistance. Of the three women who are employed, two require subsidization from social assistance and the third counts herself among the "working poor." Five women have post-secondary education.

Three of the women have no children, while two have adult children living independently. Two women have young children who have either been adopted or are living with other family members. One woman has four children—one has been adopted, one is in foster care, and two live with her.

Four of the women have psychiatric diagnoses and are receiving services from the Regina Mental Health Clinic. Two of the women are on psychiatric medication but receive treatment from their GPs and are not connected to the clinic. Two of the women do not have psychiatric diagnoses and are not on psychiatric medication, but both have histories of multifaceted problems resulting in ongoing life crisis. Three of the women suffer from chronic, physical health problems. Three of the women have struggled with addictions. Six have been victims of sexual and/or domestic abuse at some point in their lives.

*Anne recently moved back to the community, after having lived for approximately nine years in the (psychiatric) care of large institutions. Shortly after moving out on her own, she became depressed and attempted suicide. Following this, she became connected with a high level of community support services and has since been successful at maintaining her independence and mental health. Anne is in her forties, single and does not have any children. She has some post-secondary education and would like to return to school but feels she would need a lot of support to do so, having been away from it for so long.*

*Delores is in her thirties, married, with four children. She has two boys, ages eight and four, and two girls, ages 15 and six. Her teenaged stepdaughter was adopted and her eldest son is in foster care. Delores and her husband have a long history of violence and abuse and the whole family is receiving a wide range of counseling and support services from a variety of government and community agencies. She and her*

family live on social assistance. Delores describes herself as a housewife, and has some post-secondary education, as well as work experience in the service industry.

**Carol** suffers from chronic depression as a result of childhood abuse. Although she describes herself as “getting healthier as the years go by,” she still requires hospitalizations at least once, sometimes twice a year for approximately a month at a time. Carol is in her fifties, divorced, with one adult daughter. She has post-secondary education and is professionally employed on a part-time basis. While she once required social assistance, Carol is now self-sufficient—although she considers herself among the “working poor.”

As a teenager, **Beverly** lived transiently for approximately three years, staying with friends or their families for periods of time ranging from days to weeks. During this time, she lived in many rural and urban communities across western Canada, sometimes literally homeless, sleeping in tents in campgrounds. Beverly has a history of addiction, domestic abuse, depression and suicide attempts. She recently completed a drug treatment program and is managing to stay clean with the support of a self-help group. Although on psychiatric medication, Beverly is not connected with any supports specific to her mental health concerns. Beverly is in her twenties, single, with no children. She moved to Regina to look for work but has been unsuccessful in finding employment. Beverly completed Grade 12 and one of her goals is to return to school in the future.

**Jean** has a long history of abuse leading to depression and attempted suicide. She moved to Regina a year ago to escape the abuse and has recently been diagnosed with a psychiatric disorder. Jean has some post-secondary education and work experience, but is currently unemployed. She is in her thirties, divorced, with one adult daughter. Her professional supports at this time are minimal but she does make use of a fairly extensive informal support network.

**Kim** suffers from schizophrenia and an addiction problem. She has been involved with the criminal justice system and has spent some time in jail. Kim has never been able to undergo addiction treatment because of her psychiatric illness. Although resistant to formal supports, she does see her psychiatrist regularly. Kim is in her forties, single, with no children. Although she did not complete high school, Kim has a full-time, permanent job but does require subsidization from Social Services from time to time.

**Esther** suffers from schizophrenia and has a history of depression and suicide attempts. In the past, she has been involved in a physically abusive relationship and has struggled with alcohol addiction. During the onset of her psychiatric illness, she was literally homeless for a period of time and does not remember where she stayed. Presently, Esther makes use of an extensive formal support system, as well as her informal network of friends and family. She is in her forties, divorced, with two children, 16 and five years of age. Esther’s elder child lives with her ex-husband’s family and the youngest has been adopted—whereabouts unknown. Esther has post-secondary education and work experience in the business field, but has most recently worked in the service industry and is presently employed on a casual basis.

*Donna moved to Regina approximately four years ago to escape an abusive relationship. Donna has an intellectual disability and a serious, chronic physical health condition. She acknowledges coping with self-esteem problems related to her intellectual disability and her lack of ability to obtain mainstream employment but she denies having any mental health problems. However, she describes a lifetime of abandonment and neglect by family and abuse and exploitation by common-law partners, boyfriends and people she has attempted to befriend in the community. She is currently involved with an abusive, alcoholic boyfriend. She is very resistant to formal supports but does recognize her need for “protection” and social support in terms of her living environment. Donna is in her thirties, single, with three children. All three have been adopted. She knows the location of only one of them.*

*Note: A variety of pseudo names are used in the following sections to ensure the identity and confidentiality of the women.*

### ***Previous Housing Situations of the Women (within the last five years)***

*Josie states: “I was everywhere. I was just living all over. There were so many houses. There were four reserves and I lived on them all with a whole bunch of different people.” Josie cites her drug problem as the main reason she wasn’t able to stabilize somewhere: “I’d go to house parties and you wouldn’t see me for a week so that person would no longer consider me to be living there—or I’d do something wrong or steal from somebody and get kicked out of the house and just keep on moving – all over.” As well, during this period, Josie was involved in an abusive relationship: “He was in and out of jail a lot and every time he came out of jail, he’d always have a job. He worked on the rigs for \$17.50 an hour—so that’s where most of the money came from, but we’d always drink it away and use.” She also relates her lack of stability to her inability to obtain financial assistance. When in Alberta, she tried three times to get social assistance but was unsuccessful: “No one could get by her [the secretary]. Even when I did go around her, everything just went back to her. I don’t know why.” Regarding employment, Josie states, “I signed up in 40 different places for a job and no one ever called me. It’s probably because I didn’t have the proper clothes and they [Social Services] weren’t going to help me out with clothes – they didn’t give me anything. So I don’t see how they expected me to find a full-time job.”*

Carly has lived in a number of different environments in the last five years. Prior to moving to Regina, she lived with an abusive partner in another city. Her first residence in Regina was at a shelter for battered women. Carly then moved to the YWCA where she describes the atmosphere as “warm and friendly.” She highlights the support she received: “They had a lot of staff at the front desk who were there morning, noon or night. They were always there to help you and get you through a crisis or whatever you needed to go through.” However, she left because she was not able to establish relationships with the other residents: “It was like I didn’t matter or they didn’t care. They ignored me a lot and went with their own group of friends and that made me sad because I had nobody.” After this, she lived in an apartment building in North Central where a couple of the female tenants she had befriended attempted to get her involved in

drugs and alcohol and would take her groceries and money. Even though the building had a security system, *“Anybody could get in. Anybody. ’Cause all they have to do is press a buzzer and you don’t even have to say who you are. They’ll just let you in.”*

Brenda lived in a group home for people with mental illness and two apartments in the Cathedral area that were secure and affordable. Unfortunately, she had a bad experience with one of her landlords who was not understanding of her mental illness: *“If I locked myself out or whatever, he would charge me as much as \$10.00 just to open up my door to let me in. He did it to all of us. A lot of us there were sick...It just got to the point - I’ll never go back.”* As well, Brenda was physically abused in her last relationship and made use of women’s shelters from time to time: *“My relationship, which was roughly the last ten years...there were times when I couldn’t go back because of the abuse.”*

Vicki was transferred from one large psychiatric facility to another within the last five years. While she had many positive things to say about both settings, in terms of the physical environment, staff and personal relationships she formed with other patients, she recently discharged herself from institutional care. She did this not only because she needed more privacy, but also because she felt she needed the challenge of living on her own in order to get better: *“I wanted to be better—mentally better, healthier—and I didn’t think I could get any better while I was there. I felt I needed the challenge of living on my own.”*

Adeline lived with her parents before moving to Regina to look for a job. She would have liked to remain at home, but there was no work in the small town where they lived.

Jackie moved to Regina from Edmonton where she lived in an “illegal” four-plex (converted from a duplex) with her daughter. *“We were in the basement. There was no thermostat to control the heat downstairs. It was just too hard on me.”* When her daughter moved out, it became too expensive for her, and she was having difficulty finding an affordable place that would accept someone on welfare: *“Housing was very limited and landlords discriminate against people on welfare.”*

Adrienne lost the house she was renting when she went to jail. She had given all of her furniture to her family and when she got out, she lived with her sister while looking for her own place: *“She was sniffing all the time and I don’t sniff. So I kind of had it hard. I would just leave in the mornings and go looking for apartments. I’d try to find a one-bedroom that was secure enough because at the other place, people were always breaking into my house and stealing hairspray and my clothes and stuff like that.”*

Previously, Adrienne lived in a variety of rental houses in the Core area. Although she says they were in pretty good shape, she also reports having had problems with mice, plumbing and appliances not working—problems she was unable to get the landlords to take care of. In addition, she usually had to get people to live with her in order to afford the rent: *“But then that didn’t always work out because they were always drinking all the*

*time.*” While she felt that the rent for these houses was not unreasonable (from \$365 to \$400 per month), during this time Adrienne was paying approximately two-thirds of her income on rent. Because she was only allowed \$320 for rent from Social Services, she was subsidizing \$55 to 80 a month from her food money.

Jennifer and her family were most recently living in subsidized, low-income housing. It was well-maintained and affordable but located in a very noisy, poorly insulated building: *“They’re just paper walls. If my neighbour on one side of me was yelling at his son, I could hear everything he was saying!”* As well, it was in an unsafe neighbourhood. There were thefts of their property, and Jennifer witnessed a beating in an adjacent park. Shortly before the family moved out, there were two murders within a block of their home. *“That’s scary. My protection worker even had concerns about my kids being there. We always had to be out with them.”* She had been told she and her family could move into a house when one became available in a safer neighbourhood, but once they had moved in to their present location, she was told they could not transfer to another location or into a house. Jennifer has also used emergency and women’s shelters from time to time.

Jennifer and her family have lived exclusively within the North Central area for the last five years and have moved frequently in an attempt to find better housing. However, this strategy has been unsuccessful: *“In the last five years we’ve lived in nothing but dumps. We’ve had nothing but slum landlords. That’s why we moved into the low-income housing, because we were getting sick of the slum landlords.”* They have been unable to afford a move to a better, safer area: *“We’ve never escaped North Central yet...because the housing outside North Central is just too expensive.”* And even though they have lived in sub-standard housing (aside from the period they lived in low-income housing), Jennifer has always had to subsidize their rent with food money.

Emma has lived in a small community in rural Saskatchewan for many years. Her situation is unique in that she has been able to purchase her own home, largely because she lives where house prices are very low. When Emma and her husband divorced, she put her few remaining assets into a down payment on a small, inexpensive house (\$30,000) on a rent-to-own basis. Because she could not have lived on these assets for long and because her mortgage payment was substantially lower than what she would have had to pay for rent, Emma was still able to receive assistance from Social Services. She was also able to make use of the Canada Mortgage and Housing program for needed repairs and to make the house wheelchair accessible. Although she was ultimately successful with her home ownership plan, there were many obstacles along the way. Because Social Services is not set up to accommodate this kind of arrangement, there were periods when she had to bear great financial hardship. When Emma went from rent-to-own to obtaining her own mortgage, payment of taxes as well as the legal costs involved provided a great challenge. Emma was able to meet the costs (and overpayments) by supplementing her income with odd jobs. She grew a garden and with the help of friends and neighbours, who would bring her food, she was able to survive. She says, *“At that point I didn’t use food banks but my neighbours were very generous and a lot of that time was during the summer when my garden was growing and my*

*friends on the farm put a few pieces of meat in the cooler and sent them into town...things like that...Social Services didn't have any mechanism to recognize the costs. If I hadn't been able to make my own insurance and property tax payments, I would have been left really very vulnerable."*

### ***Current Housing Situations of the Women***

Jill lives in a furnished bachelor apartment in the North Central area. The apartment is too small for her and she anticipates that when her boyfriend moves in, this will contribute to relationship problems – but they can't afford anything larger. Although she has a good landlord and the building is fairly well maintained, she has had to contend with mice on two occasions. The biggest concern, however, is the area. Although Jill feels her building is quite secure, she does not feel safe going out at night: *"I'm living in a district where there's prostitutes all night and johns driving up and down the street – you see them, back and forth, back and forth. And there's no way I can go out there alone. I shouldn't have to live like that."* In terms of satisfaction, Jill comments, *"Well, it's good enough. It's better than what I might have had – but I'd rather have a one-bedroom apartment where I could get away [at night]."* While Jill is subsidized by Social Services, her main source of income comes from a disability pension. Although Jill pays only \$320 a month for rent, the cost is still slightly more than one-half her total income (of \$635 a month). She therefore supplements her income by using the food bank, a free lunch program in the community and has supper at her parents' place two times a week.

Adele and her family live in a very small, two-bedroom house in the North Central area which is quite old and in very poor repair. Although just recently moved into the house, Adele was already concerned about the landlord's reluctance to do needed repairs. There was an electrical fixture hanging by wires from the ceiling in the living room. The furnace fan was duct-taped to the furnace and ran constantly, and the house was extremely hot during the interview. The rent was \$500 a month—\$30 more than what Social Services allowed and so Adele subsidized the rent with food dollars and made maximum use of the food bank. Their rent was approximately three-quarters of their total income. Adele's frustration is evident: *"How can the landlords charge a full month's rent for your damage deposit? That's so stupid. Social Services gave my landlord a letter of guarantee that he'd get \$470. Well, he wants the full \$500. He wants me to put in the extra \$30. And where is it going to come from? Out of my child tax. Actually, it's \$90 this month I've got to give my landlord. \$50 for moving in early; \$30 for the rest of the damage deposit; and \$10 for my dog. He's getting \$470 and \$90—\$560 for this place!"* Although Adele appreciates the privacy of her own home and fenced yard, she is very concerned about the area in terms of safety and security.

Dianne lives in a run-down house in the North Central area but is currently staying with her boyfriend until she can find an apartment in a safer neighbourhood: *"It's a dangerous area. My house has been broken into three times. My lock's been busted; the doorknob's been messed with. Three blocks down there was a murder - just three blocks down from my house! Like I said, it's not a safe area but I'm living there for the time being because I had nowhere else to go."* However, the situation with her boyfriend is far

from ideal: *“He has used me for groceries for at least the last two years. He yells at me, screams at me and swears at me. He does things just to hurt me. I think he’s an alcoholic but he’s denied it.”* Dianne’s rent is more than one-half her total income.

Avery owns a small one-bedroom house in a small town in rural Saskatchewan. Her home, albeit inexpensive and “very modest,” is an important part of meeting her need for safety and security and enhancing her mental health: *“A lot of the issues that I deal with in my mental health are boundary issues and about the violation of my person. The fact that I have a place that’s mine and that is safe has been a really important part of my healing.”* In addition to having her own home, Avery highlights the importance of community in maintaining a sense of safety and security: *“I had lived in Toronto for five or six years and I never got used to the fact that I didn’t know my neighbours and my neighbours didn’t care what I was doing. I had grown up on a farm in small town Saskatchewan and so I needed to come back to that where...I’d have nosey neighbours! I mean, I think that’s an important part of my mental health.”*

Avery’s mortgage payment is \$320 a month. When she was on social assistance (even though renting a house would have cost over \$400 a month), this was 50 percent of her total income. Now that she is employed, housing costs amounts to only 25 percent of her income. Avery will own her home free and clear in three years. Her pride in her achievement of personal and financial independence is evident: *“These have been the first years in my whole life that I’ve been self-supporting; when I didn’t have either a father or husband or Social Services paying at least part of my bills. I’m quite proud that I get to pay income tax this year. Now not everybody has that same attitude and I may not have it forever, but at the same time it really does feel good to realize it. Having my house—and now I’m paying on a car—are really important incentives.”*

Della has been living at the YWCA in the women’s residence for a little over a year. She has her own bedroom but must share a bathroom with 22 other women and cooking facilities and lounge with all 35. *“You don’t get to use the shower when you want to and we don’t usually all cook at once. We cook at different times.”* She appreciates the social support and security that the women’s residence provides: *“You always have somebody to talk to. Even if you are up in the middle of the night, there is usually somebody else up too.”* However, she would prefer to have her own place: *“Right now it’s really getting to me. There are some people who do steal your stuff and it’s really hard to live like that. I don’t want to live in a place with a whole bunch of people and I can’t live out on my own because there are no decent places that are \$210.”* Della pays \$285 a month at the YWCA, which is more than one-half of her total income.

Leah has lived at the YWCA for two years. While she is satisfied with this accommodation until she can find an apartment, she comments on some of the challenges of living with 34 other women: *“Sometimes it’s really bothersome. Some of the residents think they can control everybody and they try to put other people down. It’s very hard on people who were abused and are suicidal, trying to get out of it.”* Privacy is also a major issue for Leah: *“Here at the Y we can’t have males up, so I want my own privacy and to [be able to] have visitors up to see me.”* Leah presently spends about 45 percent of her

income on housing. She knows that with her disability, she would be entitled to \$320 for rent but, to date, she has been unable to find a safe, affordable apartment in the community. *“It’s very hard to find a place that is within my means unless they are in dumps or run-down houses.”*

Rita has lived at the YWCA for the last six months and is satisfied until she can find her own place. Regarding what it is like living with so many women, she states: *“Sometimes I have to be alone, by myself, so I just go straight to my room. Some women have lived here for ten years. I don’t think I’d be able to live in this place for ten years.”* Privacy is a key issue for Rita: *“I just want to find my own place because I feel I need more privacy than what we’re getting here. I feel sometimes like we’re locked up in jail because they’re so many keys you’ve got to open doors with.”* Rita has been looking for some time but has been unable to find decent, affordable housing: *“I’ve looked in the newspaper and at the welfare office and at Welfare Rights. Sometimes they have them on the board but the ones I’ve looked at so far, the houses are run-down and they want too much money for them. The tiles are bad and the plumbing has yellow stuff dripping from the taps – so I’d have a big water bill.”*

Maria also lives at the YWCA. She has lived in the women’s residence for the last year and is very satisfied: *“I like the Y because I have the choice of having the privacy of my room to myself for as long as I want. And if I feel like being with other people, I can always go to the lounge and visit there with the girls. And that’s a lot better than having nobody to talk to at all when you really need somebody.”* Maria highlights the staff support she is able to use and advises that there are probably three or four people she relies on regularly for support. She notes that this is the longest period of time that she has been able to remain out of hospital, and she attributes a lot of this to the supportive environment at the Y: *“The environment is good and the people are here for me if I need them. Before, I just didn’t have that support.”* Because Maria is employed and able to supplement her social assistance, her rent is approximately one-third of her total income.

### ***Housing the Women Would Like***

The following excerpts concern the kind of housing the women would like to find. As is evident from these comments, the women’s hopes and expectations are very modest but, given the present housing situation in Regina, not achievable at this time:

*“I would like to have a one-bedroom apartment in an area where I can get out at night. Also, once my boyfriend moves in, it will be too crowded, but we can’t afford anything else.”*

*“I just want to move out with my friend and get a two-bedroom house or a two-bedroom apartment. But I don’t want anything that is “scummy” and that’s all we’ve been getting so far is places like that. We just want a decent place that’s not really run-down.”*

*“I don’t want to live in North Central. I don’t want to live in that area.”*

*“I’m looking for a bachelor or a one-bedroom where I can have my own space and my own bathroom and kitchen.”*

*“Affordability and it being secure. I’d rather have an apartment with an intercom system for security. I need to be able to protect myself being a female, because I don’t want to be raped or beaten up by a male.”*

*“I’d like to get into the Cathedral area because it’s quieter. I’d also like to get something with security.”*

*“I want a decent apartment that isn’t run down. There’s one over here that’s full of cockroaches and they don’t do anything about it. Otherwise, I’d get a small bachelor apartment there.”*

*“The only thing I can think of is, maybe when I’m older and I move to a senior citizens high-rise where they also have a setting where you can get together with the people who live there and socialize with them. Other than that I wouldn’t move from the Y.”*

*“I’d rather live in the community but not in a house by myself. I need more protection than just by myself. I’d like to live in a house where I’d have protection.”*

### ***Formal Supports Used by the Women***

The following section lists the range of specific formal supports used by the women, either currently or within the last five years. It is interspersed with some of the women’s comments about their need for and/or experience with formal support systems.

Elizabeth describes some of her personal life difficulties: *“Overdosing; feeling lonely, lost; missing my children and feeling my family wasn’t there for me. I’ve had a lot of emotional supports from my friends. There are still times when – I don’t dwell on it – but the odd thought will come by when I still want to commit suicide. People say, ‘Take your medication the way it’s supposed to be taken,’ so that’s what I’ve been trying to do.”*

The formal supports used by the women spanned various government and community programs—ranging from institutional to professional to community agency to self-help support groups.

Mental health supports included psychiatrists; the In-Patient Mental Health Services and the Day Hospital Program at the Regina General Hospital; Regina Mental Health Clinic workers and programs; contract workers (facilitated through the clinic and the Department of Social Services); Phoenix Residential Society support workers and programs; the Canadian Mental Health Association, Regina Branch, Drop-in Centre and programs; and many general practitioners in the city.

Pam comments on one of her mental health support workers: *“The last five years have been the most beneficial because she was always there for me. She’s the type of person who takes that extra step. If I phone her at ten to five, she’ll phone me back, even if it’s quarter after five, just to make sure that I’m OK. And there aren’t many people like that.”*

Dale is making maximum use of the mental health supports available to her in the community: *“I have counselors that are good. I have one that helps with living skills and I have another one that helps with budgeting and giving me my medications. I have another one at the Mental Health Clinic and I have a psychiatrist—so I have lots of help.”*

Dawn suffers from schizophrenia and has an addiction problem but does not think she would benefit from any more supports: *“I see a psychiatrist. I see him every three months and I get a prescription every fourteen days.”*

The Department of Social Services has, during the last five year period, provided financial support to all of the women interviewed and is currently subsidizing the majority of them to some degree. Child Protection Branch has also been involved with some of the women at various times.

Elaine also, is now connected to a wide range of community supports: *“The best way to describe our life, is like putting a strange cat and a strange dog in the same room. That’s what it was like – very physical and very abusive. Right now we’ve got a lot of team members involved with us. We’ve got a lot of supports behind us – more than we did. They are starting to realize, hey it was our problem, we should have been dealing with it.”*

Other community resources that have been used by the women include Welfare Rights Centre, Mobile Crisis Services, Family Services Regina; First Nations workers; Circle Project; Public Health; Early Learning Centre; Narcotics Anonymous, Alcoholics Anonymous, Attention Deficit Hyperactivity Disorder and survivors of abuse support groups; and in-patient alcohol and drug treatment programs.

Tracey suffers from depression and has attempted suicide a number of times. Even though she is on psychiatric medication, she is not currently connected with any formal mental health supports. *“I could probably use more support. Sometimes there are just so many people [at the meetings], that not everybody gets a chance to talk.”* Although she was looking into seeing a psychologist, she has not yet pursued this plan.

Rhonda is also on psychiatric medication and attends a couple of support groups, but at present is resistant to pursuing more formal supports. *“No. I’m dealing with it on my own. I would like to get some help but right now I’m going to support meetings which meet once a month and that is helping me to deal with it. And I know they will help me find someone that will do it. Plus I go to community outreach support groups because of*

*abuse and they will help me. They think I need help.” She suffers from depression and has attempted suicide in the past: “I’ll go see a psychiatrist for help because with my abuse and my family calling me a liar and everything, it’s telling me that I’m no good.”*

Although Betty is very straightforward about her intellectual disability, she is extremely resistant to re-connecting with support services in this area: *“No. Not ever.”*

Residential supports include the YWCA, as well as various women’s shelters, including the Isabel Johnson Centre, Transition House, Wichihik Iskwewak Safe House (WISH), as well as women’s shelters in other communities.

While Pat also makes use of the formal mental health supports available to her in the community, she also points out some gaps in service, which, if addressed, *“would lessen the pressure on both the system and on the person themselves...I use the women’s shelter and, because I’m neither First Nations nor on welfare, I pay \$30 to \$35 per night for my safekeeping. Sometimes it feels really hard to fork over \$150 for a week when I realize that if I had spent that week in the hospital, I wouldn’t have made that kind of a payment. Yet that’s part of the supportive housing [that I need] and that accepts that because my illness is a result of childhood abuse, they can stretch their guidelines.”*

### ***Informal Supports Used by the Women***

The informal supports highlighted by the women included the importance of phone and transportation in order that networks of family and friends as well as formal supports can be maintained. All women talked about the importance of their relationships with friends and family. Three of the women preferred to share a house or apartment with one or more people for the social support and security this arrangement would provide.

*“The phone plays a big part in my life because there were some weeks that my daughter and I talked for a whole hour on the phone. Now we’ve stopped that and I miss it.”*

*“One of the things that makes it possible for me to live by myself is that I have really good phone links with people. I have phone links with people six hours east and six hours west and during the time that I was on welfare, I had a friend who paid my phone bill. And that would be up to a maximum of \$200 a month. I also looked at the fact, that any day that they put me in the institution was going to cost them at least \$500. So by having a friend in Toronto who was subsidizing me for \$200 a month, the ‘system’, maybe not Social Services, but the province of Saskatchewan was saving incredible sums of money. I would say to them, “You’re paying me \$640 a month—and if I go into hospital for one day, it costs the system more than that—so why don’t you pay me enough to look after myself?” I was aware that every day I looked after myself, I was actually saving the system a lot. On the days that that was very difficult for me, I wasn’t getting any credit, and I certainly wasn’t getting any money for it.”*

*“If I had a vehicle, I could go out to the farm oftener. There used to be a bus that went out but it doesn’t travel that way any more. My family comes up once every month but this week I was just too busy to see them, so it’s been over a month and that’s a long time.”*

### ***Changes that are Needed, Ideal Pictures and Possible Future Programs***

The women had suggestions for improvements to existing programs and services, as well as ideas for new initiatives that are not presently available to them in Regina.

Regarding existing resources, Angie stresses the need for more money for rent: *“I think Social Services should allow more money for rent. It’s been that for at least ten years and that’s ridiculous.”*

Doris reiterates the need for more money—more money for food and more money for housing: *“Do you know what they are giving us right now to try to live off, for groceries? \$100 for two weeks for the four of us. That’s \$20 per person for two weeks. My kids can eat \$20 a day, let alone \$20 in two weeks.”* She also suggests that low-income housing authorities should give people the option to move within the city to safer locations, and from apartment complexes to houses. As well, she believes families should be allowed to have pets.

Fran also suggests that more money should be allowed for rent: *“They’re trying with the families because they are raising our child tax in July. It’s going up. But because they’re raising the child tax, they’ve just recently put PST on different things. So they’ve given it to you in one hand and taken it away with the other.”*

While Joy feels that a teen program would have greatly helped her a few years ago, she also stresses the issues of money and housing as the most relevant issues for her at present: *“More housing that’s affordable and the rates changed from Social Services because I can’t believe that you only get \$180 if the other person [you’re living with] is on social assistance. How are you supposed to find an apartment for \$360? We went to look at one that was \$500 and it was awful. It was on top of a realtor’s place and it had a balcony but the thing was so rotted away you could have fallen right through to the next floor. It was awful.”*

Rose stresses affordability, security and proximity to the downtown area for women who rely on community supports: *“All of my support groups are downtown and I don’t want to leave because I am familiar with it. It’s important to have housing available for females in the downtown area. There are a lot of apartment buildings but the rent is too high. There should be low income housing for people who are not on assistance but are working at minimum wage, as well as for people on welfare. And not run down or anything like that.”*

Regarding new initiatives and programs and services not available in Regina, Hillary describes the ideal support system as a continuum of safe houses for people who

experience mental illness: *“There should be different levels of safe housing. The one I want for me personally is one that is consumer-run and recognizes my own responsibility. However, I know that there are some people, when they are having a hard time, that want someone else to take a lot of control. Therefore, there is a need for a variety of these on a continuum. There is one model in Winnipeg called Seneca House. It’s always full. They could probably use a dozen of them. It’s consumer-run. That means it’s run by people who experience mental illness (but a lot of us also have many skills). It provides a safe place; it provides support; and the person themselves is involved in the assessment of what they need and how much they need. It allows people to live as fully as they can and it certainly saves the system - \$500 a day or whatever – it doesn’t cost anything like that to have this kind of support. This would be by self-referral or by referral from your mental health worker. For people who are the working poor, it wouldn’t have the costs involved. It would be seen as a health resource and supported through the health system or the social services system for people who need respite. The way I look at it, people who look after themselves need respite too. It’s become a fact that if you are looking after your disabled partner and need some time away, you can ask the senior’s lodge to provide a respite bed. Well, people who experience mental illness are doing self-care all the time and so, one of the visions that I have is that there would be places for people to have respite beds for themselves. In the days when I lived with my husband, he needed some respite time too. There were times when I went into the hospital as much because my partner was worn out, as because I was.”*

Hillary sees a system of “safe houses” taking pressure off the hospital care system in terms of dollars and because of the shortage of acute care beds: *“One of the difficulties we are facing is that the number of beds available for psychiatric care in Regina has been reduced. During the last move, they went from 65 to 50. It’s very, very difficult to get a bed (see Geller & MacNeil, 1996). So the opportunity to get that kind of support is less and less. Especially when the beds are needed for truly acute care. Some place like a safe house only would work for people who wanted to be there voluntary and were asking for help and were using the resources that they had in the mental health system in the community. It doesn’t take away the need for the acute care beds but it would lessen the pressure on both the system and the person themselves. The last time I went into hospital, I knew I was in crisis and I went to emergency. I had been trying to work with my psychiatrist and get a planned admission but that wasn’t happening, so I went to emergency. I had a friend with me and there were no beds available, so the psychiatrist gave me sleeping pills and tranquilizers and I went home with my friend and slept for two days until there was a bed available. That would have been an example where a safe house would have taken off the pressure—pressure that I don’t want to put on my friends, not to mention the pressure it put on me. The amount of energy it takes to ask for and get the resources you need is really quite high.”*

Elaine, while happy at the Y, would consider moving to housing that had the supports she requires—similar to the kind of supportive housing available to senior citizens. *“The only thing I can think of is: maybe when I’m older and I move to a senior citizens high-rise; they also have a setting where you can get together with the people who live there and socialize with them. Other than that I wouldn’t move from the Y.”* She

also notes that she would prefer a female-only building: *“I would prefer it to be all women.”* Regarding the design, she says, *“A suite would be nice rather than just a room—that would be really nice.”*

Janet points out the need for good telephone and outreach support: *“The other thing that shouldn’t be neglected is the value of, the importance of, having telephone support and people who are willing and able to come to your home during a brief crisis. Sometimes if you’re having a hard time in the middle of the night—and that for many people is a really hard time— if there is someone to talk to even for an hour or so, you don’t have to go anywhere. One of the things that I’ve found with the mental health team here is that they’re used to getting people to emergency and that becomes their focus. The other real disadvantage of that team is that the people staffing the all-night line, the on-call line, that isn’t their job. Their job is to still get up the next morning and be at the clinic at 8:00 a.m. That makes me very reluctant to ask for that sort of help because I really don’t want to impair good mental health workers.”*

Regarding people with mobility problems and mental health issues, Hilda suggests, *“ I think there needs to be a supported apartment model – and there are some like that for persons in wheelchairs – but that’s a place where there is a gap, that isn’t well-served – where people who have both a mental illness and a physical disability don’t always get coordinated services. They sometimes end up having two separate lives; they give one story to one set of caregivers and one story to another because they don’t want the attendants who come in to help them bathe to freak out about their mental illness. When they won’t get out of bed in the morning, the attendant doesn’t know how to handle it and that’s a problem.”*

Charlene highlights a need for emergency housing that is appropriate for families when they are fleeing abusive situations: *“One night we did have an emergency between my husband and myself. They stuck me in the Plains Hotel. For emergencies and when there is no place at the shelters, they have to put you somewhere, but they should find someplace else other than the grungy Plains Hotel. It was noisy, right over the bar and my kids were trying to sleep. Also, the money that I used to feed my kids came off my cheque afterwards. If I had known that I would have stuck it out.”*

Jill notes the problem of medication not covered by the health plan and the impact this has on people who are working or trying to get off welfare: *“If I was to be on my own and working, I wouldn’t be able to afford my medication. The one pill alone is \$160 a week and the other one is \$40, so it’s \$200 a week—that’s \$800 a month. So things look pretty bleak right now for me ever being off social assistance.”*

Mary suggested a support system for people wanting to go back to school after having been away from it for a long time: *“I’m concerned if I’m going to be able to study. Am I going to be able to understand it? Will the stress cause me to have a nervous breakdown? Who can I go to if I feel upset?”*

While Jessica was very resistant to becoming re-involved with formal structured programs, she did recognize her need for a supportive living environment: *“I’d rather live in the community but not in a house by myself. I need more protection than just by myself.”* In terms of supports, she said, *“I’d want a program...I’d want to do something during the day. I wouldn’t want to sit at home and do nothing. I’d want either to further my education or join a group of some type in the community—a support program or something.”*

### ***Summary of In-Depth Interview Analysis***

Several interrelated themes emerged during the course of the interview process that focused on two main areas: poverty and mental health.

Themes related to poverty included the lack of safety and security (both in terms of building and neighbourhood), sub-standard housing, inadequate income to pay for housing, and the need to supplement housing costs with food dollars. This latter theme is related to regular use of the food bank and other food sources such as Soul’s Harbour, the Marian Centre, CMHA lunch program and friends and family. Lack of privacy was also a major concern given the lack of emergency housing options for women in Regina.

Mental health themes included the need for formal and informal support systems, a history (sometimes including current experience) of physical and/or sexual abuse and consequent use of women’s shelters, and addictions and literal homelessness.

Seven of the eight women interviewed related concerns for their personal safety and security. Five reported experiences with sub-standard housing and “slum landlords.” Seven spoke of inadequate income to meet housing needs, either at present or in the recent past, with all seven paying 45 percent or more of their income on rent at some point. Five women related using food money to supplement housing costs and the regular use of the food bank and other community resources in this area. Seven women voiced concerns over lack of privacy, and one reported concerns about unacceptable noise levels.

While some of the women were resistant to accessing formal supports, others were making use of all the supports available to them. All eight, however, made use of formal supports to some degree. Six women discussed informal support systems they require to stay healthy. Six of the eight women had past and/or current experience with abuse and had made use of women’s shelters. Two of the women had been literally homeless.

An underlying theme also emerged related to “diminished expectations.” Because all of the women had been coping with very difficult issues for a number of years, including poverty, their views related to concepts such as “satisfaction” were tempered by their experience with what has been available to them and not by the more “ideal” concept of “decent, safe or affordable” housing. The limited range of housing options for women in Regina, particularly for those who desired women-only or high-support settings, was also reflected in the responses.

However, there were suggestions for a number of innovative housing models, as well as for supports and services that are needed but not currently available in Regina. Housing suggestions include a continuum of “safe houses” to provide respite and take the pressure off institutional care; a variety of safe and affordable housing options for women, including some that are all-female and more private than the women’s residence available at the YWCA; more affordable apartments in the downtown area where most supports are located; programs to enable home ownership for low-income and poor women—as part of personal safety and security and to contribute to a sense of community and neighbourhood ownership; changes to low-income housing regulations, including the ability to transfer from apartments to houses and to safer neighbourhoods, and the inclusion of welfare recipients to a greater extent than at present; and supportive apartment buildings similar to those available for seniors, some all-female, some mixed.

Other suggestions regarding needed supports and services include supports to aid people wishing to return to school, assistance with expensive medication which precludes the possibility of getting off of welfare, more drug and alcohol treatment programs for those on psychiatric medication, more teen programs, more money for clothing (to help compete in the job market), and more support of independence and self-reliance as part of personal growth and good mental health.

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## VI. Conclusions

There are dynamic interrelationships between poverty, gender, mental illness, addictions, violence and being marginally housed and/or homeless (Novac et al., 1999).

In this report we have discussed the importance of the availability of adequate, affordable housing for vulnerable women dealing with a variety of mental health issues. In addition, we have noted that most of the women need a number of supports in order to continue to function within the community. The nature of supports vary from those obtained through service providers in the community to those required to sustain the woman in her own home. And, as noted, some women require a housing environment with built-in supports.

The data obtained over a four-month period show the need for both short- and long-term housing in a wide-variety of contexts, including residential housing in such places as the YWCA, approved homes, Phoenix Residential Society programs, the Supportive Living Unit of Pioneer Village as well as independent housing units—from one-bedroom apartments to three or more bedroom houses. Housing was needed by women leaving a psychiatric facility (some of these women had left abusive relationships and were not able to return to their own homes), for women leaving prison, for women living in inadequate housing who wanted to live in better housing and in better neighbourhoods and by those wanting greater privacy. Housing was required for those women in inappropriate approved homes; for those leaving temporary placements; for those requiring greater supports, including more physical care; for those who could no longer be cared for by a family member; and for those unable to manage independently.

Almost all the participants were recipients of social assistance. Those with mental health issues accessed the services of the Regina Mental Health Clinic; others had recently resided in a women's shelter. Services used in the community included a wide variety of mental health and addictions treatment services, along with welfare services and the food bank.

Women who were not identified as dealing with mental health issues, per se, used some of the same services; however, they tended not to be clients of the mental health clinic. It is important to recognize that people using the mental health services of our community and needing adequate affordable housing are among those who live in poverty in Regina and deal with the larger problem of lack of low-income housing.

Housing has been identified as a determinant of health. As such, people who lack adequate housing find their health—both physical and mental—is compromised. In this report, we suggest that people dealing with mental health issues are among the most vulnerable. Access to suitable supportive housing is therefore a health issue in its own right, and lack of such housing has a detrimental affect on this vulnerable population.

The problem is further highlighted by the issues raised through the qualitative analysis of our interviews with eight women, who described their experiences and their

efforts to obtain adequate housing. All of these women have required substantial supports in order to cope with their mental health concerns and all have experienced difficulties locating adequate housing with their limited income. One woman who has been able to purchase her own home expressed the importance of this to her mental health and well-being.

The women were able to suggest a variety of housing options suiting their needs and those of other women. For instance, housing options would include:

- a continuum of “safe houses” to provide respite and a lower cost alternative to institutional care;
- a variety of housing options that are safe and affordable, including some that are all-female and more private than what is currently available;
- supportive apartment buildings similar to those available to seniors;
- more affordable apartments in the downtown area where most formal supports are located;
- programs to enable home ownership for low-income and poor women (and addressing safety, security and community); and
- changes to low-income housing regulations (e.g., allowing for the ability to transfer from one type of housing to another and to safer neighbourhoods within the city, and including welfare recipients to a greater degree).

The findings of our research show there is indeed a need for safe, affordable and adequate housing for low-income women and for women with a variety of mental health issues. In addition, this latter group of women needs community supports in order to function within the community.

We undertook our needs assessment in an effort to identify the extent of this need. Over a four-month period, we were able to identify a sample of women in need of a variety of supportive housing situations. This sample constitutes only a segment of those in need. Information obtained from a variety of sources indicates that a significant segment of this population is in need of housing at any one time. The housing needs range from approved homes and long-term care to residential services provided by the YWCA and Phoenix Residential Society, through to independent living in apartments and homes having a variety of supports.

Having identified a substantial need, we might ask, what can be done and who is responsible for acting upon these findings?

Those participating in the focus group meeting of March 1999 identified needs and gaps at that time. Those findings are presented below, as they are clearly relevant to the findings of this needs assessment.

Along with a needs assessment conducted in order to establish the extent and depth of the issue, the needs and gaps identified by participants at the focus group include:

- safe, affordable housing;
- supportive long-term housing;
- housing for young people in crisis, especially early intervention; and
- evening and weekend crisis services to stabilize women and avoid evictions or moves
- a continuum of services, including home care;
- co-ordination and co-operation among housing providers;
- a residential coordinator to deal with emergencies in any of the agencies;
- a 24-hour team of “first responders” to deal with crisis issues;
- advocacy for housing and services;
- more resources such as psychiatrists and crisis beds;
- more privacy in current residential care; and
- networks of support services, especially for young people unable or unwilling to live in residential care or go to approved programs

### *Solutions*

It is apparent that housing has been identified as a major social issue across the country. The federal government under the leadership of Minister Claudette Bradshaw has announced a housing initiative in an effort to counter homelessness. With the devolution of social housing to the provinces, the government of Saskatchewan has made a commitment to provide social housing to those most in need through the Saskatchewan Housing Corporation. Funds have also been provided to municipalities to facilitate co-operative home ownership for a segment of the population through upgrading substandard housing stock.

However, with the decision of the federal government in 1993 to no longer provide funds for new social housing, the province has also stated that the primary provision of housing resides with the private sector. In Regina, about 20 percent of the apartment stock has been purchased by Boardwalk Equities. The company has raised rents to the extent that many living on low-incomes have been unable to pay the additional costs. There is greater pressure on those seeking low-cost accommodation that inevitably places greater pressure on those who rely upon public assistance to maintain themselves. The Department of Social Services has not increased the housing subsidy in about 10 years and is reluctant to do so, maintaining that this would only encourage landlords to increase rents even more.

The City of Regina currently has a Task Force reviewing housing needs within the city. Many groups, organizations and individuals are actively involved in advocating on behalf of those in need of affordable, safe and adequate housing. Those involved in working on this project wish to make it clear that there are significant benefits to providing adequate supportive housing to women with mental health issues. As a determinant of health, the provision of supportive housing will assist in keeping more women in the community and out of hospital at substantial financial savings. In addition, as we show in our interviews, adequate housing and supports of various types substantially improves the well-being of the women. In some cases, it may be possible for at least some of the women to become stabilized so that they are able to sustain

independent living and perhaps continue with their education or obtain employment. It is important to recognize, however, that some women will continue to require long-term supportive housing and, as they age, further physical care.

We believe that there is a need for a joint effort on the part of federal, provincial, municipal, health district and non-profit organizations to work together to seek solutions to the need for adequate supportive housing as identified in this report. There needs to be greater integration and co-ordination of efforts among various organizations to ensure that supportive housing is available, in the short-term and in the long-term. Government bodies dealing with housing issues must meet with the health officials who deal with mental health services and with the Department of Social Services which provides funds to those unable to work. Since most mental health services are provided in the community now, Saskatchewan Health must ensure that more funds are provided to mental health services in the community, including supportive housing. With the devolution of mental health services to the community from large psychiatric facilities, and with the more recent emphasis on community-based services and the down-sizing of psychiatric beds, it is apparent that the large amounts of money once spent on institutions have not followed clients into the community. This must be rectified. Homelessness of those with mental health problems has been a partial result of the policy decision to de-institutionalize psychiatric services. The cost of housing people in residential and independent living situations must be borne by the society as a whole.

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## **VII. Recommendations**

On June 13, 2000, a community forum was held with 33 participants including service providers from a wide-range of organizations, government officials from municipal, provincial and federal agencies, representatives from the Regina Health District and a few individuals who have been consumers of mental health services. The researchers presented key findings of the project and representatives from a variety of sectors identified some of their concerns about women with mental health issues and their supportive housing needs. Four groups were formed to further discuss the research findings and the recommendations based on the issues identified by the women we interviewed, the service providers in the focus group and more general recommendations provided by the researchers. The participants at the forum were asked to prioritize the recommendations. These recommendations are summarized below in three groupings: 1) general recommendations, 2) specific recommendations and 3) other. These are the final recommendations of this project.

### ***General Recommendations***

- That a joint housing committee with representatives from the federal, provincial and municipal governments, the community and the private sector be established;

- That the City of Regina form an “implementation committee,” focused on special needs housing and the capacity to develop guidelines for enforcement of rental housing standards, including the licensing of landlords and the development of a registry of reputable landlords;
- That existing legislation and regulations about housing be enforced (i.e., through inspections) and that rent controls be reinstated;
- That the federal government becomes re-involved in housing provision so as to facilitate more public and social housing with support services and a continuum of supportive housing options, including women’s housing needs; and
- That the Department of Social Services increase rental subsidies under the Saskatchewan Assistance Plan.

***Specific Program Recommendations***

- That crisis housing for women be created which includes mental health supports and addresses the needs of both single women and women with children (gender parity) and youth, including 24-hour outreach services;
- That the goal be the provision of a continuum of housing options with priority given to supportive housing programs first; and
- That existing services be better coordinated, including the development of a Residential/Housing Advocate to provide support and advocacy and liaison with various agencies and government departments involved in housing concerns and provision.

***Other Recommendations***

- Reinforce the concept that housing is a basic human right and that universal access to adequate, safe and affordable housing is a preventive and cost-effective measure in addressing many social problems, especially as a determinant of health;
- That integration of neighbourhoods, both old and new, be a priority in community development; and
- That financial institutions be legislated to provide a small portion of their profits back to community development.

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In this report we have identified the specific needs of a sample of women who must contend with a variety of mental health issues on a daily basis. In addressing the needs of those among us who are most vulnerable, we did not intend to ignore the reality of those living in poverty in general. The recommendations presented in this report identify a range of actions that are important if we are to begin to address the housing needs of many people living in our community. We must respond to these specific needs, and if we are to do this then we must deal with the larger social problems in our midst. Among these problems is the obligation to provide affordable, adequate and safe social housing for all who require it.

We recognize that one research project and a gathering of those concerned with this issue is not likely to get the changes required to respond to the problems identified in this report. A number of the participants attending the forum indicated they would be prepared to meet further around this issue. This issue will be taken up once again by the YWCA and others in our community interested in alleviating this problem. It is through many people working together to ensure that the issue of housing receives the required action that we will ensure that when women in need of supportive housing ask for help, our community will be able to respond appropriately.

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## **Appendix A**

### **Regina Mental Health Clinic Statistics**







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## Appendix B

### Community Directory: Contacts & Profiles

#### Policy and Research Resources

- 1) Health Promotion & Programs Branch, Health Canada  
18<sup>th</sup> Floor, 1920 Broad Street  
Regina, Saskatchewan  
S4P 3V2

Gordon McGregor, Program Consultant – Population Health: 780-5104

Health Promotion & Programs Branch (HPPB) of Health Canada plays a national and regional role in improving the physical, mental and spiritual health and well-being of Canadians. HPPB develops, supports, promotes and coordinates health promotion and disease prevention programs. It also funds research projects and community-based projects which are consistent with the Branch's programs and priorities, and is involved in the collection and dissemination of information. HPPB makes an important contribution to the sustainability and renewal of Canada's health system.

- 2) Research and Evaluation Branch  
Department of Social Services  
1920 Broad Street  
Regina, Saskatchewan  
S4P 3V6

The Research and Evaluation Branch in the Department of Social Services, carries out social policy research, conducts program evaluations and collects basic data pertaining to social conditions within the province. The major activities of the Branch are:

- To provide research on the environment in which social programs operate, and to help assess the appropriateness of services to client needs;
- To provide the management of the Department with a base of reliable and current information for planning new programs or modifying existing programs;
- To assist individual programs or regions in the Department in evaluating specific activities or projects for which they are responsible;
- To inform the discussion and understanding of social issues by disseminating research both within and outside the Department.

Further information on the Branch and the Department may be obtained from the Social Services website: <http://www.gov.sk.ca/govt/socserv/>

- 3) Community Outreach  
Department of Social Services  
2045 Broad Street  
Regina, Saskatchewan  
S4P 2N6

Carolyn Lehmann, Manager: phone 787-3535; fax 787-4940;  
E-mail: [carolyn.lehmann.ss@govmail.gov.sk.ca](mailto:carolyn.lehmann.ss@govmail.gov.sk.ca)

The Community Development and Outreach Team of Regina Social Services works toward a goal to: Design, develop, facilitate and encourage with a variety of partners, new and innovative ways to carry out community, social, economic and environmental development which is sustainable in order to benefit those most in need.

- 4) Community Care Branch  
Saskatchewan Health  
3475 Albert Street  
Regina, Saskatchewan  
S4S 6X6

Phone 787-1506

The Community Care Branch provides programs, support and monitoring of mental health programs provided by provincial health districts. The Branch supports the administration of *The Mental Health Services Act*, including the appointment of Review Panels, Official Representatives and Officers in Charge. The Executive Director of the Community Care Branch is also the Director of Mental Health Services for purposes of the Mental Health Act. The Branch administers the Approved Home program, which is delivered by the health districts. They also work with the districts and other agencies to develop mental health policy and do research. More information on the Branch and the Department may be obtained from the Department of Health website: [www.gov.sk.ca/health](http://www.gov.sk.ca/health)

- 5) Saskatchewan Women's Secretariat  
7<sup>th</sup> Floor  
1855 Victoria Avenue  
Regina, Saskatchewan  
S4P 3V5

Phone 787-2389; fax 787-2058  
E-mail: [womensec@govmail.gov.sk.ca](mailto:womensec@govmail.gov.sk.ca)  
Website: [www.womensec.gov.sk.ca](http://www.womensec.gov.sk.ca)

The Saskatchewan Women's Secretariat is an agency within the provincial government which ensures that women's particular needs and perspectives are considered in the development and delivery of legislation, policies and programs of government. As a central point of contact for issues that impact on women, it provides information and referral services.

- 6) Housing Policy & Program Services  
Saskatchewan Housing Corporation  
1855 Victoria Avenue  
Regina, Saskatchewan  
S4P 3V5

Housing Policy & Program Services Branch, Saskatchewan Housing Corporation, is an agency of Municipal Affairs, Culture and Housing. This branch develops and evaluates housing policies, programs and housing services. It is responsible for monitoring and analyzing economic and demographic trends, as well as collaborating with stakeholders, other departments and agencies, and other levels of government to develop SHC policies and programs that are in keeping with broader provincial government strategies. Other primary responsibilities include co-ordinating information systems support and administering the Homeowner program. For more information call 787-4198 or contact the Municipal Affairs, Culture and Housing website at: [www.municipal.gov.sk.ca](http://www.municipal.gov.sk.ca)

- 7) City of Regina Housing Programs and Services

The City of Regina Community Services Department provides a number of programs and services that support the development of social and private housing in the city:

- The Urban Planning Division ensures construction is in accordance with the Zoning Bylaw and the City's Development Plan. The Division also administers the Inner City Housing Stimulation Strategy, a program that provides tax abatements and other incentives to encourage housing development on vacant lots in central areas of Regina.
- The Building Division issues building permits and ensures construction meets the building code. The Division is responsible for property inspection and enforces bylaws governing existing housing. It also administers the Residential Rehabilitation Program, which provides financial assistance for major home repairs for lower income households, and for accessibility-related home modifications for persons with disabilities.
- Social Development Division works with other departments and community groups to develop policy and to encourage special initiatives for low income and special needs groups.

- The City of Regina also provides a five percent capital grant to support the development of social housing.

All of the above programs and services may be reached through the City of Regina's central number, 777-7000, or by writing the appropriate Division at:

Community Services Department  
City of Regina  
P.O. Box 1790  
Regina, Saskatchewan  
S4T 1L5

Information on taxation and other issues may be found on the City's website at [www.cityregina.com](http://www.cityregina.com)

- 8) Social Policy Research Unit (SPR)  
Faculty of Social Work  
Room 626 Library Building  
University of Regina  
Regina, Saskatchewan  
S4S 0A2

Dr. Dave Broad, Director: phone 585-4117  
Fiona Douglas, Research Co-ordinator: phone 585-4036  
Fax 585-5408  
E-mail: [social.policy@uregina.ca](mailto:social.policy@uregina.ca)  
Website: [Http://www.uregina.ca/spru](http://www.uregina.ca/spru)

SPR conducts research on social policy issues, assists with proposal developments and facilitates research with community-based non-government organizations. The unit operates a resource centre and publishes and holds information on a variety of topics, including the adequacy of social assistance, employment trends, childcare, housing, home care, food banks, Aboriginal issues and women's issues such as violence and poverty.

- 9) The Seniors' Education Centre  
University Extension  
University of Regina  
GA 106 Gallery Building  
College Avenue & Cornwall Street  
Regina, Saskatchewan  
S4S 0A2

The Seniors' Education Centre is a partnership between the Seniors' University Group Inc. (SUG) and University Extension. The Centre provides more than 100 education programs for adults 55+ in Regina and some rural

communities. The Centre also conducts research and community development work in areas affecting older adults, including the area of housing. Two of these projects are:

- i) Women Health and Poverty: a community development and research project funded by Health Canada, and
- ii) Quality of Life for Seniors: research that identified health, housing, safety, belonging, income, making life meaningful, and getting around as key factors that affect quality of life.

For more information about the above projects, contact Jayne Whyte, Program Manager at 585-5729; e-mail: [jayne.whyte@uregina.ca](mailto:jayne.whyte@uregina.ca)

10) Regina Anti-Poverty Ministry  
2330 Victoria Avenue  
Regina, Saskatchewan  
S4P 0S6

Bonnie Morton or Peter Gilmer: phone 352-6386; fax 352-7455  
E-mail: [bonnie.morton@sk.sympatico.ca](mailto:bonnie.morton@sk.sympatico.ca)

The basic objectives of the Regina Anti-Poverty Ministry centre on general anti-poverty concerns. They are roughly divided between exercises in individual advocacy, where the needs of individuals in conflict with the system are supported; and systemic advocacy, where deficiencies within the system are identified and are addressed by educational campaigns and representations to governing bodies. Their objectives are to be achieved by actively networking with other denominations, faith groups and relevant organizations.

Specifically regarding housing issues, RAPM has a member who sits on the Core Community Group Board. They also deal directly with home repairs and are looking at getting into a home ownership program for low-income earners and families on welfare. They are asked to respond to City of Regina Housing Initiatives as well. Their connection with housing issues is broad, as is their advocacy work.

11) The Council on Social Development Regina, Inc.  
2201 – 1<sup>st</sup> Avenue  
Regina, Saskatchewan  
S4R 8G4  
E-mail: [cldr@sk.sympatico.ca](mailto:cldr@sk.sympatico.ca)

Lorelee Manning: 352-8356

The Council on Social Development Regina (CSDR) is a community-based not-for-profit charitable organization, dedicated to independent planning, practical research, community development and advocacy. It is committed to

enhancing the quality of life in Regina and Saskatchewan, particularly for the poor or otherwise disadvantaged residents. This is done through supporting social and community development initiatives and research leading to positive social change.

The CSDR recently published The Disappearance of Affordable Housing in Regina, phase one of an ongoing project to document the lack of access to safe, adequate and affordable housing by low-income and poor people in the City of Regina.

## **Service Providers – (Emphasis on) Housing:**

- 1) YWCA  
1940 McIntyre Street  
Regina, Saskatchewan  
S4P 2R3

Louise Burns-Murray, Director of Housing: phone 525-2141; fax 525-2171

The YWCA provides programs and services to meet the varying and changing needs of women in the community. They advocate on women's issues locally and internationally. A dormitory-style residence provides safe, affordable social housing for 35 women, with a Resident Coordinator available most days to help with any concerns and provide assistance and support. They also operate the Isabel Johnson Shelter for women and children leaving abusive relationships, as well as a 90-space day care and 40-space emergency drop-in child care. They provide before and after school care and camps over school breaks.

- 2) Regina Transition House  
P.O. Box 1364  
Regina, Saskatchewan  
S4P 3B8

Crisis Line: 569-2292

Maria Hendrika, Executive Director: phone 757-2096; fax 325-6515

Regina Transition House provides short term shelter; 24-hour crisis telephone line; individual counseling for residents; children's counseling; transportation to school and appointments; advocacy, support and referral services; public education; and professional training.

- 3) Wichihik Iskwewak Safe House (WISH), Inc.  
P.O. Box 1512  
Regina, Saskatchewan  
S4P 3C2

Sharon Crowe, Executive Director: phone 543-0493; fax 545-7677.

The WISH House provides short-term emergency shelter for abused women and their children of Treaty and Aboriginal ancestry. Services include a 24-hour crisis line; individual adult and child counseling; an Outreach Program that assists women with school age children in locating suitable housing; visits by Elders; advocacy; and public education.

- 4) Sofia House  
P.O. Box 22119  
Regina, Saskatchewan  
S4S 7G7

Doris Sheldon: Phone 565-2537; fax 565-2537

Second-stage housing provides safe and affordable housing for women and their children who are survivors of wife abuse. Services include counseling, support group and help to find low-income housing.

- 5) Lakeshore Village  
Ehrlo Community Services  
#4 – 1313 – 23<sup>rd</sup> Avenue  
Regina, Saskatchewan  
S4S 3S4

Helen Finucane, Property Manager: phone 584-3313; fax 584-3317  
Website: [www.ehrlo.com](http://www.ehrlo.com)

Lakeshore Village offers affordable, quality housing to lone parents and low-income families. The complex features 43 one and two bedroom apartments. Services include subsidized child care on site, a 24 hour emergency on call service, residents association, resident directed social support programs, food security programs, as well as an upgraded playground and family BBQ area. Lakeshore Village is close to bus, doctor's office, bank, grocery and drug store.

- 6) Gabriel Housing Corporation  
1800 – 13<sup>th</sup> Avenue  
Regina, Saskatchewan  
S4P 3Z1

Ray Hamilton, General Manager: phone 775-2905; fax 949-4446

Gabriel Housing Corporation is a non-profit housing corporation administered by a Metis Board of Directors, elected by the Metis community. The Corporation owns 255 houses, manages 24 Saskatchewan Housing Corporation houses, has built two seniors complexes and two family fourplexes, and has purchased an apartment building for their women's shelter. Affordable, low-income housing is provided to families, seniors, students and women and children leaving abusive relationships. Tenants are comprised of people of Metis, First Nations and non-aboriginal descent. Services include tenant counseling, maintenance and repairs, as well as general administration of the housing program.

- 7) Regina Housing Authority  
1850 Smith Street  
Regina, Saskatchewan  
S4P 2N3

Phone 525-2377; fax 347-7812

Regina Housing Authority provides safe, affordable housing to low income seniors and families. All applicants are assessed and subsidized units are allocated based on need. Additional services are available in senior buildings and are provided on a cost recovery basis. Market rent units are available to the general public and are allocated based on affordability.

- 8) Namerind Housing Corporation  
1121 Winnipeg Street  
Regina, Saskatchewan  
S4R 1J5

General Manager, Don Lussier: phone 525-0147; fax 525-0111

Namerind Housing Corporation provides low-income housing to Aboriginal seniors and families within the City of Regina.

- 9) Silver Sage Housing Corporation  
Suite 109, 4001 – 3<sup>rd</sup> Avenue North  
Regina, Saskatchewan  
S4R 0W8

Debbie Pelletier , General Manager: phone 721-2909; fax 545-9780

Silver Sage Housing Corporation is a non-profit organization with membership of the Corporation comprised of individuals who hold the Office of Chief of Member First Nations of The File Hills Qu'Appelle Tribal Council and The Touchwood Agency Tribal Council. Silver Sage presently manages a total rental portfolio of 389 housing units in the city of Regina. Their mission is to provide and promote high quality, affordable housing for First Nations people living in urban centres.

- 10) Community Action Alliance Regina Co-op Ltd. (C.A.A.R.)  
2201 – 1<sup>st</sup> Avenue  
Regina, Saskatchewan  
S4R 8G4

Rob Deglau, Executive Director: phone 569-2227; fax 569-2306

Email: [caar@sk.sympatico.ca](mailto:caar@sk.sympatico.ca)

Community Action Alliance Regina Co-op Ltd. (C.A.A.R.) is a community based action alliance existing to create social and economic opportunities that enhance the well being of the people of Regina. This grass roots cooperative is dedicated to developing innovative and collaborative solutions in the areas of poverty, job loss, employment and affordable housing in order to obtain a higher quality of life within the community.

## **Service Providers – Mental Health and Related Supports & Services**

- 1) Long Term Care Branch  
Regina Health District  
2180 – 23<sup>rd</sup> Avenue  
Regina, Saskatchewan  
S4S 0A5

The Long Term Care Branch operates two programs where a long term psychiatric diagnosis is one of the primary criterion for admission, along with other conditions and criteria specific to each program, and subject to assessment and approval by the Program Access Committee (PAC).

- i) **Regina Pioneer Village Ltd. Supportive Living Unit (SLU)** provides an alternative residential living option for residents who have a diagnosis of a long term psychiatric illness, do not require the intensive physical care of level 3 or 4, and have exhausted community residential living options.
- ii) **Salvation Army Waterston Centre Supportive Residential Program (SRP)** provides a 24 hour supportive residential program for individuals who have been diagnosed with a psychiatric illness and/or substance abuse.

As well, placement of all people requiring long term care, including those having a psychiatric diagnosis in addition to other (often primary) physical health involvements, is facilitated by the Long Term Care Branch. The contact point for access to these services is through:

System Wide Admissions/Discharges: 766-7200.

- 2) Mental Health Services  
Regina Mental Health Clinic  
2110 Hamilton Street  
Regina, Saskatchewan  
S4P 2E3

The Regina Mental Health Clinic provides a wide range of community-based services for adults (age 18 and over) who are having significant problems

related to their mental health and well being. The staff includes psychiatrists, psychologists, social workers and registered psychiatric nurses. The Clinic operates many programs and services with criteria for admission specific to each. These include: Rehabilitation Services for people with a long term psychiatric illness, including residential services; Adult Therapy; Abuse Intervention Services; and Intake Services. The contact point for access to these services is:

Regina Mental Health Clinic: 766-7800

- 3) Inpatient Mental Health Services  
Regina General Hospital  
1440 – 14<sup>th</sup> Avenue  
Regina, Saskatchewan  
S4P 0W5

Inpatient Mental Health Services includes the Inpatient Unit and the Day Hospital Program, located on the South side of the Regina General Hospital. The Inpatient Unit has 50 beds to which people are admitted either voluntarily or involuntarily. The Day Hospital Program is the thread that ties inpatient care to the follow-up care available in the community. Some people begin the Day Hospital Program while still a patient on the Inpatient Unit. Others start the program only after being discharged. For other people, the Day Hospital provides them with the treatment, care and support they need to avoid admission to the Inpatient Unit altogether.

Inpatient Mental Health Services: 766-4321 or 766-4523

Day Hospital Program: 766-3929

- 4) Phoenix Residential Society  
1770 Halifax Street  
Regina, Saskatchewan  
S4P 1T1

Carole Eaton, Program Director: phone 569-1977; fax 569-1986;  
E-mail [phoenixsociety@cableregina.com](mailto:phoenixsociety@cableregina.com)

Phoenix Residential Society assists persons with long term mental illness and persons with acquired brain injury to live as independently as possible in the community with an enhanced quality of life and greater self-reliance. Various psycho-social rehabilitation programs, including the Dual Diagnosis Program (psychiatric illness and addictions), Phoenix Supported Apartment Living Services (PALS) and Phoenix House and Pearl Manor, provide residents with many supports enabling them to maintain their housing, physical and mental health, financial, educational, vocational and social/recreational needs.

- 5) Canadian Mental Health Association, Regina Branch  
1810 Albert Street  
Regina, Saskatchewan  
S4P 2S8

Marie Dancsok, Director: phone 525-9543; fax 525-9579

The Regina Branch provides social and vocational programs via structured recreation, social, employment and training activities for persons with mental health problems. The aims are:

- To expand community-based rehabilitation and support services for persons with psychiatric and emotional disorders
- To change attitudes towards mental illness
- To promote mental health and work for the prevention of mental illness through research and social change

- 6) Mobile Crisis Services, Inc.  
1646 – 11<sup>th</sup> Avenue  
Regina, Saskatchewan  
S4P 0H4

Crisis Line: 757-0127

Diehl Elkin, Executive Director: phone 757-7803; fax 757-7807

Mobile Crisis Services, Inc. operates two programs: Mobile Crisis Services and Crisis Management Services. The overall purpose is to provide a comprehensive crisis intervention service, including counseling, referrals and public education. Crisis services are available 24 hours a day to anyone experiencing emotional distress and in need of immediate help. There are no waiting lists and services are completely confidential. Professionally trained counselors provide assistance over the telephone or attend in the community. Crisis workers often work in partnership with other community agencies and services, and referrals are made for longer term support if required.

Mobile Crisis Services, Inc. also operates a Community Outreach Program for women choosing to live a violence-free life, as well as providing information to women who are still in an abusive relationship. They work closely with other community agencies involved in domestic violence to fill the gaps in service, including translation and access to services for new Canadians.

- 7) Welfare Rights Centre  
1042 Albert Street  
Regina, Saskatchewan  
S4R 2P8

Morris Eagles, Executive Director: phone 757-3521; fax 565-8836

The Welfare Rights Centre provides a range of individual and family support services, including advocacy, trusteeship and education, as well as the services of a Housing Advocate. They also promote and lobby for progressive change in order to improve the lifestyle and standard of living for people on welfare and low-income wage earners in Regina and to ensure the right to maximum entitlement.

- 8) Domestic Violence Early Intervention Project, and  
Domestic Violence Community Outreach Program  
Family Service Regina  
2020 Halifax Street  
Regina, Saskatchewan  
S4P 1T1

Deb George, and

Deana Thompson: phone 757-6675; fax 757-0133;

E-mail: [familyserviceregina@dlcwest.com](mailto:familyserviceregina@dlcwest.com)

The Domestic Violence Early Intervention Project (DVIP) provides an early intervention community-based intake/assessment service to victims of domestic violence who have been, are now, or may be involved with the judicial system. The Domestic Violence Community Outreach Program (DVOP) provides information, referral services, advocacy and supportive counseling to women who are in, or leaving abusive relationships.

- 9) Regina Women's Community Centre and Sexual Assault Line  
250 – 1907 11<sup>th</sup> Avenue  
Regina, Saskatchewan  
S4P 0J2

24-hour sexual assault line: 352-0434

Phone 522-2777; fax 522-5070; e-mail [rwcc@dlcwest.com](mailto:rwcc@dlcwest.com)

The Regina Women's Community Centre's works toward a non-violent and equitable society by empowering women who have suffered various forms of abuse, and by providing community education and advocacy services. Services include 24-hour crisis line; crisis and long-term counseling; sexual abuse and sexual assault survivors groups; advocacy, a lending library; and public education.

10) South Saskatchewan Independent Living Centre, Inc.  
2240 Albert Street  
Regina, Saskatchewan  
S4P 2V2

Tracy Knutson, Executive Director: phone 757-7452; fax 757-5892  
E-mail: [ssilc@sk.sympatico.ca](mailto:ssilc@sk.sympatico.ca)

The South Saskatchewan Independent Living Centre is a community based, cross disability agency that promotes the inclusion and full participation of people with disabilities in our community. Committed to the Independent Living philosophy, SSILC empowers people with disabilities to control their lives and live autonomously in their community. The consumer's disability is not emphasized. What is emphasized is the types of supports the consumer needs to succeed in their environment. The IL model is designed to adapt the environment to meet the needs of the individual as opposed to changing the person to fit the environment.

11) Regina Health District Home Care  
4211 Albert Street  
Regina, Saskatchewan  
S4S 3R6

Home Care provides health and support services for people with assessed needs in the community. It offers the care and support necessary for people to live as independently as they can. Based on assessed need, clients meeting eligibility for Home Care may receive one or a combination of services.

Phone: 766-7200

12) Schizophrenia Society of Saskatchewan  
P. O. Box 305  
Regina, Saskatchewan  
S4P 3A1

Art Gondziola, Executive Director: phone 584-2620; fax 584-0525;  
Email: [sssprov@sk.sympatica.ca](mailto:sssprov@sk.sympatica.ca)  
Website: <http://www.t2.net/schsask>

The Schizophrenia Society of Saskatchewan provides emotional support to families, friends, and those directly affected by the illness. They provide education, promote better public awareness and share updated information about Schizophrenia. They clarify the role of caregivers in treatment and recovery, and speak on behalf of families and persons with Schizophrenia. The Society supports and promotes research to find the causes and improve the treatments. They raise funds to finance these activities and work in

partnership with other agencies, groups and departments of government in order to achieve these goals.

13) Regina Open Door Society  
1855 Smith Street  
Regina, Saskatchewan  
S4P 2N5

Keith Karasin, Executive Director: phone 352-3500; fax 757-8166  
E-mail: [rods.admin@cableregina.com](mailto:rods.admin@cableregina.com)  
Website: [www.rods.sk.ca](http://www.rods.sk.ca)

The Regina Open Door Society is a non-profit organization that offers a range of services to refugees and immigrants. They assist immigrants and promote their adjustment to and participation in the Saskatchewan community. They also strive to promote and extend community services to immigrants to foster greater awareness and understanding between the immigrant and the community. Specifically in the area of housing, some of their Settlement Services may include:

- Temporary accommodation in RODS Reception House
- Assistance obtaining permanent residence
- Interpretation/translation

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