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RUNNING HEAD: Gender, Housing, and Severe Mental Illness

Gender and Access to Housing for Individuals with Severe Mental Illness: A Qualitative Study of the Canadian Housing Service Context

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Abstract

Objective: This study was undertaken to examine the role of gender as it relates to access to housing among individuals with severe mental illness (SMI) in Canada.

Design: An exploratory, qualitative approach was used to assess the perspectives of Canadian housing experts. The focus of inquiry was upon the role of gender and associated intersections (e.g., ethnicity) in pathways to housing access and housing needs for individuals with SMI.

Setting: A purposeful sampling strategy was undertaken to access respondents across all Canadian geographic regions, with diversity across setting (urban and rural), and service sector (hospital-based and community-based).

Participants: Twenty nine individuals (6 male and 23 female) considered to be experts regarding their housing service context as it pertains to SMI were recruited. On average, participants had worked for 15 years in services that specialized in the support and delivery of housing services to people with SMI.

Measures: Semi-structured interviews with participants focused on the role gender plays in access to housing in their specific context. Barriers and facilitators were examined as were intersections with other relevant factors, such as ethnicity, poverty, and parenthood. Quantitative ratings of housing accessibility as a function of gender were also collected.

Results: Participants across geographic contexts described a lack of shelter facilities for women leading to a reliance on exploitative circumstances. Other findings included a compounding of discrimination for ethnic minority women, the unique resource problems faced in rural contexts, and the difficulties that attend access to shelter and housing for parents with SMI.

Conclusions: These findings suggest that, along with a generally poor availability of housing stock for individuals with SMI, access problems are compounded by a lack of attention to the unique needs and illness trajectories that attend gender.

Article Summary

Article Focus:

- To understand the role of gender in housing access among individuals with severe mental illness.

Key Messages:

- Misperceptions at policy and service system levels regarding the need for housing as a function of gender are leading to circumstances that compound the impacts of mental illness.
- Resource needs are particularly acute as additional points of marginalization emerge from factors such as ethnic minority status and rural context.
- Housing access problems have major impacts on the ability to parent as a person with severe mental illness.

Strengths and Limitations of this Study:

- This study is among the first to directly address the interplay between housing access and gender among individuals with severe mental illness.
- The study accesses a broad, national range of expert perspectives.
- Transferability to other national contexts outside of Canada needs clarification.
- While serving the purpose of an initial inquiry, further work is needed to confirm and expand upon the assertions of the service providers interviewed here.

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Competing Interests Statement: No author of this study will in any way gain or lose financially from the results of this study. No author has been employed by an organisation that may in any way gain or lose financially from the results of this study. No authors hold any stocks or shares in an organisation that may in any way gain or lose financially from the results of this study. No author has acted as an expert witness on the subject of this study. No other competing financial interests exist.

The lack of adequate and affordable housing for individuals with severe mental illness (SMI) is repeatedly highlighted in research, public, and policy discourses. It is a complex problem rooted in individual and structural factors. Individuals with SMI often present with a complex array of concurrent psychiatric and chronic medical conditions which are often compounded by poverty, social exclusion, and substance misuse. Many structural factors also contribute to a lack of good-quality housing for people with SMI. Rent is often unaffordable, with costs typically taking up 70-90% of an individual's public benefits. This problem is exacerbated by Canada having just over 25,000 supported housing units available[1]. As a result, over 500,000 Canadians with mental illness are inadequately housed and an estimated 120,000 are homeless[1]. This is a critical problem as adequate housing is a key determinant of health[2] and recovery[3,4.]

From research and practice perspectives, challenges arise in the very generic articulation of the housing problem for the SMI population. Considerations of the issue of housing have very seldom taken into account the intersections of resource and adversity that attend factors such as gender, race, and ethnicity. As long as the specific mechanisms by which such factors, and their intersections, remain poorly understood, housing policies and programs for people with mental illness will remain inefficient and ineffective[5]. It is in light of this shortcoming in the SMI literature that the present study was undertaken to examine the role of gender in housing access in Canada.

Gender and Severe Mental Illness

There are significant and pervasive differences between men and women with SMI that are present across the social determinants of health, illness onset and expression, and process of recovery. Taking schizophrenia as an example, women on average experience a later onset and

less severe course of illness, though suffer more depressive symptoms than men[6]. A later onset of illness carries several important implications. Women typically have greater opportunities to establish a range of competencies and a higher degree of independence before the illness commences. This may account for generally stronger skills that support independent living and longer periods of community tenure[7,8].

Women with SMI also have been found to more actively seek social contact and support, which may have implications for less dependence on service providers and greater success in living independently[7,9]. Men with SMI are, in turn, more likely to be homeless[10] and more reliant upon health services[9] which may account for a further deterioration of independent living skills[11].

Women with SMI also face several unique and prominent sources of adversity. Women are more likely to have experienced childhood abuse and trauma and symptoms of PTSD[12]. Women also experience higher rates of coercive sexual encounters and sex trade involvement as means of coping with poverty and homelessness[13]. Furthermore, women have a greater likelihood of having been socialized into passive and otherwise dependent roles, which may be reified through service providers working within models of care that cultivate dependency[7]. Such sociocultural factors are evident across a range of studies. For example, compared to women without SMI, those with SMI place a greater importance on having caring and compassionate providers than providers who encourage choice and independence[14]. Women with SMI are also more likely to be perceived by family and other supports as more emotionally vulnerable and irrational in comparison to men[15,16].

Pregnancy and child rearing is an additional consideration for women with SMI. Typically framed in the context of enhancing risk, having a child has numerous implications

around risks of medications in pregnancy and stressors associated with childrearing as poverty and illness threaten custody[17]. This is an increasingly relevant issue given evidence that the fertility rate among Canadian women with Schizophrenia is on the rise[18].

Much less developed in the literature is attention to intersections of risk and resilience that attend the intersections of race, ethnicity, sexual and gender identity. Preliminary work suggests that these points of diversity have very important implications. While unique points of resilience emerge among these populations, recovery is typically complicated by multiple forms of discrimination and marginalization, and treatment needs that are seldom adequately met[19,20].

The Present Study

Despite the consistent threads of evidence suggesting differences in mental illness etiology, expression, and recovery process as a function of gender, as a topic it is largely relegated to sidenote status in community mental health research and policy dialogues. This shortcoming is particularly evident in considerations of housing individuals with SMI. As such, this qualitative study was undertaken as an initial step to better articulating community service needs in Canada as a function of gender. Key informant interviews were undertaken with service providers across Canadian provinces and territories, in both hospital and community service sectors, and across both large urban, mid-sized city, and rural contexts.

Methods

Recruitment

In order to obtain a broad, national perspective on gender equity within the housing sector for people with SMI, service providers were sought in provinces and territories in all geographic regions. The recruitment strategy targeted balanced representation as a function of setting, with interviews conducted with providers working in the largest urban centres in Canada

as well as representative small to mid-sized towns and cities. Representativeness of smaller centres was determined by a consensus of the urban providers (the inquiry starting point in each province/territory), seeking settings that were neither disproportionally over nor under-resourced. Balance was also sought in respondent service sector, seeking representation from both hospital-based and community-based organizations.

Participant eligibility relied primarily on their being regarded as an individual who is highly knowledgeable regarding access to housing and community services for people with SMI. Recruitment started in large urban centres, with participants recommended through sources such as key informants in the Mental Health Commission's recently completed consultation on housing and the At Home study. Large urban setting respondents were then asked to provide recommendations regarding experts in smaller settings. Recruitment continued until each region was adequately represented and qualitative themes had attained saturation with subsequent interviews revealing no new information. The study was reviewed and approved by an institutional research ethics board.

Procedure

Interviews lasting an average of 45 minutes were conducted with all participants via telephone and were audio-recorded and transcribed verbatim. Demographic data collected for each participant included geographical location, type of service, number of years in current post, number of years working within mental health and housing sectors, gender, and profession. The interview then moved on to explore participant perspectives and experiences pertaining to differences regarding *access to, experiences within, and needs for* housing and associated resources as a function of gender.

The interview concluded with 2 items that were developed to quantify service provider perceptions regarding access to housing as a function of gender (e.g., In a broad, general sense, how accessible is affordable housing for women/men with SMI in your city/town?) Participants were asked to score each item using a 5 point likert scale where 1 represented 'completely inaccessible' and 5 represented 'completely accessible'. This scale was developed for this study as we were unable to identify an existing, validated tool for this purpose.

Analysis

While not a complete grounded theory design, the analysis followed the rigorous thematic analysis procedure outlined by Charmaz[21,22], beginning with line by line coding of the data to pull out key, recurrent themes. Coding was reviewed with the research team at various stages of the analysis allowing for data to be contextualized and different interpretations explored. Analysis then moved onto focused coding, where conceptual analysis took place, and patterns amongst and relationships between the most relevant and salient categories became the focus. Emergent themes were shared in subsequent interviews for feedback and further exploration, which allowed for an ongoing process of member checking and elaboration of the analysis. Quantitative data was examined descriptively with mean differences examined through independent samples t-test analysis.

Results

Participants

Twenty nine participants were recruited into the study (6 male and 23 female). All participants had worked within the mental health sector, ranging from between 1 to 30 years, with 20 years being the average length of service. Most worked in either director level or direct service positions, at 45 and 31 per cent respectively, with the remainder working in middle

management. On average, participants had worked for 15 years in services that specialized in the support and delivery of housing services to people with SMI. Most were regulated professionals in areas such as Social Work or Counseling and 59 per cent were members of local advisory committees and boards related to housing. Table 1 provides a detailed summary of participant demographics.

Ratings of Accessibility

Quantitative measures of participant perceptions regarding housing access revealed a mean score for women of 2.0/5 (SD=0.68) and for men of 2.3/5 (SD=.86), a difference which was not statistically significant (t=1.53, *p*=.13). Qualitative consideration of rating differences as a function of service sector (hospital versus community) and setting (large urban versus town/small city) revealed minimal difference for both women (difference of +/- 0.1) and men (difference +/- 0.3).

Qualitative Findings

Participants uniformly regarded housing as the basic source of 'stability' and key health determinant that is equally relevant for men and women with SMI. Numerous, generic themes recurred such as the comments on low levels of housing stock, the limited availability and allocation of funding to develop and sustain adequate housing, and client difficulties in obtaining and maintaining adequate sources of income with which to cover rent and other basic expenses. Across service sectors and geographic region, the context of supporting individuals with SMI was described as one of pronounced financial strain.

Despite several cross-cutting similarities, these key-informant narratives of poverty, under-resourced housing service sectors, and stigma differed markedly as a function of gender, ethnicity, and other points of intersection. Erroneous assumptions about service needs and

stigmatization were described as having a structural impact upon housing access. As will be described, this resulted in unique pathways of marginalization, victimization, and poverty.

"Structural" Adversity: Cycles of Invisibility, Lack of Access, and Vulnerability

Women were frequently referred to as the "invisible homeless". Participants described how the perceived absence of homeless women and the perception of homeless men as more troublesome influenced policy, funding and service provision, resulting in woman having to "turn to different systems than the formalized system" such as "couch surfing" with families, friends and often with unknown men. While one provider found women's ability to seek alternative routes as "resourceful", most voiced the opinion that the lack of shelter or emergency housing for women increased their vulnerability. For example, women with SMI would "trade sex for somewhere to stay" and "take somebody [in an exploitative context] in to help them pay the rent when they're feeling under pressure because of the costs." For the majority, this was a question of powerlessness rather than one of resourcefulness.

> "Women's [with SMI] homelessness tends to be a little bit more invisible. We certainly have a number of women who have lived with their sister for a long time or crashed with unsavory males over a series of years. They have, in fact, been homeless they have just been temporarily couched. If you look at resource availability …they operate out of men's shelters, and aren't always in a safe environment for women. [Resources] certainly seem to be centered on male-accessible places…all these guys have all these shelters to choose from and if they get booted out of one after four weeks they just move over to the next one. We turn hundreds and hundreds of women away from our shelter because we just don't have the beds."
>
> [Community service provider, small town in Central Canada]

Women were described as being pushed into a vicious cycle of unstable housing and increasingly stressful environments which led to poorer mental health, quality of life, and little access to community services. This cycle was compounded in smaller towns, as women had to leave for larger cities where there was better access to mental health and housing services.

While men with SMI were described as having relatively greater access to housing and shelter, and experiencing less victimization and sexual exploitation, they are in no way immune to the dynamics of poverty and marginalization. They were described as typically being forced to live in "drug infested" areas due to stigma and poverty. Living in such neighbourhoods leads to high levels of anxiety among both men and women, and participants describe this as greatly increasing the risk of a relapse.

The Intersection of Gender and Ethnicity

Belonging to an ethnic minority group acted as a further source of marginalization, not just within hospital and community services but also within people's own ethnic groups. The evidence of "blind spots" which fuelled gender and ethnic discrimination were evident mostly in the experiences of women.

> "I'm thinking of one woman in particular who was from Pakistan and had been married most of her life but recently divorced and found herself on her own and with no place to live. I remember taking her to the shelter just before Christmas and she walked in her head scarf into this predominately male shelter waiting area and you could just feel it, it was very striking the degree to which she didn't fit in."
>
> [Community service provider, urban area in Northern Canada]

For Aboriginal people living in rural Canada and the northern territories, the level of discrimination experienced by women with SMI was described as particularly heightened.

Geography and location, intersecting with gender, ethnicity, and intergenerational trauma, meant that women were trapped in situations compounded by lack of transportation and an inability to leave town.

> "We worked with a woman from a small Aboriginal community. Her non-Aboriginal husband got on the housing authority board and illegally had her name removed from home ownership papers just because the government could. She didn't win, because even lawyers are racist in the territories...so in small communities it is very controlled by men and they will choose men over Aboriginal women...Aboriginal women are the most marginalized."
>
> [Community service provider, small town in Northern Canada]

In the Aboriginal service context, several participants noted a conflict between the community and hospital sectors, in that "psychiatrists, psychologists, and nurses" who are considered "mainstream" were not using a "culturally competent approach", which resulted in a "racist" approach to care. These dissonances between community and hospital services created a discontinuity in care and impeded the recovery of Aboriginal women. Providers talked about how the "structural oppression" was internalized by women, who began to "talk about it like it's their fault", and used words such as "loser" and not having the "smarts or self control" to improve their lives.

Men, Perceptions of Risk, and Housing Quality

While participants described the impact stigma had on both men and women, their narratives emphasized the manner in which it pervaded men's experiences. They described how the level of "trouble" and "risk" perceived by providers seemed to shape the transitioning and access to community housing for men with severe mental illness. It was perceived as a "reality

that men are more prone to violence" compared to women, who were often viewed as "easier tenants."

> "More men end up without housing because as part of their illness they're maybe using more and tend to be more aggressive … landlords are more afraid. I mean we definitely have women that have been quite agitated but I think landlords tend to be more accepting of females."
>
> [Hospital service provider, urban area in Western Canada]

Participants also described men as being subjected to more substandard levels of accommodation, based on the perception that men "don't care" about their homes and are content with living in "dorm-like situations".

Women, Children, and Families

There was a general perception across participant narratives that men with SMI seldom had family responsibilities. For men with children, this left them at a disadvantage – if they had a child they would have even greater difficulty in accessing suitable housing than their female counterparts. The majority of the commentary in this topic, however, revolved around women's experiences. The presence of children created further complexity for women in the housing system, oscillating between facilitating and hindering housing access, recovery, and community participation. Access was described as improved by some participants based upon "the premise that women, as child bearers, will require family housing." Having children was also described by some as facilitating greater access to services as their physical and mental health needs are considered a priority by providers. Others, however, described women with children as having greater difficulty accessing care due to childcare responsibilities and fears that their circumstances of mental illness and victimization may lead to their children being taken into

custody. Additional challenges included having adolescent male children who are not allowed in female-only housing and shelter settings, and "catch-22" scenarios that can make it nearly impossible for impoverished women to regain custody once it is lost.

> "So when a woman applies for housing, if they don't have guardianship they can only apply for a single even though they need a 3-bedroom to get their kids back…so maybe she will get a one bedroom and is living in an overcrowded situation again…living in that overcrowded place plays into the mental health of the parent and the children and that creates the tension and starts to stir the pot. Then throw some alcohol on that, and then starts the domestic violence, then she flees the violence, and the partner stays in the house and she has to start the process all over again."
>
> [Community service provider, urban area in Northern Canada]

This problem was described as unfolding differently within some Aboriginal communities. For example, grandmothers were "rescuing" their grandchildren while mothers were "couch surfing" and "people take in their adult children and adult grandchildren".

Discussion

This study of housing expert perspectives was undertaken to describe the housing service context for Canadians with SMI as a function of gender. It is an initial attempt to articulate these issues in the Canadian context and advance the small, but growing knowledge base related to gendered experiences of serious mental illness.

This study highlighted several problems. Biased perspectives regarding housing needs were described as leading to women with SMI being forced into exploitative and victimizing circumstances. Even when accommodating women, the emphasis on male-focused services was described as being alienating and potentially risky for women to access. These findings are

reflective of literature that, while noting greater success with independent living among women[7,8] , also describe much higher rates of coercive sexual encounters and sex trade involvement[13]. Indeed, it brings forward the question of necessity in the greater levels of independence observed among women and whether, for many, purported observations of independence may overlie contexts of exploitation and victimization.

Additionally, while the many stresses that attend having a child for women with SMI have been documented[17], this study noted several implications for housing-related services. These included ambivalence about the net impacts for mothers with SMI. Some participants cited enhanced outreach and support extended to mothers and others describing mothers having less time to access services or actively avoiding services for fear of losing custody. Fear of losing custody of children was associated with women being forced into higher-risk living circumstances. Women who had lost custody were also described as struggling with catch-22 scenarios in which they required adequate housing to regain custody but could not obtain it unless they had custody.

Men were also described as facing significant problems accessing adequate housing, albeit with some different factors involved. This was reflected in the finding men were comparably rated with women in terms of overall access to housing services. Men with SMI were understood to have difficulties accessing stable housing due to their being perceived as being more prone to disturbance and violence. Furthermore, there existed a perception that men cared less about the quality of housing and shelter spaces, resulting in their being provided with lower quality and, more frequently, large dormitory-type spaces. These findings are reflected in observation of greater rates of homelessness among males with SMI[10].

While considered relatively rare, child custody was considered a pronounced challenge for men as supports for families was described as almost exclusively geared towards single parent women. This problem extended to women with teenaged male children who, if they appeared too adult, were likely to be sent to separate shelters due to concerns that their presence might disturb other female residents.

Ethnicity and service sector size were generally described as compounding the housing access problems faced by women. Consistent with previous work[20], it was observed that racialized women faced several forms of discrimination in male-oriented shelter and housing systems. Concerns for Aboriginal women with SMI revolved around the pronounced lack of access to housing and limited mobility that attend poverty in remote communities – risks that are enhanced when political and service leadership structures are predominantly male. Conversely, some providers spoke of small Aboriginal communities providing greater support to women with SMI, with grandparents and other family members playing a greater role in care for children and housing when needed.

While the transferability of these findings will require further study that includes a closer consideration of client perspectives and outcomes, the present findings point to a need for a systematic examination of inequities in the Canadian housing service sector for people with SMI. This group of Canadian housing experts observed structural forms of discrimination that were compounded by poverty and mental illness within the context of an ongoing pervasive difficulty in accessing adequate housing. As emphasized by Canada's mental health strategy[23], until gender and other key intersections such as ethnicity are better addressed our services will continue to ignore major determinants of illnesses such as schizophrenia[24,25] .

Table 1

		City		Small-mid sized town	
Region	**N**	**Hospital**	**Community**	**Hospital**	**Community**
Canada	29	6	12	6	5
Western Canada[a]	11	2	4	3	2
Central Canada[b]	6	1	2	1	2
Atlantic[c]	8	3	3	1	1
Northern[d]	4	0	3	1	0

Table 1: Geographical summary of participants differentiating by hospital or community sector.
a Western Canada includes Alberta, Manitoba, Saskatoon, and British Columbia
b Central Canada includes Ontario and Quebec
c Atlantic includes Prince Edward Island, New Brunswick, Nova Scotia, Newfoundland and Labrador
d Northern includes Yukon Territories, North West Territories and Nunavut

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Abstract

Objective: This study was undertaken to examine the role of gender as it relates to access to housing among individuals with severe mental illness (SMI) in Canada.

Design: An exploratory, qualitative approach was used to assess the perspectives of Canadian housing experts. The focus of inquiry was upon the role of gender and associated intersections (e.g., ethnicity) in pathways to housing access and housing needs for individuals with SMI.

Setting: A purposeful sampling strategy was undertaken to access respondents across all Canadian geographic regions, with diversity across setting (urban and rural), and service sector (hospital-based and community-based).

Participants: Twenty nine individuals (6 male and 23 female) considered to be experts regarding their housing service context as it pertains to SMI were recruited. On average, participants had worked for 15 years in services that specialized in the support and delivery of housing services to people with SMI.

Measures: Semi-structured interviews with participants focused on the role gender plays in access to housing in their specific context. Barriers and facilitators were examined as were intersections with other relevant factors, such as ethnicity, poverty, and parenthood. Quantitative ratings of housing accessibility as a function of gender were also collected.

Results: Participants across geographic contexts described a lack of shelter facilities for women leading to a reliance on exploitative circumstances. Other findings included a compounding of discrimination for ethnic minority women, the unique resource problems faced in rural contexts, and the difficulties that attend access to shelter and housing for parents with SMI.

Conclusions: These findings suggest that, along with a generally poor availability of housing stock for individuals with SMI, access problems are compounded by a lack of attention to the unique needs and illness trajectories that attend gender.

Article Summary

Article Focus:

- To understand the role of gender in housing access and needs among individuals with severe mental illness.

Key Messages:

- Misperceptions at policy and service system levels regarding the need for housing as a function of gender are leading to circumstances that compound the impacts of mental illness.
- Resource needs are particularly acute as additional points of marginalization emerge from factors such as ethnic minority status and rural context.
- Housing access problems have major impacts on the ability to parent as a person with severe mental illness.

Strengths and Limitations of this Study:

- This study is among the first to directly address the interplay between housing access and gender among individuals with severe mental illness.
- The study accesses a broad, national range of expert perspectives.
- Transferability to other national contexts outside of Canada needs clarification as do potential biases attending respondents (i.e., primarily female provider perspectives, no consumer perspectives represented).

- While serving the purpose of an initial inquiry, further work is needed to confirm and expand upon the assertions of the service providers interviewed here.

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Competing Interests Statement: No author of this study will in any way gain or lose financially from the results of this study. No author has been employed by an organisation that may in any way gain or lose financially from the results of this study. No authors hold any stocks or shares in an organisation that may in any way gain or lose financially from the results of this study. No author has acted as an expert witness on the subject of this study. No other competing financial interests exist.

The lack of adequate and affordable housing for individuals with severe mental illness (SMI) is repeatedly highlighted in research, public, and policy discourses. It is a complex problem rooted in individual and structural factors. Individuals with SMI often present with a complex array of concurrent psychiatric and chronic medical conditions which are often compounded by poverty, social exclusion, and substance misuse. Many structural factors also contribute to a lack of good-quality housing for people with SMI. Rent is often unaffordable, with costs typically taking up 70-90% of an individual's public benefits. This problem is exacerbated by Canada having just over 25,000 supported housing units available[1]. As a result, over 500,000 Canadians with mental illness are inadequately housed and an estimated 120,000 are homeless[1]. This is a critical problem as adequate housing is a key determinant of health[2] and recovery[3,4.]

From research and practice perspectives, challenges arise in the very generic articulation of the housing problem for the SMI population. Considerations of the issue of housing have very seldom taken into account the intersections of resource and adversity that attend factors such as gender, race, and ethnicity. As long as the specific mechanisms by which such factors, and their intersections, remain poorly understood, housing policies and programs for people with mental illness will remain inefficient and ineffective[5]. It is in light of this shortcoming in the SMI literature that the present study was undertaken to examine the role of gender in housing for Canadians with SMI. This initial qualitative exploration draws upon housing expert perspectives regarding service access and service needs as they intersect with gender, ethnicity, and geographic context.

Gender and Severe Mental Illness

There are significant and pervasive differences between men and women with SMI that are present across the social determinants of health, illness onset and expression, and process of recovery. Taking schizophrenia as an example, women on average experience a later onset and less severe course of illness, though suffer more depressive symptoms than men[6]. A later onset of illness carries several important implications. Women typically have greater opportunities to establish a range of competencies and a higher degree of independence before the illness commences. This may account for generally stronger skills that support independent living and longer periods of community tenure[7,8].

Women with SMI also have been found to more actively seek social contact and support, which may have implications for less dependence on service providers and greater success in living independently[7,9]. Men with SMI are, in turn, more likely to be homeless[10] and more reliant upon health services[9] which may account for a further deterioration of independent living skills[11].

Women with SMI also face several unique and prominent sources of adversity. Women are more likely to have experienced childhood abuse and trauma and symptoms of PTSD[12]. Women also experience higher rates of coercive sexual encounters and sex trade involvement as means of coping with poverty and homelessness[13]. Coercion in relationships with male partners has also been extended to include influence upon the uptake of substance abuse and involvement in criminal activities[14]. Furthermore, women have a greater likelihood of having been socialized into passive and otherwise dependent roles, which may be reified through service providers working within models of care that cultivate dependency[7]. Such sociocultural factors are evident across a range of studies. For example, compared to women without SMI, those with SMI place a greater importance on having caring and compassionate providers than providers who

encourage choice and independence[15]. Women with SMI are also more likely to be perceived by family and other supports as more emotionally vulnerable and irrational in comparison to men[16,17].

Pregnancy and child rearing is an additional consideration for women with SMI. Typically framed in the context of enhancing risk, having a child has numerous implications around risks of medications in pregnancy and stressors associated with childrearing as poverty and illness threaten custody[18]. This is an increasingly relevant issue given evidence that the fertility rate among Canadian women with Schizophrenia is on the rise[19].

Much less developed in the literature is attention to intersections of risk and resilience that attend the intersections of race, ethnicity, sexual and gender identity. Preliminary work suggests that these points of diversity have very important implications. While unique points of resilience emerge among these populations, recovery is typically complicated by multiple forms of discrimination and marginalization, and treatment needs that are seldom adequately met[20,21].

The Present Study

Despite the consistent threads of evidence suggesting differences in mental illness etiology, expression, and recovery process as a function of gender, as a topic it is largely relegated to sidenote status in community mental health research and policy dialogues. This shortcoming is particularly evident in considerations of housing individuals with SMI. As such, this qualitative study was undertaken as an initial step to better articulating community service needs in Canada as a function of gender. Key informant interviews were undertaken with service providers across Canadian provinces and territories, in both hospital and community service sectors, and across both large urban, mid-sized city, and rural contexts.

Methods

Recruitment

In order to obtain a broad, national perspective on gender equity within the housing sector for people with SMI, service providers were sought in provinces and territories in all geographic regions. The recruitment strategy targeted balanced representation as a function of setting, with interviews conducted with providers working in the largest urban centres in Canada as well as representative small to mid-sized towns and cities. Representativeness of smaller centres was determined by a consensus of the urban providers (the inquiry starting point in each province/territory), seeking settings that were neither disproportionally over nor under-resourced. Balance was also sought in respondent service sector, seeking representation from both hospital-based and community-based organizations.

Participant eligibility relied primarily on their being regarded as an individual who is highly knowledgeable regarding access to housing and community services for people with SMI. Recruitment started in large urban centres, with participants recommended through sources such as key informants in the Mental Health Commission's recently completed consultation on housing and the At Home study. Large urban setting respondents were then asked to provide recommendations regarding experts in smaller settings. Recruitment continued until each region was adequately represented and qualitative themes had attained saturation with subsequent interviews revealing no new information. The study was reviewed and approved by the Toronto Center for Addiction and Mental Health institutional research ethics board (#183/2011).

Procedure

Interviews lasting an average of 45 minutes were conducted with all participants via telephone and were audio-recorded and transcribed verbatim. Demographic data collected for each participant included geographical location, type of service, number of years in current post,

number of years working within mental health and housing sectors, gender, and profession. The interview then moved on to explore participant perspectives and experiences pertaining to differences regarding *access to, experiences within, and needs for* housing and associated resources as a function of gender.

The interview concluded with 2 items that were developed to quantify service provider perceptions regarding access to housing as a function of gender (e.g., In a broad, general sense, how accessible is affordable housing for women/men with SMI in your city/town?) Participants were asked to score each item using a 5 point likert scale where 1 represented 'completely inaccessible' and 5 represented 'completely accessible'. This scale was developed for this study as we were unable to identify an existing, validated tool for this purpose.

Analysis

While not a complete grounded theory design, the analysis followed the rigorous thematic analysis procedure outlined by Charmaz[22,23], beginning with line by line coding of the data to pull out key, recurrent themes. Line by line coding was completed by 1 coder with category reports examined by a second research team member who also reviewed full transcripts and recordings of interviews. Coding was reviewed at several stages of the analysis allowing for data to be contextualized and different interpretations explored and resolved through consensus. Focused coding, where conceptual analysis took place, commenced after 8 interviews when coherent and consistent linkages between categories and themes began to emerge. Emergent themes were shared in subsequent interviews for feedback and further exploration, which allowed for an ongoing process of member checking and elaboration of the analysis. Quantitative data was examined descriptively with mean differences examined through independent samples t-test analysis.

Results

Participants

Twenty nine participants were recruited into the study (6 male and 23 female). All participants had worked within the mental health sector, ranging from between 1 to 30 years, with 20 years being the average length of service. Most worked in either director level or direct service positions, at 45 and 31 per cent respectively, with the remainder working in middle management. On average, participants had worked for 15 years in services that specialized in the support and delivery of housing services to people with SMI. Most were regulated professionals in areas such as Social Work or Counseling and 59 per cent were members of local advisory committees and boards related to housing. Table 1 provides a detailed summary of participant demographics.

Ratings of Accessibility

Quantitative measures of participant perceptions regarding global housing access revealed a mean score for women of 2.0/5 (SD=0.68) and for men of 2.3/5 (SD=.86), a difference which was not statistically significant (t=1.53, p=.13). Qualitative consideration of rating differences as a function of service sector (hospital versus community) and setting (large urban versus town/small city) revealed minimal difference for both women (difference of +/- 0.1) and men (difference +/- 0.3).

Qualitative Findings

Participants uniformly regarded housing as the basic source of 'stability' and key health determinant that is equally relevant for men and women with SMI. Numerous, generic themes recurred such as the comments on low levels of housing stock, the limited availability and allocation of funding to develop and sustain adequate housing, and client difficulties in obtaining

and maintaining adequate sources of income with which to cover rent and other basic expenses. Across service sectors and geographic region, the context of supporting individuals with SMI was described as one of pronounced financial strain.

Despite several cross-cutting similarities, these key-informant narratives of poverty, under-resourced housing service sectors, and stigma differed markedly as a function of gender, ethnicity, and other points of intersection. Erroneous assumptions about service needs and stigmatization were described as having a structural impact upon housing access. As will be described, this resulted in unique pathways of marginalization, victimization, and poverty.

"Structural" Adversity: Cycles of Invisibility, Lack of Access, and Vulnerability

Women were frequently referred to as the "invisible homeless". Participants described how the perceived absence of homeless women and the perception of homeless men as more troublesome influenced policy, funding and service provision, resulting in woman having to "turn to different systems than the formalized system" such as "couch surfing" with families, friends and often with unknown men. While one provider found women's ability to seek alternative routes as "resourceful", most voiced the opinion that the lack of shelter or emergency housing for women increased their vulnerability. For example, women with SMI would "trade sex for somewhere to stay" and "take somebody [in an exploitative context] in to help them pay the rent when they're feeling under pressure because of the costs." For the majority, this was a question of powerlessness rather than one of resourcefulness.

> "Women's [with SMI] homelessness tends to be a little bit more invisible. We certainly have a number of women who have lived with their sister for a long time or crashed with unsavory males over a series of years. They have, in fact, been homeless they have just been temporarily couched. If you look at resource availability…they operate out of men's

shelters, and aren't always in a safe environment for women. [Resources] certainly seem to be centered on male-accessible places…all these guys have all these shelters to choose from and if they get booted out of one after four weeks they just move over to the next one. We turn hundreds and hundreds of women away from our shelter because we just don't have the beds."

[Community service provider, small town in Central Canada]

Women were described as being pushed into a vicious cycle of unstable housing and increasingly stressful environments which led to poorer mental health, quality of life, and little access to community services. This cycle was compounded in smaller towns, as women had to leave for larger cities where there was better access to mental health and housing services.

While men with SMI were described as having relatively greater access to housing and shelter, and experiencing less victimization and sexual exploitation, they are in no way immune to the dynamics of poverty and marginalization. They were described as typically being forced to live in "drug infested" areas due to stigma and poverty. Living in such neighbourhoods leads to high levels of anxiety among both men and women, and participants describe this as greatly increasing the risk of a relapse.

The Intersection of Gender and Ethnicity

Belonging to an ethnic minority group acted as a further source of marginalization, not just within hospital and community services but also within people's own ethnic groups. The evidence of "blind spots" which fuelled gender and ethnic discrimination were evident mostly in the experiences of women.

"I'm thinking of one woman in particular who was from Pakistan and had been married most of her life but recently divorced and found herself on her own and with no place to

live. I remember taking her to the shelter just before Christmas and she walked in her head scarf into this predominately male shelter waiting area and you could just feel it, it was very striking the degree to which she didn't fit in."

[Community service provider, urban area in Northern Canada]

For Aboriginal people living in rural Canada and the northern territories, the level of discrimination experienced by women with SMI was described as particularly heightened. Geography and location, intersecting with gender, ethnicity, and intergenerational trauma, meant that women were trapped in situations compounded by lack of transportation and an inability to leave town.

"We worked with a woman from a small Aboriginal community. Her non-Aboriginal husband got on the housing authority board and illegally had her name removed from home ownership papers just because the government could. She didn't win, because even lawyers are racist in the territories...so in small communities it is very controlled by men and they will choose men over Aboriginal women...Aboriginal women are the most marginalized."

[Community service provider, small town in Northern Canada]

In the Aboriginal service context, several participants noted a conflict between the community and hospital sectors, in that "psychiatrists, psychologists, and nurses" who are considered "mainstream" were not using a "culturally competent approach", which resulted in a "racist" approach to care. These dissonances between community and hospital services created a discontinuity in care and impeded the recovery of Aboriginal women. Providers talked about how the "structural oppression" was internalized by women, who began to "talk about it like it's

their fault", and used words such as "loser" and not having the "smarts or self control" to improve their lives.

Men, Perceptions of Risk, and Housing Quality

While participants described the impact stigma had on both men and women, their narratives emphasized the manner in which it pervaded men's experiences. They described how the level of "trouble" and "risk" perceived by providers seemed to shape the transitioning and access to community housing for men with severe mental illness. It was perceived as a "reality that men are more prone to violence" compared to women, who were often viewed as "easier tenants."

> "More men end up without housing because as part of their illness they're maybe using more and tend to be more aggressive … landlords are more afraid. I mean we definitely have women that have been quite agitated but I think landlords tend to be more accepting of females."
>
> [Hospital service provider, urban area in Western Canada]

Participants also described men as being subjected to more substandard levels of accommodation, based on the perception that men "don't care" about their homes and are content with living in "dorm-like situations".

Women, Children, and Families

There was a general perception across participant narratives that men with SMI seldom had family responsibilities. For men with children, this left them at a disadvantage – if they had a child they would have even greater difficulty in accessing suitable housing than their female counterparts. The majority of the commentary in this topic, however, revolved around women's experiences. The presence of children created further complexity for women in the housing

system, oscillating between facilitating and hindering housing access, recovery, and community participation. Access was described as improved by some participants based upon "the premise that women, as child bearers, will require family housing." Having children was also described by some as facilitating greater access to services as their physical and mental health needs are considered a priority by providers. Others, however, described women with children as having greater difficulty accessing care due to childcare responsibilities and fears that their circumstances of mental illness and victimization may lead to their children being taken into custody. Additional challenges included having adolescent male children who are not allowed in female-only housing and shelter settings, and "catch-22" scenarios that can make it nearly impossible for impoverished women to regain custody once it is lost.

> "So when a woman applies for housing, if they don't have guardianship they can only apply for a single even though they need a 3-bedroom to get their kids back…so maybe she will get a one bedroom and is living in an overcrowded situation again…living in that overcrowded place plays into the mental health of the parent and the children and that creates the tension and starts to stir the pot. Then throw some alcohol on that, and then starts the domestic violence, then she flees the violence, and the partner stays in the house and she has to start the process all over again."
>
> [Community service provider, urban area in Northern Canada]

This problem was described as unfolding differently within some Aboriginal communities. For example, grandmothers were "rescuing" their grandchildren while mothers were "couch surfing" and "people take in their adult children and adult grandchildren".

Discussion

This study of housing expert perspectives was undertaken to describe the housing service context for Canadians with SMI as a function of gender. It is an initial attempt to articulate these issues in the Canadian context and advance the small, but growing knowledge base related to gendered experiences of serious mental illness.

This study highlighted several problems. While considered in the broadest sense, housing access problems were considered equivalent regardless of gender and geographic context, the types of barriers faced varied greatly. Biased perspectives regarding housing needs were described as leading to women with SMI being forced into exploitative and victimizing circumstances. Even when accommodating women, the emphasis on male-focused services was described as being alienating and potentially risky for women to access. These findings are reflective of literature that, while noting greater success with independent living among women[7,8] , also describe much higher rates of coercive sexual encounters and sex trade involvement[13]. Indeed, it brings forward the question of necessity in the greater levels of independence observed among women and whether, for many, purported observations of independence may overlie contexts of exploitation and victimization.

Additionally, while the many stresses that attend having a child for women with SMI have been documented[18], this study noted several implications for housing-related services. These included ambivalence about the net impacts for mothers with SMI. Some participants cited enhanced outreach and support extended to mothers and others describing mothers having less time to access services or actively avoiding services for fear of losing custody. Fear of losing custody of children was associated with women being forced into higher-risk living circumstances. Women who had lost custody were also described as struggling with catch-22 scenarios in which they required adequate housing to regain custody but could not obtain it

unless they had custody. The issues attending custody and parenting are, however, quite complex and were not fully addressed in this study. It is an area that would greatly benefit from further inquiry that could more intensively examine the intersections (gender, ethnicity, geography) and specific contexts (family versus individual homelessness) therein.

Men were also described as facing significant problems accessing adequate housing, albeit with some different factors involved. This was reflected in the finding men were comparably rated with women in terms of overall access to housing services. Men with SMI were understood to have difficulties accessing stable housing due to their being perceived as being more prone to disturbance and violence. Furthermore, there existed a perception that men cared less about the quality of housing and shelter spaces, resulting in their being provided with lower quality and, more frequently, large dormitory-type spaces. These findings are reflected in observation of greater rates of homelessness among males with SMI[10].

While considered relatively rare, child custody was considered a pronounced challenge for men as supports for families was described as almost exclusively geared towards single parent women. This problem extended to women with teenaged male children who, if they appeared too adult, were likely to be sent to separate shelters due to concerns that their presence might disturb other female residents.

Ethnicity and service sector size were generally described as compounding the housing access problems faced by women. Consistent with previous work[21], it was observed that racialized women faced several forms of discrimination in male-oriented shelter and housing systems. Provider concerns for Aboriginal women revolved around culturally inappropriate care and the pronounced lack of access to housing and limited mobility that attend poverty in remote communities – risks that are enhanced when political and service leadership structures are

predominantly male and equitable policy can be undermined through patriarchal implementation. Such observations align with international debate and advocacy regarding human rights violations against Aboriginal women[24], violations that need to be understood within ongoing practices and effects of colonialism. Conversely, some providers spoke of small Aboriginal communities providing greater support to women with SMI, with grandparents and other family members playing a greater role in care for children and housing when needed.

While the transferability of these findings will require further study that integrates a consideration of client perspectives and outcomes and extends beyond potential biases in the sample (e.g., sample selection biases and the majority of participants being women), they point to a need for a systematic examination of inequities in the Canadian housing service sector for people with SMI. This group of Canadian housing experts observed structural forms of discrimination that were compounded by poverty and mental illness within the context of an ongoing pervasive difficulty in accessing adequate housing. As emphasized by Canada's mental health strategy[25], until gender and other key intersections such as ethnicity are better addressed our services will continue to ignore major determinants of illnesses such as schizophrenia[26,27] .

Table 1

		City		Small-mid sized town	
Region	**N**	**Hospital**	**Community**	**Hospital**	**Community**
Canada	29	6	12	6	5
Western Canada[a]	11	2	4	3	2
Central Canada[b]	6	1	2	1	2
Atlantic[c]	8	3	3	1	1
Northern[d]	4	0	3	1	0

Table 1: Geographical summary of participants differentiating by hospital or community sector.
a Western Canada includes Alberta, Manitoba, Saskatoon, and British Columbia
b Central Canada includes Ontario and Quebec
c Atlantic includes Prince Edward Island, New Brunswick, Nova Scotia, Newfoundland and Labrador
d Northern includes Yukon Territories, North West Territories and Nunavut

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- Participant Recruitment
- Data Analysis
- Manuscript Preparation

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- Participant Recruitment
- Manuscript Preparation

RUNNING HEAD: Gender, Housing, and Severe Mental Illness

~~Gender and Access to Housing~~The Role of Gender in Housing for ~~for~~ Individuals with Severe Mental Illness: A Qualitative Study of the Canadian ~~Housing~~ Service Context

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Results: Participants across geographic contexts described a lack of shelter facilities for women leading to a reliance on exploitative circumstances. Other findings included a compounding of discrimination for ethnic minority women, the unique resource problems faced in rural contexts, and the difficulties that attend access to shelter and housing for parents with SMI.

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Key Messages:

- Misperceptions at policy and service system levels regarding the need for housing as a function of gender are leading to circumstances that compound the impacts of mental illness.
- Resource needs are particularly acute as additional points of marginalization emerge from factors such as ethnic minority status and rural context.
- Housing access problems have major impacts on the ability to parent as a person with severe mental illness.

Strengths and Limitations of this Study:

- This study is among the first to directly address the interplay between housing access and gender among individuals with severe mental illness.
- The study accesses a broad, national range of expert perspectives.
- Transferability to other national contexts outside of Canada needs clarification as do potential biases attending respondents (i.e., primarily female provider perspectives, no consumer perspectives represented).

- While serving the purpose of an initial inquiry, further work is needed to confirm and expand upon the assertions of the service providers interviewed here.

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Competing Interests Statement: No author of this study will in any way gain or lose financially from the results of this study. No author has been employed by an organisation that may in any way gain or lose financially from the results of this study. No authors hold any stocks or shares in an organisation that may in any way gain or lose financially from the results of this study. No author has acted as an expert witness on the subject of this study. No other competing financial interests exist.

The lack of adequate and affordable housing for individuals with severe mental illness (SMI) is repeatedly highlighted in research, public, and policy discourses. It is a complex problem rooted in individual and structural factors. Individuals with SMI often present with a complex array of concurrent psychiatric and chronic medical conditions which are often compounded by poverty, social exclusion, and substance misuse. Many structural factors also contribute to a lack of good-quality housing for people with SMI. Rent is often unaffordable, with costs typically taking up 70-90% of an individual's public benefits. This problem is exacerbated by Canada having just over 25,000 supported housing units available[1]. As a result, over 500,000 Canadians with mental illness are inadequately housed and an estimated 120,000 are homeless[1]. This is a critical problem as adequate housing is a key determinant of health[2] and recovery[3,4.]

From research and practice perspectives, challenges arise in the very generic articulation of the housing problem for the SMI population. Considerations of the issue of housing have very seldom taken into account the intersections of resource and adversity that attend factors such as gender, race, and ethnicity. As long as the specific mechanisms by which such factors, and their intersections, remain poorly understood, housing policies and programs for people with mental illness will remain inefficient and ineffective[5]. It is in light of this shortcoming in the SMI literature that the present study was undertaken to examine the role of gender in housing ~~access~~ for Canadians with SMI ~~in Canada~~. This initial qualitative exploration draws upon housing expert perspectives regarding service access and service needs as they intersect with gender, ethnicity, and geographic context.

Gender and Severe Mental Illness

There are significant and pervasive differences between men and women with SMI that are present across the social determinants of health, illness onset and expression, and process of recovery. Taking schizophrenia as an example, women on average experience a later onset and less severe course of illness, though suffer more depressive symptoms than men[6]. A later onset of illness carries several important implications. Women typically have greater opportunities to establish a range of competencies and a higher degree of independence before the illness commences. This may account for generally stronger skills that support independent living and longer periods of community tenure[7,8].

Women with SMI also have been found to more actively seek social contact and support, which may have implications for less dependence on service providers and greater success in living independently[7,9]. Men with SMI are, in turn, more likely to be homeless[10] and more reliant upon health services[9] which may account for a further deterioration of independent living skills[11].

Women with SMI also face several unique and prominent sources of adversity. Women are more likely to have experienced childhood abuse and trauma and symptoms of PTSD[12]. Women also experience higher rates of coercive sexual encounters and sex trade involvement as means of coping with poverty and homelessness[13]. Coercion in relationships with male partners has also been extended to include influence upon the uptake of substance abuse and involvement in criminal activities[14]. Furthermore, women have a greater likelihood of having been socialized into passive and otherwise dependent roles, which may be reified through service providers working within models of care that cultivate dependency[7]. Such sociocultural factors are evident across a range of studies. For example, compared to women without SMI, those with SMI place a greater importance on having caring and compassionate providers than providers who

encourage choice and independence[15,16]. Women with SMI are also more likely to be perceived by family and other supports as more emotionally vulnerable and irrational in comparison to men[16,17].

Pregnancy and child rearing is an additional consideration for women with SMI. Typically framed in the context of enhancing risk, having a child has numerous implications around risks of medications in pregnancy and stressors associated with childrearing as poverty and illness threaten custody[18,7]. This is an increasingly relevant issue given evidence that the fertility rate among Canadian women with Schizophrenia is on the rise[19,8].

Much less developed in the literature is attention to intersections of risk and resilience that attend the intersections of race, ethnicity, sexual and gender identity. Preliminary work suggests that these points of diversity have very important implications. While unique points of resilience emerge among these populations, recovery is typically complicated by multiple forms of discrimination and marginalization, and treatment needs that are seldom adequately met[20,9,21,10].

The Present Study

Despite the consistent threads of evidence suggesting differences in mental illness etiology, expression, and recovery process as a function of gender, as a topic it is largely relegated to sidenote status in community mental health research and policy dialogues. This shortcoming is particularly evident in considerations of housing individuals with SMI. As such, this qualitative study was undertaken as an initial step to better articulating community service needs in Canada as a function of gender. Key informant interviews were undertaken with service providers across Canadian provinces and territories, in both hospital and community service sectors, and across both large urban, mid-sized city, and rural contexts.

Methods

Recruitment

In order to obtain a broad, national perspective on gender equity within the housing sector for people with SMI, service providers were sought in provinces and territories in all geographic regions. The recruitment strategy targeted balanced representation as a function of setting, with interviews conducted with providers working in the largest urban centres in Canada as well as representative small to mid-sized towns and cities. Representativeness of smaller centres was determined by a consensus of the urban providers (the inquiry starting point in each province/territory), seeking settings that were neither disproportionally over nor under-resourced. Balance was also sought in respondent service sector, seeking representation from both hospital-based and community-based organizations.

Participant eligibility relied primarily on their being regarded as an individual who is highly knowledgeable regarding access to housing and community services for people with SMI. Recruitment started in large urban centres, with participants recommended through sources such as key informants in the Mental Health Commission's recently completed consultation on housing and the At Home study. Large urban setting respondents were then asked to provide recommendations regarding experts in smaller settings. Recruitment continued until each region was adequately represented and qualitative themes had attained saturation with subsequent interviews revealing no new information. The study was reviewed and approved by the Toronto Center for Addiction and Mental Health institutional research ethics board (#183/2011).

Procedure

Interviews lasting an average of 45 minutes were conducted with all participants via telephone and were audio-recorded and transcribed verbatim. Demographic data collected for

each participant included geographical location, type of service, number of years in current post, number of years working within mental health and housing sectors, gender, and profession. The interview then moved on to explore participant perspectives and experiences pertaining to differences regarding *access to, experiences within, and needs for* housing and associated resources as a function of gender.

The interview concluded with 2 items that were developed to quantify service provider perceptions regarding access to housing as a function of gender (e.g., In a broad, general sense, how accessible is affordable housing for women/men with SMI in your city/town?) Participants were asked to score each item using a 5 point likert scale where 1 represented 'completely inaccessible' and 5 represented 'completely accessible'. This scale was developed for this study as we were unable to identify an existing, validated tool for this purpose.

Analysis

While not a complete grounded theory design, the analysis followed the rigorous thematic analysis procedure outlined by Charmaz[22,23], beginning with line by line coding of the data to pull out key, recurrent themes. Line by line coding was completed by 1 coder with category reports examined by a second research team member who also reviewed full transcripts and recordings of interviews. Coding was reviewed ~~with the research team~~ at ~~various~~ several stages of the analysis allowing for data to be contextualized and different interpretations explored and resolved through consensus. ~~Analysis then moved onto~~ Ffocused coding, where conceptual analysis took place, commenced after 8 interviews when coherent and consistent linkages between categories and themes began to emerge. ~~and patterns amongst and relationships between the most relevant and salient categories became the focus.~~ Emergent themes were shared in subsequent interviews for feedback and further exploration, which allowed for an

ongoing process of member checking and elaboration of the analysis. Quantitative data was examined descriptively with mean differences examined through independent samples t-test analysis.

Results

Participants

Twenty nine participants were recruited into the study (6 male and 23 female). All participants had worked within the mental health sector, ranging from between 1 to 30 years, with 20 years being the average length of service. Most worked in either director level or direct service positions, at 45 and 31 per cent respectively, with the remainder working in middle management. On average, participants had worked for 15 years in services that specialized in the support and delivery of housing services to people with SMI. Most were regulated professionals in areas such as Social Work or Counseling and 59 per cent were members of local advisory committees and boards related to housing. Table 1 provides a detailed summary of participant demographics.

Ratings of Accessibility

Quantitative measures of participant perceptions regarding global housing access revealed a mean score for women of 2.0/5 (SD=0.68) and for men of 2.3/5 (SD=.86), a difference which was not statistically significant (t=1.53, p=.13). Qualitative consideration of rating differences as a function of service sector (hospital versus community) and setting (large urban versus town/small city) revealed minimal difference for both women (difference of +/- 0.1) and men (difference +/- 0.3).

Qualitative Findings

Participants uniformly regarded housing as the basic source of 'stability' and key health determinant that is equally relevant for men and women with SMI. Numerous, generic themes recurred such as the comments on low levels of housing stock, the limited availability and allocation of funding to develop and sustain adequate housing, and client difficulties in obtaining and maintaining adequate sources of income with which to cover rent and other basic expenses. Across service sectors and geographic region, the context of supporting individuals with SMI was described as one of pronounced financial strain.

Despite several cross-cutting similarities, these key-informant narratives of poverty, under-resourced housing service sectors, and stigma differed markedly as a function of gender, ethnicity, and other points of intersection. Erroneous assumptions about service needs and stigmatization were described as having a structural impact upon housing access. As will be described, this resulted in unique pathways of marginalization, victimization, and poverty.

"Structural" Adversity: Cycles of Invisibility, Lack of Access, and Vulnerability

Women were frequently referred to as the "invisible homeless". Participants described how the perceived absence of homeless women and the perception of homeless men as more troublesome influenced policy, funding and service provision, resulting in woman having to "turn to different systems than the formalized system" such as "couch surfing" with families, friends and often with unknown men. While one provider found women's ability to seek alternative routes as "resourceful", most voiced the opinion that the lack of shelter or emergency housing for women increased their vulnerability. For example, women with SMI would "trade sex for somewhere to stay" and "take somebody [in an exploitative context] in to help them pay the rent when they're feeling under pressure because of the costs." For the majority, this was a question of powerlessness rather than one of resourcefulness.

"Women's [with SMI] homelessness tends to be a little bit more invisible. We certainly have a number of women who have lived with their sister for a long time or crashed with unsavory males over a series of years. They have, in fact, been homeless they have just been temporarily couched. If you look at resource availability-…they operate out of men's shelters, and aren't always in a safe environment for women. [Resources] certainly seem to be centered on male-accessible places…all these guys have all these shelters to choose from and if they get booted out of one after four weeks they just move over to the next one. We turn hundreds and hundreds of women away from our shelter because we just don't have the beds."

[Community service provider, small town in Central Canada]

Women were described as being pushed into a vicious cycle of unstable housing and increasingly stressful environments which led to poorer mental health, quality of life, and little access to community services. This cycle was compounded in smaller towns, as women had to leave for larger cities where there was better access to mental health and housing services.

While men with SMI were described as having relatively greater access to housing and shelter, and experiencing less victimization and sexual exploitation, they are in no way immune to the dynamics of poverty and marginalization. They were described as typically being forced to live in "drug infested" areas due to stigma and poverty. Living in such neighbourhoods leads to high levels of anxiety among both men and women, and participants describe this as greatly increasing the risk of a relapse.

The Intersection of Gender and Ethnicity

Belonging to an ethnic minority group acted as a further source of marginalization, not just within hospital and community services but also within people's own ethnic groups. The

evidence of "blind spots" which fuelled gender and ethnic discrimination were evident mostly in the experiences of women.

> "I'm thinking of one woman in particular who was from Pakistan and had been married most of her life but recently divorced and found herself on her own and with no place to live. I remember taking her to the shelter just before Christmas and she walked in her head scarf into this predominately male shelter waiting area and you could just feel it, it was very striking the degree to which she didn't fit in."
>
> [Community service provider, urban area in Northern Canada]

For Aboriginal people living in rural Canada and the northern territories, the level of discrimination experienced by women with SMI was described as particularly heightened. Geography and location, intersecting with gender, ethnicity, and intergenerational trauma, meant that women were trapped in situations compounded by lack of transportation and an inability to leave town.

> "We worked with a woman from a small Aboriginal community. Her non-Aboriginal husband got on the housing authority board and illegally had her name removed from home ownership papers just because the government could. She didn't win, because even lawyers are racist in the territories...so in small communities it is very controlled by men and they will choose men over Aboriginal women...Aboriginal women are the most marginalized."
>
> [Community service provider, small town in Northern Canada]

In the Aboriginal service context, several participants noted a conflict between the community and hospital sectors, in that "psychiatrists, psychologists, and nurses" who are considered "mainstream" were not using a "culturally competent approach", which resulted in a

"racist" approach to care. These dissonances between community and hospital services created a discontinuity in care and impeded the recovery of Aboriginal women. Providers talked about how the "structural oppression" was internalized by women, who began to "talk about it like it's their fault", and used words such as "loser" and not having the "smarts or self control" to improve their lives.

Men, Perceptions of Risk, and Housing Quality

While participants described the impact stigma had on both men and women, their narratives emphasized the manner in which it pervaded men's experiences. They described how the level of "trouble" and "risk" perceived by providers seemed to shape the transitioning and access to community housing for men with severe mental illness. It was perceived as a "reality that men are more prone to violence" compared to women, who were often viewed as "easier tenants."

> "More men end up without housing because as part of their illness they're maybe using more and tend to be more aggressive … landlords are more afraid. I mean we definitely have women that have been quite agitated but I think landlords tend to be more accepting of females."
>
> [Hospital service provider, urban area in Western Canada]

Participants also described men as being subjected to more substandard levels of accommodation, based on the perception that men "don't care" about their homes and are content with living in "dorm-like situations".

Women, Children, and Families

There was a general perception across participant narratives that men with SMI seldom had family responsibilities. For men with children, this left them at a disadvantage – if they had a

child they would have even greater difficulty in accessing suitable housing than their female counterparts. The majority of the commentary in this topic, however, revolved around women's experiences. The presence of children created further complexity for women in the housing system, oscillating between facilitating and hindering housing access, recovery, and community participation. Access was described as improved by some participants based upon "the premise that women, as child bearers, will require family housing." Having children was also described by some as facilitating greater access to services as their physical and mental health needs are considered a priority by providers. Others, however, described women with children as having greater difficulty accessing care due to childcare responsibilities and fears that their circumstances of mental illness and victimization may lead to their children being taken into custody. Additional challenges included having adolescent male children who are not allowed in female-only housing and shelter settings, and "catch-22" scenarios that can make it nearly impossible for impoverished women to regain custody once it is lost.

> "So when a woman applies for housing, if they don't have guardianship they can only apply for a single even though they need a 3-bedroom to get their kids back…so maybe she will get a one bedroom and is living in an overcrowded situation again…living in that overcrowded place plays into the mental health of the parent and the children and that creates the tension and starts to stir the pot. Then throw some alcohol on that, and then starts the domestic violence, then she flees the violence, and the partner stays in the house and she has to start the process all over again."
>
> [Community service provider, urban area in Northern Canada]

This problem was described as unfolding differently within some Aboriginal communities. For example, grandmothers were "rescuing" their grandchildren while mothers were "couch surfing" and "people take in their adult children and adult grandchildren".

Discussion

This study of housing expert perspectives was undertaken to describe the housing service context for Canadians with SMI as a function of gender. It is an initial attempt to articulate these issues in the Canadian context and advance the small, but growing knowledge base related to gendered experiences of serious mental illness.

This study highlighted several problems. While considered in the broadest sense, housing access problems were considered equivalent regardless of gender and geographic context, the types of barriers faced varied greatly. Biased perspectives regarding housing needs were described as leading to women with SMI being forced into exploitative and victimizing circumstances. Even when accommodating women, the emphasis on male-focused services was described as being alienating and potentially risky for women to access. These findings are reflective of literature that, while noting greater success with independent living among women[7,8] , also describe much higher rates of coercive sexual encounters and sex trade involvement[13]. Indeed, it brings forward the question of necessity in the greater levels of independence observed among women and whether, for many, purported observations of independence may overlie contexts of exploitation and victimization.

Additionally, while the many stresses that attend having a child for women with SMI have been documented[1,8,7], this study noted several implications for housing-related services. These included ambivalence about the net impacts for mothers with SMI. Some participants cited enhanced outreach and support extended to mothers and others describing mothers having less

time to access services or actively avoiding services for fear of losing custody. Fear of losing custody of children was associated with women being forced into higher-risk living circumstances. Women who had lost custody were also described as struggling with catch-22 scenarios in which they required adequate housing to regain custody but could not obtain it unless they had custody. The issues attending custody and parenting are, however, quite complex and were not fully addressed in this study. It is an area that would greatly benefit from further inquiry that could more intensively examine the intersections (gender, ethnicity, geography) and specific contexts (family versus individual homelessness) therein.

Men were also described as facing significant problems accessing adequate housing, albeit with some different factors involved. This was reflected in the finding men were comparably rated with women in terms of overall access to housing services. Men with SMI were understood to have difficulties accessing stable housing due to their being perceived as being more prone to disturbance and violence. Furthermore, there existed a perception that men cared less about the quality of housing and shelter spaces, resulting in their being provided with lower quality and, more frequently, large dormitory-type spaces. These findings are reflected in observation of greater rates of homelessness among males with SMI[10].

While considered relatively rare, child custody was considered a pronounced challenge for men as supports for families was described as almost exclusively geared towards single parent women. This problem extended to women with teenaged male children who, if they appeared too adult, were likely to be sent to separate shelters due to concerns that their presence might disturb other female residents.

Ethnicity and service sector size were generally described as compounding the housing access problems faced by women. Consistent with previous work[2,10], it was observed that

racialized women faced several forms of discrimination in male-oriented shelter and housing systems. Provider c~~C~~oncerns for Aboriginal women ~~with SMI~~ revolved around culturally inappropriate care and the pronounced lack of access to housing and limited mobility that attend poverty in remote communities – risks that are enhanced when political and service leadership structures are predominantly male and equitable policy can be undermined through patriarchal implementation. Such observations align with international debate and advocacy regarding human rights violations against Aboriginal women[24], violations that need to be understood within ongoing practices and effects of colonialism. ~~-~~Conversely, some providers spoke of small Aboriginal communities providing greater support to women with SMI, with grandparents and other family members playing a greater role in care for children and housing when needed.

While the transferability of these findings will require further study that ~~includes~~ integrates a ~~closer~~ consideration of client perspectives and outcomes and extends beyond potential biases in the sample (e.g., sample selection biases and the majority of participants being women), ~~the present findings~~they point to a need for a systematic examination of inequities in the Canadian housing service sector for people with SMI.~~-~~ This group of Canadian housing experts observed structural forms of discrimination that were compounded by poverty and mental illness within the context of an ongoing pervasive difficulty in accessing adequate housing. As emphasized by Canada's mental health strategy[2~~53~~], until gender and other key intersections such as ethnicity are better addressed our services will continue to ignore major determinants of illnesses such as schizophrenia[2~~64~~,2~~75~~] .

Table 1

		City		Small-mid sized town	
Region	**N**	**Hospital**	**Community**	**Hospital**	**Community**
Canada	29	6	12	6	5
Western Canada[a]	11	2	4	3	2
Central Canada[b]	6	1	2	1	2
Atlantic[c]	8	3	3	1	1
Northern[d]	4	0	3	1	0

Table 1: Geographical summary of participants differentiating by hospital or community sector.
a Western Canada includes Alberta, Manitoba, Saskatoon, and British Columbia
b Central Canada includes Ontario and Quebec
c Atlantic includes Prince Edward Island, New Brunswick, Nova Scotia, Newfoundland and Labrador
d Northern includes Yukon Territories, North West Territories and Nunavut

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- Study design and grant writing
- Participant Recruitment
- Data Analysis
- Manuscript Preparation

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- Participant Recruitment
- Manuscript Preparation

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation
Title and abstract	√	(*a*) Indicate the study's design with a commonly used term in the title or the abstract
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/rationale	√	Explain the scientific background and rationale for the investigation being reported
Objectives	√	State specific objectives, including any prespecified hypotheses
Methods		
Study design	√	Present key elements of study design early in the paper
Setting	√	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	√	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants
Variables	√	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	√	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	√	Describe any efforts to address potential sources of bias
Study size	√	Explain how the study size was arrived at
Quantitative variables	√	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	√	(*a*) Describe all statistical methods, including those used to control for confounding
		(*b*) Describe any methods used to examine subgroups and interactions
		(*c*) Explain how missing data were addressed
		(*d*) If applicable, describe analytical methods taking account of sampling strategy
		(*e*) Describe any sensitivity analyses
Results		
Participants	√	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
		(b) Give reasons for non-participation at each stage
		(c) Consider use of a flow diagram
Descriptive data	√	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders
		(b) Indicate number of participants with missing data for each variable of interest
Outcome data	√	Report numbers of outcome events or summary measures
Main results	n./a	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included
		(*b*) Report category boundaries when continuous variables were categorized
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	n/a	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses

Discussion		
Key results	√	Summarise key results with reference to study objectives
Limitations	√	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	√	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	√	Discuss the generalisability (external validity) of the study results
Other information		
Funding	√	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.