Mental Illness and Homelessness
Experiences of Francophone, Anglophone, and Indigenous Persons in Northeastern Ontario

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**Mental Illness and Homelessness: Experiences of Francophone, Anglophone, and Indigenous Persons in Northeastern Ontario**

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**Abstract:** Homeless Francophones in northeastern Ontario are proportionately overrepresented when compared to homeless Anglophones and Indigenous people among those who self-reported that they suffered from mental health problems during the previous year. This study compares levels of physical and mental illness amongst the three main ethno-cultural groups—Francophones, Anglophones, and Indigenous People—in the three principal urban areas of northeastern Ontario, Canada. This study utilizes data collected using a service-based survey of poor and homeless people accessing front line services in the cities of North Bay, Timmins, and Sudbury. Participants provided information about their physical and mental health in the year prior to the survey and described their health-related issues. The sample is composed of 2,148 men and women either absolutely homeless or at risk of homelessness. Of the total, 352 are Francophone, 594 Indigenous, and 1,202 Anglophone. In 11 previous studies, Francophones were consistently underrepresented in comparison to their proportion in the general population. However, the current study shows that homeless Francophones had a greater incidence of mental and physical health problems than the other homeless groups studied. They were proportionately overrepresented when compared to homeless Anglophones and Indigenous people who said that they suffered from mental health problems during the previous year. Culturally and linguistically specific services are required to address mental health issues for Francophones and Indigenous people.

**Keywords:** Homelessness, Mental Illness, Francophones, Anglophones, Indigenous Persons, Northeastern Ontario

**Introduction**

The relationship between homelessness and mental health has been the subject of numerous studies (Patterson, Somers and Moniruzzaman 2012; Merscham, Van Leuwen and McGuire 2009; Lesage, Vasiiliadis, et al. 2006; Frankish, Hwang and Quantz 2005; Riordan 2004; Kauppi et al. 2001). Homeless people have poorer mental health than the general population (Frankish, Hwang and Quantz 2005; Goering, Tolomiczenko, et al. 2002; Hwang 2001), and Riordan (2004, 6) stated that about “66% of the homeless persons have a lifetime diagnosis of mental illness. This is 2 to 3 times the rate of the general population.” According to Goering et al. (2002), two-thirds of the clients at Toronto shelters had a diagnosis of chronic mental illness. The Canadian Community Health Survey found that 2.6 million Canadians, or about one in ten reported symptoms of mental illness at some point in their lives (Statistics Canada 2003). According to the Report on Mental Illnesses in Canada, 20% of Canadians will, at one time or another in their lives, personally experience a mental illness (Health Canada 2002) compared to 66% of homeless people (Riordan 2004). The prevalence of mental illness among the homeless population is thus two to three times greater than in the general population.

According to Pallard, Kauppi, and Hein (2015), homelessness or poor housing adversely impact on mental health. Because of poor housing and living conditions, homeless persons are exposed to tuberculosis, scabies and lice (Frankish, Hwang and Quantz 2005); diseases or infections—that may be associated with extreme poverty—can increase the risk of depression (Canadian Mental Health Association, Ontario 2008). Furthermore, the relationship between the problems of physical and mental health and homelessness is complex (Hwang 2002) because of intersections between homelessness and several other determinants of health.
Despite the wealth of information, there are some difficulties associated with studies on the prevalence of homelessness and mental health. Homeless counts conducted in shelters or large agencies have often neglected to collect data about mental illness, alcoholism and addictions (Buckland, Jackson, et al. 2001). The approach inherent to standard methodologies for collecting data from homeless people may both underestimate the number of homeless persons (non-users of services) and fail to take into account the health profiles of the individuals studied.

Our homeless studies conducted in three cities in northeastern Ontario—North Bay, Sudbury and Timmins—sought to address these limitations. Homeless people living in shelters as well as persons accessing other types of services were surveyed. The goal was to gather information about their health by using a questionnaire that allowed for the collection of data about both their living conditions and their health.

This article analyses the self-reported mental health of homeless people in northeastern Ontario, taking into account cultural and linguistic dimensions. Francophones comprise a linguistic minority group in rural and northern Ontario; they perceive themselves to be less healthy than Anglophones (Bouchard, Gaboury, et al. 2009). We examined the relationship between homelessness and health in a minority context to better understand a critical aspect of the quality of life of homeless Francophones. The main objective of this paper is to examine the mental health problems reported by homeless Francophones in North Bay, Sudbury and Timmins in comparison with homeless Anglophone and Indigenous persons in these cities. We explore the relationship between the types of mental illnesses self-reported by homeless Francophones, Anglophones and Indigenous persons.

**Mental Health and Mental Illness**

Mental health is a state of well-being which allows persons to realise their full potential and to cope with the normal stresses of life, to work productively and to contribute to the life of their community (World Health Organization 2010). Mental illness is a set of problems affecting the mind and is manifested in challenges with functioning. These disturbances cause feelings of discomfort, emotional or intellectual, as well as behavioural problems (Health Canada 2002). Participants reported being affected by various forms of mental illness.

**Absolutely Homeless and At Risk of Becoming Homeless**

Persons are considered to be “absolutely homeless” in situations where they do not have a place to call home, their home is not a room, an apartment or a house or they have no arrangement to sleep there regularly. Persons “at risk of becoming homeless” are, in the short-term, at risk of becoming absolutely homeless because of their particular circumstances, such as impending eviction, extremely low income, domestic violence, or health problems without benefits (Kauppi, Shaikh, et al. 2013). Homelessness thus refers both to absolutely homeless persons and those at risk of becoming homeless.

**Sampling, Tools, and Method of Data Collection**

The methodology that we used allowed for a reasonable estimate of the homeless population. Our surveys included homeless people who used shelters, social service agencies and other support services, as well as health services accessible by the general population. The participation, over a seven-day period, of the vast majority of service providers that assist homeless people in North Bay, Sudbury and Timmins, including services for people experiencing poverty, such as thrift stores, food banks and health services, made possible a more complete estimate of this population compared to studies conducted in a short period (e.g., 24-hour counts) and those that are based primarily on shelters for homeless people. Our participants were recruited through a wide range of agencies and services.
The purpose of the Poverty, Homelessness and Migration project is to deepen our understanding of homelessness among persons in northeastern Ontario, to document the factors leading to homelessness and to describe their experiences. This study uses survey data collected in three cities of northeastern Ontario—Sudbury in 2003, 2007 and 2009, and North Bay and Timmins in 2011. The socio-economic profile of each city studied must be taken into account. The economy of Sudbury, a larger urban centre than the other study communities, is based on health care, services and the mining industry. In contrast, the economy in Timmins centres, to a greater extent, on resource-based industries including mining. North Bay differs in that its economy relies on a mix of services, healthcare and tourism. In 2011, according to the National Household Survey, Sudbury had a population of 160,376 which was 46% English, 40% French and 11% Indigenous. North Bay’s population of 53,651 was 58% English, 32% French and 8% Indigenous. The Timmins population of 42,997 was 48% Anglophone, 42% Francophone and 8% Indigenous (Statistics Canada 2012). Thus Anglophones constitute the dominant population group but the Francophone populations are sizeable, even though percentages based on “mother tongue” yield smaller proportions of Francophones than statistics based on “ethnic origins” (Statistics Canada, 2012). Indigenous people, the first peoples of Canada, make up less than 10% of the populations of these northern cities.

The total sample in the current study consisted of 2,148 participants; it included subgroups of persons who were absolutely homeless (n=885) of which 348 were women and 537 were men, as well as people at risk of becoming homeless (n=1,128). The latter group comprised 508 women and 620 men. In addition, 352 were Francophones, 594 Indigenous and 1,202 Anglophones. By city of residence, 328 persons resided in North Bay, 1,487 in Sudbury, and 399 in Timmins. The larger number of surveys conducted in Sudbury explains the larger subsample from Sudbury.

The questionnaire was administered to people who were accessing services such as food banks, soup kitchen/drop-in centres, and shelters. Participants had the option of completing the questionnaire in one of the two official languages, English or French, either by themselves or with the help of a service provider or a research assistant. Data in the three cities were collected using a period prevalence count—conducted over a period of seven consecutive days—at the end of the month when there is an increase in the number of homeless persons (Peressini, McDonald and Hulchanski 1996). The use of such a strategy makes it possible to reach the population at risk of homelessness that needs help to make ends meet at the end of the month. Collecting data over seven consecutive days ensures that most persons requiring assistance will be invited to participate in the survey. The same set of questions about health problems was included in the surveys in all three cities.

By collecting detailed information on each participant, we were able to identify unique cases. We analysed basic demographic information on the initials of their first, middle and last names, their date of birth, gender, ethnicity or culture, family status and linguistic orientation, which allowed for an unduplicated count of the homeless persons in the three cities. We also collected information from the participants about their access to social and health services, about the reasons for their homelessness, and about their physical and mental health. SPSS (version 19)

1 Since it is difficult to determine how many persons who are at risk of homelessness will actually become homeless, they are integrated into our sample. Also, except for shelters, persons at risk often use the same services as absolutely homeless persons. It is consequently helpful for research purposes, such as determining the impact of homelessness on service use, to group together persons who are at risk of homelessness and absolutely homeless into a single category of persons who are homeless.

2 Prior to beginning this project, the Laurentian University Research Ethics Board reviewed and approved the project and the data collection method. When required, community partners also received approval from their ethics boards. Prospective participants were informed about the nature and purpose of the project and told that their refusal to participate would have no adverse impact on their access to services. Many participants remarked positively that it was one of the few times when someone actually showed interest in their housing conditions and living situation.

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software was used for statistical analysis of the data collected. In addition to descriptive data analysis, we used chi-square tests and analysis of variance.

**Results**

The data show that 34% of absolutely homeless and 46% of those at risk of homelessness in our sample suffered from mental illness and other health problems in the year before their participation in the survey. Our objective was to compare the mental health of homeless Francophones, Anglophones and Indigenous homeless persons in North Bay, Sudbury and Timmins, three cities in northeastern Ontario, in order to identify the extent of self-reported mental illness, and the types of mental illnesses reported by homeless Francophone, Anglophone and Indigenous persons. The results reported in Table 1 indicate that proportionately more homeless Francophones reported health problems than did Anglophones or Indigenous persons. More than half (53%) of Francophones, but only 45% of Indigenous persons and 44% of Anglophones reported that they had experienced mental illness. Also, nearly 41% of Francophones, but only 34% of Anglophones and 32% of Indigenous persons reported having had physical health problems. Chi-square tests indicate that the differences between the groups are statistically significant (Table 1).

<table>
<thead>
<tr>
<th>Health Problems</th>
<th>Socio-Cultural Groups</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anglophones</td>
<td>Francophones</td>
</tr>
<tr>
<td>N=1202</td>
<td>%</td>
<td>N=352</td>
</tr>
<tr>
<td>Mental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>525</td>
<td>43.8</td>
</tr>
<tr>
<td>No</td>
<td>674</td>
<td>56.2</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>405</td>
<td>33.7</td>
</tr>
<tr>
<td>No</td>
<td>797</td>
<td>66.3</td>
</tr>
</tbody>
</table>

Based on $\chi^2$.

Participants were asked if they had previously experienced mental health problems, whether they had occurred during the last year and what kind of mental health problems they experienced. From the self-reports of the participants, their mental health challenges were listed under one of five headings: (i) alcohol and drug abuse for those using words such as alcoholism, substance abuse, addiction; (ii) schizophrenia and delirium for those using words such as schizophrenia, delirium, psychosis; (iii) affective mood disorders for people using words such as depression, acute depression, mania, mood disorder, bipolar disorder; (iv) stress and anxiety for those using words such as panic attacks, anxiety attacks, post-traumatic stress disorder, obsessive-compulsive disorder, trauma. (v) All remaining references to mental health problems identified by the participants are grouped into “other” (see Table 2).

These headings are adapted from the *ICD-10 Classification of Mental and Behavioural Disorders* (World Health Organization 1992). Headings i to iv follow respectively the categories listed in F10-F19, F20-F29, F30-F39 and F40-F48 in the *ICD-10*; the last heading amalgamates categories listed in F00-F09 and F50 to F99.

The participants in this study reported having suffered from several types of mental illness. Participants reported multiple responses; therefore the percentages shown in Table 2 could be greater than 100, as occurred with Francophone participants. This allowed for the identification of all mental illnesses self-reported by individuals in the sample. In all three cultural groups, participants reported stress and anxiety as the category with the highest frequency (93%). Given
the challenges of living absolutely homeless or with extreme poverty, it may not be surprising
that people suffer from stress and anxiety. Of the three groups, Francophones (104%) reported
experiencing stress and anxiety-related disorders in a proportionately greater number than
Anglophones (92%) and Indigenous persons (88%). All Francophone participants stated that they
suffered from one or more types of mental illness in this category.

Table 2: Comparison of the Groups According to Self-reported Mental Illnesses

<table>
<thead>
<tr>
<th>Declared Mental Illness</th>
<th>Socio-Cultural Groups</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anglophones</td>
<td>Francophones</td>
</tr>
<tr>
<td>Stress and anxiety</td>
<td>274</td>
<td>91.6</td>
</tr>
<tr>
<td>Affective mood disorders</td>
<td>77</td>
<td>25.8</td>
</tr>
<tr>
<td>Schizophrenia and delirium</td>
<td>22</td>
<td>7.3</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>20</td>
<td>7.0</td>
</tr>
<tr>
<td>Other</td>
<td>51</td>
<td>17.0</td>
</tr>
</tbody>
</table>

Totals may exceed 100% as participants could give multiple responses for all types of self-reported mental illnesses.

Affective mood disorders ranked second and represented 23% of the recorded statements. Proportionately more Anglophones self-reported having suffered from such disorders; 26% of statements made by Anglophones related to these disorders. Among Francophones, this proportion was 21% compared to 20% for Indigenous persons. The third category is schizophrenia and delirium which represents 7% of all mental illnesses reported. Proportionately more Indigenous persons, followed by Francophones said that they had experienced these disorders.

Without distinguishing the types of mental illness reported and because many participants reported having suffered from several types concurrently, we examined the number of mental illnesses reported. Francophones were slightly more likely to report that they suffered from four or five mental health problems at once (see Table 3).

Table 3: Number of Mental Illnesses Declared by Participants

| Number | Socio-Cultural Groups | | | | | | |
|--------|------------------------|------------------------|------------------------|------------------------|
|        | Anglophones | Francophones | Indigenous |
|        | N=301        | N=119        | N=157        | |
| One    | 199 | 66.1 | 78 | 65.5 | 101 | 64.3 |
| Two    | 66 | 21.9 | 26 | 21.8 | 45 | 28.7 |
| Three  | 28 | 9.3   | 8 | 6.7 | 9 | 5.7 |
| Four   | 7 | 2.3 | 5 | 4.2 | 0 | 0.0 |
| Five   | 1 | 0.3 | 2 | 1.7 | 2 | 1.3 |

Results of analysis of variance are shown in Table 4. Based on mean scores, Francophones were slightly more likely than Anglophones and Indigenous persons to have reported that they suffered from more than one mental health disorder. However the results of analysis of variance indicate that there is no statistically significant difference (P=0.62) between the number of
mental illnesses reported. Nevertheless, it is notable that the proportion of Francophones is larger, given the small sample sizes amongst those reporting four or five mental health challenges. With regard to other health problems, the results show that there is a significant difference (P=0.03) between the number of physical illnesses reported for the three groups studied. Francophones self-reported a larger number of health problems.

Table 4: Comparison of Groups—Mental and Physical Illnesses

<table>
<thead>
<tr>
<th>Socio-Cultural Group</th>
<th>Mental Illness</th>
<th>Physical Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Anglophones</td>
<td>301</td>
<td>1.49</td>
</tr>
<tr>
<td>Francophones</td>
<td>119</td>
<td>1.55</td>
</tr>
<tr>
<td>Indigenous</td>
<td>157</td>
<td>1.45</td>
</tr>
</tbody>
</table>

Discussion and Conclusion

With regard to the proportion of homeless people suffering from mental illness, our results corroborate those reported by several other studies; according to these, about one-third of the homeless people experience mentally illness (Golden, Currie, et al. 1999). However the estimate of homeless persons with mental illness has varied from 30 to 50% (Ontario Medical Association Committee on Population Health 1996); some estimates have indicated that two-thirds of homeless people experience mental illness (Riordan 2004). Many studies agree that homeless populations experience more mental health problems than others (Shinn, Weitzman, et al. 1998; Fischer and Breakey 1991) and are generally in poor health (Aubry, Klodawsky and Coulombe, 2012; Frankish, Hwang and Quantz 2005; Hwang 2002). For the vast majority of participants in our study, their mental health problems stemmed from anxiety, stress and depression.

Of the three groups, Francophones self-reported more physical and mental health issues. On some of our measures, we found that the three groups were significantly different in terms of health problems experienced during the previous year. The analysis of variance also reported differences in average number of health problems, other than mental illness. However, regarding the number of mental health problems specifically, there were no statistically significant differences between the three groups despite the slightly larger proportion of Francophones reporting that they were experiencing four or five different types of mental health challenges.

In each of the nine previous studies conducted in Sudbury, as well as the studies in North Bay and Timmins, proportionately fewer Francophones were identified as at risk and absolutely homeless while Indigenous persons were significantly overrepresented (Kauppi, Gasparini et al. 2009). However, in the current study on the mental health of homeless persons, Francophones were proportionately overrepresented compared to Indigenous persons and Anglophones who reported having a mental health disorder during the previous year. Further study is needed to determine why Francophones are under-represented as a proportion of the total homeless population, yet over-represented with regard to certain aspects of mental and physical health challenges.

Using qualitative methods, we have previously found, that the under-representation of Francophones among homeless people may in part be explained by efforts to “pass” as Anglophone which allows them to access services more easily, especially mental health services, that are provided in English (Kauppi, Pallard, et al. 2012). As for their over-representation among those with physical or mental health problems, it could also be exacerbated by a lack of mental health professionals able to serve homeless Francophones in their own language and in a culturally relevant way. Further research should be conducted to examine patterns in access to services which could be contributing to a greater number of homeless Francophones experiencing mental health problems.
Being at risk of homelessness or being absolutely homeless has a negative impact on a person’s physical or mental health (Pallard, Kauppi and Hein, 2015). According to our analysis, there is a significant difference between the three groups with respect to aspects of physical or mental health. Yet the underrepresentation of Francophones amongst homeless populations could be interpreted to imply that they are less disadvantaged (Kauppi, Pallard et al. 2012). Nevertheless, it appears from the results of the current study that proportionately more Francophones compared to Anglophones or Indigenous persons reported mental illness during the year prior to our study. The link between mental illness and homelessness appears to be slightly more pronounced among Francophones than in the other two groups in northeastern Ontario. Further research is needed to examine this difference.

Factors contributing to homelessness are complex. To support homeless people or to reintegrate them into the community, they need access to a range of services. People become homeless as a result of many different systemic factors, stressors or changes in their lives; they may have been severely traumatized by abuse or may be suffering from loss of employment, housing or illness. Goering et al. (2014) highlighted the importance of comprehensive housing programs and services for homeless people. Moreover, according to community members in northeastern Ontario cities, services must, among other things, provide clean and safe housing, housing support services, physical and mental health services, income support, literacy and training to develop workplace skills, counselling and job placement, education, child care, respite care and drug treatment (Kauppi, Pallard et al. 2012).

**Implications**

According to Hwang (2001), there are frequently co-occurring disorders (dual or multiple diagnosis of mental illness) among homeless people. Our data confirm these results. Findings indicating that the health of homeless persons, particularly Francophones in a minority situation, is precarious can be used to support the development of strategies to counter this phenomenon. Moreover, many homeless people, especially those who are migratory or transient, report barriers to accessing services (Kauppi, Gasparini et al. 2009).

Francophones have expressed the need for services in French (Kauppi, Pallard et al. 2012). Inventories of health services provided to Francophones have been compiled and a commitment made to work with health service providers to establish more French language services (North East Local Health Integration Network, 2013). In addition, further investigation should be undertaken to ensure that services are available and accessible by Francophones who experience homelessness. Homeless Francophones in Sudbury have a unique provider, the Clinique du Coin operated by the Centre de santé communautaire. This clinic was established to provide health services in French to disadvantaged Francophones, although it also serves people in English who seek services from the agency. Clients have access to varied health professionals such as physicians, nurses and nurse practitioners, dentists, and mental health counsellors. Offering services in French is important to Francophone clients and can be a way to ensure that services are effective, appropriate and culturally sensitive. The provision of health services in the native language can have a positive effect on the health of homeless Francophones. Therefore, it is vital to ensure that services, such as those offered by Clinique du Coin, which are responsive to the cultural and linguistic requirements of the population, continue to be offered to homeless Francophones.

Considerable attention has been given to the need to provide services to Indigenous people in a manner that is culturally appropriate and safe. Research has emphasized findings indicating that, compared to non-Indigenous people, Indigenous people have a higher rate of health problems (Anand, Yusuf, et al. 2001). Given this concern, Shkagamik-Kwe Health Centre was established in Sudbury to provide Indigenous persons with access to health services with an Indigenous cultural orientation. Thus the benefits of the Clinique du Coin for Francophones may
also apply to the Shkagamik-Kwe Health Centre for Indigenous people where they can receive appropriate and effective health services and care.

**Limitations**

Like much research with people experiencing homelessness, the current study has some limitations. It is difficult to accurately determine the number of homeless persons who experience mental illness and to study the relationship between the living circumstances of homelessness and mental illness. Mental illness is often under reported due to the associated stigma and the challenge of studying mental health issues amongst homeless people—an inherently difficult group to study—is substantially greater. For homeless persons, other obstacles are evident beyond acknowledging prior experiences of mental illness; these include a lack of resources and the problem of barriers to accessing services (Lesage, Vassiliadis, et al. 2006). Studying homeless persons with a mental illness poses many problems such as the diversity of the population, identifying homeless persons, and the transient nature of approximately a quarter of homeless persons (Kauppi, Pallard et al. 2013). In addition, the hidden homeless population, such as those who have temporary housing, are even more difficult to access by researchers using service-based methods. All of these issues amplify the challenges of studying minority groups, such as Francophones, who are experiencing the living circumstances of homelessness or near homelessness.

Another limitation of the current research is that it is a descriptive study and thus cannot determine the related factors that explain the phenomena studied through the utilization of inferential statistical methods. Thus it seems fundamental that a cohort study, ideally one that utilizes mixed methods, should be conducted to identify the determinants of the relationship between homelessness and mental health and to understand the mechanisms underlying this relationship.

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**REFERENCES**


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