BOYDELL CONSULTING GROUP

More than a Building

Supportive Housing for Older Persons Living with Mental Illness

November 2006
# More than a Building: Supportive Housing Services for Older Persons Living with Mental Illness

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EXECUTIVE SUMMARY

PURPOSE: The purpose of this study was to examine the impact of a values based model of supportive housing services and supports to older persons with mental health and addictions problems. This was achieved through qualitative interviews with older persons living in supportive housing in a large urban city. The perspectives of staff working in this model program as well as other community stakeholders including mental health case managers, psychiatrists, academics, policy makers, housing personnel and family members were also obtained.

MAIN OUTCOME MESSAGES FROM THE RESEARCH

Results confirmed that a value based approach to supportive housing is essential to best practice. This is characterized by:

- choice and control
- flexibility
- meaningful activity
- access to support
- community integration

The value based approach with its emphasis on psychosocial and recovery models, led to demonstrably enhanced quality of life for older persons.

In addition to personal level benefits, this living environment resulted in cost savings to the larger system in terms of reduced 911 calls, reduced emergency room visits, and reduced hospitalizations (both for physical and mental health reasons).

BACKGROUND: Adequate housing is an integral component of the well-being of all individuals. A stable home has been recognized as an important prerequisite in the mental health treatment and recovery process. Mental health systems have recently become more focused on assisting people with psychiatric backgrounds to live normal and meaningful lives in the community. Supportive housing has been referred to as the basis of an effective community mental health system. The demand for housing alternatives has increased as a result of the downsizing of psychiatric hospitals and the concomitant growth in community-based treatment. The essential elements of a comprehensive community support and rehabilitation approach to people with long term psychiatric histories includes adequate, stable housing and the availability of a wide variety of supports.
A significant number of older people have a serious mental health problem which is not a form of dementia related to their age (Adams & Wilson, 1996). Many are accommodated in long-stay psychiatric wards, long term care facilities and hostels for homeless persons. Few community care plans consider the special needs of this group or how they might be provided with more suitable housing. Health and housing issues for older persons are many and diverse. As seniors age, health care requirements and the need for personal support often increase. As an individual's health needs increase, it can be difficult and often impossible to meet one’s needs without moving into a long-term care facility, however, the majority of seniors want to age without moving. There are too few options in Ontario to support seniors as they strive to maintain their autonomy and independence (MacCourt, 2004).

Furthermore, there is growing evidence that mental health consumers’ perceptions of what they need in a living environment are the best predictors of success in housing. In fact, consumer choice and control over their environment has been posited as the single most important determinant of success and is an important principle of supported housing. These findings are supported by several studies suggesting that consumers who feel satisfied and perceive a good fit between their needs and the home environment may make a better adjustment. As a result, mental health services are increasingly implementing policies that reflect consumer driven or client centered systems. A need has been identified to further explore the perspectives of key stakeholders (older persons, their families, and service providers) regarding the impact of supportive housing settings (Percival, 2002).

The existing literature focused specifically on older persons living in supportive housing settings is limited, despite the proliferation of studies in the supported housing area. The evidence base to date strongly suggests that such housing contributes to enhanced quality of life for older people. Unfortunately, it is difficult to find supportive housing programs that focus on mental health and addictions problems for older persons. A community organization that has taken on this work in a significant way is LOFT Community Services. They have done this without full funding from the Ontario Ministry of Health and Long Term Care, using charitable donations to create and sustain their housing programs. This study is based on research conducted at four of their housing sites for older persons with mental health and addictions challenges. This provided a unique opportunity to examine how a value-based approach and recovery model to supporting seniors in their housing was applied across four sites.

RESEARCH DESIGN: The research describes:

- the client experience of the program/housing
- the effect of the housing on clients' lives (feelings of well-being, access to services, support networks, income security,
- the staff experience of the program
- the family experience of the program
- community stakeholder (referrers, decision makers) experience of the program
- the cost of supportive housing for seniors vis-à-vis alternate living situations
- the wait list for supportive housing services and supports
FRAMEWORK: The theoretical underpinnings of the proposed research are a determinants of health perspective, that is, how the health and mental health of older persons is affected by individual, community and societal factors. Triangulation of qualitative methods was used, which highlights the need to examine a particular issue from a number of perspectives (Boydell & Everett, 1994). Consequently, in addition to interviews with older people receiving supportive housing services (N=35), interviews were conducted with the staff members (N=7) who serve them as well as key stakeholders from the community (N=20). All interviews (face-to-face and telephone) were audio-taped and transcribed verbatim. Analysis involved utilization of a series of steps in keeping with the interpretive interactionist framework (Denzin, 1989). Transcripts were then examined for possible themes by the principal investigator and a coding scheme was developed to reflect these themes. The investigative team then systematically coded transcripts using the codebook.

RESULTS: The 35 older persons in this study consisted of 16 men and 19 women, who ranged in age from 55 to 89 years (mean age=64). They had been living in supportive housing for an average of 8.8 years. The majority of individuals were Canadian born. Those born outside of Canada had immigrated at an early age. The majority had been patients of the Centre for Addiction and Mental Health (psychiatric hospitalization) and/or boarding homes prior to their current housing. A significant number of individuals previously resided in public housing. All participants suffered from serious and persistent mental illness and had a long history of previous psychiatric hospitalizations and interaction with the mental health system. For example 21 (60%) had a primary diagnosis of schizophrenia or schizoaffective disorder. Approximately 20 percent also had a history of substance abuse.

Analyses of transcripts revealed a number of pervasive themes that contributed to enhanced quality of life and the creation of a home. These included community integration, a social support network and a significant element of choice and control within the environment. The findings of this study support the vision outlined in the recently completed Kirby/Keon Report (2006), which describes a vision for mental health services which are delivered in the community and champion consumer choice and integrated services. Further themes that emerged consistently throughout the client interviews included freedom, stability, social relationships, meaningful activity, flexible support, and a sense of space and belonging. These themes are consistent with the elements of current best practice in housing in the mental health field (Forchuk, Nelson & Hall, 2006).

Older persons spoke at length of the role that supportive housing staff played in their lives, and detailed the instrumental and affective dimensions of this support. An all encompassing theme in the data was the sense of freedom that older persons felt in their housing community. This freedom was often contrasted to previous living situations that were extremely rigid and structured and required tenants to be out of the house between certain time periods.

Community resources available in the neighbourhoods surrounding the housing sites were identified as key contributors to satisfaction with housing and community. Tenants also described the physical elements of the milieu within the building itself. This was linked with the positive social aspects of the supportive housing—the formal and informal gatherings among friends in the building. "A world of difference" is the phrase that truly captures the experience of living in supportive housing as disclosed by older persons interviewed. They identified the enhanced quality of life they enjoyed as a direct result of being in supportive housing.
A sample of five family members were interviewed regarding their perspectives on the supportive housing provided to their relative. All family members were children whose parents were living in one of the four housing sites for seniors. The main message that family members conveyed was that they were extremely pleased with the fact that their parent lived in this model housing program. They felt that the support staff genuinely cared about their family members and that they no longer had to navigate the health and mental health system on behalf of their parent. They did not feel any guilt because they knew that their loved one was happy and experienced a degree of independence and dignity. Family members invariably made the comparison to past housing arrangements and their inadequacy.

Twenty diverse community stakeholders were interviewed. Stakeholders included a building supervisor for Toronto Community Housing Corporation, academic researchers in the seniors housing field, service providers in geriatric addictions, mental health service providers, Community Care Access Centre staff, executive officers of LHIN’s and executive directors of seniors mental health and addictions organizations. With the exception of the academic researchers, all service providers and community agency personnel indicated that they worked very closely with supportive housing staff in seniors services. They noted that the supportive housing program promotes a great deal of involvement from outside agencies and providers in order to bring forward housing, health and mental health related issues. The model of supportive housing was repeatedly referred to as an example of best practice.

Interviews were conducted both face-to-face and via telephone with 7 staff providing services and supports to older persons within the four housing sites. Staff were asked to describe the services and supports they provide for older persons with mental illness and/or addictions problems, and to describe some of the successes and challenges they encountered in doing so. Staff provided numerous ‘stories’ regarding their work with clients that reflected the diverse activities they engaged in to help older persons. These numerous roles and responsibilities were described by staff as “a little bit of everything.” What they have in common is that everything done is related to the unique needs of each particular client. Several staff reiterated the philosophy of the housing model “leap of faith together” and the impact it had on ‘taking a chance’ on people that were not expected to succeed. The amount of time taken to develop a trusting relationship was an omnipresent theme in the staff interviews. The phrase “it takes time” was heard repeatedly.

Staff emphasized the importance of creating meaningful activity for their clients. It was acknowledged that it was sometimes extremely difficult to encourage involvement and this often translated into a wide variety of both passive and active social opportunities within and outside of the housing setting itself. Staff identified their efforts to assist individuals in making choices and the importance of becoming involved in something that is meaningful to them. Staff narratives illustrated the sense of belonging they observed in many of their clients. This translated into pride in having a place of their own and the importance of the social network and peer support within the housing was critical.

Data collected from multiple stakeholders suggests that supportive housing for older persons is providing the core values identified as essential to best practice in the provision of housing and supports for individuals with mental illness (Parkinson & Nelson, 2003). These key values include consumer choice and control, access to valued resources and community participation and integration. Other values include respect, hope, the non-judgmental approach of staff, flexibility and acceptance. Valued resources such as meaningful activity, social support and finances are the important link between consumer choice and participation in the community. The resource base is necessary in order that empowerment and community integration are made a reality (Nelson & Peddle, 2005).
A holistic view of the well-being of clients is evident in the consideration of broad determinants of health. A recovery orientation is taken with all clients as they are encouraged to develop new meaning and purpose in their life and move beyond the catastrophe of mental illness (Parkinson & Nelson, 2003). It involves overcoming the effects of being a ‘mental patient’, an identity that includes rejection from society, poverty, inadequate housing, isolation, unemployment, loss of meaningful roles, and loss of self. The recovery approach also involves a redefinition of values, attitudes and goals. The services and supports provided to individuals who have experienced a mental illness are flexible and are geared to each client’s individual preference and needs.

Results of this study suggest that a balance has been established between providing structure and protection on one hand and fulfilling the goals of normalization and community integration on the other. Many client interviewees indicated that although they appreciated the freedom that they had to make choices in their day-to-day lives, they were equally appreciative of the fact that there were rules and regulations that made sense within the housing site that made them feel safe and secure. Once again, the ability to maintain this balance within the housing model was sustained over time.

There were important shifts in the personal stories of client interviewees as they recounted their housing experience prior to and following their current status. The lives of all participants prior to supportive housing were extremely troubled and frequently involved extended hospital stays and poor housing in either shelters or boarding homes. With the provision of stable housing and multiple supports, individuals were able to regain a sense of freedom, power and control and become more active participants in their community. The support offered to tenants of supportive housing was individualized and flexible and this support was realized once the individual was ready to accept help and/or change. This supports the finding in previous research that consumers of psychiatric services prefer easy access to help but do not want to have live-in support that is often perceived as invasive and inconsistent with ‘normal’ living (Forchuk, Nelson & Hall, 2006).

Future research is required in order to examine the extent to which factors such as gender, sexual orientation and ethnicity influence the supportive housing stories of older people with mental illness and addictions problems. In addition, longitudinal studies are required in order to follow the temporal aspects of the day-to-day lives of older persons living in supported housing settings. Due to the complexity of factors that impact the lives of older persons, non-biomedical, multidisciplinary research approaches are needed.
Adequate housing is an integral component of the well-being of all individuals. More specifically, a stable home has been recognized as an important prerequisite in the mental health treatment and recovery process. Mental health systems have recently become more focused on assisting people with psychiatric backgrounds to live normal and meaningful lives in the community. Supportive housing has been referred to as “the foundation of an effective community mental health system” (George, Sylvester, Aubry et al, 2005, p.1). The demand for housing alternatives has increased as a result of the downsizing of psychiatric hospitals and the growth in community based mental health systems. The key components of any comprehensive community support and rehabilitative approach for people with long-term psychiatric histories include adequate, stable housing and the availability of a wide variety of supports.

A significant number of older people have a serious mental health problem which is not a form of dementia related to their age (Adams & Wilson, 1996). Many are accommodated in long-stay psychiatric wards, long term care facilities, and hostels for homeless persons. Few community care plans consider the special needs of this group or how they might be provided with more suitable housing. For seniors, the available treatment and support services are, in general, inadequate. More specifically, specialized treatment programs and support services for seniors are lacking, as are the research and knowledge exchange necessary for their development and improvement. Housing must be inclusive of all persons in any community including people with disabilities, the old, young and middle aged (The Standing Senate on Social Affairs, Science and Technology, 2006).

There is growing evidence that mental health consumers’ perceptions of what they need in a living environment are the best predictors of success in housing (Nelson & Peddle, 2005). In fact, consumer choice and control over their environment has been posited as the single most important determinant of success and is an important principle of supportive housing. These findings are supported by several studies suggesting that consumers who feel satisfied and perceive a good fit between their needs and the home environment may make a better adjustment (Tsemberis, Rogers, Rodis, Dushuttle & Shrya, 2003). As a result, mental health services are increasingly implementing policies that reflect consumer driven or client centered systems.

The growth of research on consumer preferences in the area of housing and support services follows from this shift and mirrors the increased attention paid to housing issues in the mental health field in the 1990’s. Following from these findings, it is critical to consult with consumers themselves about their perceptions of what they need and want in the way of housing and support in order for communities to develop appropriate plans for people with long-term mental illness.
The Senior Population

The senior population is expected to almost double in the next 40 years. By 2041, it will increase to 25 per cent of the population from its current 13 per cent (National Advisory Council on Aging, 2005). With these figures in mind, there is a serious need for policy enhancements regarding alternatives to institutional long-term care facilities (Ontario Coalition of Senior Citizens Organizations, 2003).

Seniors Mental Health

For seniors with mental disorders, the challenges of ageing can be even more daunting and complex as they deal with a multitude of issues. Conn (2002) has defined mental disorders as ‘a recognized, medically diagnosable illness that results in a significant impairment of the individual’s cognitive, affective or relational abilities’. Recent facts from the Mood Disorders Society of Canada indicate that the chance of living with mental illness in one’s lifetime is one in five. Yet, data specific to seniors, indicate additional alarming numbers and some would suggest that seniors’ mental health is poorly identified and tracked. Among Canadian seniors living in the community, over 100,000 have a depressive illness and an additional 400,000 live with substantial depressive symptoms. For seniors living in long-term care institutions, the prevalence rate is estimated to be as high as 50 percent.

Mental illnesses in seniors are significantly under diagnosed and under treated. Geriatric mental health has been identified as one of the most under researched and misunderstood areas of all health care (The Toronto Sun, April 2, 2006). Alcohol abuse is estimated to affect between 5 and 11 percent of seniors (McEwan et al, 1991). Between 40 and 70 percent of older individuals seeking help for a primary substance abuse concern were also found to have a comorbid mental health problem (CMHA, 2000).
Seniors Mental Health and Housing

Health and housing are inextricably linked. Lack of affordable housing creates distress for many seniors and also connects to an array of other issues that influence health: transportation, access to services, home care, and home support.

Health and housing issues for seniors are many and diverse. As they age, health care requirements and the need for personal support often increase. As this occurs, it is often difficult or impossible to meet these needs without moving to a long-term care facility. However, most seniors want to age in place, without moving. Currently, there are far too few options in Ontario for seniors as they strive to maintain their autonomy and independence.

To remain in their homes, seniors require a flexible range of supportive options to meet their needs. However, there are many barriers to achieving successful ‘aging in place’. They include lack of home care, culturally inappropriate services and discrimination, poverty, lack of affordable housing, and elder abuse (Ontario Coalition of Senior Citizens Organizations, 2003). In addition, a well defined and resourced system for supportive housing and community care for seniors with mental health and substance abuse challenges fails to exist.

Supportive Housing: Definition

The Ontario Ministry of Health and Long-Term Care defines supportive housing for seniors as the 24 hour availability of personal care and homemaking services (2000). Several community agencies have disagreed with this definition, as they view it as emphasizing individual services. Instead, they prefer to define supportive housing in terms of a holistic, comprehensive and coordinated package of programs and services needed to support the changing needs of seniors aging in place. A report by the former Toronto District Health Council similarly highlights the integration of housing, personal care and supports that link seniors to a broad network of services and enable them to remain in the community rather than in a long term care facility (Robinson, 2002).

The Canada Mortgage and Housing Corporation and the National Advisory Council on Aging utilize the same working definition, namely, housing that helps individuals in their day-to-day lives through the provision of a physical environment that is safe, secure, enabling and home-like. This is coupled with the provision of support services including meals, housekeeping and social and recreational activities. It is the type of housing that maximized independence, privacy decision-making and choice and preference (Canada Housing and Mortgage Corporation, 2000; The National Advisory Council on Aging, 2003). In addition, supportive housing services stress flexibility in responding to seniors needs, recognizing that needs change over time as health and mental health improve or decline.

There are virtually no supportive housing resources available if you are an older person with mental illness and/or addictions....only options are a hospital or a nursing home, but these are expensive, institutional and often not necessary

Terry McCullum, CEO, LOFT
A Model of Supportive Housing for Seniors—
Sites Used in this Research

This study is based upon interviews with seniors living in four different supportive housing residences and receiving support services from a non-profit community service organization which offers a system of integrated permanent housing, housing support, community case management and community outreach to vulnerable individuals in the Greater Toronto Area. LOFT (Leap of Faith, Together) offers services to over 3,000 vulnerable and homeless people at more than 50 sites. The majority of these people have mental health and substance abuse challenges. Their policy is to accept people on their own terms, providing the necessary resources to support them as they recover their health, dignity, and self-esteem.

Of specific relevance to this research is that the community agency’s housing portfolio includes support of older persons (55+) with a variety of physical and mental health needs. In addition to providing affordable housing for seniors, the organization also provides supportive housing services which include assistance with personal care, light housekeeping, laundry, medication support, mental health supports and social supports to seniors. Their goal is to provide support with activities of daily living and to help residents connect with community resources and one another, enabling them to maintain their independence and age in place.

Purpose of the Research

The primary purpose of this research study is to examine the impact of a values based model of supportive housing services and supports to older persons with mental illness. One of the critical ingredients of successful supportive housing is that it is experienced as a home (Ridgway & Zipple, 1990, p.116). As a result, an essential part of examining a supportive housing program is to consult with clients about their experiences and perspectives of their housing (Jones, Chesters & Fletcher, 2003).

A secondary purpose is to also obtain the perspectives of staff working in the program as well as other community stakeholders (also referred to as key informants) who are in one of more of the following areas: seniors/older persons/mental health/housing. Community stakeholders include service providers in these fields as well as academics and family members.

Specific research objectives include:

- To describe the client experience of the program/housing
- To document the effect of the housing on clients’ lives (feelings of well-being, access to services, support networks, income security)
- To describe the staff experience of the program
- To document community stakeholder (referrers, academics, family) perspectives on supportive housing and their experience of the program
- To explore the cost of supportive housing for seniors vis-à-vis alternate living situations
- To examine the wait list for supportive housing services and supports

A home is the base from which we have security to build our lives as we choose

CMHA, 1995
Conceptual Framework

The theoretical underpinning of the research is a determinants of health perspective, that is, the ways in which the health and mental health of older persons is affected by individual, community and societal factors. Much of the research is telling us that we need to look at the big picture of health to examine factors both inside and outside the health care system that affect our health. At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior. These factors are referred to as ‘determinants of health’. They do not exist in isolation from each other. It is the combined influence of the determinants of health that determines health status. Health Canada’s determinants of health include income and social status, social support networks, physical and social environments, etc. (Bryant, Brown, Cogan et al, 2004).

Interpretive Interactionism

Following the work of Denzin (1989), an interpretative interactionist framework was used to guide the research. Interpretive interactionism is both a perspective and a method, and seeks to highlight the world of problematic lived experience of individuals. These narratives of lived experience are collected through thick description and personal experience stories, which are then interpreted to reveal the voices, emotions and actions of those studied. A personal experience story is a narrative that relates the self of the teller to a significant set of personal experiences that have already occurred (Denzin, 1989; p. 38). A major aim of the interpretive interactionist researcher is to grasp the subjective meanings of the individual positioned within a social context. The interconnection between private lives and public responses to personal troubles is addressed (Mills, 1959). Like other qualitative research methodologies, the epistemological posture taken by interpretive interactionism questions the possibility of value free inquiry, an objective researcher, and interpretation based on causality (Guba, 1990; Lather, 1990). It assumes that knowledge is socially constructed and that the concept of truth depends on the perspective one takes in interpretation (Williams & Collins, 2002).

Literature Review

A tightly focused literature search examined the extant literature in the following fields: seniors and older persons in community services, seniors and older persons with mental health problems, and housing for individuals with psychiatric disabilities. The research team conducted a focused search of both the published and unpublished (grey) literature. Keyword search strategies were developed, on-line searches of bibliographic databases for potentially relevant publications were conducted, abstracts were screened to identify studies for further review, and the references sections of publications were reviewed for potentially useful studies. Selected articles and reports were entered into End Note and an annotated bibliography was produced as a separate companion document.
Literature review (cont.)

The following bibliographic databases were searched from 1990 to 2006 for relevant publications.

Ovid (Ovid Technologies) including:
All Evidence Based Medicine (EBM) Reviews, including:
- Cochrane Database of Systematic Reviews (DSR)
- American College of Physicians (ACP) Journal Club
- Database of Abstracts of Reviews of Effects (DARE)
- Cochrane Central Register of Controlled Trials

Books@Ovid
- Cumulative Index to Nursing & Allied Health Literature (CINAHL)
- Journals@Ovid Full Text
- OVID Medline 1966-Present
- PsycINFO 1967-Present
- Your Journals@Ovid

EBSCOhost Research Databases (EBSCO Publishing) including:
- Academic Search Premier (ASP)
- General Science Abstracts
- Social Sciences Abstracts

ProQuest Dissertations and Theses - Full Text

Web of Science, including:
- Science Citation Index Expanded (SCI Expanded) 1945-Present
- Social Science Citation Index (SSCI) 1956-Present
- Arts & Humanities Citation Index (A&HCI) 1975-Present

World Wide Web using the search engines: Google (www.google.ca) and Vivísimo (http://vivisimo.com).

Search of specific journals for relevant articles, including:

Canadian Journal of Psychiatry (1999-Present)
Canadian Medical Association Journal (1997- Present)
Community Mental Health Journal (1996- Present)
Evidence Based Mental Health (1998- Present)
Health and Social Care in the Community (1998- Present)
Health Services Research
International Journal of Psychosocial Rehabilitation
International Psychogeriatrics
Journal of Community Psychology
Journal of Community Mental Health
Journal of Mental Health (1992- Present)
Psychiatric Services (1995-Present)
Social Science and Medicine (1979-Present)
Overview of the Extant Literature—The History and Trends of Housing

Past Approaches to Housing

Deinstitutionalization began in the 1960s in Ontario and the main approach to housing individuals with serious mental illness was custodial (Trainor, Morrell-Bellai, Ballantyne & Boydell, 1993). This type of housing involved placing people in large congregate housing operated by private landlords for profit. The settings included lodging homes, approved homes, board-and-care homes, domiciliary care, Homes for Special Care, and single-room occupancy hotels. They provided custodial care rather than active rehabilitation programs. Evidence from a 10 year follow up study of custodial settings demonstrated that it did not lead to an improved quality of life for residents (Segal & Kotler, 1993).

Non profit community mental health and housing agencies began to develop supportive housing as an alternative to custodial housing in the 1970s. Supportive housing involved the provision of case management, support or rehabilitation in a wide variety of settings including halfway houses, group homes and supervised apartments. This often involved a residential continuum ranging from high support settings to lower support apartments (Ridgway & Zipple, 1990). Although many people living in these settings showed improved outcomes, there were problems with the approach which became apparent in the 1980s (Nelson & Peddle, 2005). Namely, consumer-survivors did not have choice over where they lived or with whom they lived and when they showed improvement, they were forced to move to another setting which often disrupted relationships and sense of stability.

The Shift in Housing Terminology

In the early 1990s, Carling and his colleagues coined the term ‘supported’ housing, which emerged from the independent living movement for people with physical and developmental disabilities (Carling, 1993, 1995; Ridgway & Zipple, 1990). The underlying premise of this type of housing was the importance of choice and control over where and with whom one lives. Rather than a focus on the medical model, this approach draws on a disability rights perspective. Community integration is a key principle of supported housing, wherein separate facilities for people with mental illness are discouraged.

The supported housing approach also recognizes that financial and social support are key requirements needed to assist individuals to thrive in the milieu of a normal housing market. Supported housing is designed to help individuals with mental illness “choose, get and keep” the type of housing that they desire (Forchuk, Nelson & Hall, 2006). Unfortunately, the “keeping” part of this equation is often a major barrier.

As a result of this change in paradigm from supportive to supported housing, there emerged a corresponding emphasis on independence and the realization of more individualized, flexible, and recovery based approaches to the implementation of housing services and supports.
The Shift beyond Supportive Housing/Supported Housing to a Values Perspective

In the current era, it has been noted that the distinction between supportive and supported housing has blurred as many supportive housing programs have shifted to more of a supported housing approach (Nelson & Peddle, 2005). Very few supportive housing programs have limits on how long tenants can remain in the housing, there is no longer a ‘levels of support’ system, and consumer choice and control are maximized.

As a consequence of this blurring of the two concepts, Nelson and Peddle (2005) indicate that the terms ‘supportive’ and ‘supported’ have outlived their usefulness. Instead, it is suggested that a value-based approach should be used for future housing development for people with mental illness. This also allows for housing support to be not solely defined by housing type (e.g. clustered or scattered housing). The principle values of this approach include consumer empowerment—choice, control, independence, access to valued resources (financial, housing, social resources), and community integration. They also include the values associated with what is known as the ‘recovery model’ of service or psychosocial rehabilitation. Community integration results from housing and supports that allow people with mental illness to move beyond the formal service system.

Review of Research on Housing and Support for People with Mental Illness

Several literature reviews on supported housing for people with mental illness have been published over the past few years (Chilvers, MacDonald & Hayes, 2002; Fakhoury, Murray & Shepherd, 2002; Newman, 2001; Parkinson, Nelson & Horgan, 1999), however none focus on housing and supports for older persons who have a mental illness. There is a large range of supported/supportive housing models and a corresponding diversity of definitions describing them. As a result, it is a challenging task to compare both process and outcomes.

The housing literature indicates that there are key qualities that contribute to a sense of empowerment and recovery, including services and supports that are individualized and consumer controlled, a broad range of social support and help with accessing basic resources (Parkinson & Nelson, 2003). In spite of the fact that studies of supported housing outcomes are relatively recent (Parkinson et al, 1999), results of these studies demonstrate that these housing models increase resident stability and independent living and decrease rates of homelessness (Bolton, 2005). In addition, hospitalization rates (Burek, Toprac & Olsen, 1996; Hanrahan, Luchins, Savage et al, 2001) and psychiatric symptoms (Dixon, Krauss, Myers & Lehna, 1994) are reduced.

With respect to psychosocial outcomes, supportive housing has been found to be related to increased involvement in instrumental roles such as work and education, increased community involvement and independent functioning (Nelson, Hall & Walsh-Bowers, 1997). Clients with severe mental illness and addictions problems are capable of getting and keeping independent housing when provided with the opportunity and required supports (Tsemberis & Eisenberg, 2000).
Although little attention has been given to seniors housing, we do have some knowledge about the needs of those over aged 65. Older persons face a multitude of barriers such as lack of home care, culturally inappropriate services, discrimination, poverty, lack of affordable housing and elder abuse (The Standing Senate Committee on Social Affairs, Science and Technology, 2006; Ontario Coalition of Senior Citizen Organizations, 2003). Mental health services are frequently unavailable to older persons in the places where they reside, and a correspondingly lack of attention is given to the more limited mobility of this population. In addition, and of particular note, is the discrimination and oppression of gay and lesbian seniors which has had an impact on their identify and health throughout their lives (Brotman, Ryan & Cormier, 2000).

Loneliness and isolation can be a major source of unhappiness and contribute to depression and mental illness in older age (Andrews, Gavin, Begley & Brodie, 2003). There is a clearly documented lack of a full range of services for this group of individuals (Pastalan, 1990). In this context, a positive environment and sense of belonging to a community are critical.

Domestic spheres have a significant impact on the capacity that older people have to retain a sense of self-determination. Older people require adequate, accessible, and personalized space to facilitate routine and responsibilities (Percival, 2002). Studies have shown the superiority of residential care over institutional care, particularly in relation to enhanced quality of life for older people with serious mental illness (Young, 2004). Bagovic (2005) has indicated that the move from non-institutional care resulted in increased housing satisfaction and decreased depression in a senior population.

The effectiveness of the supported housing approach for older homeless persons has been shown (Kasprow, Rosenheck, Fisman et al, 2000). In general, activities of case managers, such as accompanying individuals to the public housing authority and securing additional sources of income, were associated with success in the housing process. Ultimately, the project resulted in the attainment of permanent housing for a large proportion of clients.

There has been a recognized need to change attitudes and practice to enable older individuals to more fully participate in residential settings (Abbott, Fisk & Forward, 2000). Correspondingly, there should be more opportunities for older people to make choices and for more extensive involvement in housing issues (Gilroy, 2003). Gilroy (2003) found that older people gained as individuals and as a group from the housing project, and were able to develop collective influence through a representation role. Consequently, he argues that a foundation of dialogue with older people regarding housing matters is needed.

In summary, the literature focused specifically on older people living in supportive housing settings is limited, despite the proliferation of studies in the supported housing area. The evidence base to date strongly suggests that such housing contributes to enhanced quality of life for older people. A need has been identified to further explore the perspectives of key stakeholders (older persons, their families, and service providers) regarding the impact of supportive housing settings (Percival, 2002).
Methods—Semi-structured Interviews

Triangulation of qualitative methods was used, which highlights the need to examine a particular issue from a number of perspectives (Boydell & Everett, 1994). Consequently, in addition to interviews with older people receiving supportive housing services, interviews were conducted with the staff members who serve them as well as key stakeholders from the community.

Settings

Tenants were selected from the four sites that house older persons with mental health and addiction problems. These four sites are described below.

ST ANNE’S PLACE

St. Anne’s Place served as a seniors’ residence since 1968, and was taken over by LOFT community services in 2000. Major renovations took place in 2001, which involved the addition of kitchen facilities to the units, addressing wheelchair accessibility and other physical upgrades. These upgrades also included attention to social space. St. Anne’s place is a 110-unit (with 90 subsidized units) non profit apartment residence for seniors 59 years of age and older, located just west of the downtown Toronto city centre. Each studio and one bedroom apartment has a newly remodeled kitchenette along with a bathroom. Many common areas are featured throughout the building, including a solarium and TV room on the top floor, a café area and living room on the main floor and a large outdoor patio area. There is a dining room located on the top floor with a panoramic view of the downtown city core and Lake Ontario. Supportive housing services are provided to 35 tenants who require further assistance with activities of daily living in order to enable them to remain in their homes. Approximately 80 percent of residents have mental health and/or addictions problems. In addition, there are approximately 152 individuals on the wait list for supportive services.

DUNN AVENUE

Dunn Avenue Supportive Housing Services provides access to 24-hour on site supportive housing services to more than 40 seniors living in a public housing apartment complex located in Toronto’s Parkdale area. The building houses more than 698 tenants, comprising a wide diversity of cultures and family situations. LOFT is the only community support agency located in the building. Those receiving supportive housing have many special needs including cognitive impairments, mental health and addiction issues, and severe social isolation. Many are extremely at risk seniors who need support regarding their medical issues as well as personal day-to-day care. The Dunn Avenue supportive housing program offers 24-hour on-site access to support services that enables older persons to remain in their home and have necessary services such as personal care, housekeeping, meal preparation, medication supports, escorts to appointments, laundry, caregiver relief, social and emotional support, and a 24-hour emergency response system. To address issues of social isolation, staff regularly organize a wide variety of social events and activities. There are currently about 138 individuals on the wait list to receive supportive housing services at the Dunn location.
JOHN GIBSON HOUSE

John Gibson House supportive housing is located in the west end of Toronto and serves some of the most vulnerable, at-risk and frail older persons in the community. The physical dwelling sits on the edge of a lush park and overlooks a river.

The neighbourhood surrounding John Gibson House (JGH) has recently become more trendy with a mix of beautifully renovated Victorian style homes interspersed with homes that are visibly in need of repair. JGH itself is situated right in the park, overlooking a ravine. (interviewer field notes)

It utilizes a multi-service approach to offer 24 hour on-site access to services for seniors who have traditionally been underserved. These individuals receive assistance with health and medical concerns, mental illness and substance abuse problems, and other related issues. Specifically, it provides supportive housing services for 50 seniors at the Crawford Street site and for other seniors living in LOFT apartment buildings in downtown Toronto. The residents are actively involved in the operations and programs of their home. Currently, there are 61 individuals on the wait list for supportive housing services.

COLLEGE VIEW

College View Supportive Housing Services is owned by the Metro Toronto Housing Corporation. They work in partnership with LOFT who provide service to 65 seniors living in a high-rise apartment building at Yonge and College in downtown Toronto. It serves many vulnerable and high risk seniors who need support in coping with declining health and mobility, mental health and addictions issues and acute social isolation. LOFT also operates the dining room for seniors in order that on-site meals can be provided. This building serves a diverse ethno-cultural group of seniors, 33 percent of whom are of Chinese origin. Services have been adapted to meet these specific needs through staff members who have Chinese and other cultural backgrounds.

Although all four study sites were extremely different in terms of their physical structure and the communities that they were located in, they possessed a similarity in the physical efforts made to make them homes. For example, there was attention to the use of social space, both indoors and outside. Ample opportunities for interaction were facilitated by the location of seating at outside entrances, in gazebo areas, and overlooking park land. Inside, lobbies were warm and friendly and encouraged residents to linger.
Sampling

Maximum variation sampling was used, wherein the sample is selected in ways that provided a broad range of information (Lincoln & Guba, 1985). Our sample included supportive housing residents with mental health issues, staff of the supportive housing sites, and a wide variety of key stakeholders in senior’s mental health and housing from the community.

Following the sample size guidelines for long interviews suggested by McCracken (1988), the following populations were selected.

OLDER PERSONS

Our maximum variation sampling strategy was used to obtain a sample of eight to ten older persons from each of the four LOFT housing locales (for a total of 32-40 interviews). Participants from each of our four study sites were selected based on age, gender, culture and length of time in the housing setting. Candidates were also selected based on their interest in the study and willingness to talk about personal experiences (i.e. information-rich cases).

FAMILY MEMBERS

A sample of five family members were interviewed regarding their views of supported housing for their ill relative.

SUPPORTIVE HOUSING STAFF

Seven personal support workers who provided services under the LOFT auspices were interviewed. These staff members ranged from front-line staff to those in managerial positions.

COMMUNITY STAKEHOLDERS

Twenty key informants identified as having an important role in supportive housing services and supports in Canada were interviewed. These informants included, for example, representatives of the Canadian Coalition for Seniors Mental Health, the Older Persons Mental Health and Addictions Network of Ontario, the Canadian Mental Health Association, the Centre for Addiction and Mental Health and academic institutions. They also included referrers and other community agency personnel who served clients.

CLIENTS ON LOFT WAIT LIST

Three older persons who are currently on wait lists for LOFT services were interviewed via telephone to determine the length of time they had been waiting and to gain their perspectives on what it was like to be on the wait list.


Research Design—Data Collection

In-depth interviewing, using the long interview method, described by Charmaz (1991) as a “directional conversation that elicits inner views of respondents’ lives as they portray their worlds, experiences and observations” (p.385) was used. The qualitative interview is a particularly useful approach for accessing the perspective and experience of the individual (Devers, 1999; Sandelowski, 1997; Shortell, 1999). It has been documented that qualitative interviews have the advantage that many seniors like them and appreciate the opportunity to “storytell” (Bryant, Brown, Cogan et al, 2004).

Thirty five older persons, drawn proportionally from each of the four study sites were interviewed in depth. Interviews took about 45 minutes to conduct on average. Four research assistants were responsible for data collection, one at each housing site. Program directors from each site worked very closely with the research assistants to facilitate access. They also reminded participants of the interview date and time and facilitated scheduling.

The research team developed guideline questions and probes for the in-depth interviews. Prior to the qualitative interviews, a sample of stakeholders who have a knowledge base regarding supportive housing for older persons were asked to assist the research team in the finalization of the guideline interview questions. This ensured that the proper content, language and wording were used in the final versions of the interview guide. The research team has successfully utilized this approach to the refinement and finalization of surveys and semi-structured interview guides in the past (Boydell, Pong, Volpe, et al., 2005). We also drew on the investigative team’s earlier work which identified the key issues to consider in community based mental health research (Boydell, Greenberg & Volpe, 2004).

The interview guide, composed of open-ended questions and probes (McCracken, 1988), was used to invite participants to describe perceptions and experiences of receiving supportive housing services and supports (next page). In many cases, the questions in the interview guide were simplified in order to offer a more complete explanation to participants. This interview guide included a cover sheet that was used to collect basic descriptive demographic data for the participant group (including age and gender of the older person, previous living arrangements, household composition, diagnosis, and duration of residency) as well as the staff and stakeholder groups.

Field notes taken by researchers during and immediately after each interview included visual information such as non-verbal aspects of the interview, the physical setting, and personal interaction which may otherwise have been lost with the use of audiotape alone (Kvale, 1996; Poland, 1995). Field notes are considered a central activity in qualitative research although they are often not reported upon and as such are described as an invisible activity by Hammersley and Atkinson (1995). As partial, interpretive accounts, field notes are not a record of everything observed, but of selections made that change as issues emerge and analytic ideas develop during the course of a study (Hammersley & Atkinson, 1995; Kvale, 1996). Field notes are used in conjunction with the transcripts from individual interviews to assist in the interpretation of data and to provide further in-depth descriptive and reflexive information.
Semi-structured Interview Guide

Older Person Interview

A face sheet accompanied each interview and included basic demographic data (e.g. location, age, sex, length of time in the housing, previous housing), which was used to describe the sample. This information was extracted during a documents analysis of the client files held at LOFT community services and/or provided by the managerial staff at the study site.

All questions were repeated or reworded if interviewees had difficulty understanding what was meant.

Tell me a little bit about what it’s like to live here?

Can you describe a typical day for me from the time you get up in the morning until you go to bed at night?

What is important to you in your life? (prompts include individual, community and societal factors)

What are the events or situations that have improved quality of life for you or for people living in your community?

What are the events or situations that have diminished quality of life for you or for people living in your community? (prompts: what things do you think you need to make your life better? What things make it hard for you to enjoy your life?)

What are the kinds of things your personal support worker does for you? (prompts include is this helpful? What more could be done? How often do you see your worker?)

Is there anything else you would like to talk about regarding your housing or the supports that you receive here?

Following the interview, participants were offered an honorarium to signify that their time is valuable and to express appreciation for their participation.

Interviews with family members, clients on wait lists, supportive housing staff and community stakeholders followed a similar pattern to the above questions. For community stakeholders, questions included the relationship they had with LOFT community services, the role of their organization in the seniors/mental health/housing field, and their opinions vis-à-vis the role of supportive housing in the wider system.
Data Analysis

Most interviews (face-to-face and telephone) were audiotaped and transcribed verbatim. In a few cases, interviewees preferred not to be audiotaped and instead detailed notes were taken. Analysis involved utilization of a series of steps in keeping with the interpretive interactionist framework (Denzin, 1989). The first step of the analysis is bracketing, followed by construction and finally the contextualization of findings. Bracketing involves isolating the essential elements under investigation. This process is commonly known as coding. The process of construction classifies orders and reassembles the phenomenon back into a coherent whole. Contextualization is a process in which greater meaning is sought across individual experiences.

More specifically, this analytic approach involves the reading and rereading of each transcribed interview by the lead researcher to obtain an overall understanding. Transcripts were then discussed with each research assistant, and a coding scheme was subsequently developed to reflect these themes. The lead researcher then systematically coded transcripts using the codebook. Any disagreements encountered were resolved by returning to the original text. Members of the investigative team have experience successfully conducting such team analysis with colleagues, including those in different geographical settings (e.g. Boydell, Pong, Volpe, et al., 2005; Boydell, 2005; Boydell & Volpe, 2004; Boydell, Jadaa & Trainor, 2004; Boydell, Goering & Morrell-Bellai, 2000; Morell-Bellai, Goering & Boydell, 1997; 2000; Boydell, Trainor & Intagliata, 1986).

Research Rigor

As qualitative methods have become more commonplace in health services research, the issue of the quality of qualitative research is of special interest (Devers, 1999; Eakin & Mykhalovskiy, 2003; Mays & Pope, 2000; Popay, Rogers & Williams, 1998). In this study, the concept of rigor was used in three ways: research practice as rigor, analytic or theoretical rigor and procedural rigor.

The term rigor commonly refers to the reliability and validity of research in a general sense (Davies & Dodd, 2002). However, we want our qualitative research to be reliable but not in the sense of replicability over time and across contexts. Rather, reliability in our data is based on consistency and care in the application of research practices, reflected in their visibility (Fossey, Harvey, McDermott, et al., 2002). Moreover reliability in our analysis and conclusions are represented in an open account that remains mindful of the partiality and limits of our research findings.

We conceptualize research practice rigor in terms of attentiveness to research practice vis-à-vis elements of attentiveness, carefulness, respect, sensitivity, honesty, reflection, conscientiousness, engagement, awareness, openness and sensitivity to context. Analytic rigor generalizes from a particular empirical instance to a theoretical one. The analysis and interpretation of data provides theoretical insights, which possess a sufficient degree of generality to allow projection to other comparable contexts. The researcher recognizes parallels at the conceptual and theoretical level; comparability between two contexts is a conceptual one,
Research Rigor (cont.)

not one based on statistical representation (Sim, 1998). **Procedural rigor** is traditionally understood within qualitative research methodology as a way of establishing the ‘trustworthiness’ of findings (Erlandson, Harris, Skipper, et al., 1993).

### Strategies to Address Research Rigor

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<tr>
<th>Quantitative Term</th>
<th>Qualitative Term</th>
<th>Current Project Techniques</th>
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<tbody>
<tr>
<td>Internal validity</td>
<td>Credibility</td>
<td>Prolonged engagement: Team members from diverse backgrounds (sociology, education, psychology) with history of research with individuals experiencing mental health problems as well as individuals in supportive housing</td>
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<tr>
<td></td>
<td></td>
<td>Triangulation: A series of interviews with older people; team approach to analysis</td>
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<td>External validity</td>
<td>Transferability</td>
<td>Sampling to saturation: A series of interviews and sufficient numbers to ensure theme saturation</td>
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<td>Reliability</td>
<td>Dependability</td>
<td>Audit trail: Minutes of team meetings, documentation of analysis decisions, and knowledge translation and exchange materials</td>
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<td></td>
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<td>Reflexive journal: Extensive observational and interpretive field notes throughout research process by research team</td>
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<tr>
<td>Objectivity</td>
<td>Confirmability</td>
<td>Peer Review: Regular co-investigative team meetings, peer debriefing, team approach to analysis</td>
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**A note on generalizability**

Qualitative research is susceptible to ongoing misconceptions about generalizability and replicability (Sandelowski, 1997). In quantitative research, emphasis is placed on monolithic generalizations, or universal laws or principles toward which such techniques as random sampling and assignment are utilized. In qualitative research, emphasis is placed on idiographic or naturalistic generalizations or conclusions that are drawn from and about cases. The stories collected in most qualitative research encounters are representations of the particular and the concrete, but also of the universal and the general. Lives are lived and told in relation to other lives as well as in historical and cultural context. As Sandelowski (1997) states: “Generalization in qualitative research must be understood in more expansive ways as providing idiographic knowledge, promoting the artful understanding of the cultural and universal singular, and providing the means to extend our work beyond the confines of any one project” (p.128). In other words, in qualitative research we generalize to theory rather than to populations.
Ethical considerations

Following an internal scientific peer review, the research proposal was approved by the Research Ethics Board at the primary investigator’s home institution. Information about the study was provided to all participants so that they were able to provide informed consent regarding participation in the study. The information sheet and consent forms were written in age appropriate language and were always consolidated with verbal explanation. Interviewees participated voluntarily, knowing that they could withdraw at any time without consequence. Consumer participants received a token honorarium to recognize their involvement in the study. This honorarium was frequently met with surprise and the research field workers indicated to participants that this was to acknowledge and value participant’s time.
Findings
Interviews with Older Persons

The findings of this study support the vision outlined in the recently completed Final Report of the Standing Senate Committee on Social Affairs, Science and Technology "Out of the Shadows at Last" chaired by The Honorable Michael Kirby" (2006), which describes a vision for mental health services which are delivered in the community and champion consumer choice and integrated services. The older persons interviewed in this study strongly prefer to live in the community in settings which enhanced their quality of life and created a home like environment. They described the positive impact of integrated services, a social support network, choice and control within their environment. Further themes that emerged consistently throughout the interviews included freedom, stability, social relationships, meaningful activity, flexible support, and a sense of space and belonging. These themes are consistent with the elements of current best practice in housing in the mental health field (Forchuk, Nelson & Hall, 2006).

Results are based on in depth face-to-face interviews held with 35 older persons identified as having a mental illness and/or problem with addiction. Participants were selected according to the sampling strategy identified above, specifically with the goal to achieve maximum variation on age range, sex and housing location. The 35 participants consisted of 16 men and 19 women, who ranged in age from 55 to 89 years (mean age=64). They had been living in supportive housing for an average of 8.8 years. All but 3 individuals were Canadian born. Those born outside of Canada had immigrated at an early age. The majority had been living at the Centre for Addiction and Mental Health (psychiatric hospitalization) and/or boarding homes prior to their current housing. A significant number of individuals previously resided in public housing. All participants suffered from serious and persistent mental illness and had a long history of previous psychiatric hospitalizations and interaction with the mental health system. For example 21 (60%) had a primary diagnosis of schizophrenia or schizoaffective disorder. Approximately 20 percent also had a history of substance abuse.

Taking Care of Business

All clients interviewed spoke at length about the role that supportive housing workers played in their lives. This role included both instrumental and affective dimensions of support. Their descriptions depicted a wide and varied list of functions that included but were not limited to helping with laundry, house cleaning, repairs, grocery shopping, medication support, assistance with finances, making appointments, and escorting to appointments. Reference was often made to the competence of staff in statements such as "they know what they’re doing". Other commonly heard statements were ‘there’s always somebody there’ and ‘they’ll do anything for you’.

The LOFT. They are so good. They do everything. If you need anything, you just call them. They’ll go to the store for you and they’re so great.

If I need help, I just need to press a button and they’d be right up.
Most important was the frequent reference made to the more affective dimensions of support, namely talking to and being listened to by staff. The critical role of housing staff in the provision of advice and social companionship was apparent. In fact, several of the clients interviewed used the word 'love' when describing their relationship with staff.

She tells me stories and talks to me and she’s very pleasant. She asks you questions and she doesn’t make them sound like questions...she interesting. More than just a worker. More like a friend.

We have long talks. She is kind.

She knows how to talk to me. She relates to me.

She talks to me and asks how I am.

Second to None

In addition to the many detailed illustrations of the role of supportive housing staff, clients also described their unique qualities and the important contribution that it made to their continued sense of well being. It was noted that there is “absolutely almost minimal turnover of staff”.

The human touch here has been more than significant in my own personal getting well. I define the human touch as being strict when necessary but having the ability of showing compassion, not just for physical ailments, but for the emotional ailment that cannot be seen.

A Sense of Freedom

An all-encompassing theme in client transcripts was the sense of freedom that they felt in their housing community. This freedom was often compared to previous living situations that were extremely rigid and structured and required tenants to be out of the house between certain time periods. This freedom included things like choosing what could be eaten at a meal. The sense of freedom was also coupled with a feeling of stability because there were fair rules, regulations and expectations associated with being a resident and associated with the supported housing.

You can come and go as you please.

You’ve got freedom. You can go out.

Being made to feel at home as much as possible and also having as much freedom as I could wish for. You can come and go pretty well as you please.
**Meaningful Activity**

The importance of having something meaningful to do was a common theme in all interviews. In addition, interviewee transcripts showed that routine was extremely important to many of these individuals. Meaningful activities were broad based and included both formally organized and informal activities. Informal activities were both passive and active and included reading, watching TV, listening to music, playing pool, darts, and hobbies such as sewing, artwork, and crocheting. Taking walks was a frequently mentioned activity, which highlighted the importance of mobility to these individuals. The phrase "always something to do" was voiced repeatedly. More organized activities within the residence included regular bingo, movie nights, themes days, excursions within and beyond the local community, and involvement in the housing organization’s annual general meeting. It was noted that activities tended to occur in the afternoon, allowing residents the opportunity to sleep in if they so chose. For some tenants, volunteer work or paid employment offered further meaning in their lives on a day-to-day basis.

It’s a pretty good place. We have programs and during the summer we have outings and we go all over the place, out of town, whatever. And we have a camping program in the summer too.

I have a job here and it has helped me with finding my self-respect again and having a little bit more confidence in myself.

They have...with people who live here, when we have a birthday, the people sing happy birthday in the dining room and they have cake and ice cream.

Downstairs, they have so many good things going on, like they have St. Patrick’s Day. They had a party on Valentine’s Day. They have a party at Christmas. They have a huge Thanksgiving. There’s always something going on downstairs. Lots and lots of things....you don’t have time to be bored

**Better than Before**

When asked to reflect on their current housing, respondents invariably compared it to their prior housing experiences, even though many of them had lived in LOFT supportive housing for many, many years. This did not appear to dim the memory of past negative housing experiences. In all cases, the current housing status was regarded as superior.

You were pretty well on your own in [apartment]. But here, you meet people. You talk to people...compared to living on my own, this is the Royal York.

Tenants often recounted the length of time they had waited to get into supportive housing.

Everybody wants to come in here...It’s better than a shelter. I couldn’t get in for along time...When I first come here, I thought I wasn’t going to make it. Now, it’s just like home.
Among Friends

The social support and social relationships described by older persons in this study included both formal—professional services, and informal supports—peers, family and intimate relations. The social support networks within the building itself were critical and were described throughout the interviews.

I have many friends in the building...I come down to the lounge until 10pm to talk with my friends.

The people keep me well. They are helpful. I get along with everybody. I help my friends when they need me.

I come down and talk to my friends in the morning...I can have my friends over...I ma friends with all the people.

I have more friends here...before I had nobody.

I have a few friends in the building. We sit together or phone each other. We all met through LOFT. That’s how we got to meet each other. It’s nice to have people your own age...everybody knows each other.

In spite of the pervasiveness of the informal friendship network among interviewees, there were still some who did not have as wide a network.

Well, I would like to have more company because I’m a lonely soul. I always search for somebody.

I don’t have any friends. I meet friends here, but not too many. I talk too much. I talk to people and I learn English too.

Family support was available to the vast majority of older persons interviewed. Tenants often had family visit them or were picked up by family members for outings in the community.

My family is first. They’re always calling me and there’s always something happening. It’s always somebody’s birthday with the grandchildren...

My son was here last weekend and God willing, he’s coming this weekend to put my clocks ahead for me...he’s so good to me...he always comes and picks me up.

There was a sense of loss expressed by many older persons in terms of the lack of intimate relationships in their lives.

Interviewee: I don’t have a boyfriend.
Interviewer: LOFT doesn’t have a dating service?
Interviewee: (laughs)
Among Friends (cont.)

Interviewer: What things do you think you need to make your life better?
Interviewee: A man...no! I'm kidding. I had to say that.

For one interviewee, romance was actually found within the housing.

[My wife] and I met here and got married there. We had the wedding upstairs...she’s my queen.

Although the majority of respondents had a solid network of friends in the immediate building, there were a few exceptions. In a couple of cases, other residents were perceived as somewhat bothersome.

There are people that sometimes upset me...sometimes I say no to them, and they can’t take no for an answer, some of them. And they keep bugging you and bugging you.

Money would Help

Prevalent in the narratives of older people was the fact that much of their lives were characterized by their struggle with mental illness and the associated poverty as a result of frequent hospitalizations and other interruptions to their work lives. They indicated that more money would make their lives better and give them the added freedom to do more within their own communities.

One older person in particular mentioned the travel that he would like to be able to do, if he only had the financial resources available to him to make that possible. Many residents also mentioned the fact that money management was also a feature of the support services they received in the supportive housing context.

More money would help because of doing a little bit more things...it would make me go out instead of the donut shop.

She [PSW] helps me manage my money, which makes me feel in control.

Interviewer: What kinds of things make it hard for you to enjoy life here?
Interviewee: Finances.
The Illness Interferes

Analysis of transcripts revealed the reality of living with serious mental illness. Participants spoke of the need to be taking pills to control their mental illness and often mentioned the key role of staff in assisting with medication support.

*When I get schizophrenia again, I hear the devil, you know, and he tells me things I don't want to do. I pray to God and God tells him to leave me alone.*

*In the night somehow, they get together in our minds. I don’t know how they do it...I think I’m related to kings and queens.*

*I have a history of alcohol abuse and a touch of schizophrenia.*

*My mind...right now I’m having a bit of trouble with my head you know. It’s unstable in a certain sense.*

*I am bipolar right now, so if I’m going through a rough patch, they’ll walk me through it.*

Physical Health Issues

In addition to mental health and addictions issues, the older persons receiving supportive housing services suffer from a wide variety of physical illnesses and ailments including, but not limited to cancer, heart disease, diabetes, Parkinson’s disease, arthritis, and chronic pain. In fact, several interviewees were in a wheelchair or used walkers or canes to assist them. Despite these fairly major health issues, older persons described lives that were not defined by these physical issues.

*The staff comes and changes my catheter.*

*I’m supposed to go for surgery for my hernia.*

*I had triple bypass surgery.*

A Place of One’s Own

Analyses indicated that tenants were extremely proud of their apartments—clearly a space of their own, a place they felt they could retreat to and be surrounded by the items that provided positive memories and made them feel at home.

*I love my apartment. I bought a new couch.*

*I have my own space and own apartment.*

*We got new cupboards, nice white ones. I was like a kid with a new toy. But, it makes a difference though. Perks you up.*
The Neighbourhood

The community resources available in the neighbourhoods surrounding the housing facilities were identified as key contributors to satisfaction with housing and community.

I’m close to the mall and the flower shops. I like the community.

I don’t think I’d want to live anywhere else because everything’s here in this small area. There’s the No Frills down the street here, Price Chopper, IGA...

Everything is close by. My bank. My hairdresser. Shopping. My church is across the street.

I meet my friend at the donut store, then I go to the library.

Safety issues were raised in one of the buildings in particular, however, the older persons interviewed appeared to have concrete strategies for dealing with their uncertainties. For example, several tenants living in this community talked about minding their own business and keeping away from people who may be dangerous.

I’m a little uneasy about the neighbourhood, but I’m learning to deal with it...I’m very scared to be out—even dusk—I won’t go outside...the area still has a bad reputation. Always will have, for people that remembered it. It’s not nearly as bad as it was.

I’d sooner be living here than other districts...I was nervous, I’m over that now.

I don’t go out at night except when my girlfriends take me in their car.

This area is dangerous because a man was attacked at the bank...Day time is bad enough with all this prostitution and the pimps on the street.

There’s a lot of nice people but it’s the ones on the street always asking for money

The Building Milieu—A Sense of Community

Tenants described the physical elements of the milieu within the building itself. For the most part, this was linked with the positive social aspects of the supportive housing—the formal and informal gatherings among friends in the building.

And the man right here [looking at the lobby on television screen], I call him Santa Claus. He helps everybody.

Observational field notes taken by research interviewers supported the positive comments made by tenants regarding the physical space that was available to them in the housing environment. Many references were made to the careful attention paid to the space surrounding the buildings in terms of the creation of opportunities for social interaction.
Client interviewees spoke at length about the impact that living in their current housing had on the quality of their lives. They talked about getting better—specifically making mention of reduced psychiatric hospitalizations, feeling less worried, and more self-confident. The following quotes exemplify this impact in an extremely powerful way.

"It has helped me with finding my self-respect again and having a little bit more confidence in myself. It's been very good for me and it probably helped to save my life. I haven't experienced suicidal depression or feelings of suicide for many, many years...I'm just trying to tell you what a significant change there has been in me after deciding to stay."

Tenants described the impact that living in supportive housing had on their day-to-day lives. "A world of difference" is the phrase that truly captures the experience as disclosed by client participants. They identified the enhanced quality of life they enjoyed as a direct result of being in supportive housing. This resulted in large part from the balance that was achieved between having the freedom to make choices and be largely independent and have on call assistance and support when needed.

"Before LOFT was here, I can't remember what we did...we were just sitting vegetating watching TV. But this housing has made a whole lot of difference in my life. Now, there's always something going on."

"This house has given me back the freedom I lost, you know, and respect for people outside of myself and its given me a respect for the society in which I live...there's so much to be grateful for, you see, no one human being can overcome their own difficulties all by themselves. And, I learned that here and accepted the help graciously."

"They've improved me."

"If it wasn't for [supportive housing] I wouldn't even get dressed...I told my friend if I win the million dollars, I don't want to move from here. I like it because I have all my friends. If I go somewhere else, I'd be lost."

"Living at [name of housing site] hasn't diminished my quality of life, in fact, it has improved."

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**A World of Difference**

As I sat in the front lobby, I couldn’t help but notice the plush and comfortable couches, the side tables with current newspapers and the overhead chandelier and warm fireplace. Posters hung from the lobby walls announcing events to celebrate older LGBT populations.

There was a distinct homey-ness to the building... Two cats roamed the sitting area and I felt self-consciously too professional with my black leather briefcase. Residents were very friendly and approached me with “Hi, I’m so-and-so. What’s your name?”

As I approached the building, I noticed groups of older people sitting and chatting on park benches, gathered in the gazebo and walking around the grounds.

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**“There’s nothing more than I enjoy than coming home. I call this home.”**
**Personal Stories**

The previous section outlining the results of interviews with clients of supportive housing illustrated the commonly identified themes across all personal narratives. It is critical to illustrate the common elements across participants, but in so doing, the personal story is often fractured. Consequently, a series of sample stories were captured to illustrate the temporal aspect of the housing and support experience.

**Personal Story 1—Bill**

Bill’s life story did not start out on a happy note. People labeled him as ‘retarded’ during his early formative years. His parents put him in a special school where he always felt that he was different, ‘not normal’. His education was extremely limited. Although he felt no different from anyone else, he was treated by others as though there was something wrong.

As he entered early adulthood, difficulties in getting along with others resulted in placement in a group home. Residing in the group home only made matters worse, and Sam did not perceive the setting to help in any way. As soon as he was old enough, he moved out of the group home to live independently, however, did not possess the requisite skills to cope on his own. In addition, he had no one to turn to for assistance.

His adult years have been characterized by him as "a struggle for survival". Alcohol was his constant companion. He attempted suicide and engaged in self-harmful activities on several occasions. In terms of housing, he moved in and out of a series of rooming houses and ended up on the streets on multiple occasions. He also spent some time incarcerated. This period was characterized by "a great sense of hopelessness and despair". He felt that he could not escape from this lifestyle.

Upon his release from jail, he was taken to a psychiatric hospital where staff referred him to the supportive housing program. He was extremely hesitant to move to this housing and finally consented to a room. He had a difficult time adjusting to life in the housing project, and admits that he gave staff a "run for their money". He was surprised that the staff were not frightened of him and did not get angry at him. Over time, he saw that the staff actually cared about him and were willing to support him through his struggles.

Now in his late sixties, he has lived in supportive housing at LOFT for the past six years and acknowledges that it has made a big difference in his life. He stated that, for the very first time, "I actually feel I have a home". He feels that the other residents and staff really care about him—he is accepted for who he is and not treated differently. He experiences respect from others in his environment, something he has never before felt. Family members, who would previously have nothing to do with him, are now in his life again. In his words, “This is the best place I have ever lived and I never want to leave!”
**Personal Story 2 - Mary**

Mary is a woman in her mid seventies who has a long history of severe and persistent mental illness, including multiple diagnoses. Coupled with this is a long history of drug dependency. She suffered from severe anxiety and very dependent behaviour that included following staff and others around and crying and yelling out. Prior to coming to supportive housing setting over three years ago, Mary was an in-patient in a psychiatric facility for more than a year. This was a result of the need for respite on the part of the general hospital where she was previously a patient. Previous attempts at housing Mary in long-term care facilities were unsuccessful as Mary was escorted out after less than two weeks. Subsequent applications to long-term care were refused as resources were not available to provide the type of support that Mary required. Entry to the supportive housing setting was gradual, starting with brief stays. The first few months were extremely difficult, with very dependent behaviour and great disruption to other tenants. The staff continued to offer support and coordinated numerous additional services to ensure that Mary had a regular family physician and continued clinical mental health supports.

There have been significant changes to Mary’s life, particularly a move from the intensely dependent behaviour to increased independence. She now spends much time in her apartment with family or friends or hangs out with other tenants in the building. The massive amounts of narcotics she was once addicted to have been discontinued and she experiences much less pain.

Two of the most important elements in her life—family and art—have returned. There is increased contact with family members who often come to visit and her artwork is proudly displayed in her apartment. Mary would surely have been living on the hospital ward or some shelter if it weren’t for the flexible and creative supports available in her housing setting.

**Personal Story 3 - Sylvia**

For many years, Sylvia has faced serious challenges related to severe depression and chronic drinking. She was isolated in her apartment, and did not go out at all. She did not have access to any medical or psychiatric care. Physically, she was extremely unkempt and suffered from malnutrition due to poor eating habits and alcohol consumption. The turning point in her life began with an accident that left her hospitalized. Following this, she decided that a healthier lifestyle was required. With the assistance of the supportive housing staff, she had the support and motivation to focus on her recovery.

She has indicated that the supportive and encouraging phone calls from staff have made a huge difference in her life. She expressed the fact that previously, she did not feel worthy of anyone’s care or attention. Once confined to her apartment, Sylvia is now an active member of all of the supportive housing social gatherings, where she feels extremely welcome. She has given up on alcohol and has even donated some of the money she has saved as a result to the supportive housing program. She is now linked with the appropriate medical and social resources in the community where she lives.
**Personal Story 4—Don**

Don had a history of chronic homelessness and found it exceedingly difficult to remain in one place. His life was characterized by frequent psychiatric hospitalizations, medication non-compliance and addictions problems. Since he has been in supportive housing, there has been a systematic progression in a number of different areas. Supportive housing staff have documented that at first, he was reluctant to take his medications even when he decompensated and that this gradually changed to the point where he is now successfully supported in taking the appropriate medication.

Previously, when he was ill, he would simply disappear until he was located by the case management team that he was affiliated with. Currently, he may retreat to his room, but he does not leave. The supportive housing staff attribute this to his increased sense of security in the housing setting. In addition, his addiction problem, primarily drinking, is now a rare occurrence. Don has experienced some major health concerns in addition to his mental health issues. With the support of supportive housing staff and case management team, he has developed a sense of family and has moved from being quite aloof to integrating with the residents in the housing site.

Although the four stories are unique, they share common elements. These individuals had long histories of serious mental illness often coupled with addictions problems. They have experienced life in psychiatric hospitals, boarding homes or the streets. Frequently, the move to a supportive housing setting was not smooth, and an adjustment phase was necessary. After a period of time, their lives seem to change in a positive way. They become connected with others on a day to day basis, and are linked to appropriate formal service providers. They now experience a sense of independence and dignity, often for the first time in their lives.
Interviews with Family Members

A sample of five family members were interviewed regarding their perspectives on the supportive housing provided by LOFT. All family members were children whose parents were living in one of the four supportive housing sites for seniors. The main message that family members revealed was that they were extremely pleased with the fact that their parent lived in this model housing program for the following reasons. They felt that the support staff genuinely cared about their family members and that they no longer had to navigate the health and mental health system on behalf of their parent. They did not feel any guilt because they knew that their loved one was happy and experienced a degree of independence and dignity. Family members invariably made the comparison to past housing arrangements and their inadequacy.

Peace of Mind

Interviewees were unanimous in their descriptions of having peace of mind because their parent was housed in supportive housing. They mentioned that both emotional and instrumental needs were taken care of and that help was available to their parent on a constant basis. Because 24/7 on call emergency care is available, families know immediately if there is something wrong and they get a full report. In addition, interviewees revealed that the added benefit of knowing that the staff were kind, compassionate and caring added to their comfort level vis-à-vis their relative’s housing.

You know that she’s being taken care of...It’s a relief to know that she doesn’t have to move...my big theme here is peace of mind.

I don’t feel guilty that she’s there. She’s happy.

I have absolutely no guilt when I leave.

When I go there, I never feel sad.

There’s a real kindness there.

They catch things before they happen.

“Even if my dad wasn’t crazy, I would want him there.”
Impact on Relative

Family members spoke repeatedly of the positive impact of supportive housing and addressed issues such as enhanced quality of life, social integration, and the importance of the physical milieu itself.

Her quality of life is better now. She used to be in an apartment alone, suicidal, lonely. In supportive housing, she has connections with people.

She’s well now. Alert. She asks about me and notices when I get my hair cut.

She’s very happy there and comfortable...she likes her independence...She has her friends there and she’s able to manage.

Reduced Caregiver Burden

The family members interviewed were unanimous in their expressions of reduced caregiving strain and clearly linked this to the fact that the support provided to their parents left them with more time to actually enjoy a quality relationship with their family member. This was also supported in the client’s narrative descriptions of relationships with their family members.

I have my own disabilities. I don’t have the means to take care of my mother. I don’t know what I’d do without it [supportive housing]. I don’t have the capabilities...couldn’t do without it.

It helps us [family members] out a lot too because we work during the week. [Supportive housing] staff will bring her to appointments when we can’t.

Giving Back

Family members were extremely appreciative of the care that was received by their relatives living in supportive housing. Consequently, several individuals indicated that they wanted to do something positive in return.

I can donate some money now...I want to give back.

Whatever I can do to help. I want to give back. Write a letter? Whatever.
Interviews with Community Stakeholders

Twenty community stakeholders were interviewed. Stakeholders included a building supervisor for Toronto Community Housing Corporation, academic researchers in the seniors housing field, service providers in geriatric addictions, mental health service providers, Community Care Access Centre staff, executive officers of LHIN’s and executive directors of seniors mental health and addictions organizations.

With the exception of the academic researchers, all service providers and community agency personnel indicated that they worked very closely with LOFT staff in seniors services. They noted that the supportive housing staff promotes a great deal of involvement from outside agencies and providers in order to bring forward issues related to supportive housing.

Team Work

Community stakeholders described a team approach that was not only mutually beneficial to them, but to their clients residing in LOFT supportive housing as well. They refer clients to supportive housing or the supportive housing staff refer clients to them. LOFT is perceived as a critical partner in client rehabilitation and management. For example, service providers in geriatric addictions noted that there is regular communication with supportive housing staff regarding their mutual clients.

The integrated services provided by [supportive housing] make it easier for us. Without LOFT would have to deal with various outside providers for each client.

Many interviewees stated that supportive housing services actually contributed to their own job satisfaction.

They make my life easier. I’m so impressed I give all of my charitable donations to LOFT.

One stakeholder described a particular situation where LOFT effectively solved a case where drug dealing was involved.

They stay on top of difficult clients rather than letting them continue to be problems in the building.

Stakeholder narratives of collaboration extended beyond their own personal experience as illustrated in the following quote.

The [supportive housing] staff works well with other non-staff providers including the ACT team, doctors, psychiatrists etc. in order to take care of patients.

Opportunities to partner with LOFT staff in new initiatives was also mentioned. For example, the development of a smoking cassation program.
An Example of ‘Best Practice’

Analysis of stakeholder transcripts revealed that all interviewees made reference to the uniqueness of the services provided. Particularly relevant was the emphasis on the integration of housing with all other supports. Out of province interviewees lamented that they lacked such a service in their province.

**LOFT is regarded as unique and is an example of best practice.**

*Nobody in Toronto matches their housing services.*

*There is no other group like LOFT.*

*You can’t compare LOFT to any other housing provider.*

*LOFT is a best practices example.*

*LOFT is seen as a really good model, integrated with housing and all the related supports. There is no similar housing in [another Canadian province].*

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**Consummante Staff**

Interviewees who worked with LOFT staff were unanimous in their praise of the special characteristics of these staff members. Common terms used to describe these staff included ’wonderful’, ‘supportive’, ‘respectful’ and ‘dedicated’. They specifically noted that the staff were extremely good to work with and communicate well. Consequently, without exception, their relationship with the staff was described as strong. In addition to this, many community stakeholders also described the impact that staff had on the lives of their clients. For example, there was respect for the client group, no matter what the situation, coupled with a sensitivity in dealing with ethnic groups.

Many community stakeholders stated that their clients praised the LOFT staff and that this was reflected in the fact that no-one ever wants to leave. Familiarity of the staff was also identified as being of critical importance. Interviewees noted the extremely low turnover rate and its importance as it reduces the ’fear factor’ for clients in terms of having to deal with new faces and establish trust.

*Staff are very dedicated and stay around a long time.*

*A family atmosphere is created and it provides a human touch.*

*The staff truly cares for their clients. Even the senior managers work on the front lines.*

Community stakeholders also observed that staff members engaged in a great deal of preventive work, recognizing potential problems and dealing with them before an incident occurred. This preventative work resulted in the prevention of crisis situations.
A House becomes a Home

A pervasive theme in the community stakeholder transcripts was the reference to the provision of supportive housing as being more than simply bricks and mortar. The sense of belonging and sense of community within the housing facilities was described as making clients “feel at home”. Many interviewees spoke of the fact that the supportive housing is viewed as a home to the tenants.

Clients have a sense that they are a part of and accepted by a community.

Other housing facilities are just rooms.

Having a place to call home and Knowing that the housing provider is not just there to rent a room.

The sense of security provided within the building and through caring staff was also mentioned as important as it reduced resident fear of losing their home.

Reduced Stigma

The relative lack of identification of stigma as an issue in the day to day lives of the older people who were interviewed for this study is significant in its absence. In only two cases did the issue of stigma arise in interviews.

Currently, older adults with substance use and mental health problems are stigmatized and often considered a risk by building management. The potential for eviction is always a problem and in the client’s mind.

Stigmatization is slowed at LOFT.

Flexibility

Community stakeholders identified the flexibility that the model of housing espoused. Each client in the supportive housing was treated as a unique individual and the services and supports provided were geared to each particular case.

LOFT is not fixed on one working model for all clients—they make available whatever services are needed to make it work.

There is no pressure on clients to change but staff will work with them over time to gradually alter behaviour.

Hard Core Clientele

Stakeholders identified the tenants served in the housing sites were ‘hard core’, meaning that they had lived lives characterized by serious and persistent mental
Illness, poverty, social isolation, marginalization, and addictions challenges.

"This housing takes clients that other facilities will not touch. It does not shy away from the hard core cases."

**System Level Challenges**

Community stakeholders were asked to discuss their views on the current challenges in the provision of supportive housing. All interviews revealed the top issues which included funding, long wait list, the need for staff training. Several interviewees also mentioned the need for a strong advocacy group for older persons in this area.

**FUNDING**

Not surprisingly, all stakeholders identified the need for greater resources in order to be able to provide supportive housing services for all who need them.

*Money is important and agencies can be resourceful to a point, but sooner or later they will come up short.*

**LONG WAIT LISTS**

The extremely long wait lists to get into LOFT and other supportive housing was identified by all. These wait lists are the result of the lack of such housing supports and services in Toronto and the surrounding GTA. Many interviewees also identified the fact that, with the aging population, future needs will be even greater.

*There is currently just not enough space for all those who could use supportive housing...there is always a waiting list.*

**STAFF TRAINING**

It was noted that there is currently limited training available for service providers to handle substance abuse problems. Such specialized training should be provided to all staff who work with individuals in these supportive housing settings.

*Getting qualified staff will be a problem in the future.*

**ADVOCACY GROUPS FOR OLDER PERSONS**

Several interviews indicated that there is a need for advocacy groups to provide direction to legislators. It was felt that there needs to be a best practices model that can be presented to decision makers.

*There is no central advocacy group for older adults with mental health problems.*

*From a health legislation and policy perspective, there is no single voice providing direction to legislators—each group has its own perspective on best practices.*
Interviews with Supportive Housing Staff

Interviews were conducted both face-to-face and via telephone with 7 staff providing services and supports to older persons within the four housing sites. Staff members included personal support workers as well as program managers. Most of the staff members interviewed had been working at LOFT for many years, however one interviewee was very recent hire and had only been with the organization for a few months. This was clearly not evident as demonstrated in the following excerpt taken from research assistant field notes: “I was quite surprised to hear that [staff name] had only been there for a few months. It definitely wasn’t apparent when interviewing the clients there. They felt very comfortable with her and even mentioned she was more a friend than a support worker”.

Staff were asked to describe the services and supports they provide for older persons with mental illness and/or addictions problems, and to describe some of the successes and challenges they have encountered in doing so.

Helping Clients “Pull Through”

Staff interviewees provided numerous ‘stories’ regarding their work with clients that reflected the diverse activities they engaged in to help older persons in whatever ways they needed. These numerous roles and responsibilities have been detailed earlier in this report and described by staff as “a little bit of everything.” What they have in common is that everything done is related to the unique needs of each particular client. Several staff reiterated the philosophy of the housing model “leap of faith together” and the impact it had on ‘taking a chance’ on people that were not expected to succeed.

Sometimes residents are really depressed and they’re not really themselves and you really sit and listen to them. You allow them to do what they have to do or say what they have to say, you know, unless they are harming themselves. We help them to really pull through stuff like that.

We manage to keep people out of the hospital.

Conflict Resolution

Staff described the conflict resolution work that they engage in on a fairly regular basis with the tenants residing in the supportive housing site.

We try to keep things, you know, have a little intervention sometimes, a conflict, you know...one person can set another person off, so, we have to intervene there and try to calm the situation.

Because of some of their illnesses, then they get into conflicts and dealing with them is difficult...
Developing trust

The amount of time taken to develop a trusting relationship was an omnipresent theme in the staff interviews. The phrase “it takes time” was heard repeatedly. Several situations were described wherein older persons came to the supportive housing setting after extended periods of psychiatric hospitalization and were very wary of others in their new environment. These individuals remained reclusive in their apartments for the first several days or weeks and gradually came to know the staff who worked extremely hard to “be there” in subtle ways.

It was impossible to work with him when he first arrived...he would yell and scream. Over time, he has improved and is now quite good. I think it’s the result of staff support.

They’ve had some bad experiences too [referring to past housing] and they’re always a bit concerned that somebody’s maybe going to do something to them or hurt them. They have to learn to trust a little bit.

You have to let them, you know, they have to see you really care for them...it would take us a long time sometimes for someone to really trust us.

Promoting Choice

Many staff spoke of their struggle to assist clients in making the right decisions, and the associated difficulty watching people make bad decisions over and over again, feeling that they cannot really step in.

Sometimes it’s difficult, because we want to allow them their freedom to make choices, but it’s hard when they make bad choices. It is important for them to make their own decisions.

Job Satisfaction

Staff interviewees expressed a unmistakable sense of pride in their work supporting older persons with mental illness and addictions problems to “age in place”. The positive influence of professional development was identified as impacting day-to-day activities.

I feel personally, I feel really happy and comfortable at the end of the day...when you do something and you can leave somebody smiling and walk away, you think you really achieved something.

I enjoy [doing things for clients]. It gives me satisfaction too.
Creating Meaningful Activity

Staff emphasized the importance of creating meaningful activity for their clients. It was acknowledged that it was sometimes extremely difficult to encourage involvement and this often translated into a wide variety of both passive and active social opportunities within and outside of the housing setting itself. Staff identified their efforts to assist individuals in making choices and the importance of becoming involved in something that is meaningful to them.

Lots of people would look at them [activities] as frill, but it’s really important in their lives to be able to go to the movies or just go out together as a group for coffee or even activities arranged within the house...something for them to do apart from watching TV all day.

To begin with, you have to convince them to get involved. Because sometimes they just grow more depressed when they are not active.

A Sense of Belonging

Staff narratives illustrated the sense of belonging they observed in many of the older persons living in supportive housing. This translated into pride in having a place of their own and the importance of the social network and peer support within the housing was critical.

They love it here. They’re very comfortable and I guess it’s because of both the staff and also the older persons who live here are welcoming when a new tenant comes.

We try and maintain a very homelike atmosphere here so people can honestly feel like it’s their home and not just a residence or an institution or a building where they happen to live but it’s really a place where they can call home. There’s a sense of family here.

Never Enough Time

An often mentioned frustration was the lack of time to spend with clients.

The hardest part is we don’t have enough time with the residents because you really have to rush to do stuff sometimes...someone might be having an emergency like a seizure or something, the other staff might be doing meds or whatever, and she would have to leave until someone assists with the emergency. And, that can be challenging because these residents don’t like to wait.

Sometimes I wish we had, as staff, more time to spend with individuals.
Amazing Transformation

Many circumstances were recounted by staff that illustrated the positive changes clients experienced following their entry to supportive housing. For many, previous housing consisted of group living in boarding homes or extended periods of time in psychiatric hospital. They were deemed by staff at these settings as being institutionalized and "not really having any hope of ever being reintegrated back into the community." Sometimes, clients came to the supportive housing on a trial basis which reflected the caution of formal providers.

Staff were perceptibly very proud of the outcome of so many of these 'success' stories and stressed that major positive changes often occurred over extended period of time and did not happen overnight. Successes were the result of a lot of hard work and patience.

_We go the second, third, fourth and fifth mile [laughs]. But we really try and bed over backwards as much as we can to work with people to really give them that opportunity._

_Shé’s adapted very well. Shé’s calmed down a bit. You know, you can see the difference._

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Wait Lists for Supportive Housing

As elucidated in community stakeholders narratives, one of major challenges in the supportive housing field is the lack of available resources. There are simply not enough supportive housing beds to fill the extant need. Consequently wait lists are common. In order to understand the wait list dilemma further, the wait list polices and clients currently on the wait list for supportive housing at LOFT were examined.

For St. Anne’s Place, 152 individuals are currently on their wait list, 80 percent of whom have a diagnosed mental illness. They range in age from 59 to 87 years, with the majority between 59 to 64 years. Almost all (95%) require rent-g geared-to-income (and close to 50% are in receipt of OSDP only). Eighty-five percent of those on the wait list are in need of the supportive housing services. The wait listed individuals were referred by hospital staff (30%), other community agencies (35%), shelters (25%), and self (10%).

At Dunn Avenue, there are 38 clients who are currently on the wait list for supportive housing services. All are residing in the building. All referrals that come from outside the building are told that the wait list for non Dunn residents is more than five years in duration. Although the wait list is organized in terms of the order of referral, there are a number of names that are highlighted, to indicate that a health care professional has contacted the housing manager to indicate the urgency of need. In some cases, the Housing Company calls to say that the client is at risk of losing their housing. Residents leave supportive housing only if they are discharged to a nursing home setting or if they die. Referrers include the Housing Company, friends, family, LOFT staff, hospitals such as St. Joseph’s, and Parkdale Health Centre.
Wait Lists (cont.)

John Gibson (JG) House organizes its’ wait list by gender—there are both male and female wait list binders. A total of 61 individuals are currently on the wait list, 45 men and 16 females. A great many of these individuals are residing in a major psychiatric hospital and many others in boarding home settings. Referrals are generated by mental health professionals, community agency representatives, and more infrequently, by self. The procedure is such that if a referral meets the admission criteria, an appointment is made for a tour of the housing site and an interview with the service co-coordinator, program director and staff member. This interview serves to assess suitability and determine whether or not the client wants to live at JG. A resident’s committee is also involved in the selection process. Review of wait list data conducted for this study indicated that a few applicants had been on the wait list since 2001, with most having waited for the last two to three years.

The College View site has 16 applicants with serious mental illness currently on the wait list—when the people move through this list, the housing manager lets referrers know, and the list is replenished. These individuals are already living in the building or are transferring from another Toronto Housing setting. This approach has proved to be more practical rather than have long wait lists. Many in house residents have need for and are eligible for supportive housing services. More importantly, staff from Community Care Access Centres have repeatedly stated that there is a strong demand for the supportive housing outside of the building as well.

Interviews with Individuals on the Wait List

In addition to the descriptive wait list data for each of the housing sites, three in-depth interviews were conducted with individuals currently on the wait list for LOFT supportive housing services for older persons. The length of time of the wait list ranged from eighteen months to four years. All interviewees were living in the housing sites, but not receiving the supportive housing services they required. Two respondents had been participating in the outings and lunches, but were anxious to receive the house cleaning, laundry and nurse/doctor visits. One interviewee mentioned that she wants to live in supportive housing so that she can enjoy the company of other people.

K. (supportive housing staff member) lets me go on the lunches but I really want to have the support that they can offer by making sure that I can get to my nurses and doctors visits.

I have been on the wait list for more than one year and I want to have other people to talk to.
Costs of Supportive Housing

Canadian Evidence:
In their 2005 campaign for supportive housing, Toronto’s own Dream Team noted that it costs $486 a day - $170,000 a year - to keep a person in a psychiatric hospital, compared to $82 a day for supportive housing. Further, it has been noted that hostels and shelters are 40 to 50 percent more expensive per night than supportive housing.

The current regional cost per client paid by the Ontario Ministry of Health and Long-Term Care for supportive housing services in Toronto is $6,984.27 per year compared to the annual cost to government for nursing and personal care in a long-term facility of $24,553.55 per year (Lum, Ruff & Williams, 2005). Maintaining seniors in supportive housing is thus approximately one-third the cost of maintaining them in long-term care facilities.

LOFT’s own statistics have demonstrated that over a two year period in supportive housing, the number of 911 calls was reduced from 33 to 16 percent, emergency room visits from 38 to 18 percent and hospital admissions from 27 to 12 percent. This translates to an enormous cost saving to the health and mental health systems of care as emergency and institutional care are typically more expensive than supportive housing.

The following chart represents data taken from LOFT’s data base indicating that the number of 911 calls, emergency room visits, and hospital admissions were reduced in the period between 1999 to 2001. Specifically, the number of calls to 911 were reduced from 34 to 15, emergency room visits were reduced from 37 to 18, and hospital admissions were reduced from 27 to 11 over the two year period of time. More recent statistics indicate that this trend continues. The ultimate implication of these reductions in emergency room visits and hospital admissions over time is reduced costs to the system.
Unites States Evidence:

Evidence for the cost effectiveness of supportive housing has been demonstrated in the literature (Lewin Group, 2004). The daily cost of supportive housing in San Francisco, Los Angeles, Atlanta, New York City, Columbus (OH), Chicago, Boston, Seattle, and Phoenix was calculated and the results showed that a day in supportive housing costs significantly less than a day in a shelter, jail or a psychiatric hospital. For example, in New York City, a day of supportive housing costs $31.23, compared to a day in jail ($164.57), a psychiatric hospital ($467) or community hospital ($1,185).

Previous studies have shown some evidence that supportive housing may be cost beneficial. One study in particular, demonstrated that when formerly homeless individuals use supportive housing, they experience a 58 percent reduction in emergency room visits; 85 percent reduction in emergency detoxification services; 50 percent decrease in jail time; and a 50 percent increase in earned income. More than 80 percent stay housed for at least one year. A landmark study conducted by researchers from the University of Pennsylvania (2003) found that supportive housing -- independent housing linked to comprehensive support services -- provided major reductions in costs incurred by homeless mentally ill people across different service systems - $16,282 per person in a housing unit year round. (http://www.endhomelessness.org/pub/toolkit/housing.htm)

Discussion

The Narrative Approach

The narratives in this study have provided a way of evaluating the success of supportive housing services older persons living with mental illness. Listening to and analyzing these stories has provided a means to assess what clients think of their housing and more specifically, to determine whether or not they consider their housing to be a home.

To be successful, mental health services must reflect the preferences and desires of clients (Jones, Chesters & Fletcher, 2003), and, as a result, consulting with clients about their opinions is a crucial component of any mental health services, especially a supportive housing program.

A great deal of the research in community mental health is comprised of outcome studies of different programs. While valuable, this type of research is limited in several important respects (Parkinson & Nelson, 2003). First, when the program is in the foreground, research participants are reduced to aggregated outcome statistics. Second, outcome measures fail to capture the richness of the many different experiences of the individuals under study, both related to the program and to other factors in their social environments. Third, with its emphasis on determining cause and effect, outcome research designs depict individuals as passive, people who are influenced by the program, rather than as agents who actively...
cope with their life circumstances. It has been suggested that community research should overcome these limitations by pursuing research in which: (a) persons are in the foreground, not programs; (b) multiple dimensions of people's experiences are examined; and (c) the agency of individuals is emphasized (Riger, 2001).

This study has attempted to overcome the above limitations by consulting directly with older persons, a group whose voice has typically not been heard. In fact, seniors have complained that governments do not listen to their voices (Bryant, Brown, Cogan et al, 2004). In addition, in order to reflect multiple dimensions of people's experience, the interview schedule reflected the determinants of health approach and inquired as to many elements that constitute health and well being, not simply housing. Triangulation of multiple perspectives including community stakeholders, family members and housing support staff add to the credibility of findings, particularly when the same themes are revealed across all stakeholder groups.

**Value Based Housing**

Data collected from multiple stakeholders suggests that LOFT’s approach to supportive housing for older persons is providing the core values identified as essential to best practice in the provision of housing and supports for individuals with mental illness (Parkinson & Nelson, 2003). These key values include consumer choice and control, access to valued resources and community participation and integration. Other values include respect, hope, the non-judgmental approach of staff, flexibility and acceptance. Valued resources such as meaningful activity, social support and finances are the important link between consumer choice and participation in the community. The resource base is necessary in order that empowerment and community integration are made a reality (Nelson & Peddle, 2005).

A holistic view of the well-being of clients is evident in the consideration of broad determinants of health. A recovery orientation is taken with all clients as they are encouraged to develop new meaning and purpose in their life and move beyond the catastrophe of mental illness (Parkinson & Nelson, 2003). It involves overcoming the effects of being a ‘mental patient’, an identity that includes rejection from society, poverty, inadequate housing, isolation, unemployment, loss of meaningful roles, and loss of self. The recovery approach also involves a redefinition of values, attitudes and goals. The services and supports provided to individuals who have experienced a mental illness are flexible and are geared to each client’s individual preference and needs.

Older persons living in this supportive housing model expressed confidence in the 24/7 availability of staff in times of crisis. Basic supports such as vacuuming, laundry, cleaning and shopping allow the tenants to remain independent. Many clients also spoke of the assistance they received vis-à-vis personal care, such as obtaining help with showering and basic grooming.
**Value Based Housing (cont.)**

There were important shifts in the personal stories of client interviewees as they recounted their housing experience prior to and following their current status. The lives of all participants prior to supportive housing were extremely troubled and frequently involved extended hospital stays and poor housing in either shelters or boarding homes. With the provision of stable housing and multiple supports, individuals were able to regain a sense of freedom, power and control and become more active participants in their community.

A number of central principles and recommendations were made several years ago in a policy consultation document respecting older persons with mental health/psychogeriatric issues (CMHA, 2000). They included empowerment, person-driven care, individualized support, a holistic perspective, flexible and responsive support, accessibility, and non-discriminatory practice. These elements describe the provision of supportive service offered in LOFT housing. By taking a value based approach to housing, the actual ‘model’ of housing becomes unimportant—rather, it is the principals underlying the model that are critical.

**Balance Achieved**

Results of this study suggest that a balance has been established between providing structure and protection on one hand and fulfilling the goals of normalization and community integration on the other. The support offered to tenants of supportive housing was individualized and flexible and this support was realized once the individual was ready to accept help and/or change. This supports the finding in previous research that consumers of psychiatric services prefer easy access to help but do not want to have live-in support that is often perceived as invasive and inconsistent with ‘normal’ living (Forchuk, Nelson & Hall, 2006).

Many client interviewees indicated that although they appreciated the freedom that they had to make choices in their day-to-day lives, they were equally appreciative of the fact that there were rules and regulations that made sense within the housing site that made them feel safe and secure. Once again, the ability to maintain this balance within the housing model was sustained over time.

**Outcomes**

The narratives obtained from older persons, their families, supportive housing staff and community stakeholders were unanimous in terms of highlighting the positive outcomes realized from living in such a model housing program. In addition to the reduction in emergency room visits and hospitalizations (both for physical and mental health reasons), were factors such a sense of freedom, meaningful activity, and social networks which contributed to an enhanced quality of life for older persons. In addition, the positive impact on family members cannot be ignored. Knowing that their ill relative was in supportive housing lessened their feelings of guilt, reduced the caregiver strain and allowed them to spend some quality time with their family member.
Housing and a Sense of Community

Because of the experience of being pushed to the margins of society, persons with serious and persistent mental illness often experience alienation, isolation, and demoralization in their attempts to live in community settings. Individuals who are older also face ageism. The promotion of social support networks, opportunities to participate in self-help/mutual aid, and social integration into community settings can help to address these issues.

The concept of ‘place’ is gaining popularity and the advantages of creating and maintaining strong bonds between individuals and communities and homes. Housing environments can be used as the crux for efforts to facilitate interpersonal relationships and sense of community that supports overall well-being.

While the development of greater housing options is relatively new, policy makers and service providers have long emphasized the importance of encouraging collaborative relationships with people outside of mental health settings who can support successful community living for people with serious and persistent mental illness (Smith & Hobbs, 1966; Rappaport, 1977). People who act as informal supports, in contrast to formal service providers, interact with an individual in ways that provide assistance or facilitate recovery although they are not employed to do so. These may include neighbours, shopkeepers, church members, or others who interact socially with individuals needing support.

In the case of supported housing, people acting as informal supports are viewed as potentially more responsive to tenants’ social needs by virtue of being located in the settings where tenants live. This was demonstrated in the descriptions of the peer relationships existing within the supportive housing sites themselves. These informal relations can help make supportive changes in the neighborhood environment and thus, are often in a better position than service providers to ask fellow tenants to participate in community activities and organizations.

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A full range of treatment and support services should be available for BOTH the mentally ill and the physically ill.

Standing Committee on Social Affairs, Science and Technology, 2006
Policy Implications

Recent policy documents of mental health reform in Ontario have recognized that older persons with mental health problems have distinct mental health issues that are sure to be overlooked if special attention were not paid to this specific population. To date, the system has largely been shaped by providers delivering services to adults 20 to 65 years of age. Moreover, there is a recognized need to assess policy from a seniors’ mental health perspective (MacCourt, 2004) as much of the policy that shapes the lives of older adults has been developed without the input of older persons and frequently without reference to their specific needs. As a result, policies often fail to reflect the priorities and values of seniors.

Current seniors mental health policy is more often than not situated within a biomedical framework, which focuses on individual pathology. This framework results in the failure to develop broader non-medical interventions and community-based services needed to support the mental health of older persons. There are a number of extant frameworks that utilize a social determinants of health approach, suggesting that policy implications should be considered at the micro (individual), meso (community) and macro (societal) levels. Such models of care are holistic and focus not only on the individual, but also the social context in which he or she lives.

Some examples include the use of The Seniors Mental Health Policy Lens (SMHPL; MacCourt, 2004) and the World Health Organization’s (WHO) Healthy Aging Policy (1998). The SMHPL was developed, based on a determinants of health approach, as a method for identifying the negative effects of current and planned policies, programs and practices on seniors’ mental health. It incorporates the perspectives and values of older persons regarding the factors that influence their mental health. The use of this framework can influence the development of policies, programs and services that promote and support the mental health of older persons. The Healthy Aging Policy, developed by WHO and the Health Promotion Directorate of Health Canada provides an approach that provides a clear template for policy makers who wish to promote social environments that support the mental health of seniors.

Education and Training

The need for enhanced staff (service provider) training and professional development was identified by community stakeholders. A Canadian example of one such strategy is demonstrated by the Alberta Council of Aging and their Senior Friendly TM. This program’s goal is to sensitize staff to the aging process. During the International Year of Older Persons, this program was launched in every province and territory across Canada as well as other parts of the globe. The program helps business, communities, and organizations recognize the myths about seniors (and change negative attitudes) and provide services in a way that addresses the special needs of the aging population. In addition, it has been recognized that enhanced education is needed for older persons as well as the general public on the aging process for persons with mental health issues, diversity and elder abuse issues.
Stigma Reduction

There is a recognized need to increase media and public awareness of older persons mental health and housing issues. Stigma reduction is critical when exploring the needs of older persons with mental illness and addictions challenges. The double whammy of mental illness and aging, have been acknowledged as very powerful stigmas that influence the care that people seek and receive. Stigma manifests itself in attitudes towards older persons, namely, that their symptoms of distress are often dismissed as just getting older (Standing Committee, 2006). Seniors are often viewed as a drain on resources that are better invested in younger people. One of the essential mandates of the proposed Canadian Mental Health Commission is to launch a ten year anti stigma campaign to change public attitudes toward seniors living with mental illness.

Advocacy

Interviewees indicated the need for advocacy groups for older persons with mental illness and addiction problems. This would help to provide direction to policymakers. Current organizations such as the Canadian Coalition for Seniors’ Mental Health (CCSMH) and Older Persons Mental Health and Addictions Network of Ontario (OPMHAN) are good models of such advocacy organizations, whose goal is to ensure that seniors’ mental health is recognized as a key Canadian health and wellness issue. The CCSMH are currently developing a collaborative advocacy strategy to create public awareness and influence policy development in service, education and research. Similarly, OPMHAN has launched a broad public and professional awareness campaign.

Enhanced Resources

There is no question that there is not enough supportive housing to meet the current demand, particularly when focusing on the senior sector. Wait lists are extremely long and the turnover in such settings remains low (MacCourt, 2004). Specialized treatment programs and support services for older persons are scarce, as identified in the Kirby/Keon Report (2006). This is particularly critical as mental health services are often not available to seniors in the places where they live.
Conclusion

This qualitative study has added to the extant literature on housing for older persons with mental illness and addictions problems. Employing in depth interviews allowed for the elucidation of individual stories and experiences and focused on the narratives of participants. It provided an avenue of expression wherein the voices of many stakeholders in the field could be heard. In particular, the literature review conducted for this study indicated that older persons with mental illness have not had the opportunity to participate in research examining their perspectives on supportive housing. It has been noted that it is important to understand housing and mental health issues from the perspective of consumers of psychiatric services (Forchuk, Nelson & Hall, 2006). In this case, participants were older persons who had been living with serious mental illness for most of their lives.

Interviewer field notes indicated that client interviewees were pleased and often surprised that they were asked to participate in research that was exploring their perspectives on social housing. It was also observed that several interviews were quite difficult to conduct due to memory problems, as well as difficulty in finding the words to express their opinions and feelings. One field researcher wrote "this client was almost catatonic, with blunted affect...difficult to understand, slow moving...went off on tangents...yet was happy about this research incentive." The researcher went on to explain that despite these challenges, valuable information was gained in terms of the impact that supportive housing had on the life of this woman.

Data from this study suggests that the model of supportive housing investigated reflected best practices. The values espoused in this model of housing reflect an emerging consensus vis-à-vis a vision of supportive and supported housing (Carling & Curtis, 1997; Parkinson, Nelson & Horgan, 1999).

It is critical to ensure that information gained from this and other research on supportive housing is communicated with the key stakeholders for whom it can be informative (Barwick, Boydell, Stasiulis, Ferguson, Fixen & Blasé, 2004). This suggests a variety of different mechanisms are required for knowledge translation and exchange. This includes, for example, summaries of the research in lay language, poster and paper presentations at local, provincial and national/international conferences and academic papers.

On a broader level, the recent report of the Standing Committee (chaired by Senator Kirby) (2006) recommended the creation of a Knowledge Exchange Centre to foster the sharing of information among gerontology researchers and between providers of specialist care to seniors and other mental health and addictions providers. This Centre would overcome the current lack of knowledge exchange amongst researchers in gerontology as well as between those who provide care to geriatric populations and the broader mental health and addictions practitioners.
Conclusion (cont.)

One of the greatest challenges to mental health research in Canada is the increase in mental health problems seen in late life, coupled with the aging population (MacCourt, 2004). Currently, there is inadequate recognition and attention to the unique characteristics of older persons and their mental health and addictions needs.

Future research is required in order to examine the extent to which factors such as gender, sexual orientation and ethnicity influence the supportive housing stories of older people with mental illness and addictions problems. In addition, longitudinal studies are required in order to follow the temporal aspects of the day-to-day lives of older persons living in supported housing settings. Due to the complexity of factors that impact the lives of older persons, non-biomedical, multidisciplinary research approaches are needed.

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Seniors complained that governments do not listen to their voices.

Bryant et al, 2004
ACKNOWLEDGEMENTS

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Research field workers: Karen Conte, Angela Kertes, Tony Macdonald, Elaine Stasiulis, and Kristine Train.

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Devers, K.J. (1999). How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research. Health Services Research. 34(5): 1153-1188.


Popay, J., Rogers, A. and Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research. 8*(3):341-351.


The Toronto Sun, April 2, 2006. *Geriatric mental health under researched*.


Williams, CC, Collins, AA. (2002). The social construction of disability in schizophrenia. *Qualitative Health Research.* 12: 297-309.


APPENDICES

Script for Community Support Workers
Script for Community Stakeholders

Semi-structured Interview Schedules
  Older Persons
  Community Stakeholders
  Supportive Housing Staff

Consent Forms
  Older Persons
  Community Stakeholders
  Supportive Housing Staff
LOFT Community Services has hired an independent research team (led by Dr. Katherine Boydell) to conduct a study that examines the impact of LOFT supportive housing services and supports and the role of supportive housing for older persons. This involves qualitative in-depth interviews with a sample of tenants from 4 LOFT sites as well as interviews with key staff providing services. Another important component of the research is a consultative process with key stakeholders in the mental health housing/seniors/older person’s field such as you.

If you are interested in participating in this study, a member of the research team will conduct a telephone interview with you to ask you about the supportive housing system and your role as well as to discuss the services and supports that LOFT provides, from your perspective.

This interview will be set up at your convenience and can occur any day, evening or weekend, if you prefer. The interview will take about 30 to 45 minutes.

If you are interested in participating or want to hear more about the study, can I have your permission to give your name and number to the researcher who will contact you to tell you more about the study. Then, you can decide whether or not you would like to participate.
Filling the Gap: Supportive Housing Services and Supports for Older Persons

Script for Community Support Workers

LOFT Community Services has hired a researcher to conduct a study that looks at what people who live here think of the services and supports they receive and how they are doing. This involves talking to people who live here and in the other buildings that LOFT services are provided for older persons. If you are interested in participating in this study, a research assistant will meet with you in a place that you feel comfortable in (it could be your apartment or another private space in the building) to talk about your experience receiving LOFT services. The interview will take about an hour and can be set up whenever your wish (during the day, evening, or on the weekend). Because your time is valued, you will be given a $20.00 honorarium for participating.

If you are interested in participating or want to hear more about the study, can I have your permission to give your name and number to the research assistant who will contact you to tell you more about the study. Then, you can decide whether or not you would like to participate.

For those individuals who do not have a phone, community support worker can ask whether they would agree to meeting with the research assistant to further discuss the study.
A face sheet will accompany each interview and will include basic demographic data (e.g. location, age, sex, length of time in the housing, previous housing), which will be used to describe the sample. This information will be extracted during a documents analysis of the client files held at LOFT community services.

1. Tell me a little bit about what it’s like to live here?
2. Can you describe a typical day for me from the time you get up in the morning until you go to bed at night?
3. What contributes to your well-being, so that you and those in your community have a good quality of life? (prompts: what is important to you in your life? prompts include individual, community and societal factors)
4. What are the events or situations that have improved quality of life for you or for people living in your community?
5. What are the events or situations that have diminished quality of life for you or for people living in your community? (prompts: what things do you think you need to make your life better? What things make it hard for you to enjoy your life?)
6. What are the kinds of things your personal support worker does for you? (prompts include is this helpful? What more could be done? How often do you see your worker?)
SEMI STRUCTURED INTERVIEW SCHEDULE
Community Key Stakeholder Interview
LOFT Supportive Housing Services for Older Adults

A face sheet will accompany each interview and will describe the key stakeholder
(e.g. professional degrees, qualifications, length of time in the housing/mental health/seniors
field, role in their current organization/service)

1. Tell me a bit about your organization and the work it does/you do in the area of
   seniors/housing/mental health.
2. Please describe the relationship you have with LOFT services and supports for seniors
   (as referrer, advocate, community partner).
3. What role do you think supportive housing services and supports provided by LOFT play
   in the housing continuum?
4. What do you perceive as the major challenges associated with housing services and
   supports for older persons?
5. How do you perceive what is important to these older persons in terms of achieving a
   sense of well being/quality of life?
A face sheet will accompany each interview and will describe the personal support worker (e.g. professional degrees, qualifications, length of time in the housing field, length of time with LOFT community services)

1. Tell me about the services and supports you provide for older persons with mental health problems?
2. Can you describe some of the successes you have had in serving this client population?
3. Please describe the challenges you encounter regarding the support and services you provide to clients.
4. What is your perception of what is needed for these clients in order to improve or enhance their quality of life/sense of wellbeing?
Title of Research Project:
Filling the Gap: Supportive Housing Services for Older Adults with Mental Illness

Investigator(s):
Dr. Katherine Boydell
Research Scientist
(416) 813-8469

Purpose of the Research:
The purpose of this study is to find out what older adults receiving services and support from LOFT Community Services think about those services. We want to give you the opportunity to tell us what you like and don’t like about the services you receive from your personal support worker in your housing. This study will also get the perspectives of staff working for LOFT as well as other people in the community who refer people to LOFT services.

Description of the Research:
We will be interviewing ten people from each of the four LOFT settings that house older people. These interviews will be conducted in a place of your choosing (your apartment, a private office in the building) and at a convenient time. This could be any day of the week, evenings or weekends. A researcher will interview you and ask you some questions about what it is like to live where you do and the kinds of supports that you receive. This interview will take about an hour.

Potential Harms:
We know of no harm that taking part in this study could cause you

Potential Discomforts or Inconvenience:
There is a time commitment involved in participation, but this will be no more than one hour.

Potential Benefits:
Although there may not be any direct benefit to you for participating in this study, your experience will help LOFT to know what they are doing that works and what sorts of needs you may have that they could attend to. We have also found that many people like to “tell their story” and participate in this kind of research.
To individual subjects:
You will not benefit directly from participating in this study

The results of the research will be available to you. We will make sure that you receive a one page summary of the main findings of the study. If you would like to have a copy of full report, that will also be made available to you.

Confidentiality:
We will respect your privacy. No information about who you are will be given to anyone or be published without your permission, unless the law makes us do this.

For example, the law could make us give information about you
- If a child has been abused
- If you have an illness that could spread to others
- If you or someone else talks about suicide (killing themselves), or
- If the court orders us to give them the study papers

The data produced from this study will be stored in a secure, locked location. Only members of the research team will have access to the data. Following completion of the research study the data will be kept as long as required by the SickKids “Records Retention and Destruction” policy. The data will then be destroyed according to this same policy.

Reimbursement:
You will be offered reimbursement for reasonable out-of-pocket expenses; (e.g. transportation costs, meals, baby-sitters, etc.).

Participation:
It is your choice to take part in this study. You can stop at any time. The care you get from LOFT and other community services will not be affected in any way by whether you take part in this study.

We will give you a copy of this consent form for your records.

Sponsorship:
The sponsor/funder of this research is the Ministry of Health and Long-Term Care.

Conflict of Interest:
The lead investigator on this study will receive consultant fees for her work on the project.
Consent:

By signing this form, I agree that:
1) You have explained this study to me. You have answered all my questions.
2) You have explained the possible harms and benefits (if any) of this study.
3) I know what I could do instead of taking part in this study. I understand that I have the right not to take part in the study and the right to stop at any time. My decision about taking part in the study will not affect my health care or the services I receive from LOFT or any other community services I am free now, and in the future, to ask questions about the study.
4) I have been told that my medical records will be kept private. You will give no one information about me, unless the law requires you to.
5) I understand that no information about who I am will be given to anyone or be published without first asking my permission.

7) I have read and understood pages 1 to 3 of this consent form. I agree, or consent, to take part in this study.

_____________________________  _________________________________
Printed Name of Participant    Participant’s signature & date

_____________________________  _________________________________
Printed Name of person who explained consent  Signature & date

If you have any questions about this study, please call Katherine Boydell at 416-813-8469

If you have questions about your rights as a subject in a study or injuries during a study, please call the Research Ethics Manager at (416) 813-5718.
Title of Research Project:
Filling the Gap: Supportive Housing Services for Older Adults with Mental Illness

Investigator(s):
Dr. Katherine Boydell
Research Scientist
(416) 813-8469

Purpose of the Research:
The purpose of this study is to find out what older adults receiving services and support from LOFT Community Services think about those services. We want to give them the opportunity to tell us what they like and don’t like about the services they receive from your personal support worker in your housing. This study will also get the perspectives of staff working for LOFT as well as from key community stakeholders in the seniors/housing/mental health field like yourself.

Description of the Research:
We will be interviewing ten people from each of the four LOFT settings that house older people. These interviews will be conducted in a place of their choosing (your apartment, a private office in the building) and at a convenient time. This could be any day of the week, evenings or weekends. A researcher will interview them and ask them some questions about what it is like to live where they do and the kinds of supports that you receive. This interview will take about an hour. We would like to interview you, as a key stakeholder, by telephone, to ask you about the role that supportive housing services and supports play in the current health care system. This telephone interview will take about 30-40 minutes and can be conducted at a time convenient to you (days, evenings or weekends).

Potential Harms:
"We know of no harm that taking part in this study could cause you"

Potential Discomforts or Inconvenience:
There is a time commitment involved in participation, but this will be no more than one hour.

Potential Benefits:
Although there may not be any direct benefit to you for participating in this study, your experience will help LOFT to know what they are doing that works and what they could be doing to improve
services to their clientele. We have also found that many people like to “tell their story” and participate in this kind of research.

**To individual subjects:**
"You will not benefit directly from participating in this study."

The results of the research will be available to you. We will make sure that you receive a one page summary of the main findings of the study. If you would like to have a copy of full report, that will also be made available to you.

**Confidentiality:**
“We will respect your privacy. No information about who you are will be given to anyone or be published without your permission, unless the law makes us do this.

For example, the law could make us give information about you
- If a child has been abused
- If you have an illness that could spread to others
- If you or someone else talks about suicide (killing themselves), or
- If the court orders us to give them the study papers

The data produced from this study will be stored in a secure, locked location. Only members of the research team will have access to the data. Following completion of the research study the data will be kept as long as required by the SickKids “Records Retention and Destruction” policy. The data will then be destroyed according to this same policy.

**Reimbursement:**
You will be offered reimbursement for reasonable out-of-pocket expenses; (e.g. transportation costs, meals, baby-sitters, etc.).

**Participation:**
“It is your choice to take part in this study. You can stop at any time.
“We will give you a copy of this consent form for your records”.

**Sponsorship:**
"The sponsor/funder of this research is the Ministry of Health and Long-Term Care."

**Conflict of Interest:**
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“By signing this form, I agree that:

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Printed Name of Participant  Participant’s signature & date

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Potential Harms:
"We know of no harm that taking part in this study could cause you"

Potential Discomforts or Inconvenience:
There is a time commitment involved in participation, but this will be no more than one hour.

Potential Benefits:
Although there may not be any direct benefit to you for participating in this study, your experience will help to describe and understand the services and supports provided by LOFT. We have also found that many people like to “tell their story” and participate in this kind of research.
To individual subjects:
"You will not benefit directly from participating in this study."

The results of the research will be available to you. We will make sure that you receive a one page summary of the main findings of the study. If you would like to have a copy of full report, that will also be made available to you.

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