When Home is Community

Community Support Services and the Well-Being of Seniors in Supportive and Social Housing

Janet M. Lum, Simonne Ruff and A. Paul Williams

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EXECUTIVE SUMMARY

This report summarizes the findings of a research project that examined the role of community support services provided to seniors by community service agencies[1] in Toronto. It was conducted by a partnership of community and university-based researchers at Neighbourhood Link/Senior Link, Ryerson University, and the University of Toronto, in collaboration with Etobicoke Services for Seniors, St. Paul's L'Amoreaux, and The Toronto Community Housing Corporation, Canada's largest provider of non-profit social housing with over 164,000 residents, of which 36% are seniors.

We believe our findings are significant for a number of key reasons.

- First, they emphasize the important role played by community support services in maintaining the health, well-being, independence and quality of life of seniors.

- Second, they indicate that community support services are most effective when integrated and managed around the needs of the individual. While the political fear is always that given access to services, people will maximize use and costs, thus creating new cost pressures, under intensive case management[2] the incentive is the reverse: to use the minimum level of services necessary to maintain the individual at the highest possible functional status.

- Third, the findings suggest that community support services make important contributions to the sustainability of the health care system as a whole by moderating demand for more costly acute and institutional care, and particularly, by reducing utilization of emergency (911) services. Rather than being viewed as an "add-on" to the hospital and doctor mainstream of Canadian Medicare, our findings suggest that community services in effect subsidize the Medicare mainstream.

- Finally, the results demonstrate that the provision of client-centred and integrated support services through intensive case management is facilitated in supportive housing as compared to social housing. This is also true for seniors with cultural and language barriers, who without case management, could face significant barriers to accessing needed services.

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1 Community service agencies or community-based agencies in this report refer to charitable, non-profit organizations as distinct from for-profit, and public, government-run agencies.

2 In this report, we use "intensive case management" to refer to Crisis Intervention and Assistance, which is the model of case management provided by community support agencies. This model contrasts with other types of case management that focus on assessing client eligibility for services, the coordination of services, or referrals.

Key Objectives

- To establish an innovative community-academic partnership in research.
- To document patterns of community support service use by seniors in three pairs of proximate supportive and social housing buildings in Toronto.
- To analyze the impact of support services on functional independence, social connectedness, physical and mental well-being, and the use of formal emergency services (e.g. 911 and hospital emergency departments) during crisis.
- To assess supportive housing as a viable option for aging in place.

Methods

- We interviewed 226 seniors living in comparable senior's supportive and social housing buildings in the east, north west, and downtown areas of Toronto.
- Over 64% of the seniors contacted participated.

Findings

Seniors= Characteristics and Risk Factors

Age. Older people are more likely to experience health problems and functional limitations. In Toronto, 65% of seniors are 60-74 years old; less than 8% are over 85 years.

- In social housing, 70% are 70-84 years; 9% are over 85 years.
- In supportive housing, 53% are 70-84 years; *40% are over 85 years*.

Sex. Women live longer than men on average. Females make up 58% of seniors in Toronto. Women may have higher risk of institutionalization because they are more likely to experience poverty and social isolation.

- Elderly women outnumber men in both social (77%) and supportive (81%) housing.

Living alone. Seniors living alone may experience social isolation. They have no immediate family caregiver and may face barriers accessing community services. In Toronto, 27% of seniors live alone while 63% live with others.

- Most seniors in the study live alone B 68% of seniors in social and 90% of seniors in supportive housing live alone.

Income. Poor people are more likely to get ill, but less likely to access needed services.

- The median income for seniors in both housing types is below $19,256, the

Statistics Canada Low Income Cut-Off (LICO) level for individuals in Toronto in 2002.

Ethnoracial background*.* Minorities face challenges accessing language and culturally appropriate services. In Toronto, 23% of seniors are visible minorities.
- 45% of seniors in social housing and 25% in supportive housing are visible minorities.
- 20% of seniors in social housing and 13% of seniors in supportive housing report English language difficulties.

Health status. Statistics Canada reports that 42% of seniors have arthritis; 33%, high blood pressure; and, 16%, heart problems.
- 61% of seniors in social housing and 69% in supportive housing have arthritis.
- 56% in social housing and 59% in supportive have high blood pressure.
- 36% and 38% respectively have heart problems.
- 21% and 44% respectively have osteoporosis.
- 8% in social and 15% in supportive housing have cancer.

Seniors= Use of Community Agency and Family Supports

Seniors in social housing may receive basic support services; in supportive housing, service needs are assessed and services are managed on an on-going basis.

Supports for PADL. To remain healthy and independent, seniors may require some help with daily activities such as eating, dressing, bathing, and using the toilet.

- 17% of seniors in social housing and 28% in supportive housing need help bathing.
- 4% and 9% respectively need help getting dressed.

Supports for ADL. Seniors may also require help with basic household tasks.
- 42% of seniors in social housing and 80% in supportive housing, get help with laundry, vacuuming, cleaning and changing bed linens.

Family supports. Families are an important source of help even in supportive housing.
- 95% of seniors in social housing and 84% in supportive housing get help from family for grocery shopping, banking, seeing the doctor, filling out forms and paying bills.
- Seniors say that family members are over-burdened and cannot do more.

Intensive case management. Ongoing assessment by intensive case managers ensure services are appropriate (including linguistically and culturally appropriate),

predictable, integrated and reliable.

< Seniors in supportive housing automatically get intensive case management (Crisis Intervention and Assistance).

< Seniors in social housing do not automatically get intensive case management and may have to access and manage services themselves.

Outcomes

Social connectedness. Social interaction enhances mental well-being, and offers opportunities to assess risks and monitor changing needs.

< 54% of seniors in social housing and 69% in supportive housing see visitors 3-4 times a week.

< 6% and 38% respectively get visits from community agency staff 3-4 times a week.

Physical health status. Seniors in both housing types report Abetter@ health than their peers.

< 72% of seniors in social housing and 62% in supportive housing report Abetter" health status than peers.

Mental health. Confidence about getting help when needed promotes mental well-being.

< 63% of seniors in social housing but 86% in supportive housing report Apeace of mind@ about getting needed help in the future.

Crisis management. Social housing seniors make greater use of 911 services.

< 64% of seniors in social, 34% of seniors in supportive housing will call 911 at night.

< Supportive housing seniors are more likely to use emergency response Apanic button,@ which calls on-site staff instead of emergency services.

Conclusions

T **At-risk seniors remain independent**. Seniors have multiple risks for loss of independence. Virtually all seniors in supportive housing meet current thresholds for facility placement. However, with minimal supports, they continue to live independently.

T **Low-cost services are key**. These include vacuuming, laundry, cleaning and grocery shopping. Ministry of Health and Long-Term Care data confirm that supportive housing at about one-third the cost of institutional care is a cost-effective alternative to long-term care facilities.

- **Community services = reduced reliance on 911.** Intensive case management and 24-hour assistance in supportive housing reduce the reliance on an already over-burdened and costly emergency services system.

Recommendations

- **Build an evidence base into the costs and outcomes of community support services.**
  A continuing evidence gap means that ideology and opinions rather than data will be the basis for policy decisions. Making informed decisions that provide choices and optimal outcomes for seniors and for the health system is crucial as health system transformation takes place.

- **Establish new funding methods for the community sector that are consistent with the logic of a health system that is moving towards integration and coordination.**
  The results presented here demonstrate the clear need to move away from the "line-by-line" funding mentality for the community sector.

  We suggest that governments consider funding mechanisms that provide incentives for innovation and accountability. Global budgets adjusted for client needs could facilitate the work of case managers and give them further incentives to provide the services necessary to encourage and support the highest level of functional capacity and independence possible, and not to promote dependence. Currently, line-by-line funding marginalizes the services that seniors get and treats them as residual rather than essential, and marginalizes community agencies providing the supports rather than including them as integral and critical to the broader health system.

- **Promote intensive case management model of supportive housing as an institutional basis for integrating services and assessing outcomes.**
  Our data suggest that supportive housing provides a viable, cost-effective option for integrating services, assessing outcomes, and ensuring accountability in the provision of care for the province's growing population of seniors. Judging by the relative risks of seniors in our study, supportive housing is a cost effective alternative to institutionalization, preferable in terms of quality of life and independence even for the oldest old. We especially stress the critical role of intensive case managers in supportive housing in integrating services around needs of client, substituting lower cost services for more expensive institutional supports, and reducing demand on emergency services through ongoing assessments. particularly important as our society ages and becomes more diverse, supportive housing under intensive case management goes a long way toward helping seniors to overcome systemic barriers

to access to care posed by sex, living alone, poverty, and cultural and linguistic differences.

1.0 Introduction

This report summarizes the findings of a research project that examined the role of community support services provided to seniors by community service agencies[3] in Toronto. It was conducted by a partnership of community and university-based researchers at Neighbourhood Link/Senior Link, Ryerson University, and the University of Toronto, in collaboration with Etobicoke Services for Seniors, St. Paul's L'Amoreaux, and The Toronto Community Housing Corporation, Canada's largest provider of non-profit social housing with over 164,000 residents, of which 36% are seniors.

We believe our findings are significant for a number of key reasons.

- First, they emphasize the important role played by community support services in maintaining the health, well-being, independence and quality of life of seniors.

- Second, they indicate that community support services are most effective when integrated and managed around the needs of the individual. While the political fear is always that given access to services, people will maximize use and costs, thus creating new cost pressures, under intensive case management[4] the incentive is the reverse: to use the minimum level of services necessary to maintain the individual at the highest possible functional status. We found that relatively inexpensive services such as vacuuming and housekeeping are crucial to keeping seniors independent.

- Third, the findings suggest that community support services make important contributions to the sustainability of the health care system as a whole by moderating demand for more costly acute and institutional care, and particularly, by reducing utilization of emergency (911) services. Rather than being viewed as an "add-on" to the hospital and doctor mainstream of Canadian Medicare, our findings suggest that community services in effect subsidize the Medicare mainstream.

- Finally, the results demonstrate that the provision of client-centred and integrated support services through intensive case management is facilitated in supportive housing as compared to social housing. This is also true for seniors with cultural and language barriers, who without case management, could face significant barriers to accessing needed services.

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4 In this report, we use "intensive case management" to refer to Crisis Intervention and Assistance, which is the model of case management provided by community support agencies. This model contrasts with other types of case management that focus on assessing client eligibility for services, the coordination of services, or referrals.

1.1 Community services in the continuum of care

Canadians are once again engaged in an ongoing and impassioned debate about the future of Medicare, Canada's most popular social program. While governments argue about who will pay, and attempt to shift blame for public perceptions of eroding access to hospital and doctor care, all political parties, and all provincial/territorial governments (with some complaints along the way), continue to support publicly the five principles of the Canada Health Act: universality, comprehensiveness, accessibility, public administration, and portability.

Yet, in fixating on the Medicare "mainstream" of hospital and doctor services, relatively little attention has been paid to the broader range of community-based health and social services which support the functional independence and quality of life of a growing number of Canadians and prevent or delay their hospitalization or institutionalization in long-term care facilities. There is now a broad recognition that most health care does not create health, but rather cures illness (Kirby, 2002; Romanow, 2002). Nonetheless, the recent federal/provincial/territorial *10-Year Plan to Strengthen Health Care* (Office of the Prime Minister, 2004) reproduced an historical tendency to focus on episodic illness care with additional billions promised to alleviate waiting lists for cancer, heart, diagnostic imaging, joint replacements, and sight restoration. Although the *Plan* also promised additional resources for home care, these are targeted at short-term acute, mental health and end-of-life care.

Strikingly absent is any significant discussion of services required on an ongoing basis to promote health, maintain functional ability, and avoid the need for acute care even as the Canadian population ages and chronic care needs grow. More specifically, there is little recognition of the role played by community service agencies in supporting and maintaining individuals in their communities (Teplitsky, Williams & Lum, 2003; Toronto District Health Council, 2003; Liberal Task Force on Seniors, 2004).

Community service agencies are non-profit organizations that provide a broad array of non-medical services to individuals living in the community. Such services may include combinations of transportation, adult day programs, crisis intervention, homemaking, home maintenance, personal care, meals-on-wheels, adult day program, congregate dining, transportation and escorting, friendly visiting, telephone reassurance, security checks, 24 hour emergency response system, respite care for care providers, supportive housing, and rehabilitation services (Ontario Community Support Association, 2001). While growing numbers of children and adults with chronic illnesses, physical disabilities and post-hospital care needs also use community support services, the majority of users are seniors.

1.2 Community support services: where's the evidence?

Multiple factors, including a tendency by decision-makers to equate health with medical care, and current Medicare funding arrangements which require coverage only for "medically necessary' hospital and doctor services, militate against community support services taking a more central place on the public policy agenda. As we have noted in previous work (Teplisky, Williams & Lum, 2003) such services remain "at the margins" politically. Recent reports on the future of Canadian health care, although making some comment on the crucial role played by informal caregivers, make scant mention of community support services or the agencies that provide them. Instead of being seen as an integral part of the continuum of care, they are treated as residual.

A continuing lack of evidence on the costs and outcomes of community support services is a key problem in this regard. Mirroring and reinforcing the prevailing policy focus on acute care, Canadian researchers have generated relatively little systematic data on the costs and outcomes of community support services. In a policy environment where evidence is supposed to drive decision-making, a lack of evidence is a liability. Moreover, available evidence is inconsistent.

On the positive side of the ledger, the widely cited Hollander report concludes that minimal support services can delay, or substitute for, admission to acute care hospitals and long-term care facilities, at a lower cost (Hollander & Tessara, 2001). Community support services proponents often present this report as scientific "proof" that these services work for individuals and for the health care system as a whole. Another Canadian study of a randomized trial of a health promotion program for frail elders found that preventive home care keeps seniors alive or living independently longer (Hall et al., 1992).

Internationally, British evidence also suggests that community-based care can positively affect costs and outcomes. The British moved away from institutional care, strengthened home-based care, and introduced care management for community-based care for seniors in the 1990s.The British population has also aged more quickly than in Canada. Studies conducted by the Personal Social Services Research Unit (PSSRU)[5] based at the Universities of Manchester and Kent, and the London School of Economics, documents improvements in the quality of life for seniors and their caregivers who receive specialized community-based care compared to those who receive more conventional services, including institutional care. Four separate research studies have suggested that seniors receiving community care coordinated by intensive

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5 The Personal Social Services Research Unit was established in 1974 at the University of Kent at Canterbury. Since 1996, it has been a multi-site unit, with branches at the London School of Economics and the University of Manchester. PSSRU's mission is to conduct high quality research on social and health care to inform and influence policy, practice and theory.

case management experience significantly improved quality of life along with a reduction in the use of institutional care facilities, as these individuals are able to remain living in their homes and communities longer. Moreover, such gains were achieved at lesser or no greater direct costs than “the usual”[6] services available to everyone (Challis, 1993; Challis & Traske; 1997, Challis et al., 1997; Challis et al., 1998). A review of the impact of community-based care over the last decade points to the need for a standardized approach to service eligibility and to the key role of specialist clinicians in managing community-based care for seniors who would otherwise enter nursing homes (Challis & Hughes, 2002).

However, other studies have had less positive findings. Longitudinal research on seniors in Saskatchewan concluded that seniors receiving care are more, not less, likely to lose independence and die (Health Services Utilization and Research Commission, 2000). Data from the recent SIPA (Services integres pour les personnes agees) experiment in Montreal found few cost benefits since savings in emergency services and long-term care institutions were offset by increased home/community costs, even though quality of life was better (Béland, Bergman & Lebel, 2003). Based on a review of available evidence, another Saskatchewan study concluded that definitive evidence supporting the case of preventive community care appears elusive in Canada (Health Services Utilization and Research Commission, 2002) although there was also little evidence to suggest that they did not achieve desirable outcomes.

1.3 Filling the evidence gap: competing ideological perspectives

Filling this evidence gap are two conflicting ideologically based lines of political argument.

The first, associated with proponents of a minimalist state role in health and social welfare, argues that as governments scale back their commitments in health and social services, they can look to family, friends, neighbours and community to provide needed supports. This view sees that publicly funded community services are in effect an “add on” cost to the health and social care system. Their presence also discourages individuals, families and communities from fulfilling their own responsibilities, creating a “lose-lose” situation. To the extent that the state has any role in this field, it is seen as residual, as a last resort.

The alternative argument, promoted by advocates of a strong state presence in health and social welfare, is that the functional inter-dependency between government and community strengthens both. Thus, instead of promoting greater community capacity,

6 The “usual” services are the health and social services that are normally available to everyone. In the PSSRU projects, clients in a control group who receive the “usual” services are compared with an experimental group of clients who receive services based on a model of intensive case management.

state retrenchment policies erode capacity with detrimental effects for individuals, their families and communities. Such arguments link the rise of the voluntary sector not just to grass-roots initiatives and neighbours helping neighbours, but also to the expansion of government in the post-war period. This period saw the extension of state support to health care, education, social welfare and to voluntary organizations as a way of providing services that communities could not themselves provide, or at least, could not provide on a sustained and equitable basis (Hall & Reed, 1998). Proponents of community services claim that rather than filling a gap left by the state, community-based support services are essential elements of the social infrastructure. Moreover, by leveraging family, neighbourhood, and community, such services in fact reduce the burden on the state resulting in a "win-win" situation.

2.0 Research Objectives

This research aims to introduce evidence into ongoing debate over the role of community support services during a period of major health system restructuring. It aims to contribute to knowledge not only about community support services, but also about the extent to which patterns of utilization and outcomes vary in different housing settings. It also explores the extent to which supportive housing, by virtue of the fact that it often offers intensive case management of services, constitutes a viable and cost-effective alternative to long-term care facilities and nursing homes (British Columbia, 1999; National Advisory Council on Aging, 2002).

To this end, it established two essential research building blocks. The first is an innovative community-academic partnership between Neighbourhood Link/Senior Link and academic researchers from Ryerson University and the University of Toronto in collaboration with Etobicoke Services for Seniors, St. Paul's L'Amoreaux, and the Toronto Community Housing Corporation. While academics bring with them research experience and methodological and conceptual tools, community partners bring front-line knowledge of services and service-delivery as well as networks for the dissemination of research findings to the field. This partnership was reinforced by the establishment of a research Advisory Committee that included academics; Executive Directors, Managers, Case Managers and social workers from community service agencies; Managers and policy analysts from the Toronto Community Housing Corporation; a senior health planner from the Toronto District Health Council, and, individual seniors living in supportive housing.

The second element is a methodology for studying the impact of community-based support services on the health and well-being of seniors. A crucial issue is that individuals with widely varying needs, resources and circumstances use community support services, with widely varying outcomes. The research problem is to be able to separate out the independent effects of community support services when individuals

have very different support needs, living arrangements, and access to services through governments, institutions, community agencies, commercial providers and families. A further complicating factor is that, particularly among frail seniors, community support services are unlikely to produce a "cure." Aging seniors will decline and eventually die regardless of the care provided, although appropriate services can arguably enhance quality of life and maintain independence and functional ability to the highest degree possible for the longest time possible. We suggest, in fact, that a failure to understand and address this complexity adequately may partly explain the inconsistencies in previous research.

As detailed below, our research methodology attempts to narrow the range of confounding factors by analysing patterns of utilization and outcomes of community support services provided to seniors in two comparable types of residential settings: supportive housing and social housing. In both settings, seniors live independently in private apartments apart from extended families; they are in their own homes and they exert substantial control over their daily lives. Their rents may be geared to income, and particularly within buildings, they are in similar geographic proximity to community agencies and other resources such as public transportation, public libraries and shopping malls. Moreover, in supportive housing and social housing, it is possible to determine from building managers, and community agencies what services are available and typically provided to seniors.

The key difference between supportive housing and social housing is that while seniors in social housing may access and receive one or more community support service, those in supportive housing do so under intensive case management. In supportive housing, case managers assess client needs, organize appropriate services, and monitor outcomes on a continuous basis. Services are adjusted as needs change and may be "ratcheted" up or down. This contrasts with social housing, where individuals with similar needs may receive services, but usually without the coordinating function of intensive case management. Access will depend on the ability of seniors themselves to self-assess their needs, and then locate and access services. This is a crucial distinction since access to services is likely to be most important precisely when seniors, due to illness, dementia or frailty, are least likely to be able to access services themselves. Moreover, in addition to challenges connected to physical or mental status, seniors may experience other barriers to accessing services, including language and culture. In previous work done by the research team, it was found that access to community services varied substantially based on ethnoracial background (Lum & Springer, 2004a; Lum et al., 2002). However, in supportive housing, intensive case managers can go a long way toward overcoming these barriers, since they are familiar with, and know how to access appropriate services on behalf of their clients.

In our study, we sample seniors from three geographically proximate pairs of supportive and social housing buildings in three different areas of Toronto: Scarborough, central

downtown Toronto and Etobicoke.

In detail, our research objectives are to:

- document patterns of access to and the use of community support services by seniors in these two different types of housing buildings in proximate geographical settings;
- analyze the extent to which such patterns are associated with positive outcomes in functional independence, social connectedness, physical and mental well-being, and the use of formal emergency services (e.g. 911 and hospital emergency departments) during crisis;
- assess the general benefits of supportive housing specifically as a viable option for aging in place;
- identify differences related to ethnoracial characteristics of seniors in all of the above;
- develop perspectives on policy and resource allocation strategies appropriate to vulnerable individuals and seniors, in particular, and to recommend actions and next steps.

2.1 Working definitions of supportive and social housing

While definitions of supportive housing vary within Canada and internationally, the Ontario Ministry of Health and Long-Term Care defines it by the 24-hour availability of personal care and homemaking services (2000). Some community agencies take issue with this definition, which they see as emphasizing individual services, choosing instead to define supportive housing in terms of a comprehensive and coordinated package of services and programs necessary to support the changing needs of seniors aging in place.

In its definition of supportive housing, The Toronto District Health Council also emphasizes the integration of housing, personal care and supports that “connect seniors to a network of services, enabling them to remain in the community for as long as possible, avoiding inappropriate and unnecessary placement into a long-term care facility” (Robinson 2001; 2002).

The Canada Mortgage and Housing Corporation offers a working definition that is also used by the National Advisory Council on Aging. Accordingly, supportive housing is housing that “helps people in their daily living through provision of a physical environment that is safe, secure, enabling and home-like and through the provision of support services such as meals, housekeeping, and social and recreational activities. It is also the type of housing that allows people to maximize their independence, privacy, decision-making and involvement, dignity and choices and preferences” (Canada

Housing and Mortgage Corporation, 2000; The National Advisory Council on Aging, 2002).

Our operational definition of supportive housing integrates key elements of these definitions, again stressing the fact that services are managed around the needs of the individual, not on a service-by-service basis. The incentive is to provide services necessary to keep clients healthy and independent, without providing unnecessary or redundant services. Key characteristics of supportive housing include:

- affordability -- an option for rent-geared-to-income apartments
- security and safety
- privacy
- intensive case management linking clients to a range of community support services (transportation, 24 hr emergency responses)
- access to assistance with daily living, personal care and home making (meals, laundry, bathing)
- common areas for social interaction
- organized volunteer opportunities

In supportive housing, services are not necessarily provided on-site, but may be provided for example, in senior's centres. Thus, supportive housing is neither fully independent living, nor institutional long-term care.

For social housing, we adopt the definition provided by The Toronto Community Housing Corporation, which refers to shelter with the following key characteristics:

- affordability --an option for rent-geared-to-income apartments
- security and safety
- privacy

In social housing, seniors do not automatically have access to support services, although they may access them through a variety of different channels. For example, community service agencies and/or Toronto Community Housing Corporation community health officers and tenant associations may organize social and recreational activities. Community agencies and Community Care Access Centres (CCACs) may provide support services. As well, there may be opportunities for volunteer activities. Access to services is likely to vary widely between individuals, with need being only one, and possibly not even the most important variable.

3.0 Methods

A crucial research issue highlighted by work of the Health Services Utilization and Research Commission (2002) is that much existing research on the impact of "preventive home care" does not take into account confounding factors such as the care

level needs of different groups, or pre-existing functional limitations. In order to control confounding factors in this study, we selected respondents using a two-stage sampling strategy.

3.1 Sampling

An important advantage of analyzing populations in supportive and social housing is that this limits the range of possible living arrangements as well as immediate access to family caregivers. Because units are mostly one- or two-bedroom apartments, it is unlikely that seniors will be living with extended family in multi-generational settings. By selecting pairs of buildings in geographic proximity, we also limit variation in access to necessities such as banking, shopping and public transportation.

Another advantage is that it is possible to derive accurate income figures directly from rent. Because of potential sensitivities around income questions, seniors were asked what they paid in rent. In both building types, the formula for establishing rental rates is the same: rent levels are based on a review of income tax returns, income from all sources and savings. Thus, it is possible to estimate income with considerable accuracy.

Our two-stage sampling strategy is described below.

Building selection

In the first stage, we selected comparable pairs of senior's supportive and social housing buildings.

We began by using data from the Toronto District Health Council (Toronto District Health Council, 2001a) and Statistics Canada (2003) to map the locations of supportive housing buildings in Scarborough (the north east end of the city), Etobicoke (in the west end), and the old city of Toronto. We then mapped the locations of community service agencies to ensure that there were no geographic barriers to service and that each building was served by at least two different agencies. We also assessed population characteristics to confirm that each building was in an area characterized by either ethnic and cultural diversity (European, eastern European, Latin American) or ethnic and racial diversity (Asian, South Asian, Black).

With help from Toronto Community Housing Corporation managers, we then identified comparable social housing buildings. After potential pairings were made with supportive housing buildings, members of the research team visited each pair to determine that buildings were proximate geographically, that they had similar access to community support services, and that they were located in culturally diverse neighbourhoods within walking distance of necessities such as public transit, grocery stores, banks, and pharmacies. Pairs were then confirmed by our Advisory Committee.

Selection of seniors
Prior to approaching individuals, we held an information session in each building to provide information about the objectives, significance and voluntary nature of the study and the need for informed consent. Seniors were assured that there was no link between the study and the community service agencies or property management and that all personal information gathered would remain confidential. Posters in different languages were also put up on each floor of the buildings to publicize and explain the purpose of the study. In addition, flyers describing the study were delivered to every unit in the buildings.

We aimed to complete 40 interviews in each building to enable comparisons between buildings and building types. To do this, a team of five interviewers (three females and two males) knocked on every door, or every second or third door depending on the number of units in each building. If a senior indicated willingness to participate, the interviewers obtained written informed consent before proceeding. Most interviews were completed at the time of this first contact; in a small number of cases, interviewers made appointments to return at a specified time. When required, translation services were provided; this occurred in 28 cases where Cantonese and Spanish language translation was provided.

Between March and September 2004, 226 seniors were interviewed --115 seniors in social housing and 111 in supportive housing with approximately 36 to 40 seniors responding in each building. Interviews averaged 90 minutes and with the explicit consent of the respondents, were audio recorded for transcription and analysis. Of those we contacted to be interviewed, 64% agreed to participate, a notably high response rate for surveys of seniors.

3.2 Questionnaire design

The questionnaire design integrated knowledge from a number of different sources.

Questions concerning whether seniors get help in their personal activities of daily living, activities of daily living and chores, who provides help, patterns of social interactions, what seniors do in emergencies, and seniors' physical health have been validated in previous studies of seniors and were adapted for this study (Lum & Springer, 2004a; Toronto District Health Council, 1998). As well, our Advisory Committee provided invaluable input by reviewing and suggesting revisions to interview questions. The final interview schedule was the result of an iterative process during five meetings with Advisory Committee members. Questions that were difficult to understand, ambiguous, or unreliable were revised and brought back to the Advisory Committee for discussion. Finally, the interview schedule was pre-tested with three seniors to ensure that questions probed what they were designed to probe. Further modifications were made

following results from the pre-tests.

An important consideration was to find out whether and to what degree our samples living in supportive and social housing were distinctly different in their level of care needs. Rather than pre-screening seniors regarding their level of independence or frailty, we asked a series of questions probing aspects of daily living so that different levels of needs could be documented and controlled in the analysis. For example, we asked seniors whether they had help in personal activities of daily living (PADL) such as eating, bathing, grooming, dressing or using the toilet. We also asked whether they received assistance in their activities of daily living (ADL), including preparing meals, vacuuming, changing bed linens, and bathroom and kitchen cleaning.

The interview included open-ended and close-ended questions. Open-ended questions enabled seniors to elaborate and add depth, richness and texture to their responses. The questions analyzed in this report are presented in Appendix C.

3.3 Analysis

To maintain confidentiality, each interview was assigned a unique identifier or ID prior to analysis; actual names of respondents were kept in a separate file under lock and key. Interviews were then transcribed verbatim for analysis using Nvivo, a powerful qualitative software program which facilitates the identification of common themes and sub-themes in the responses. Quantitative responses were coded for analysis using SPSS, a statistical package.

For the qualitative portion of the study, the responses from each transcribed interview were organized into themes reflecting our key outcome variables:

- functional independence
- social connectedness
- mental and physical well-being
- crisis management

Each theme was then further analyzed to identify what respondents said, if anything, about living independently; the nature, frequency and sources of support or interventions by others including family, friends, case managers; ethnoracial challenges to accessing services; health problems; what they do in emergencies; and, their use of the formal health care system. The sections in this report that summarize the qualitative results present narratives that best capture the dominant themes expressed by many other seniors. Where responses reflect conflicting views, the qualitative results report as many comments as necessary to give an accurate depiction of the range of responses.

As detailed below, qualitative and quantitative findings were integrated within three main

categories:

- seniors' characteristics and risks for loss of independence
- services used
- outcomes: functional independence, social connectedness, physical and mental well-being, crisis management.

4.0 Findings

4.1 Seniors' characteristics and risk factors

We begin by considering the characteristics of the seniors we interviewed. In addition to describing the demographics of our sample, these characteristics provide a basis for estimating relative risk of loss of independence and institutionalization.

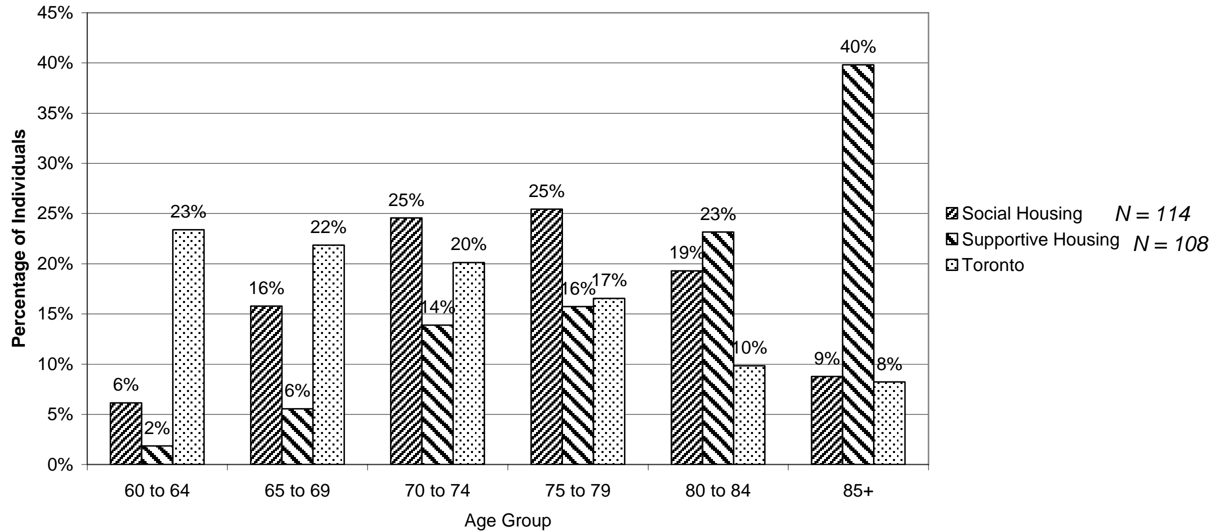
As will be seen in the data presented below, our study population is characterized by multiple risks. The seniors in our sample are older than the senior population in Toronto generally. They are mostly female, live alone, and have incomes below the poverty line. Many are ethnoracial minorities. There is much literature pointing to the likelihood that people with such multiple risks or "jeopardies@ are less likely to access appropriate services and more likely to lose their independence and be institutionalized (Lum & Springer, 2004a; Teplitsky, Williams & Lum, 2003; Lum et al., 2003). Our data show that these risks are most marked among seniors in supportive housing.

4.1.1 Age

As seniors get older, they are likely to have higher levels of need for health and social care and to be at greater risk of institutionalization. A Statistics Canada study using data from the National Population Health Survey longitudinal file found that the rate of institutionalization increased with age. Of seniors living by themselves surveyed in 1994/95, those aged 75 to 84 had five times the odds of living in a long-term care facility by 1998/99, compared with those aged 65 to 74. Seniors aged 85 or older were 10 times more likely than 65 to 74 year olds to be institutionalized (Statistics Canada, 1999b). Against this background, the age distribution of our respondents in both social and supportive housing is truly striking.

Fig. 1 - Age

Age Grouping by Statscan Definition



$P < 0.01$

Looking at the overall figures for Toronto, the majority of seniors (65%) are between 60 and 74 years of age while less than 8% are over 85 years (Statistics Canada 2005). In comparison, older seniors are over-represented in both social and supportive housing.

Approximately 70% of seniors in social housing are between 70 and 84 years of age with a mean age of 75 years. The population of seniors in supportive housing is even older: 78% are over 75 years and the mean age is 81 years. An astounding 40% of respondents in supportive housing are among the oldest old – over 85 years. We note that because the oldest old may be less likely to open the door to “strangers” these data are likely conservative and underestimate the true age distribution of seniors in our study.

The age difference between seniors in social and supportive housing is statistically significant.

4.1.2 Sex

Since women live longer than men on average, they tend to be overrepresented in the older cohorts of Canadians. Among seniors living in the City of Toronto, females make up 58% of the total senior population. Women's risks of institutionalization may be multiplied by the fact that they are more likely to experience poverty and social isolation.

Fig. 2 – Sex

	Social Housing (N = 115)	Supportive Housing (N = 111)	City of Toronto*
Males (65+)	23%	19%	42%
Females (65+)	77%	81%	58%
*Statistics Canada, 2005. E-Stat 2001, 2001 Census of population: 2001 population by age and sex.			

$P > 0.1$

Figure 2 shows that women outnumber men in both social (77%) and supportive (81%) housing. Social housing buildings tend to have a higher percentage of males (in part due to a younger age distribution), but this difference is not significant statistically. Furthermore, women are significantly overrepresented in both social and supportive housing in comparison to the population of female seniors in the City of Toronto.

4.1.3 Living alone

Living alone is often considered a strong risk factor for physical injuries such as falls, which may precipitate hospitalization. Since individuals have no immediate caregiver, minor health issues may go unnoticed or unattended, before becoming a serious problem requiring hospitalization. Furthermore, living alone exacerbates the risk of social isolation that has serious mental health repercussions. Senior women living alone are also at greater risk of poverty because they may not have a significant pension income based on participation in the paid work force. Thus, while seniors today are generally healthier, are in better physical and mental shape than their predecessors (National Advisory Council on Aging, 1999), living alone nonetheless increases their risk of loss of independence and institutionalization.

Fig. 3 – Living alone

	Social Housing (N = 115)	Supportive Housing (N = 111)	City of Toronto*
Living Alone	68%	90%	27%
With Others	32%	10%	63%
*Statistics Canada, 2001b. Family and household living arrangements: Household living arrangements, age groups and sex for population, 2001. Statistics Canada Catalogue Number 95F0315XCB2001006.			

$P < 0.01$

As seen in Figure 3, 90% of seniors in supportive housing live alone as compared to 68% in social housing. This is in stark contrast to seniors generally in Toronto where only 27% live alone while 63% live with others.

Of those who live by themselves, we see that the sex distribution is similar in both housing types: about the same proportion of women in social (85%) as supportive (84%) housing live alone (Figure 4). In both cases, these figures are higher than the proportion of senior women who live by themselves in the City of Toronto (74%).

We note here that “living alone” in supportive housing, where needs are assessed and services adjusted according to the needs of the individual on an ongoing basis, is probably less likely to produce social isolation, as compared to situations where seniors may live by themselves apart from family, peers and social support networks.

Fig. 4 –Living alone and sex

	Social Housing (N = 78)	Supportive Housing (N = 100)	City of Toronto*
Males (65+) Who Live Alone	15%	16%	26%
Females (65+) Who Live Alone	85%	84%	74%
*Statistics Canada, 2001b. Family and household living arrangements: Household living arrangements, age groups and sex for population, 2001. Statistics Canada Catalogue Number 95F0315XCB2001006.			

$P > 0.1$

4.1.4 Income

According to research based on Canadian data (Mustard et. al., 1999), level of income is associated with institutionalization. Seniors in the lowest or lower-middle income groups have over twice the odds of being institutionalized, compared with those in the middle or highest incomes groups (Statistics Canada, 1999b). Individuals with lower incomes face the double jeopardy of being more likely than individuals with higher incomes, to become ill or dependent, while being less likely to afford the health and social support services they require.

As indicated earlier, income levels were estimated from rent. Because of potential sensitivities around income questions, seniors were asked what they paid in rent. Since the rent-geared-to income formula is the same in supportive and social housing, it is possible to derive the respondent's actual income with considerable accuracy.

Fig.7 – Income

	Social Housing (N = 103)	Supportive Housing (N = 85)	Low Income Cut-off (LICO) for a single person in Toronto in 2002*
Median Income	$16,880	$18,800	$19,256**
*Definition of LICO: Income levels at which families or unattached individuals spend 20% more than average on food, shelter and clothing or approximately 34.7% of total income. Statistics Canada, 2001c. ** Community Social Planning Council, 2002.			

$P < 0.05$

The median income for seniors in social housing is $16,880 and $18,800, for those in supportive housing (Figure 7). These levels are below what Statistics Canada defines as the low-income cut-off (LICO) level at which families or unattached individuals spend 20% more than average on food, shelter and clothing, or approximately 34.7% of total income (Statistics Canada, 2001c). The LICO for 2002 was $19,256 for individuals for Toronto; below this figure, individuals may be considered to live in poverty (Community Social Planning Council of Toronto, 2002).

4.1.5 Ethnoracial background

Ethnoracial minority seniors may face linguistic or cultural barriers in accessing services. Results from a previous study suggest that these risks are likely to be greater for seniors belonging to newer ethnoracial communities, which have not yet developed a service infrastructure. In that study, we found that less well-established communities with less extensive resources had little capacity to Afill in@ when publicly funded

services were cut as compared to Aestablished@ ethnoracial communities with more extensive resources, but whose capacity also had limits. When health and social costs are off-loaded by governments, newer communities are hit hardest (Lum & Springer, 2004a; Lum et al., 2003; Sadavoy et al., 2004). Thus, seniors in newer ethnoracial communities may face the double jeopardy of having to negotiate access to needed services themselves, with few culturally and linguistically appropriate services actually available.

Fig. 8 – Ethnocultural background--Seniors

	Social Housing (N = 115)	**Supportive Housing (N = 110)**	**City of Toronto***
Visible Minority Seniors (65+)	45%	25%	23%
Top 3 Visible Minorities Groups – Seniors	Black (12%) S. Asian (10%) Asian (10%)	Asian (11%) S. Asian (5%) Black (5%)	Asian (12%) S. Asian (5%) Black (3%)
*Statistics Canada, 2001a. Ethnocultural Portrait of Canada: Visible Minority Groups, Sex and Age Groups for Population, 2001, 95F0363XCB2001006.			

$P < 0.01$

In our questionnaire, we used standard Statistics Canada categories to ask respondents about their ethnoracial backgrounds. While recognizing that such categories are always open to interpretation, these categories have the advantages of relative simplicity and direct comparability with census data. Figure 8 reveals that 45% of respondents in social housing and 25% in supportive housing self-identify as visible minorities. Asians, South Asians and Blacks make up the largest subcategories. In comparison to the City of Toronto, where visible minorities make up 23% of the population over 65 years, there is a significant degree of diversity among both supportive and social housing residents. While the visible minority population in supportive housing is comparable to that of the City of Toronto, the social housing population is more diverse (Statistics Canada 2001a).

4.1.6 English language capacity

Navigating complex health and support services is complicated enough without English language challenges. Seniors who do not speak English well must rely on formal translation services, which are not always readily available, or on family members, who may also not be available or who may not understand or be able to express accurately the needs of seniors (Lum et al., 2004b)

Fig.9 – English language capabilities

	Social Housing	**Supportive Housing**
% Respondents Who Understand English “Well”*	80% (N = 114)	87% (N = 107)
% Respondents Who Understand Written English “Well”**	84% (N = 115)	84% (N = 99)

**P > 0.1*
*** P > 0.1*

Our data show that 87% of respondents in supportive housing and 80% in social housing say they understand English “well”. Similarly, 84% in social housing and 84% in supportive housing say they understand posters or signs written in English “well” (Figure 9). Of course, this leaves a sizable minority that are likely to experience difficulties communicating in English. In fact, 28 seniors in our study required Cantonese or Spanish language translation in order to participate.

4.1.7 Health status

Many seniors in supportive and social housing have significant health risks. Yet, they live independent lives while managing these ailments and even say that their health is “better” than their peers.

According to the National Advisory Council on Aging, the most widespread ailments for seniors living at home based on 1966 Statistics Canada data include:

- Arthritis or rheumatism (42%)
- High blood pressure (33%)
- Heart disease (16%)
- Cataracts (15%)
- Incontinence (6%).

Fig. 10 – Physical Ailments

Physical Ailments	Social Housing (N = 114)	Supportive Housing (N = 110)	Seniors Population in Canada*
Arthritis	61%	69%	42%
Back Problems	60%	51%	-
Cataracts	-	-	15%
Diabetes	23%	16%	-
Emphysema	7%	6%	-
Glaucoma	-	-	5%
Heart Problems	36%	38%	16%
High Blood Pressure	56%	59%	33%
Incontinence	-	-	6%
Osteoporosis**	21%	44%	-
Stroke	10%	10%	-
Tumour/ cancer	8%	15%	-

* National Advisory Council on Aging, 1999. A quick portrait of Canadian seniors: Aging vignette #13.

$^{**}P < 0.01$

Looking at Figure 10, we find that:

- Over 60% of seniors in both social and supportive housing live with arthritis, which may seriously limit their mobility and functional capacity.
- 60% of seniors in social housing and 51% in supportive housing have back problems, which may also limit their ability to carry out activities of daily living.
- More than half of seniors in social (56%) and supportive housing (59%) have high blood pressure, a potentially life-threatening condition.
- Over a third of seniors in both housing settings have heart problems.
- 10% of these seniors overall have experienced a stroke.
- 23% in social housing and 16% in supportive housing have diabetes.
- Supportive housing seniors have about double the rate of osteoporosis (44%) compared to those in social housing (21%) which means they are especially vulnerable if they fall.
- 8% of seniors in social housing but 15% of those in supportive housing have cancer.

4.1.8 Summary of seniors' characteristics

Taken together, our data suggest that the seniors in our study exhibit multiple risks for loss of independence and institutionalization, with those in supportive housing at higher risk. Based on the judgements of community service agency case managers who work directly with Community Care Access Centres for facility placements, *all the seniors in our supportive housing sample would meet current thresholds for facility placement*. Yet

they continue to live independently in community settings.

The key question therefore is this: What factors contribute to maintaining these seniors so that they are able to live independently outside long-term care institutions? A step towards answering this question is to examine the supports seniors receive.

4.2 Seniors' use of community agency and family supports

This section examines the patterns of service utilization of seniors in supportive and social housing. It shows the type of support services seniors get in the two different building types, and who provides which services. In order to outline and then compare the level of service seniors receive, the supports are described service-by-service.

However, we note that alone, this approach does not adequately reveal the extent to which services are coordinated or integrated around the needs of the senior. This is crucial, since seniors in social housing may receive basic support services, but the services may be self-managed, or accessed on a one-off basis while service packages for seniors in supportive housing are arranged by intensive case managers.

We examine three categories of supports:

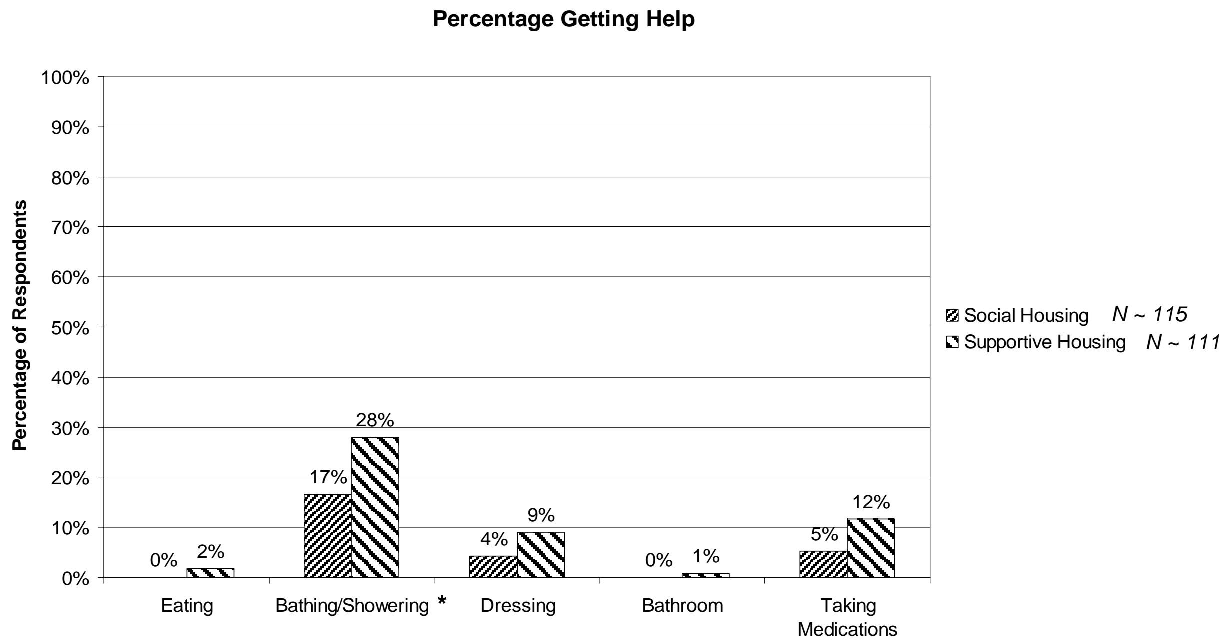
- help with personal activities of daily living such as eating and bathing (PADL);
- help with activities of daily living such as vacuuming (ADL);
- help with chores such as shopping for groceries.

4.2.1 Help with personal activities of daily living (PADL)

Seniors were asked, "Do you get help with any of the following: eating, bathing/ showering, dressing, going to the washroom and taking medications?"

Based on assessment tools used by community agency case managers, seniors getting help in these areas would require significantly more resources than those who can take care of their personal needs.

Fig. 11 – Help with personal activities of daily living (PADL)



$^*P < 0.05$

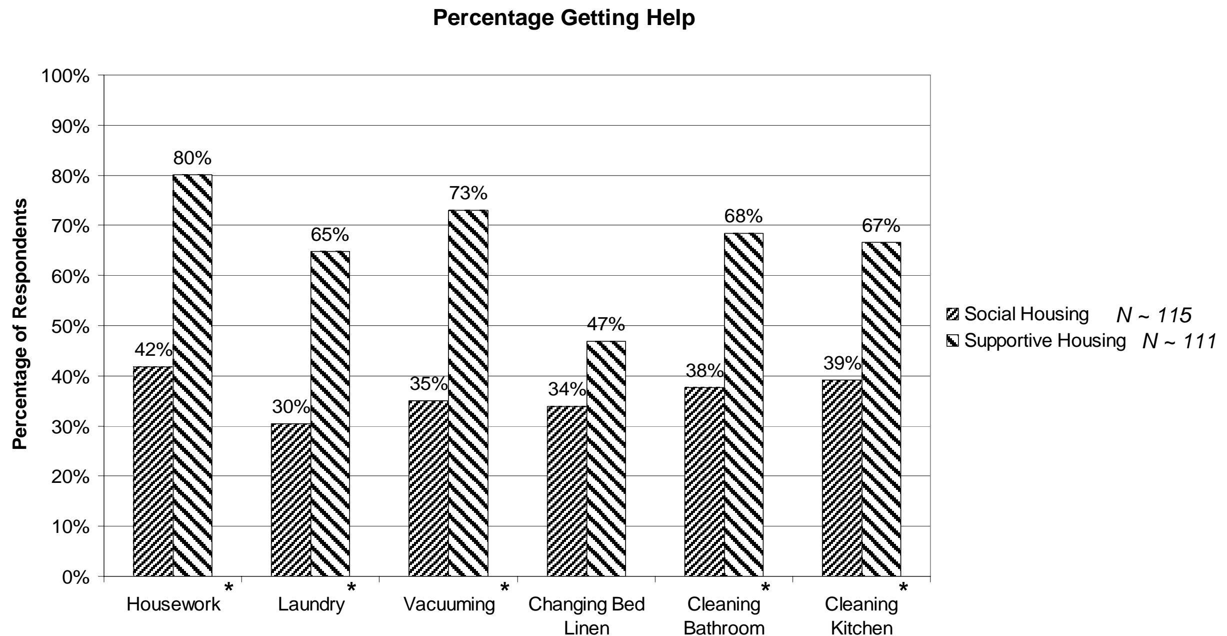
Figure 11 reveals that only small percentages of seniors in social or supportive housing receive any assistance with PADL. Percentages are higher for seniors in supportive housing, but differences are not statistically significant. The exception is bathing where approximately 17% in social housing as compared to 28% in supportive housing receive assistance. Considering the age and health status of seniors in both settings, these levels of support seems moderate.

4.2.2 Help with activities of daily living (ADL)

Seniors were asked, “Do you do your own housework? Do you receive help with any of the following: doing the laundry; vacuuming; changing bed linen; cleaning bathroom; cleaning kitchen?”

While, as shown above, the majority of seniors look after their own personal needs, greater proportions get assistance with activities of daily living such as housework, laundry, etc. Approximately 80% of seniors in supportive housing compared to 42% in social housing state that they receive help with housework. Figure 12 illustrates that this difference is sustained across various activities of daily living. About twice as many seniors in supportive housing than in social housing say they get help with doing laundry, vacuuming, changing bed linens and cleaning the bathroom and kitchen.

Fig. 12 – Help with activities of daily living (ADL)

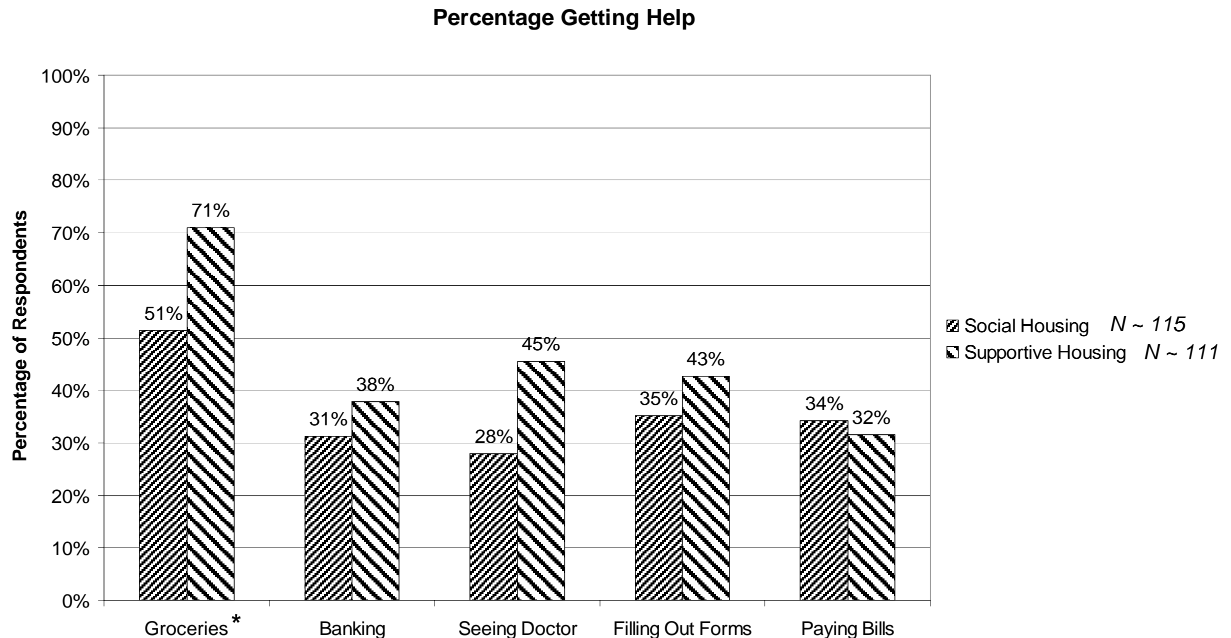


**P < 0.01*

4.2.3 Help with chores

Seniors were asked, “Do you get help with chores: shopping for groceries; banking; seeing the doctor; filling out forms; paying bills?” Seniors in both housing types get about the same level of assistance. The only significant difference appears to be in assistance with grocery shopping (Figure 13) where 51% of seniors in social housing, as compared to 71% of seniors in supportive housing report that they receive help.

Fig. 13 – Help with chores



* P < 0.01

We note that while help in these areas is clearly not "health care" per se, a failure to do chores such as grocery shopping, banking, seeing the doctor, and so on, can lead to health problems and demands that are more serious on the health and social care systems

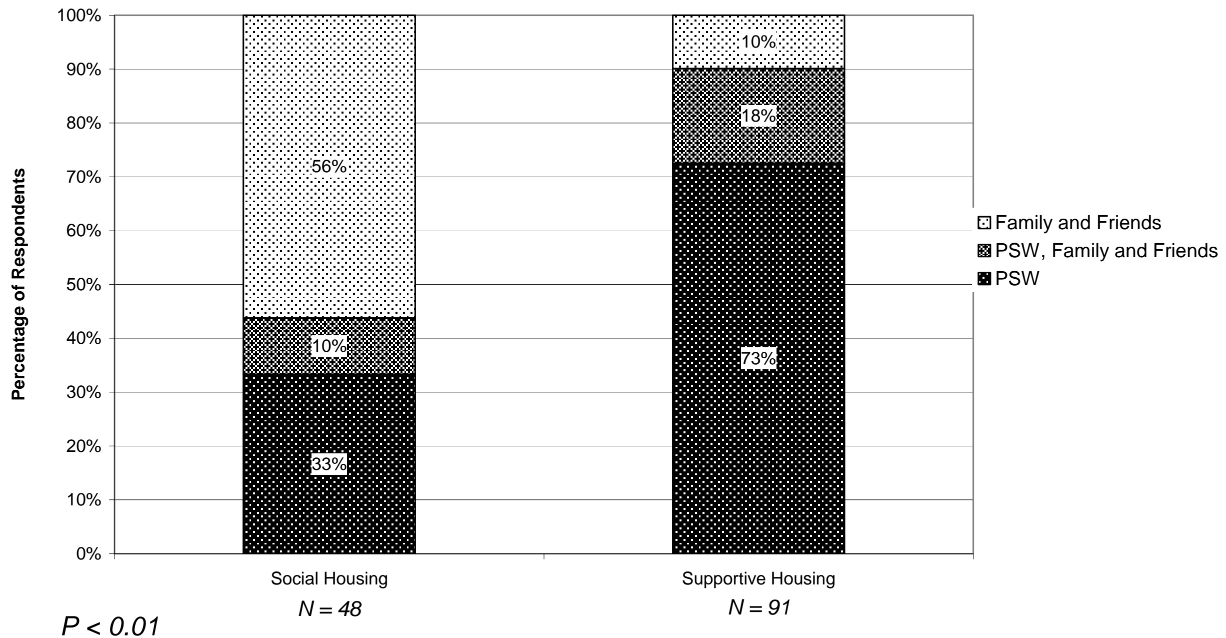
4.2.4 Sources of help: Who does what?

Who provides supports to seniors? Are they formal caregivers, mainly personal support workers provided by community agencies? Or, are they primarily informal caregivers including family and friends? Recall here that a key policy issue is the extent to which these different sources of help complement or substitute for each other.

Seniors were asked the following questions:

- "Do you do your own housework? If not, who does it? If you receive help with your housework, what does the person help you with? What do you do yourself?"
- "Do you need help in chores: shopping for groceries; banking; seeing the doctor; filling out forms; paying bills? If you receive help, who helps you? "

Fig. 14 – Who helps with ADL?

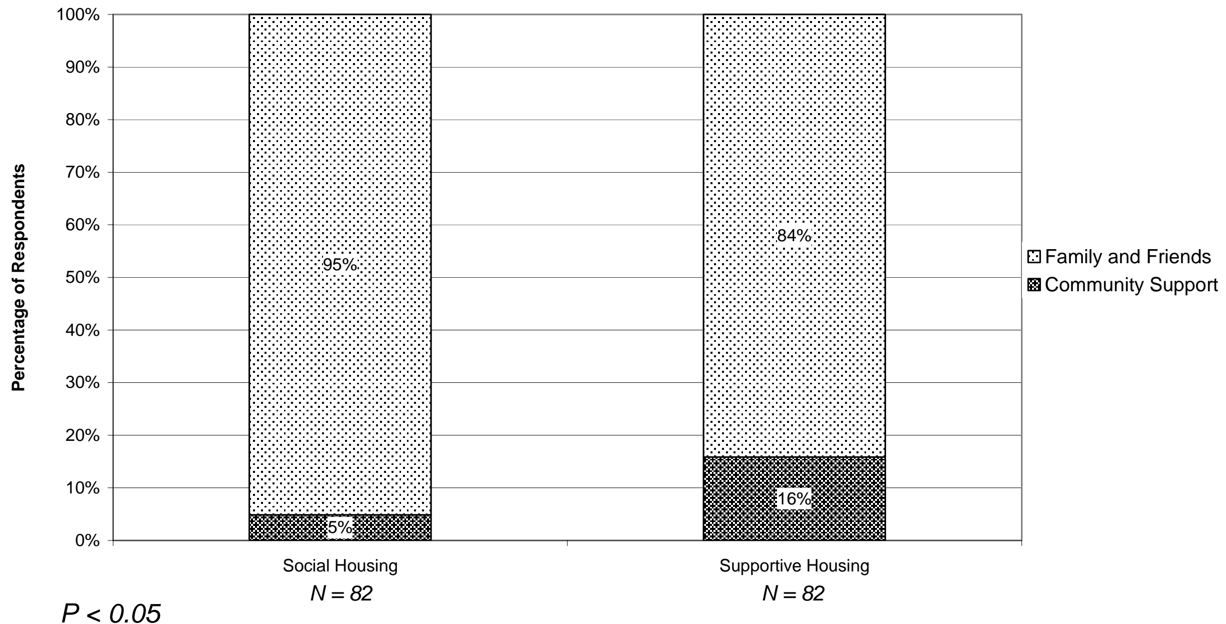


P < 0.01

Among seniors who said they receive help with ADL (48 seniors in social housing and 91 in supportive housing), 73% of those in supportive housing say that personal support workers only (PSWs) provide assistance, while 10% receive support from family and friends only, and an additional 18% get help from some combination of family and friends and PSWs. By contrast, in social housing family and friends are the main sources of support for 56% of seniors, while 10% receive support from some combination of family and friends, and 33% receive help from PSWs only (Figure 14).

We saw earlier that similar proportions of seniors in social and supportive housing settings get help for chores (shopping for groceries, banking, seeing the doctor, filling out forms and paying bills), Figure 15 shows that family and friends are the main source of this support for seniors in both settings. However, family and friends tend to be a source of support for more seniors in social housing (95%) than seniors in supportive housing (84%).

Fig. 15 – Who helps with chores?



N = 82 *N = 82*

P < 0.05

4.2.5 Help from family/ friends

At face value, the numbers tell us that seniors in supportive housing get more help than their counterparts in social housing, and that PSWs provide most of this help. What we do not know is whether PSWs provide assistance that presumably family and friends can provide, thereby “replacing” family support. Do PSWs and family/ friends provide supports to seniors in much the same way? Can seniors in social housing continue to rely on family and friends as they age?

To probe these issues, we now turn to our qualitative data. The qualitative responses reveal the following key points.

- Seniors in both supportive and social housing derive help from a variety of sources: from family, friends, neighbours and community support services. Even in supportive housing, families and friends are an important source of help, often encouraged by intensive case managers who proactively attempt to involve families.

- However, family/ friends and community agencies play different roles in supporting seniors. In both social and supportive housing, family/ friends take on chores that do not require daily attention. They take on chores that seniors cannot do, or PSWs often do not have the time to do, such as cleaning windows, drapes, under couches and behind refrigerators, or shopping for groceries, and they provide transportation to medical appointments or help with administrative details around banking or filling out forms.

- The help provided by families/friends tends to be infrequent or intermittent, and squeezed into busy schedules, when it is convenient for daughters and sons, not seniors. By contrast, the help provided by PSWs in supportive housing is typically scheduled and planned around the needs of seniors.

What follows are characteristic responses from both supportive and social housing residents about help from family/friends.

- “...my kids are working and they have responsibilities at home. I never expect them to come do my shopping. I have two in Barrie, and one here. But their hands are full. I don't want them thinking they have to cater to me. My daughter took me shopping two weeks ago…She took me out. I got my hair done and we went out for dinner. But when it comes to asking for things, I don't do it. Because I figure if they offer, then fine. But if they don't ask, fine. I know they have responsibilities... So I just sit back and not say anything. But she comes once in a while.”

- “My son-in-law just does groceries when he can, but he's not obliged to."

- “I do it [shop for groceries] on my own, but periodically I could phone my son up more often, but he's a very busy man. And if things get really low, I'll phone him up, and he'll pick me up and take me to do a big shopping.”

- “My children help. I give them the bills and sometimes it takes a long time. They are very busy.”

- “My daughter will help me once every two weeks with groceries but she has three kids so it's in and out, bring it and run. She's busy as well.”

- “My daughter does the paperwork and taxes, but she complains that she has to do it. She says she's too busy for me. So she says she needs someone else to help with government letters."

- "…I usually go down once a day and get bits, but my daughter will do my big grocery

shopping…it's not a regular thing. Maybe once a week, maybe longer than that…"

- “You see, I vacuumed sitting on the floor for 30 years. My children didn't know that because they left home and I didn't tell them.”

Can families do more? The seniors in our sample clearly express reluctance to “burden” already busy family members with additional requests for help. As one person stated, it is not a burden to ask PSWs for help. “That’s what they’re [PSWs] there for…” As seniors age, it is unclear whether they can expect additional support from already “too busy” sons and daughters.

4.2.6 Reasons for using services

The interview schedule included a number of questions inviting seniors to talk about why they do, or do not, use available services, and the factors that would persuade them to use additional services in the future.

For example, they were asked:

- “What would encourage you to use services in the future that you are currently not using?”
- “If you didn’t get help with housework, what would happen?“
- “Are there services or supports that you feel you need now but don’t get?”

The responses among seniors in both supportive and social housing consistently reflect a desire to remain as independent and self-reliant as possible, accessing services only when necessary (e.g., “if my health failed,” or “if I become disabled,” or “if I really can’t manage,” or “when I get too old”). Seniors confide that if they get household help, they need it, and really do not have a choice, especially if they want to remain at home. They are careful to use the minimal amount of help necessary for independence, and for the minimal amount of time, mindful of the needs of others.

The following quotes from supportive housing residents illustrate this point.

- “As long as I can walk and do things, I am not going into a nursing home. It’s called ‘independence’”

- “Let someone that can't walk have services...There are lots of people out there that can't really walk. Others need it. I don't want to take the services away from them.”

- “Well, right now I don’t need services or supports... Somebody asked me and I said when I need them. Too many people need them more than me.”

- “I don't abuse them [PSWs]. I only call them when I need them. I find them very helpful. I'm doing more on my own now but as I say last winter, they were a real blessing. Stripping the bed and doing the laundry.”

Seniors in social housing make the same point.

- “When I had trouble with this shoulder, I got help --a woman came in a couple of times a week. I didn't have to pay for it but I only had it for about two weeks and then I phoned and said I didn't need help anymore. I'm not about to take something I don't need.”

- “Sometimes I get frustrated because I can't carry things. But you deal with it. If sickness comes then I'll ask for it. Right now I'm not that helpless. ..A little depressed but I can help myself. I'm 67, but people here are 70 or 80. They need more help than I do.”

Equally importantly, both supportive and social housing seniors want to preserve their self-reliance. Even if they receive community support services, they are quick to add that they also “do things for themselves”, as if to underline their continuing capacity to look after themselves.

- "Sometimes I manage to do something myself, so [PSWs] might just do the vacuuming…I'd struggle to do it myself, but…when I had my back pain…I couldn't stretch up, I couldn't do anything, so I got the help then, but now I've been getting a wee bit better…I've always been an independent person, so I try to do what I can"

- “Thank god that I can have assistance in this building to live independently… Otherwise I couldn't be here, I’d be in a nursing home!”

What do seniors say they will do if they do not get the help they are currently receiving? Few would ask for additional help from family members. Most respondents would rather struggle, even if this means risking their health, or “taking a million years to vacuum,” or letting their surroundings run down and “get dirty”. Some muse about paying for help but recognize that this alternative is expensive and not realistic. A few mention that they would be forced to go into a long-term care facility.

Supportive housing residents confide:

- “I'd struggle to do it myself...and try to do what I can. It would take me a million years...”

- “I can do the vacuum cleaning if I stay up all night…. “

- "I'd let them [floors] get dirtier, then I'd make some effort to get on my knees. I have a mop. I've used it a couple times but it really is hard for me."

- "If I didn't get help with housework, I would sit in a chair and vacuum, and then move to another chair and vacuum a little bit more."

- "If I didn't get help with housework, I'd have to pay for it…which would be um….there's a point where service is so expensive. It's just outrageously expensive, and it would be prohibitive for me…the alternative…if supportive housing wasn't here…would be to go into a nursing home... I'd do anything not to go into a nursing home."

What about social housing residents? As shown above in Figures 12 and 13, the social housing seniors in our population get less household help than supportive housing seniors, and the help they get comes primarily from family and friends. Furthermore, the household help from family and friends tends to be intermittent and unscheduled. Those who have received community support services in the past express that the temporary help was critical to enable them to recover from an injury or illness.

- "There was one time I had to get help from [a community service agency] and that was about five years ago. My back was really bad…One of the ladies came, I think twice a week it was, and she did the balcony, made my lunch for me…I appreciated it. The [community service agency] office allotted me two hours. If I didn't get help with housework during that time, I couldn't have managed."

- "I used the meals on wheels a few years ago when I was sick. I also got some homemaking. I don't use any of these services anymore. The meals were because I was so sick I could not feed myself properly. I got help and got better because I was able to rest."

4.2.7 Help from intensive case managers

Accessing services is a challenge in itself. Getting services that are appropriate, integrated and coordinated presents another level of challenge. A recurring theme in the literature is that seniors and their families often have difficulties navigating the complicated and fragmented system of health and social services, with the consequence that seniors may enter nursing homes prematurely.

Seniors living in social housing and supportive housing theoretically have access to very similar programs and community support services, including personal care and intensive case management. However, seniors in supportive and social housing indicate

that they have very different patterns of accessing support services.

Our interviews suggest that whereas seniors in supportive housing know where to get services, know how to access them, and know that services will be coordinated, reliable and predictable, seniors in social housing are less certain about where to get services, how to access them, and worry that service may be haphazard and unreliable. This is especially true for people with cultural and language barriers. Seniors in supportive housing have automatic access to intensive case management. They know their case managers by name and are confident about the role of intensive case managers in providing a package of appropriate supports when needed.

The following quotes illustrate the critical interventions provided by intensive case managers. It should be noted that in supportive housing help from PSWs result from assessment and coordination by intensive case managers.

- “...once a week the workers [PSWs] come in on Friday, if you have laundry, they'll do it downstairs. They mop and clean the bathroom and kitchen. They come in a whirlwind on Friday. ..I do my own dusting...but they do general cleaning...every other week they do the laundry ...sheets and towels, they'll take them down and wash them...but I hand wash these pants and this top... they're easy to wash and why wear them out in the washing machine?”

- “I feel very comfortable and safe here because if there was anything I had that I had difficulty with, I'd feel very comfortable and not worried because of [name of case manager and PSWs]. They are a marvellous comfort and support.”

- “It’s a good feeling, knowing that you have everything [services] you need. It gives me security. You can depend on people. “

4.2.8 Help with language and cultural barriers

As noted above, ethnoracial seniors may face added challenges in accessing services. Seniors were asked the following questions.

- “What would encourage you to use services in the future that you are not currently using?”
- “Are there services or supports that you feel you need now but don’t get?”
- “Are there some programs or activities that you don’t participate in now? Why not?”
- “What activities do you do? How often do you do these activities?”

The qualitative responses reveal that the most pressing problem for ethnoracial seniors with poor English language skills is finding translation supports. In addition, they say

that they hesitate to participate in programs or activities that they feel are not culturally appropriate.

However, ethnoracial minority seniors in social and supportive housing experience very different patterns of interventions to address these challenges. In social housing, seniors say they must rely on a variety of ad hoc methods to make themselves understood, not always with successful outcomes. In supportive housing, seniors have the advantage of intensive case managers who help them overcome language and cultural barriers through an ongoing process of coordinating client-centred care.

“Mrs. C [case manager] comes by often. If I need help, I’ll call her. Doesn’t matter what…non-medical emergency, medications haven't arrived, toilet gets plugged, stove doesn't work, home is too cold…I would go downstairs and tell her.” [translated from Cantonese]

The following quotes are from seniors in social housing. They communicate the frustration seniors feel in dealing with language barriers.

- “There is this man from El Salvador. He’s very old and walks slow. The wheel-trans won’t wait for him. There are no benches. So he has to stay at home and when the wheel-trans arrives, he can’t get there fast enough. He lives in this building. There is no one to complain for him. I want to say something but can’t because I can’t speak English at the meetings either.” [translated from Spanish]

- “I’d like all information in Spanish. That would help --all notes and letters, posters in Spanish.” [translated from Spanish]

- “If I have a problem, I have to go to the community center where there is a Spanish-speaking social worker.” [translated from Spanish]

- “It can be really degrading. You’re reduced to sign language and pointing. This is OK if your toilet is plugged but how do you explain more serious health matters?” [translated from Cantonese]

- “The two superintendents downstairs can't understand Chinese. There are a lot of Chinese seniors here.” [translated from Cantonese]

- “Last time the phone wasn’t working. My daughter told me exactly word for word what to say to the super. I would call my daughter and my daughter has to dictate to me, word for word, and then I take the sheet to the super and he reads it.” [translated from Spanish]

To overcome language difficulties, seniors in social housing rely on family, friends and

the helpfulness of people in the community such as pharmacists or bank tellers who "speak my language. "

- "Banking is hard because of the language barrier. I go to TD bank and they have a teller who is Spanish. But he's always busy with people. So when it comes my turn to go to the next teller, I move aside and let others pass, and wait for the Spanish teller to be free. It takes a long time." [translated from Spanish]

- "I have a Chinese teller to help me at the bank for banking and paying bills." [translated from Cantonese]

In a previous study comparing Chinese and Caribbean seniors in Toronto Community Housing Corporation buildings, the research team found that the presence of a large number of seniors of the same ethnoracial background living in the same building helped bridge language gaps. Equally important was the location of social housing buildings close to vibrant and diverse neighbourhoods, which enabled seniors to shop, bank, and see health professionals in their own language (Lum & Springer, 2004a). Thus, despite greater barriers in English language fluency and literacy among Chinese seniors, Chinese seniors as compared to Caribbean seniors used a more comprehensive range of services both in Toronto Community Housing Corporation buildings and in the broader community.

In supportive housing, however, seniors do not have to rely on piece-meal interventions; intensive case managers attempt to coordinate supports to ensure that services are linguistically and culturally appropriate. As one person stated, "Having staff members in the building who can speak your language is the biggest help you can get!"

Aside from coordinating supports, intensive case managers may intervene to defuse potentially tense dynamics stemming from cultural and ethnoracial differences in buildings. Social networks tend to form around shared language and culture. Seniors report that these tight networks may be beneficial to those who belong to a particular language or cultural group, but that they may also effectively exclude and isolate those who do not belong. This can give rise to fractious cliques and social tensions rooted in cultural and linguistic differences.

Note the following quotes from seniors in social housing.

- "If I wanted to use the place downstairs for a family gathering, like use the barbecue downstairs, we can't. They [the other club] don't want to share the place. We're not a part of the club because we have a different language and culture. They have bingo, a pool table and some meetings but we don't go because of the communication problems and we don't play bingo. What would be nice is to have activities like listening to music downstairs or just a time to meet and chat, exchange opinions with

others." [translated from Spanish]

- "When I came here, the residents seemed tidier and neater...they were all veterans on the 4th and 5th floor...Caucasians. Everyone seemed more courteous. But now, 70% of the building is Indian or Chinese. They stick together. Now it's very complicated."

In supportive housing, intensive case managers are on-site to address problems arising from exclusionary behaviour based on ethnoracial backgrounds before they become entrenched.

4.2.9 Summary of seniors' use of supports

What enables older adults to retain their independence as they grow older? The most salient finding is that despite the multiple risk factors that characterize seniors in our sample, particularly those in supportive housing, seniors in both social and supportive housing manage to maintain their independence with minimal personal supports. In fact, the most important supports were relatively low cost assistance with household activities and chores like vacuuming, doing the laundry or shopping for groceries as opposed to relatively high cost care from health care providers.

Furthermore, seniors in supportive housing appear to benefit from the intervention of intensive case managers. Although seniors in both housing types access community agency support services, under intensive case management, seniors in supportive housing, in contrast to those in social housing receive a greater number and range of services that are appropriate (including linguistically and culturally appropriate), integrated, reliable and predictable. In social housing, community supports for seniors tend to be temporary, ad hoc and happenstance.

Finally, the data show that family/ friends and community agencies provide different types of assistance. Regardless of building type, the nature of family/ friends help is similar. In both supportive and social housing, family/ friends take on chores (shopping, banking, transportation to medical appointments) that do not require daily attention. When sons and daughters help with housekeeping, the assistance depends on when they "have time" rather than on a regularly scheduled basis.

4.3 Outcomes

What are the outcomes of these different patterns of service utilization? This section examines the impact of supports for seniors along a number of dimensions that are critical for continued independence and well-being.

4.3.1 Social connectedness

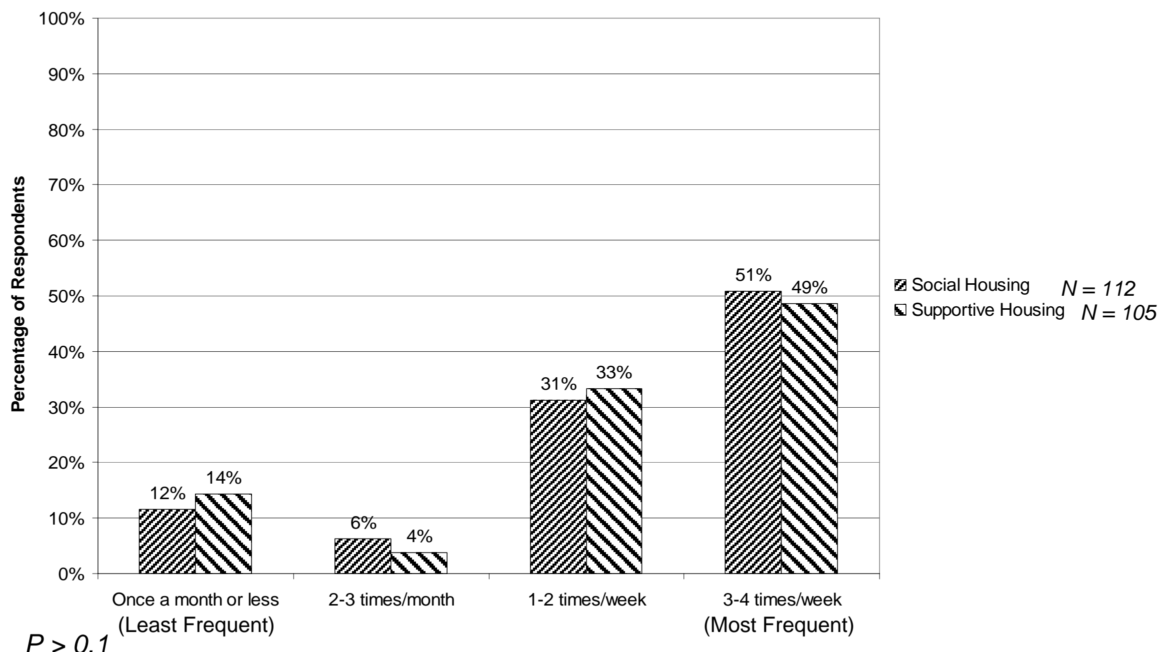
In this study, social connectedness is measured through the social contacts and interactions seniors have with others. Seniors were asked, "Is there someone who visits you, or who you visit when the weather is nice? How often do you get visits?"

The literature on aging underscores the importance of social connectedness for seniors' mental health; isolation and loneliness can precipitate depression and contribute to a loss of independence (Parent et al., 2002). Not only does social interaction enhance mental well-being, frequent contact with others offer opportunities to assess risks and to identify health problems that may require attention.

How do seniors in social and supportive housing differ along the dimension of social connectedness?

Our findings show that seniors in both building types have high levels of social contact, and that the frequency of visits from family and friends is similar for seniors living in both social (51%) and supportive (49%) housing (Figure 16).

Fig. 16 – Social contact with family and friends



Differences between housing types emerge when all types of social contacts are considered: 54% of those living in social housing see visitors 3-4 times a week as compared to 69% of seniors living in supportive housing (Figure 17). The difference is statistically significant.

Fig. 17 – Social contact with community service agency staff, family and friends

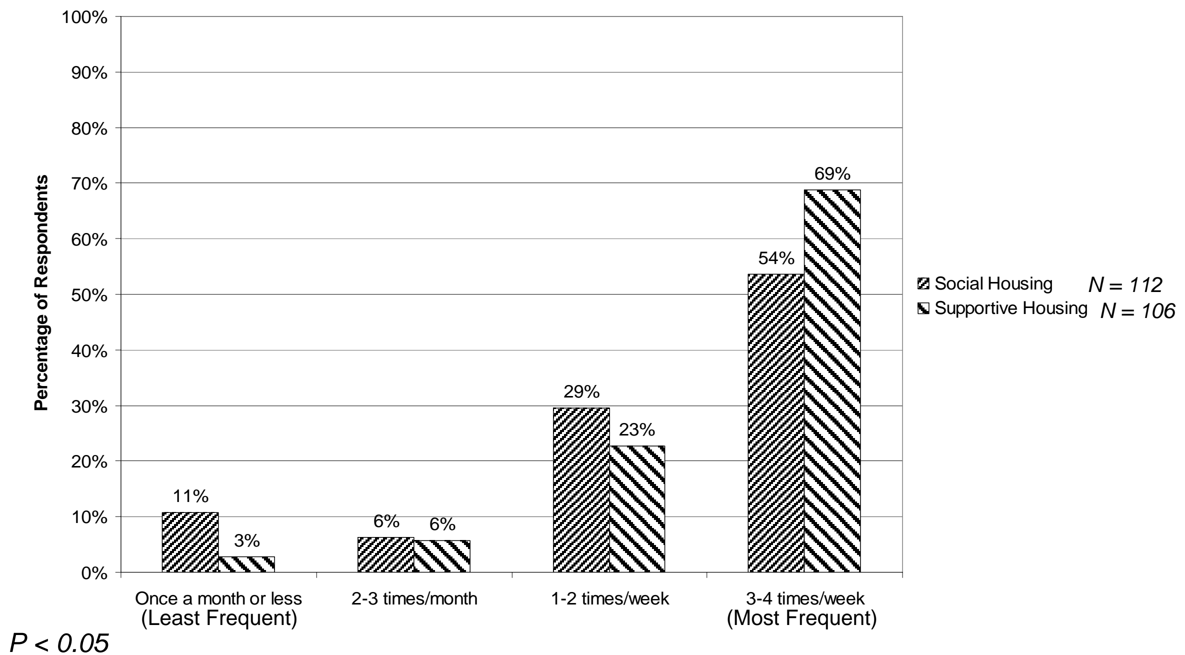
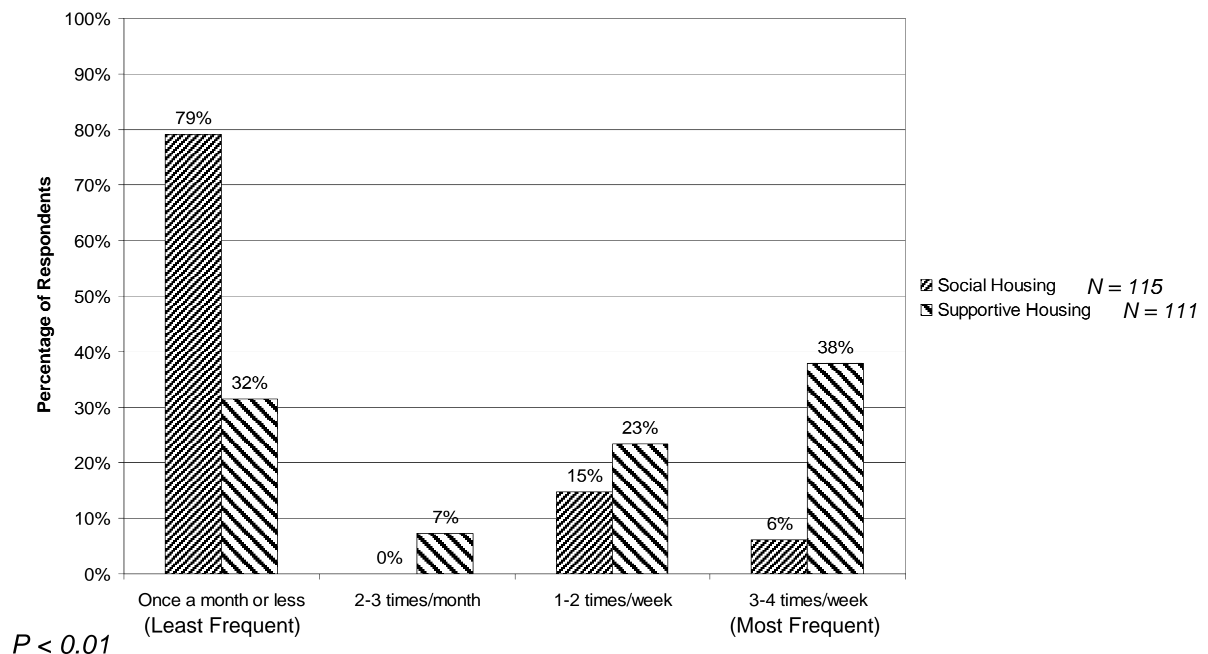


Figure 18 shows that the higher levels of social contact for seniors in supportive housing is accounted for by a greater frequency of visits by community agency personnel, including PSWs, intensive case managers, and community agency volunteers. It is interesting to note that few respondents in either building type are socially isolated, perhaps revealing an advantage of living in a dense apartment complex. Nonetheless, 11% of seniors in social housing but only 3% in supportive housing said that they received visits “once a month or less.”

Fig. 18 – Social contact with community service agency staff



Social connectedness and ethnoracial challenges

Are linguistic or cultural differences social stressors that contribute to social isolation? Seniors were asked:

- “Are there some programs or activities that you don’t participate in now? Why not?”
- “What activities do you do? How often do you do these activities?”

As is the case elsewhere in the literature (Sadavoy et al., 2004), the seniors in our sample with English language difficulties or cultural differences express greater isolation and less willingness to participate in social activities and to join in social events. This is especially true for those living in social housing.

- “I feel alien here, strange. They play bingo but I’ve never played bingo in my country so I and my friends don’t do it here. And it’s very hard because of the language barrier. The language barrier also makes it hard to meet people and make friends in

the building." [translated from Spanish]

- "I like social gatherings and being around people. But I have to feel comfortable with them to share with them. English is a problem." [translated from Spanish]

- "What causes me the most stress in my everyday life is that I don't speak English, and I can't talk to others. I am dependent on neighbours that speak English. Or my children, but they are not always available. It's important to have staff members who can speak my language." [translated from Spanish]

- "I would like to participate in the meetings downstairs but can't because I don't speak English. I would like to volunteer but I can't because I don't speak the language." [translated from Spanish]

In social housing, seniors report that the presence of others who share their language and culture in the building or in the neighbourhood helps reduce isolation and enhance independence.

- "It's easy to make friends in the building. With other Chinese, I say 'hello', and if we get along, we chat for a bit and for those I've known for awhile, I'll invite them to my apartment to visit."

In the study of Chinese and Caribbean seniors in Toronto Community Housing Corporation buildings cited above, we noted that Chinese seniors as compared to Caribbean seniors participated in a broader range of social programs and activities despite greater barriers in English language fluency and literacy. The study concluded that a concentration of Chinese-speaking seniors in the same building helped bridge language gaps and foster social connections. As well, the location of social housing buildings near a "Chinatown" enabled seniors to shop, bank, and see health professionals in their own language and encouraged social connectedness (Lum & Springer, 2004a).

Whereas social housing buildings may or may not facilitate social connectedness depending on building location and the characteristics of residents, supportive housing actively nurtures social connectedness. This happens in a number of ways. Intensive case managers ensure that there is a broad range of culturally appropriate programs and services and then encourage seniors to participate. They coordinate other support staff, PSWs and volunteers who speak the client's language and can offer a ready communication line. The regular "popping in" by PSWs and the checking by volunteers also guards against social isolation.

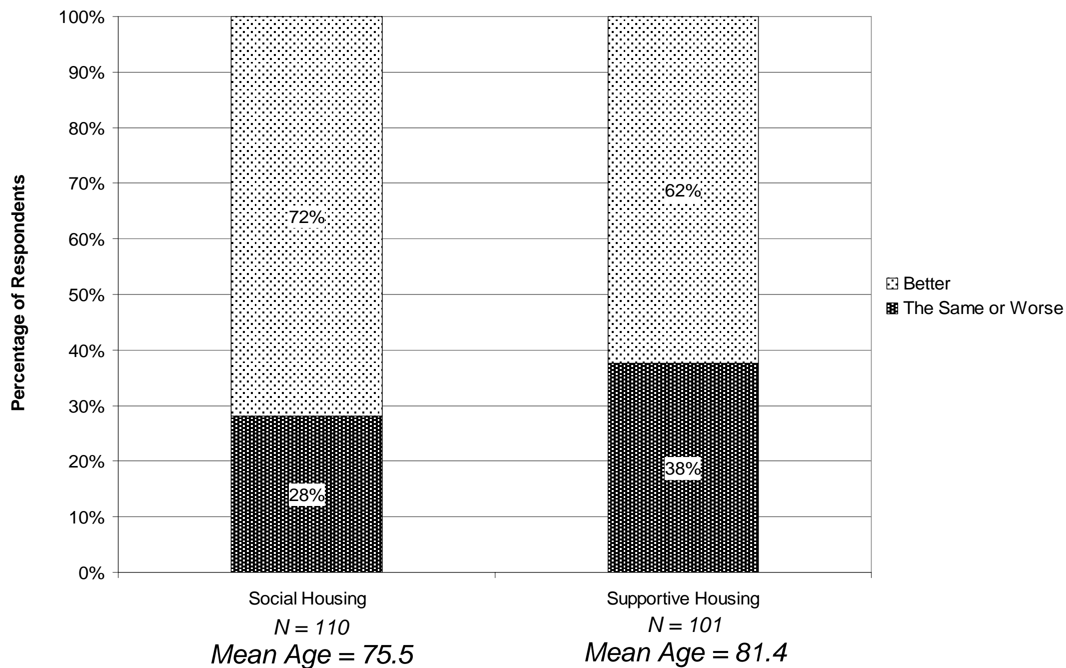
4.3.2 Physical health status

To examine the impact of support services on health, respondents were asked, "Comparing your health with other people your age, how do you rate yourself: better, the same or worse?"

Studies have shown that self-rated health is an important predictor of mortality, morbidity, and nursing home admission among older people (Mossey & Shapiro, 1982; Steinbach, 1992). Although self-ratings of health is not synonymous with medical diagnoses, there is some evidence to suggest a high relationship between health self-ratings and more objective health ratings based on medical evaluations (Statistics Canada, 1999b; Maddox & Douglass, 1973). In our study however, seniors living in both social and supportive housing report "better" health than their peers (Figure 19), despite reporting a number of high-risk physical ailments (Figure 10).

Of seniors living in social housing, 72% report that their health is "better off" than their peers while 62% of those living in supportive housing did so. This difference is not statistically significant despite the much older population in supportive housing.

Fig. 19 – Self-reported health



"They check on me everyday"
Seniors in supportive housing make clear that the constant "checking" keeps them safe and healthy. Because "there is always someone around," responses to strokes, heart attacks, falls or other health emergencies are "very quick." They are convinced that speedy responses are vital for avoiding long-term negative consequences including hospitalization and placement in long-term care facilities.

The following comments are from seniors living in supportive housing buildings.

- "Well like I said, when I had a broken arm, they kept knocking. So that's good to see, checking on people."

- "When I was home from the hospital the girls popped their head in the door to see if there was anything I needed...they're just such a nice bunch of girls, you know, they'll come in and say 'Are you sure you're alright? Is there something we can do?' It's great."

- "Workers [PSWs and volunteers] phone every day and call to see if I need anything, I tell them I'm fine. If I don't answer the phone, they'll come up. I feel like a kid again, I can't go anywhere without telling them. It's nice cause if I fell down, I couldn't reach the phone."

- "I took a low blood sugar attack in the tearoom at lunch one day. And if you ever see anybody with a low sugar attack, it's (makes a fist and punches hand hard)…the person's out of this world. And they put me in a wheel chair and brought me up to my apartment, called the paramedics, and they stayed with me. I would have had to go to the hospital if they hadn't been willing to come check on me every so often…it was super. I know the help's there if I ever need it."

- "They were um…they were at my door when I took the stroke. The girls were knocking to see if I needed any help. And I was at the door and I collapsed at the door. So they called an ambulance right away, and I uh…things worked very well because they got me there fast."

- "They [PSW] used to put my eye drops in. I don't need eye drops anymore, so it's okay. But they still check up on me. I'm okay. If I'm still alive, that's what they do. People can get hurt. So they always check up, so that's good."

Seniors in social housing have fewer options. Those connected with community service agencies through outreach programs also mention having emergency response systems, and visits from case managers. Their monitoring is not as systematic as in supportive housing buildings where there is 24-hour coverage, usually by staff PSWs.

The following are quotes from social housing residents.

- “If I needed quick help, like if I fell, I wouldn’t get it. Once I fell and I couldn't get up. I had to grab my body over to the chair and table to pull myself onto the chair. It took a long time.”

- "I don't have anyone that checks on me but if my neighbours don't see my car, they will knock on my door.“

- “Only if it's severe, I'd call my friends, because we're all getting older my dear. I'd be able to talk to them to see if they may know what it [illness] is. Places like this, if one of us gets a cold, you can be sure ten of us are gonna get a cold. If they know that I'm not being active they'll know something's wrong.”

- “My husband died in 1997 and my health was not good. Sometimes on the way to the bathroom I would blackout and there’s nobody to help me.”

- “My blood pressure went sky high two weeks ago. I have to go back to my doctor. My pharmacist took my blood pressure and it was so high, so she said don't go home, go straight to your doctor. But I came home. I've been monitoring it myself.”

One possible potential risk is not eating nutritious meals. A surprising number of social housing residents confessed that they are sometimes “too tired,” or “have no energy to cook and clean after themselves” and so, “skip meals” or “open a can,” although they recognize “it's bad not to get a proper and nutritious meal”.

- “We’ll eat whatever is simple and available...milk and bread for breakfast...oatmeal for lunch...noodles, biscuits. Whatever is available, basically.”

- “Maybe I’ll cook two or three times a week. I might just open up a can or something.”

- “I skip meals when I’m sick. I was very sick for 6 weeks. I have…what do you call it? Very high blood pressure. I woke up in the morning with vertigo, it's awful. Since then I've been very sick. That's why I skip the meals.”

In supportive housing, the presence of PSWs minimizes this risk.

- “I can’t prepare my meals. The girl (PSW) you saw does it. She won’t let me skip meals at all.”

- “They won’t let me use the stove. Because after the stroke um there was uh…this

hand doesn't work too well. They were afraid of me burning myself, or burning down the building. So, girls do my breakfast, like I don't boil the kettle or anything like that, because I have got strips in my hands. And so, I usually have a soup and a sandwich, and they do my soup at noon. And then I have a frozen dinner from meals on wheels, and they just zap it in the microwave. I can't skip meals. They're [PSWs] very strict."

Finally, we should add a word about medication checking. Seniors in supportive housing say they appreciate the active checking by PSWs to make sure that medications are taken correctly. People in social housing, particularly those with language issues, must look for senior-friendly pharmacists with appropriate language skills to explain instructions.

- "I ask the pharmacist to write down the instructions in Chinese so that I won't forget them. I can't read English instructions." [translated from Cantonese]

4.3.3 Mental well-being

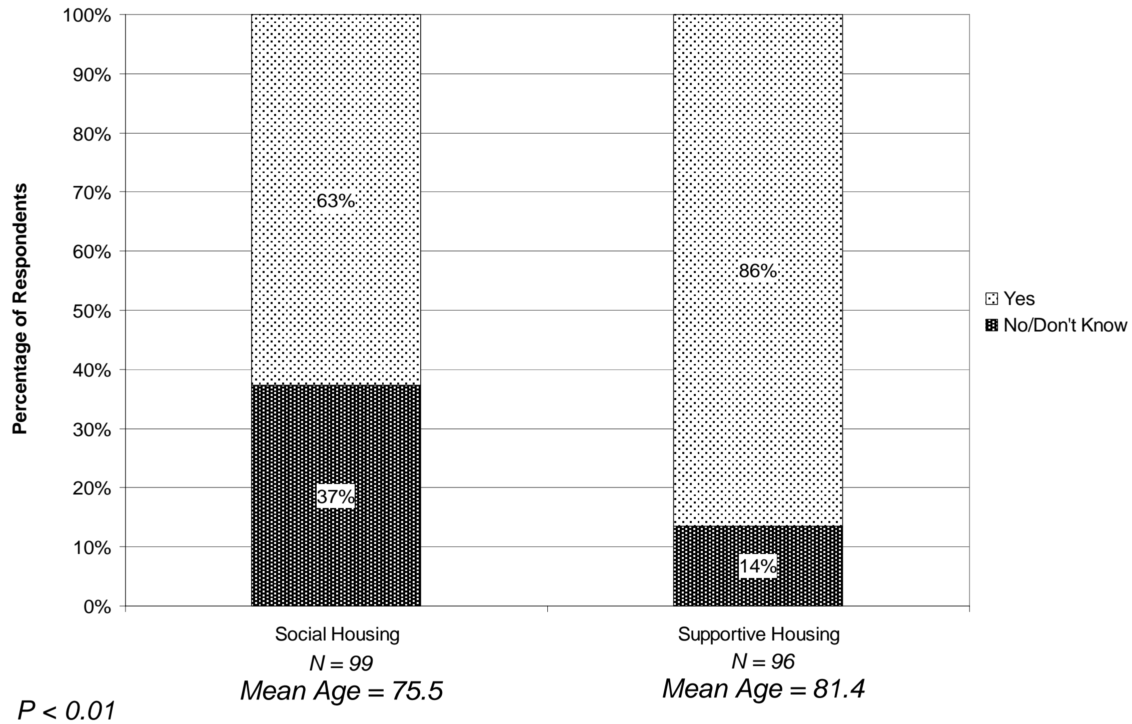
Given their personal characteristics, seniors in both public housing and supportive housing are at relatively high risk for poor mental health. Yet both tend to have positive ratings in these areas, with supportive housing seniors doing better in spite of higher risks.

This study uses non-clinical signposts for mental health, consistent with the frameworks advocated by the Canadian Mental Health Association, Health Canada, and the VON Canada Health Model (Parent & Anderson, 2002; Health Canada, 1998; VON Canada, 1998). Advisory committee members impressed upon us that an important indicator of mental health is the peace of mind people have about their future. For seniors, uncertainty about getting help as they become less able to do things for themselves is a source of much anxiety. Confidence about getting help when needed, including help that is culturally and linguistically appropriate, translates into feeling at ease, calm, safe and secure --key contributors to mental well-being.

Seniors were asked, "Do you have peace of mind about getting support services in your home if you need them in the future: yes, no or don't know?"

In social housing, 63% of seniors say they have peace of mind about getting help when needed. In supportive housing, 86% of seniors say they are confident that they will get help in the future (Figure 20). The difference is statistically significant.

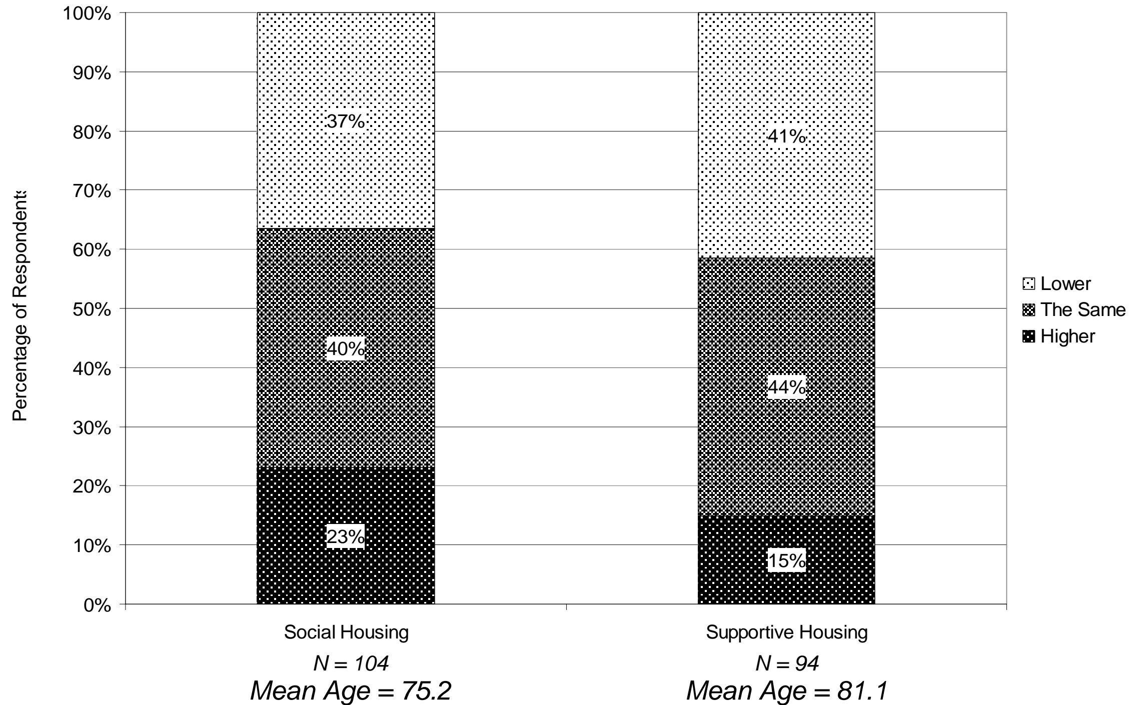
Fig. 20 – “Do you have peace of mind about getting support services in your home if you need them in the future?”



In another question gauging mental well-being, seniors rated their stress levels in comparison to their friends. They were asked, “In comparison to my friends, I would rate my stress level as: lower, the same or higher?”

Figure 21 shows that despite a higher mean age, 41% of seniors in supportive housing and 37% in social housing rate their stress level lower than their friends. In our view, these data again reflect the degree of calm experienced by an older population in supportive housing concerning their future.

Fig. 21 – "In comparison to my friends, I would rate my stress level as:"



P > 0.1

Our research corroborates the results of other studies linking mental health and home care. Care in the client's home is said to promote mental health by fostering independence, self-sufficiency and self-reliance and provides opportunities for social connections (Parent et al., 2002). According to Health Canada's principles of the national framework on aging (1998), among the most important contributors to mental health are feelings of "being appreciated;" "being in control of one's life," "doing as much as possible for oneself and making own choices;" "having access to a support system, resources and services;" "getting involved and staying active in the community;" and "having a supportive living environment and physical security." Seniors insist that getting help with housework contributes to such positive feelings.

"Getting help to keep my place neat and tidy" goes far beyond instrumental outcomes, and is as vital for dignity and well-being as bathing and good grooming. Seniors talk about the critical connections between getting supports, "staying involved and active" and "feeling good about themselves and others. Having untidy surroundings "is depressing." Even more depressing is not being able to do anything about it.

- "Why is this service most important? Because I feel the house is clean. It's a

psychological feeling.”

- “I think housekeeping is very important for people who aren't well. There's nothing more depressing than a place needing vacuuming, dusting, cleaning, and you can't get up and clean it.”

As indicated in the section on social connectedness, living in supportive housing affords greater opportunities for social interaction that in turn foster mental well-being. PSWs’ “popping in” translates into being surrounded by people who “care.” One person admitted that she likes someone coming in and helping her with her medicine mainly because of the social contact. “I’m not that outgoing and I get lonely…having contact… I like that.” As a result, seniors express not feeling “lonely,” having people to talk to,” and “being reassured.”

- “What’s most important to me? The kind, caring attitude of the people who work here and the people who come and check on you.”
- “It’s comforting. You don't feel lonely.”
- “It’s really important to have someone make my meals, clean up, and to be here. Yeah so I have somebody to talk to. Can't talk to the four walls.”
- "Having the girls drop in just to check is reassuring. If I need help, I know they'd be here. Mostly it's the reassurance I get from having them. And my family… it makes a lot of difference to them.”
- "Yeah, even if they don't come in to do something, they're checking on me, and will keep doing it. The girls dropping in, makes me feel safe."
- “I feel confident about getting help because they are right here in the building.”
- “It's like a heaven here so I feel content”
- “I like the general friendliness and knowing someone’s around.”

In contrast to seniors in supportive housing, and despite reporting similar levels of stress, seniors in social housing convey more loneliness and less certainty and confidence about the future, and a less positive mental attitude. Furthermore, visits from friends, while appreciated, tend to be occasional.

- “What causes me a lot of stress? I know I am responsible for myself and can't depend on anyone ... everyone is always busy.”

- “I couldn't cook after I had the operation and I felt awful about myself, except that my neighbours helped me out.”

- “Sometimes I feel like I would like someone to come visit on a friendly basis, but I haven't had anyone. Sometimes your own company is great and other times you feel very lonely. I feel loneliness is a thing that can make you sick too. Especially if you can't get out.”

- “Sometimes I'm not feeling well. Sometimes she [neighbour] comes and makes coffee for me in the morning and then she will sit down and talk with me. She is a nice lady.”

Seniors say they feel good about themselves when they have things to do, are useful and have social contact with people. In supportive housing, there is always “something to do,” “opportunities to do something useful,” and little occasion for boredom. Seniors in social housing are more likely to report “not having enough to do.”

- “What causes me stress? Not having enough to do. I use to be very active but now my eyes are preventing me from reading and doing all sorts of things. I used to walk a lot and now I cannot do those things.”

- “I used to volunteer. I was helping with the knitting club but because of my hands and shoulder pain, I don't do it anymore.”

- “I haven't been to church in a long time. I never go out too much anymore. I used to go play bingo up at the club, but with this incontinence problem, where am I going to go? You think, ‘What if you do something?’ Sometimes you don't mean to, but you're bowels will just go. I want to go out. Before this catheter, I had a backpack that I'd take in case I had an accident, but now I just find it an inconvenience to go out. I wouldn't be able to stay out a couple hours. “

- “Right now since I've been sick, I don't do anything. I'm so depressed. My blood pressure is 210/110. But right now, I read. I love to cook, bake, crochet, and knit. I can’t do those things.”

- “I volunteered before I broke my hip. Like if I went to the store, I would go to the store for other people too. Now I just go downstairs.”

- “I used to go and feed patients at some of the hospitals that had to be fed. I liked to do those things, but I can't anymore. I feel very close to people.”

When home is community

Our qualitative data suggest that the sheer number and diversity of activities in supportive housing facilitates the conditions essential for mental well-being. Activities such as bingo, bake sales, tea parties, and volunteer opportunities bring seniors together, keep them socially active, provide social stimulation, and "get them out of the apartment." Many also say they have been encouraged by PSWs or case managers to participate. In social housing, the range of activity is more limited and the "prompting" by case managers does not take place very often.

- "I volunteer. We serve dinners to seniors, and it's every Thursday nights. I help out with the bingo here. I enjoy these activities. For one, it's social, and it's helping people. I enjoy that. I like working with people. And it's better than sitting around."

- "Meal programs are really important to me. I go to them just so I can socialize. Although companionship is technically not a service, I feel it is a service to me because I get a chance to talk with others. Just from going down for meals, I've made friends with some of the people here and now we go out for coffee regularly and go to garage sales, believe it or not, every Saturday."

- "I'm on a few committees, and I'm on the board and I do volunteer work around here. Actually I'm available for whatever they ask me to do in the building. I find it very stimulating work."

- "Bingo on Saturday, cards Monday and Wednesday, exercise class on Thursday, sing song every Sunday night with the Sri Lankans. I volunteer as a friendly visitor. I like these activities. I get to be with people."

- "I love movies, I love social dining, and I love exercising. I guess I like the companionship. I feel we all need to have something to do."

- "Monday I go to cribbage, Tuesday I play bingo, Wednesday I go to Euchre, Thursday I go to Euchre, Friday I go to Bingo again, Saturday I go to Euchre again, and Sunday I go to Church. So I'm busy. I try to do as much as I can, for as long as I can, because they'll be a time when I won't be able to do it. Then I'll say 'I've done it, that's it.' And I like the people that go to them. We have a lot of laughs, we enjoy each others company."

Social activities in social housing tend to be less diverse, not formally organized and often based on the initiative of a handful of tenants. For this reason, some activities tend to be less inclusive, and, in the opinion of some residents, more "clique" driven. In supportive housing, the intervention of PSWs, intensive case managers or activity coordinators can often mediate tensions among cliques. This is especially true for inter-group tensions rooted in language or ethnocultural differences. Such tensions erupt

more commonly in social housing where there are limited resources for staff to intervene than in supportive housing where staff members are on-site to mediate conflicts.

4.3.4 Crisis management – What would you do in an emergency?

An important policy question is whether, and how, community support services moderate the costs of the health care system by reducing or diverting health care needs.

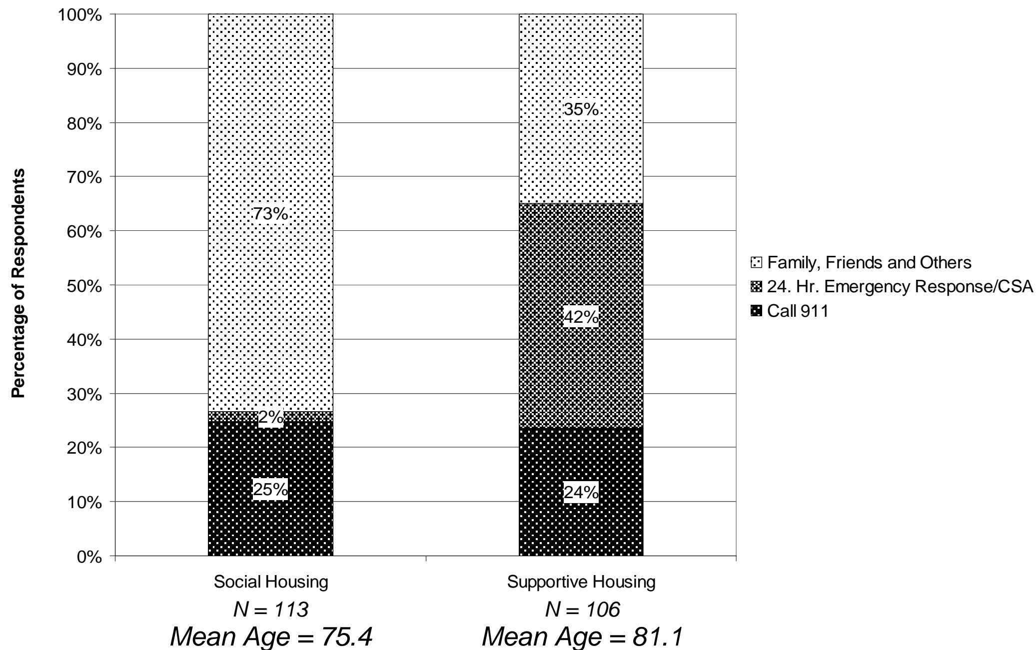
This section suggests that access to relatively inexpensive services such as ongoing daily monitoring and addressing root causes of “crises” before they escalate may avoid the use of more costly emergency services.

Seniors were asked the following questions:

- “If the management office is closed and you’re not feeling well, what do you do?”
- “If a medical emergency occurred at night during the week, what would you do?”

During the day, about 40% of seniors in supportive housing would use their emergency response system that alerts a PSW within the building. In contrast, almost three-quarters of social housing residents would call family or friends or do something else (“other”). About the same number of seniors (about 25%) in both housing settings would call 911 (Figure 22).

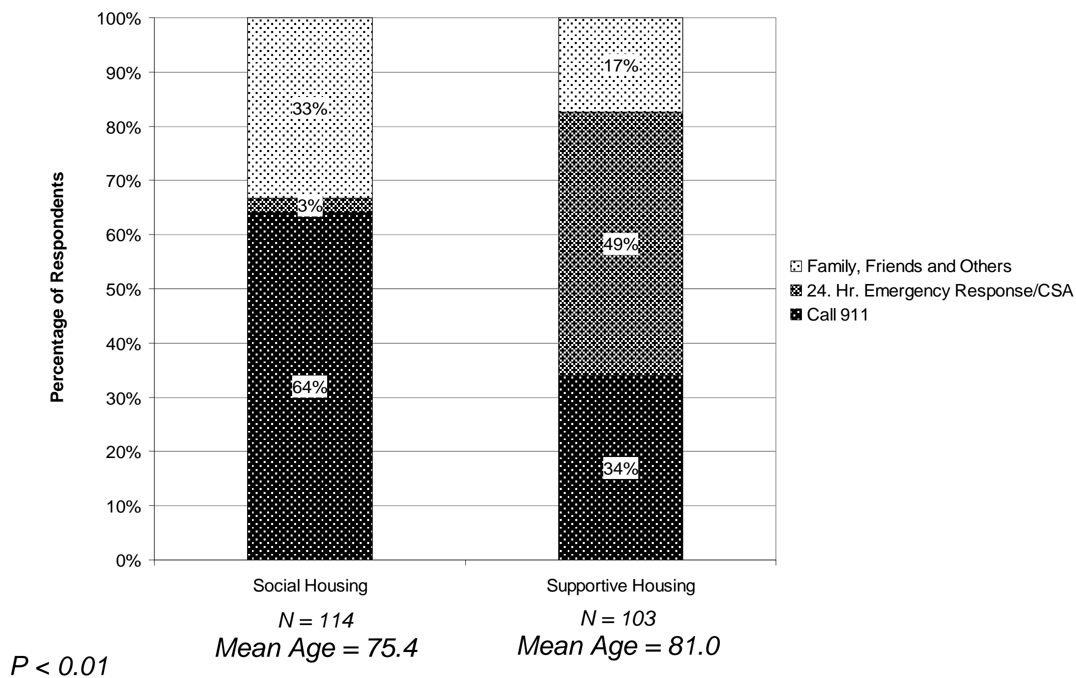
Fig. 22 – Daytime Emergency



P < 0.01

The picture at night is markedly different. Social housing seniors are almost twice as likely (64%) to call 911 in comparison to supportive housing seniors (34%). Supportive housing seniors are more likely to use their emergency response “panic button” which calls on-site staff than emergency services. Approximately 1/3 of seniors living in social housing would call family, friends or “other.” The category “other” includes behaviours that could actually exacerbate medical crises such as “waiting for the pain to go away,” “drinking a big pot of herbs or black coffee,” “taking a teaspoon of salt to help my blood pressure go down.”

Fig. 23 – Night time Emergency



Clearly, language frustrations intensify emergencies. Seniors say they must rely on the availability of family and friends to translate and even hesitate to call 911, fearing language barriers. The level of apprehension appears greater for those living in social than supportive housing where seniors tend to have access to emergency response “panic buttons” and where language supports tend to be in place.

- “I don’t speak English. I worry because sometimes my children are busy and it's hard to get hold of them...There are times when they're just not home, besides they have children of their own.” [translated from Spanish]

“They told me any time I feel bad, I should press the button and not stop until someone gets there. The girls here carry a phone. They’ll know what to do.”

According to our quantitative data, about the same number of seniors in social and supportive housing would first call family and friends in emergencies during the day. However, as the comments below disclose, calling family members may not bring about effective outcomes.

- ”I could call my friends but I wouldn’t call them in the middle of the night.”
- “I wouldn’t call my daughters because they’re in Brampton, and they wouldn’t be able to get here right away.”
- “I’d call my daughter, if she’s available because she works and everything. If she was alone, if her husband was away, I couldn’t call her at 5 in the morning. But what could she do? It’s better to call an ambulance.”
- “My daughter lives in Markham. It’s too far. And my other daughter lives in Brampton, and works night shifts.”
- “I’d call the 24 hour supportive housing number first because of this experience I had. I had an unusual angina attack in the late winter. I phoned my daughter but she was at the Queensway, and it was so long before she got here. When we got down to St. Joe’s, they said it was too long. That’s why if I don’t feel well, I would phone supportive housing, and they would call an ambulance if needed.”
- “Actually when I’m not feeling well I don’t call them [friends and family] because I don’t want to panic them.”
- “I’d press the 24 hour Lifeline button because my friends aren’t too close and they don’t have a car either.”

At night, supportive housing seniors are more likely to use their panic buttons than to call 911 or family and friends. Not only are they “taught” to push the panic button in an emergency, they are confident that PSWs will know what to do, and will call an ambulance if necessary. In fact, many confide that PSWs will get to them faster than a paramedic and ambulance.

- “They taught me - if there are any emergencies, to press the button and someone from downstairs will come and have a look and help me.”
- “The people from downstairs will get here quicker than 911. The staff here is good and close. They will help.”

- "I will first call the lifeline because they come at once and decide whether to call an ambulance."

- "Well they [PSWs] come, and assess the situation and see that I get to the hospital if necessary."

- "The lifeline is reassuring. I did have a tumble a month ago in the middle of the night. I couldn't get up. I didn't get my slipper on properly. And when I got into the bathroom, the sole of it got caught on the floor and it threw me. I was able to bum my way into the bedroom and call supportive housing. They were here in short order. I wasn't hurt, but could have been."

- "Well I wouldn't call family or friends over a sick stomach. I'd call [CSA] and they would decide what to do with me."

In contrast, social housing seniors have few options but to call 911, or find other ways to get help from the formal system.

- "I will first call a cab because you never know where you're going to end up if you call an ambulance. One of the ladies in the building ended up in Brampton because the ambulance has to take you where it's available. But if you go on your own in a taxi, they have to take in emergency. But an ambulance, they ship you off where ever if they don't have the room."

- "911. I would also call the visiting doctor. You know the visiting doctors eh? It's called Doctors Housecall Service Inc. They have visiting doctors. A lot of people call them. The fee is very low. And it goes on your phone bill. The fee is $8 or $9 or at least it was before. Fully covered by OHIP, this is wonderful for seniors."

- "I'd call an ambulance. It's the only thing to do…to go to the hospital. Going to the hospital is the safest place to go. Whenever I don't feel right, I call my doctor -- every 2 months at least."

4.3.5 Summary of outcomes

In examining the impact of supports for seniors, the data presented in this section demonstrate positive outcomes for seniors in both supportive and social housing, with seniors in supportive housing systematically demonstrating even better outcomes despite the fact that they are significantly older and have multiple risks. In comparison to seniors in social housing, seniors in supportive housing had higher levels of social connectedness because of the greater frequency of visits from community agency personnel, reported "better" health status than their peers despite being older, and had

significantly more confidence about getting help in the future, and hence greater “peace of mind.” Importantly also, seniors in supportive housing were more likely to use their emergency response “panic buttons” at night and less likely to call 911 than their younger social housing counterparts. The qualitative and quantitative data suggest that seniors in supportive housing display better outcomes than those in social housing because of the active intervention by intensive case managers.

5.0 Conclusions

In this report we have summarized the findings of a research project which examined the role of community support services in maintaining the independence and well-being of seniors in social and supportive housing settings in Toronto.

The research is noteworthy for two main reasons. First, it was conducted by a groundbreaking partnership of community and university-based researchers at Neighbourhood Link/Senior Link, Ryerson University, and the University of Toronto, in collaboration with Etobicoke Services for Seniors, St. Paul’s L'Amoreaux, and The Toronto Community Housing Corporation. This establishes an important model for future research.

Second, it has accomplished a small but important step toward filling the evidence gap surrounding community support services. Our findings emphasize:

- the important role played by community support services in maintaining the health, well-being, independence and quality of life of seniors.

- that community support services are most effective when integrated and managed around the needs of the individual through intensive case management, and that such management is facilitated in supportive housing as compared to social housing.

- that community support services make important contributions to the sustainability of the health care system as a whole by moderating demand for more costly acute and institutional care, and particularly, by reducing utilization of emergency (911) services. Rather than being viewed as marginal to the health care system, and a last resort for those who have no other option, our findings suggest that community support services meet the needs of individuals who would otherwise be hospitalized or institutionalized at considerably greater cost.

These findings suggest an important consideration for policy-makers at they move to achieve greater integration and coordination in Ontario’s health care system, and attempt to control costs

We elaborate these points below.

5.1 Supporting at-risk seniors at home or in a home

At-risk seniors are avoiding institutionalization. Seniors, who could be in long-term care facilities, are living with minimal, low-cost, basic supports in the community.

The seniors in this study displayed multiple risks for loss of independence and institutionalization. They are mostly women who are on average older than the senior population in Toronto, have low incomes which on average, are below the poverty line, and most live alone. Many have serious health problems including combinations of osteoporosis, high blood pressure, heart disease, cancer and diabetes. A significant number are ethnoracial minorities, and many experience linguistic and cultural barriers in accessing services. Yet, they continue to live independently outside of institutions, have frequent and vibrant social connections, report physical health status comparable to their peers, and mental health status better than their peers.

Particularly astonishing are the 40% of seniors in supportive housing who are among the oldest old (over 85 years). In the judgement of community service agency case managers who work directly with Community Care Access Centres for facility placement, all of the seniors in our supportive housing sample meet current criteria for placement in long-term care facilities. Although these seniors are on the cusp of losing their independence, they maintain their independence and well-being in the community.

5.2 Low cost, integrated services are key under intensive case management

Low cost, basic supports are especially effective when they are coordinated and integrated around the needs of the individual.

A key finding is that the most important factor in enabling seniors to stay in community is the option to access coordinated and integrated low cost basic services such as laundry, vacuuming, cleaning the bathroom and kitchen and grocery shopping (ADL). While we recognize that some seniors may require higher levels of care, the seniors in this sample for the most part did not receive assistance with their personal activities of daily living (PADL). However, seniors made clear that without ADL help, many would not be able to remain in their homes.

A key difference between supportive housing and social housing is that seniors in supportive housing access supports under intensive case management whereas in

social housing, seniors may have to access and manage one or more community support services themselves.

In supportive housing, seniors are paired with an intensive case manager. Intensive case managers play a critical role in ensuring that the services clients receive are appropriate (including linguistically and culturally appropriate), coordinated, predictable, integrated, and reliable. They assess client needs, organize appropriate services, and monitor outcomes on a continuous basis. They “prompt, guide and direct” seniors to participate in social activities. Even seniors who claim to be reclusive admit that their intensive case managers “encourage” them to take part in social and recreational activities. Seniors know their intensive case managers by name and say they are comfortable about contacting them when needs arise. Thus, barriers to accessing needed services linked to culture and language, for example, are effectively overcome in supportive housing since intensive case managers access and manage services on an ongoing basis around the needs of the senior.

Equally important is the role of case managers in providing ongoing assessment and monitoring. The incentive is to ensure that seniors receive what is necessary to maintain functional status, but not more than is necessary, since resources are always constrained. Thus, while the political fear is that people will maximize use and costs, thus creating new cost pressures, client-centred care may mean providing more services, in some cases, but fewer services in other cases, depending on the changing needs of seniors. The intensive case manager’s ultimate goal is to support seniors’ well-being while encouraging as much independence as possible. The presence of intensive case managers reduces the tendency for seniors to “stockpile” services since they can be confident about getting services when they are needed. Throughout the study, many seniors talked about how they used certain services when they were recovering from an illness or a stroke, but now no longer needed them since they are “better and can do things for themselves.” This clearly builds upon the sentiment that we heard again and again: seniors do not wish to become dependent on family or community services, and prefer to do as much as they can for themselves, and for others.

This intensive case management model (currently funded by the MOHLTC under Crisis Intervention and Assistance) is to be distinguished from other models that may focus more on managing services and costs, rather than needs. The definition of case management in supportive housing entails:

- a holistic approach to clients’ well-being by considering many of the broad determinants of health;
- client-focus;
- intervention and “prompting” to avoid crises and promote wellness;
- encouraging seniors and their family members to take responsibility for their own well-being;

- providing ongoing client assessment;
- integrating and coordinating services along a continuum of care.

Seniors living in social housing may access and receive one or more community support service but do not have automatic access to intensive case management and hence, do not have the benefit of an integrated package of services unless they are capable of accessing and managing one themselves. Of course, seniors who are most at risk because of illness, poverty, and so on, are also least likely to be able to manage their own services when they are most needed. A senior would have to request services from a community service agency or be referred by a concerned neighbour or another organization in order to access community support services. As our study shows, the very task of accessing services presumes some working knowledge about how to navigate the community support system. This is frequently not the case, particularly for ethnoracial minority seniors who do not know about the availability of services, or have linguistic or cultural barriers. Thus, individuals outside of supportive housing with similar needs might or might not receive needed services, depending on their ability to self-assess their needs, and then locate and access services. Even then, they would do so without the coordinating function of intensive case management.

5.3 Does more community support mean less family support?

Community support services complement and do not replace supports provided by family and friends.

Our findings also address the political apprehension that people will maximize use if given access to services, instead of prevailing on family members. As the qualitative data show, seniors, whether in supportive or social housing, say they want to use as few services as possible, and only when necessary. Furthermore, when they need assistance, they get help from a variety of sources -- from family, friends, and senior-friendly pharmacies, banks, health providers and grocery stores. In contrast to social housing residents, supportive housing seniors can augment the support they receive from family and friends with predictable and integrated community support services. Seniors will work along side PSWs –dusting, cleaning the sink etc. while PSWs do the tasks seniors cannot do. In supportive housing, an important component of the ongoing assessment process by intensive case managers is to encourage seniors and their family to take as active a role as possible. The point is to encourage and support the highest level of functional capacity and independence possible, not to promote dependence, which benefits neither the senior nor the agency.

Early on, we alluded to the political debate between publicly supported services and the voluntary supports provided by family and friends. One side of the debate insists that the voluntary help provided by family, friends, neighbours (community capacity) is

undermined by state-funded support services. Thus, fewer government-funded services will theoretically push family and friends to take on greater responsibilities to support elderly relatives. Voluntarism will presumably fill any support gaps left by the state. However, it is not at all clear from our interviews that family members have any additional capacity to take up the slack if publicly funded community-based services are further withdrawn. When asked what they would do if services were not available, most seniors responded that they would "struggle," or "wouldn't know what to do" possibly putting themselves at greater risk of hospitalization or institutionalization. In addition, the data show that seniors living in social housing and in supportive housing have similar frequency of contact with family and friends. The family and friends of seniors living in supportive housing have not "withdrawn" their support as seniors are able to access a case managed package of services. Family and friends continue to be an active part of seniors' lives.

In Toronto, it has been observed by other researchers that provincial downloading and the subsequent erosion of public services are overloading already compromised social support networks (i.e., family, friends, religious communities etc.). In their 2002 report, Clutterbuck and Howarth noted that there have been significant cuts to public health, social housing, public transportation, libraries, recreation programs, childcare and family resource centres, language and settlement services for new immigrants and grants to community service agencies. Public services and welfare state programs which aim to correct the root causes of illness and dependency such as poor nutrition, poor housing, unsafe work, lack of work, lack of education, poverty, economic and social inequality, and racism have sustained cuts. When public governments offload, families must grapple with effects. Consistent with this, the seniors in our study report that their families are stretched "to the limit" and are unable to do more.

Particularly under such conditions, supportive housing provides a safety net and contributes to a sense of security about remaining functionally independent. Our data suggest that the regular, predictable and integrated nature of supportive housing services, rather than promoting dependency, fosters independence, autonomy and well-being. We suggest that this goes a long way toward explaining the stunning difference in the age profile between seniors in supportive and social housing. The oldest old account for 40% of the senior population in supportive housing but only 9% of the senior population in social housing.

5.4 Moderating the demand for more costly acute and institutional care

Community support services reduce the reliance on formal emergency services and moderate the demand more costly hospital or nursing home care.

The quantitative and qualitative data presented here reveal a number of ways in which community support services moderate demand for more costly acute and institutional care.

First, the research findings indicate significant differences between supportive and social housing seniors in their use of formal emergency services, particularly at night. The intensive case management model of supportive housing enables the oldest old with relatively high health risks to live independently with decreased reliance on 911 than seniors in social housing. Older seniors living in supportive housing are confident that pressing the emergency response “panic button” which calls on-site staff will bring help faster than 911.

Second, ongoing risk assessments of clients living in supportive housing allow for preventive strategies that can anticipate, delay or avert potentially serious illnesses, accidents, or mental health problems. When case managers interact with PSWs, or when PSWs “pop in” to provide services, they are integrating homemaking with a cost effective way of monitoring changing needs. The constant monitoring during the course of providing care reduces potentially costly problems. For example, “keeping an eye” on an unsteady elderly woman with osteoporosis may prevent a fall that can result in a protracted hospital stay.

The level of integration between homemaking, personal care and ongoing risk assessment is not possible in social housing where there are fewer and less diverse services and programs available, and where a close day-to-day working relationship between PSWs and intensive case managers does not exist.

Third, if emergency personnel are called to attend to a senior living in supportive housing, the use of health system resources may be very different from seniors living in social housing. Here is an example. Paramedics were called to attend to a diabetic senior who fainted. They determined that the senior needed to stabilize her blood-sugar levels. In this situation, the person was not taken to hospital because a PSW was present to monitor her condition and blood sugar levels. Paramedics attending to the same senior living in social housing would likely have no choice but to transport her by ambulance to the emergency room, further burdening the formal emergency system (Hall, 2005; Talaga, 2005; Carey, 2005). In contrast to seniors in social housing, seniors in supportive housing have access to additional supports that may effectively divert them from emergency services, hospital waiting rooms, and medical beds, thereby saving costs to the system.

Finally, our study shows that with low-cost, basic supports such as vacuuming, laundry, cleaning and grocery-shopping seniors are able to remain independent. Ministry of Health and Long-Term Care data confirm that supportive housing is a cost-effective alternative to institutional care. The current regional average annual cost per client paid

for by the Ministry of Health for supportive housing services in Toronto is $6984.27/year (Ministry of Health and Long-Term Care, 2005). This figure can be compared with an annual cost to government for nursing and personal care in a long-term care facility of $24,553.55/year (Ontario Association of Non-Profit Homes and Services for Seniors, 2005). In effect, the personal care in supportive housing is 28% of the cost of the nursing and personal care in a long-term care facility. Other costs that are more difficult to compare, such as the cost of rent/accommodation, programs, other services and food, are not included in this financial analysis as they vary widely and there is no consensus on a method of comparing the costs of services provided by long-term care facilities with the cost of those provided by community service agencies.

5.5 Supportive housing as a model of aging in place

This report shows that both social and supportive housing do a good job at maintaining seniors in their own homes. The elements of affordability, safety and privacy provide viable basic housing options for low-income seniors. Furthermore, the sites selected for this study are located in diverse and lively communities, offering important social opportunities for seniors who may otherwise become isolated.

However, our results suggest that supportive housing appears to facilitate better outcomes than social housing. Seniors in supportive housing, including those with cultural and linguistic barriers commented on the importance of the range and choice of supports, including:

- predictable and reliable assistance;
- access to diverse social and recreational activities;
- organized volunteer opportunities and the “chance to give back to others;” and,
- access to a range of community support services when needed (security checks, transportation and escort, etc.).

We are suggesting that these essential elements are brought together through the intensive case management model present in supportive housing.

Supportive housing, as an effective model of care for seniors, is more than simply “the 24-hour availability of personal care and homemaking services,” as currently defined by the Ontario Ministry of Health and Long-Term Care, or any of the individual support services described above. Supportive housing includes an integrated support system that continually flexes and responds to changes in clients’ health status and service needs. These service “threads” cannot be disentangled. They come together synergistically to form a “whole” service package that enable high-risk seniors who are among the oldest old to live independently.

5.6 At a policy crossroad

Despite this, and despite the wishes of seniors to stay out of institutions, current policy makers face two policy options.

The first option is to view community support services, and supportive housing, as residual to the health care system and as a source of add-on costs. In this view, such services respond to “wants” rather than “needs,” and should really be left to families and communities to do what they can on a voluntary basis; the state’s role is limited, and should remain so.

The alternative option, the one supported by this study, sees community supports as a crucial element of the health care system, and an alternative to more costly care in hospitals and long-term care facilities. It may seem ludicrous to argue that services such as vacuuming and doing laundry should be treated as universal entitlements similar to medically necessary hospital and doctor services under Medicare. In this study, we have seen that in supportive housing, under intensive case management, these services are relatively inexpensive elements of an integrated package of care, which clearly has the ability to moderate demands on an already stretched health care system. As noted above, the Ministry of Health and Long-Term Care confirms that the cost of maintaining seniors in supportive housing is about one-third the cost of maintaining them in long-term care facilities. Clearly, the seniors in our supportive housing sample, while continuing to live in the community, could have been placed in long-term care facilities. Our data suggest that supportive housing substitutes for long-term care facility placement and it reduces demand for emergency services. Most importantly, supportive housing supports independence and quality of life that seniors want. The data reveal a “win-win” situation where supportive housing makes sense for seniors and the health system.

Of course, a complicating factor is the current over-supply of long-term care beds in Ontario. As is well known, the former Progressive Conservative government committed to funding 20,000 new long-term care beds, even though the evidence suggested that 7,600 beds would have been adequate (Coyte et al., 2002). While it has been clear for decades that Ontario would face increasing demand for long-term care due to an aging population, there was nothing to suggest that such care must be provided in institutional settings. Indeed, the prevailing wisdom had been that rates of institutionalization in the province were inordinately high, and that the goal should be to maintain a greater proportion of seniors in their homes and communities through the introduction of enhanced community-based support services (Baranek, Deber & Williams, 2004). The Progressive Conservative effectively turned this wisdom on its ear, and in the process, committed future governments, and seniors, to paying the cost. In May 2004, the current Liberal government of Ontario, faced with media stories of horrifying conditions in some long-term care facilities, added $531 million to the facilities pot as 4,000 beds came on stream. In February 2005, it added another $29.2 million (Lightman, 2005).

Thus, current options for expanding community-based, aging in place residential alternatives (Spindel, 2004) face the very real political problem of competing with rising facilities costs whether or not current bed levels can be justified.

Clearly, there is no pat and painless solution to this political conundrum. In the short term, it may be that government will have to bear the costs of the surplus of long-term care beds while committing to “re-balance” care toward community through incremental adjustments. In this connection, our data suggest such a commitment by forward-looking policy-makers will also be an investment in the health of the health care system since, particularly in supportive housing, community support services offer the prospect of *lower system costs with better outcomes for seniors*. Investment in supportive housing and a re-balancing of care away from institutional and toward community care promises to reduce costs by over two-thirds over the long term (i.e., when comparing the cost of personal care in supportive housing and long-term care facilities).

Our policy choices must keep pace with an aging population that is more diverse, healthier, more politically astute and vocal than past generations. Canada’s oldest old (aged 85 and over) will increase rapidly from a little over 400,000 Canadians in 2000 to almost 2 million by 2051. Many of these seniors will be women who live alone and have little, if any capacity to absorb higher living expenses. Furthermore, with Canada’s changing immigration patterns, increasing numbers of seniors will belong to groups that require linguistically and culturally sensitive services and programs. As immigrants age, the diversity of seniors will also likely also rise.

The compelling narratives in this study point overwhelmingly to one overall conclusion. We need to do more of what seniors say works. Like the seniors in our study, many of us also do not wish to live out our lives in institutions.

6.0 Balancing care for the oldest old - next steps and recommendations

1. Build an evidence base into the costs and outcomes of community support services.
A continuing evidence gap means that ideology and opinions rather than data will be the basis for policy decisions. Making informed decisions that provide choices and optimal outcomes for seniors and for the health system is crucial as health system transformation takes place.

2. Establish new funding methods for the community sector that are consistent with the logic of a health system that is moving towards integration and coordination.
The results presented here demonstrate the clear need to move away from the "line-by-line" funding mentality for the community sector.

First, line-by-line funding is cumbersome and costly to administer, both from an agency perspective, and from the point of view of government; this diverts resources from care provision to overhead.

Second, line-by-line funding does nothing to encourage service integration. In fact, it may be seen to encourage service duplication without incentives for the substitution of less costly services when appropriate

Third, line-by-line funding makes it almost impossible to estimate the true costs of services to seniors or to link services to outcomes.

From the perspective of clients, line-by-line funding encourages "hoarding" of services as a rational response to anticipating future needs in a climate where seniors are anxious about maintaining their independence. Comments by seniors in this study suggest that when seniors are certain about getting help when needed in the future, they see no point in "stockpiling" services.

Similar reasons led to the end of line-by-line funding for Ontario's hospitals several decades ago. Regional health authorities across Canada are funded through budget envelopes aimed at achieving care integration and a rebalancing of resources toward community-based options. In Ontario, the province's newly established regional LHINs (Local Health Integrated Networks), aim to achieve the greater coordination and integration of care within budget envelopes tied to population needs.

We suggest that governments apply the same logic to community support services and

that they consider funding mechanisms that provide incentives for innovation and accountability.

We believe that global budgets adjusted for client needs could facilitate the work of case managers and give them further incentives to provide the services necessary to encourage and support the highest level of functional capacity and independence possible, and not to promote dependence. Currently, line-by-line funding marginalizes the services that seniors get and treats them as residual rather than essential, and marginalizes community agencies providing the supports rather than including them as integral and critical to the broader health system.

3. Promote intensive case management model of supportive housing as an institutional basis for integrating services and assessing outcomes.
Our data suggest that supportive housing provides a viable, cost-effective option for integrating services, assessing outcomes, and ensuring accountability in the provision of care for the province's growing population of seniors. Judging by the relative risks of seniors in our study, supportive housing is a cost effective alternative to institutionalization, preferable in terms of quality of life and independence even for the oldest old. We especially stress the critical role of intensive case managers in supportive housing in integrating services around needs of client, substituting lower cost services for more expensive institutional supports, and reducing demand on emergency services through ongoing assessments. particularly important as our society ages and becomes more diverse, supportive housing under intensive case management goes a long way toward helping seniors to overcome systemic barriers to access to care posed by sex, living alone, poverty, and cultural and linguistic differences.

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Appendices

Appendix A – Terms of Reference for Advisory Committee

When Home is Community
Advisory Committee

Terms of Reference

The Advisory Committee of the Social Research Project *When Home is Community* plays a key role in assisting the Project to identify issues related to supportive housing and the impact of community-based care for seniors across Toronto.

Advisory Committee members represent the voice of the community and enable the investigators to identify and respond to community based issues, especially as they relate to supportive housing and the impact of community supports. The Committee's role in the project is to inform the committee of community trends, the dynamics of community supports (or lack of community supports), and provide feedback on research directions.

The Advisory Committee will meet on a quarterly basis beginning in the fall of 2003. Meeting locations will rotate amongst key research locations across the City of Toronto. Transportation assistance will be provided when appropriate. Committee members may also have an impact by working on an ad hoc basis on research areas requiring further support. Members will include:

- **Research Project Team Leaders** including the Principal Investigator, Academic (Ryerson), Community Agency Lead (Neighbourhood Link/Senior Link), and the Research Co-Investigator (University of Toronto).
- **1 staff representative** from each of the following agencies: Etobicoke Services for Seniors, Neighbourhood Link/Senior Link, and St. Paul's L'Amoreaux.
- **1 volunteer representative** from each of the following agencies: Etobicoke Services for Seniors, Neighbourhood Link/Senior Link, and St. Paul's L'Amoreaux.
- **1 independent Senior Health Planner** (Toronto District Health Council).
- **Research Associates** from Ryerson University and Neighbourhood Link/Senior Link.

The participation and input of Advisory Committee members is essential to the success of the research project. Members will take a proactive role in identifying community trends and information as it relates to the research. In addition, Advisory Committee members may provide knowledge and community connections that will enrich this project. Thanks must go to all Advisory Committee members and their contributions to the *When Home is Community* project.

Appendix B – Members of Advisory Committee

Research Project Leaders
Janet M. Lum
Simonne Ruff
A. Paul Williams

Etobicoke Services for Seniors
Berl Beal
Dolores Ellerker
Catherine Grenaway
Diane Kubath
Carol Marchetti
Kathy Snow

Neighbourhood Link/Senior Link
Gerrie Burnett
Judith Leon
Berhe Tewolde
Olga Fragis

The Toronto Community Housing Corporation
Barb Kapeluch
Ahmed Samater

Ryerson University
Christa Couturier
Jeremy Danson
Maryam Khan
Casaria Mills
Alvin Ying

St. Paul's L'Amoreaux
Hugh Nelson
Sharon Snitman
Roberta Wong
Zoe Yu

Toronto District Health Council
Cory Ross

Appendix C – Selected Interview Questions

WHEN HOME IS COMMUNITY: A COMPARATIVE STUDY OF SENIORS IN SUPPORTIVE AND SOCIAL HOUSING IN TORONTO

Interview No.______
Building:____________________

PERSONAL CHARACTERISTICS

A1. In what year were you born?
A2. Male/Female?
A3. Do you share your apartment with another person?
A4. What is your monthly rent?
A5. What is your main ancestry or ethnic group?
- White
- Asian
- South Asian
- Black
- Latin American
- Arab
- West Asian
- Aboriginal
- Other

A6. When people speak English, how well do you understand what they are saying?
A7. How well can you understand posters, notes written in English?
A8. Do other seniors do translations for you?
A9. In dealing with problems that come up in your daily living, is it important to have staff members in the building who speak your language?

PERSONAL ACTIVITIES OF DAILY LIVING (PADL)

B1. Do you get help with any of the following: eating, bathing/ showering, dressing, going to the washroom and taking medications.

ACTIVITES OF DAILY LIVING (ADL)

B2. Do you do your own housework (ADL)? Do you receive help with any of the following: doing the laundry; vacuuming; changing bed linen; cleaning bathroom; cleaning kitchen?

B3. If not, who does it? If you receive help with your housework, what does the person help you with? What do you do yourself?
B4. If you didn't get help with housework, what would happen?

CHORES

B5. Do you get help with chores: shopping for groceries; banking; seeing the doctor; filling out forms; paying bills?
B6. If you receive help, who helps you?
B7. What would encourage you to use services in the future that you are not currently using?
B8. Are there services or supports that you feel you need now but don't get?

SOCIAL CONNECTEDNESS

C1. Is there someone who visits you, or who you visit when the weather is nice? How often do you get visits?"

- 3-4 times a week or more
- 1-2 times a week
- 2-3 times a month
- Once a month
- Less than once a month
- Never

C2. Are there some programs or activities that you don't participate in now? Why not?
C3. What activities do you do? How often do you do these activities?

PHYSICAL HEALTH

D1. Comparing your health with other people your age, how do you rate yourself? (better or the same/worse)
D2. Do your have any of the following medical problems?

- Arthritis or rheumatism
- Asthma
- Back problems
- Cholesterol
- Chronic pain
- Dental problems
- Diabetes
- Emphysema
- Foot problems

- High blood pressure
- Liver disease
- Osteoporosis
- Stroke
- Thyroid
- Tumor/cancer
- Ulcer
- Other

MENTAL WELL-BEING

E1. Do you have peace of mind about getting support services in your home if you need them in the future? (yes or no/don't know)
E2. In comparison to my friends, I would rate my stress level as: (lower or the same or higher)

CRISIS MANAGEMENT

F1. If the management office is closed and you're not feeling well, what do you do?
F2. Why would you first call <respondent's answer in E1>.
F3. If a medical emergency occurred at night during the week, what would you do?
F4. Do you feel confident about getting help from someone quickly in medical emergencies? Why?